Risk and responding to self injury: is harm minimisation a step too far?

Patrick Joseph Sullivan

Abstract

Purpose – The purpose of this paper is to consider some of the legal implications of adopting a harm minimisation approach in supporting people who self-injure within inpatient mental health units. It is argued that a focus on risk and the increasing influence of the law and legal styles of thinking often associated with the allocation of blame have produced a more risk adverse clinical environment. As a result health professionals are more likely to err on the side of caution rather than engage in practices that although potentially therapeutic are not without their risks.

Design/methodology/approach – The analysis draws on the clinical, philosophical and legal literature to help understand how harm minimisation may support people who self-injure. It considers some of the complex medico-legal issues that arise in a clinical environment dominated by risk.

Findings – A focus on risk and accountability has produced an environment where the law and legal styles of thinking have come to influence practice. This is often associated with blame in the minds of the health professional. Given the legal obligation to prevent suicide, health professionals may take a conservative approach when working with people who self-injure. This makes the adoption of harm minimisation difficult.

Originality/value – This paper provides a legally informed analysis of some of the challenges associated with using harm minimisation techniques with people who self-injure. It adds to the literature regarding this area of clinical practice.

Keywords Suicide, Risk, Self injury, Harm minimization, Rabone

Paper type Conceptual paper

Introduction

Self-injury is a serious health issue; the long-term outcomes for people who repeatedly self-injure are often poor (Morgan et al., 2017) and the demands on both general hospital and mental health services are high (Tsiachristas et al., 2017). The causes of self-injury are complex and multifaceted and its treatment involves a range of different approaches and no specific intervention that is supported by a valid and reliable body of evidence (Hawton et al., 1998; National Collaborating Centre for Mental Health, 2004). The dynamics of the relationship between the patient and the health care professional is complicated and clinical staff often struggle to know-how to care appropriately for people who self-injure (Morales and Guarnero, 2014).

Self-injury is common in mental health units; research undertaken in mental health inpatient settings indicates that the percentage of patients who harm themselves during the course of their admission varies from 4 to 70 per cent. The rate of self-injury in adult inpatient units being 2.54 per 100 available bed days (James et al., 2012). In such units it is often normal practice to try and stop the person hurting themselves and a range of restrictive practices may be implemented in pursuit of safety (Sullivan, 2017; Morrissey et al., 2018). People who self-injure perceive these approaches negatively (Duperouzel and Fish, 2010). Harm minimisation has been proposed as an alternative way of supporting some individuals who self-injure (Guttridge, 2010; Edwards and Hewitt, 2011; Inckle, 2017; Sullivan, 2017).

Harm minimisation accepts that someone may still need to self-injure at a given point in time. Therefore, instead of trying to prevent self-injury, the focus is on supporting the individual in...
reducing the risks associated with the self-injury (Shaw and Shaw, 2009). The approach is controversial as it allows the patient to continue to self-injure as part of a therapeutic process. The use of some harm minimisation techniques in inpatient facilities has been criticised (Pickard and Pearce, 2017) and examples of harm minimisation within such settings are uncommon. In a recent paper, James et al. (2017) interviewed 18 participants drawn from 15 wards. Some of these practitioners had no knowledge of harm minimisation techniques and only a small number had experience of harm minimisation practices. They point to a number of practical, ethical and complex medico-legal issues that may contribute to this situation.

This paper will consider a number of these issues in attempting to explain why implementation of harm minimisation is not more widespread. In order to achieve this, the paper will be structured in the following way. First, some preliminary comments will be made about harm minimisation and self-injury. Second, the paper will consider the important role risk plays in mental health services. It will be argued that a preoccupation with risk goes beyond clinical requirements to assess and manage risk and is related to a wider societal preoccupation with accountability. This forms part of what Heimer et al. (2005) describe as a legalised environment in which not only the law but other types of legal thought and practice impact on the day-to-day work of those providing mental health services. This focus on risk and legal styles of thought is often associated in the minds of health professionals, with the attribution of blame. Third, in light of this context, the paper will consider the complex interrelationship between self-injury and suicide. It will be argued that the way the courts have interpreted the legal obligation to prevent suicide, and particularly the evidence used in supporting the decision-making process may result in health professionals erring on the side of caution when working with people who self-injure, given that suicide is always a possibility. Such caution makes the adoption of harm minimisation less likely. Finally, the paper will consider the implications of this situation and it will be argued that the failure to make use of harm minimisation, might in some situations, increase the risk of harm and lead to negative outcomes for the patient.

Self-injury and harm minimisation

Harm minimisation is an alternative means of dealing with self-injury based on the principles of harm reduction (Hawk et al., 2017). This approach was advocated by people with lived experience of self-injury (Pembroke, 2006; Shaw, 2012), and it has been adopted in community settings and some inpatient facilities (Crowe and Bunclark, 2000; Holley and Horton, 2007; Pengally et al., 2008; Holley et al., 2012). The essence of the approach is that it accepts that attempts to stop self-injury are often futile and may be counterproductive. Therefore, instead of trying to stop individuals hurting themselves, health care professionals allow harm to continue more safely. Thus, harm is allowed as part of the therapeutic process and as such conflicts with the well established principle that health care professionals do no harm.

Using harm minimisation in supporting people who self-injure includes a number of techniques, which vary depending on the clinical environment. Not all components of harm minimisation are contentious and the approach consists of a spectrum of interventions some far less controversial than others (Hewitt, 2004). Guttridge (2013) describes these interventions in terms of, the provision of advice, the supervision of the action, omitting to remove implements that could be used to self-injure and proactively providing the implement. Alternative methods to self-injury may also be provided. Examples include squeezing ice cubes and snapping elastic bands against the skin. These initiatives, it is argued, replicate the feelings associated with self-injury. In addition, psychological therapies are provided in order to support the individual to explore the meaning and function of their behaviour. This forms part of a longer-term strategy to help promote change and is an essential component of the approach. Ultimately the aim is for the individual to change in ways that mean self-injury is no longer used as a means of coping with psychological distress (Inckle, 2011).

Risk, legalisation and a blame culture

The concept of risk plays a major role in the provision of mental health services. The idea of risk has its origin in decision theory and the mathematical models associated with statistical
probability theory. More recently it has taken on a wider social meaning associated with the negative consequences resulting from some form of adverse event (Lupton, 2013). In various areas of organisational life, including health care, risk has taken on a more important function (Giddens, 1990; Beck, 1992; Luhmann, 2002).

At both a theoretical and practical level risk influences mental health care. Fanning (2013, 2016) has argued that risk determines the nature of the patient’s interaction with mental health services. For example, the objective of avoiding or minimising the risks of harm associated with mental disorder has become central to mental health law (Fanning, 2016, pp. 417/418). This was illustrated by the amendments made to the Mental Health Act in 2007. These amendments incorporated an increasing requirement to make clinical decisions based on the person's risk to self and/or others in order to detain such individuals for assessment or treatment under the Act (Glover-Thomas, 2011; Fanning, 2013). Moreover, the concept has come to dominate decision-making outside the scope of compulsory powers (Fanning, 2016).

Both conceptually and clinically, risk can be perceived as either positive or negative. A positive risk approach involves weighing the potential benefits and harms of exercising one choice over another and accepts taking risks in making this decision. A focus on negative risk-taking is more concerned with the mere prevention of harm. It is the latter that appears to be the main focus in mental health care. In this sense risk has two key elements. The possibility of an adverse event, combined with a belief that the prevention of such an event is achievable (Lupton, 2013). In a clinical sense this translates into two practical activities. First, risk assessment, which involves examining the potential outcomes of this probability, and second, risk management, which involves the development of a plan to minimise harm and maximise benefits (Callaghan, 2015; Callaghan and Grundy, 2018, p. 3).

This preoccupation with risk has been accompanied by a situation whereby the law, legal actors and legal styles of thought have penetrated much more deeply into health care (Heimer et al., 2005, p. 94). This goes beyond a legal responsibility to act in accordance with the law and the development of a litigation culture, to a situation whereby a whole range of legal, regulatory and professional accountability frameworks impact upon the way that health care professionals work. This means, that there is pressure to intervene using only techniques, which can be judged defensible in legal and regulatory terms. This suggests Heimer et al. (2005, p. 95) is partly a response to the pervasive influence of risk. In mental health care as in other areas of health care this is illustrated by the increasing role of the civil and criminal law, the role of the Care Quality Commission (CQC) and the regulations and legal rules associated with the role of professional bodies such as the Nursing and Midwifery Council and the General Medical Council in maintaining appropriate clinical standards (GMC, 2013; NMC, 2015).

These factors interact in a way that promotes a drive to ensure that standards of practice do not fall foul of the above requirements and an increasing concern about what is defensible (Power, 2007, p. 170). In one sense this is unproblematic as there is no doubt that health care professionals must work to agreed standards and both they and the organisations in which they work should comply with relevant legal and regulatory standards. Furthermore, if problems occur then health professionals should be held to account and public expectations in relation to the performance of health professionals and health organisations have changed in this direction (O’Connor et al., 2011). There is, however, a concern that the pendulum has swung too far.

Although there is an ongoing debate regarding the importance of an open learning culture as opposed to more punitive forms of accountability, there does appear to be a perception amongst health care professionals that they work in a blame culture (Khatri et al., 2009). For example, in a study completed in a mental health setting, seventy one per cent of staff felt responsible for problems in relation to risk assessment and management following an untoward incident (Wand, 2017, p. 3). A concern which has been exacerbated, albeit not in a mental health context, by the case of the doctor Hadiza Bawa-Garba, who was convicted of gross negligence manslaughter and removed from the medical register (General Medical Council v. Bawa-Garba, 2018). The case has recently been overturned on appeal and Dr Bawa Garba will be allowed to return to practice (Bawa-Garba v. General Medical council, 2018). However, the issues raised by the case remain pertinent. Health professionals have been concerned that the high court failed to look at
the realities of clinical practice, particularly the pressures faced by clinical staff and the presence of system wide failings. They have argued that the case demonstrates the persistence of a culture characterised by an unwillingness to take risks and accept responsibility for errors or mistakes due to a fear of criticism and blame (Cohen, 2017). As Laurie et al. (2016, p. 129) have previously argued, “somebody, somewhere, must be made to answer for what has happened”. This has both clinical and organisational implications.

In recent years health care professionals have seen the development of increasingly formalised policies, procedures and protocols supported by routine and standardised ways of working, which are often developed with an eye to the courts and the regulator. The clinical implication of this situation is that it promotes an approach to intervention that is procedurally rigid. Clinical practice is increasingly focused on the routine use of risk assessments and risk management plans, making use of standardised questions often in the form of checklists. This has led to the criticism that risk assessment is merely a tick box exercise resulting in the development of a paper trail that serves no other purpose than providing an audit trail in the event of an untoward incident. Critics argue that such assessments are implemented without any real concern for the individual needs of the patient (Manuel and Crowe, 2014, p. 340; Morrissey et al., 2018, p. 39).

At an organisational level there is an impetus to avoid blame and litigation. This fear that something may go wrong becomes associated with a fear that the organisations reputation will be damaged. Power et al. (2009, p. 317), talk of an underlying cognitive awareness regarding the possibility of being blamed or criticised in some way. They suggest that this has affected the way that organisations work. As a result practices are increasingly focused on possible reactions to organisational conduct and how this may affect key external perceptions. In these circumstances being cautious becomes necessary but the danger is that it will produce approaches to intervention that are risk averse. If this occurs then the ability to respond to complex problems in a flexible way is reduced. There is some evidence that this is the case.

In a recent paper, Slemon et al. (2017) argue that the practices associated with identifying possible risks and taking preventative action constitutes the predominant aim of mental health nurses. Their comments could also apply to the work of other health professionals. They suggest that it is more than a goal but a fundamental value and that the pursuit of safety results in an increasingly restrictive approach to practice. They argue that the nursing care in inpatient settings is dominated by risk aversion. The work completed by Gutridge on harm minimisation is cited as an example of a practice that adopts a risk-taking approach in the clinical setting for therapeutic purposes (Gutridge, 2010). They do not pursue the challenges that such an approach may encounter and it is to this issue that we now turn.

Risk, legalisation and blame: suicide prevention and the implications for harm minimisation

In their analysis of the reasons why harm minimisation should not be used in mental health inpatient units, Pickard and Pearce (2017) argue that the risk of serious harm or even death cannot be discounted if the patient is allowed to self-injure. This is a particular risk if information is provided about safer ways of self-injuring, as this information could be used to cause increased harm. This is exacerbated if the means to self-injure are provided or not removed. Notwithstanding the serious implications that such an untoward event would have for the patient, their family and friends and the emotional repercussions on the staff involved, there are also questions about how the practices that lead to such an event may be perceived in a context where health professionals are increasingly risk conscious and more aware of the legal implications associated with their work.

The possibility of serious harm or death brings the issue of risk into focus. On the one hand risk is permitted if an overriding concern would justify it (Pillsbury, 1996), on the other hand, if the level of risk cannot be justified this may raise questions regarding culpability (Stark, 2016). The legal implications of harm minimisation are not clear and Hewitt’s (2004) observation that a lack of precedent in the civil or criminal courts make it only possible to speculate on how the courts would view such practices still stands. However, such speculation is to some extent now informed by the way that the law has addressed risk in its deliberations, not in relation to
self-injury, but in the related matter of suicide. These deliberations have taken place not in the
criminal courts or in relation to clinical negligence but under the auspices of human rights law.
They are important, as an untoward incident arising in the context of a harm minimisation
programme could be the result of suicide or a suicide attempt.

Prior to considering the developments in human rights law it is worth making a brief comment about
the civil and criminal law. In the right circumstances both could be engaged. For example,
there is a theoretical possibility that a charge of gross negligence manslaughter could be brought
(Hewitt, 2004). However, the circumstances would need to be quite exceptional. A case of suicide
has never resulted in such a charge (R (Secretary of State for Justice) v. Her Majesty’s Deputy
Coroner for The Eastern District of West Yorkshire (2012)). Moreover, gross negligence
manslaughter requires a high threshold for conviction (R v. Adomako, 1994). A high level of
recklessness would be required on the part of the health professional.

A civil action is more likely as such actions are common as people are increasingly well informed,
more minded to use the courts as a form of redress and access to legal advice through no claim
no fee arrangements makes funding such a course of action less problematic. However, it is
difficult to pre-empt the outcome as the legal tests are complex and there is a high threshold for
success. For example, the existence of a causal link between self-injury and harm may be difficult
to demonstrate. It could be argued that given the patients existing propensity to self-injury, the
harm would have occurred in spite of the harm minimisation programme rather than because of it.
Alternatively, the expert witnesses may have very different views about the validity of harm
minimisation as a therapeutic option and make its practice difficult to defend. In the absence of
case law this is mere conjecture but this is not the case in relation to human rights law.

Suicide could result in a claim made on the basis of Article 2 of the European Convention on
Human Rights whereby the state has a responsibility to protect an individual’s right to life. This is
formalised in European law which was incorporated into the UK’s legal framework through the
Human Rights Act 1998. Article 2 imposes quite stringent responsibilities on health care
professionals to prevent suicide. In a mental health context this duty has been established in
English law and relates to both patients detained under the Mental Health Act (Savage v. South
Essex Partnership NHS Foundation Trust, 2010) and those admitted to hospital on a voluntary
basis (Rabone v. Pennine Care NHS Foundation Trust, 2012). This position is confirmed in the
European jurisprudence (Reynolds v. United Kingdom, 2012).

The clinical implications of this are illustrated in the case of Rabone v. Pennine Care (2012). If a
health care professional knew or ought to have known that there was a real and immediate risk to
life then reasonable steps have to be taken to preserve that life. A risk of harm, even serious harm
would be insufficient. The legal test in use in such a claim is exacting. First, evidence of the threat
of death occurring from real and immediate threat to life must be compelling. Second, the actions
taken must not impose a disproportionate burden on the defendant. This appears to suggest that
there is an implicit recognition that the risk cannot be eliminated. This has led to the proposition
that the high threshold required in an Article 2 case may mean that its application is limited to a
small number of extreme situations (Allen, 2013). The fact that there has been no significant influx
of cases since those of Savage and Rabone supports this argument. It would appear that unless
there are exceptional circumstances then a case is unlikely to succeed. However, there is some
indication that such cases may have resulted in increased risk aversion amongst health
professionals (Department of Health, 2018). Furthermore, what Rabone does, is give an
important steer around the way that courts may interpret the evidence in relation to risk and the
implications are important.

Risk and rabone

Expert evidence is crucial to any legal case in health care regardless of the legal context.
For example, in a case of clinical negligence the Bolam test and its subsequent modification in
Bolitho impose the requirement for expert evidence to possess a logical base (Bolam v. Friern
Hospital Management Committee, 1957; Bolitho v. City and Hackney Health Authority, 1997).
Such evidence would also be key in a gross negligence manslaughter prosecution. The Rabone
case gives some indication of how such evidence would be interpreted from a human rights
perspective. This is important as given the absence of any precedent in either the civil or criminal courts it may have a wider relevance. The expert evidence used in Rabone focused around the risk of suicide. There is no dispute here with the findings of the court, what is important is the way that evidence was used by the court in drawing their conclusions.

The judgement concerned itself with matters of risk assessment and management and required the experts involved to comment on the standard of these assessments and plans. This evidence was then used to make judgements about the overall standard of care provided and whether it was possible to ascertain whether there was a real and immediate threat to Miss Rabone’s life. The court concluded there was. However, in drawing these conclusions the court appeared to attribute the process of risk assessment with a degree of certainty, which the clinical evidence available would suggest it does not have.

All patients are subject to a risk assessment and risk management plans are developed on the basis of these assessments. As Newton-Howes (2018, p. 15) argues, this implies that such assessments can adequately categorise risks in a way that can be linked with an appropriate intervention. This will reduce the chance of a negative outcome. The problem, as Newton-Howe’s states, is that such an argument fails to stand up to scrutiny in relation to suicide. The empirical evidence available would suggest that the level of risk is difficult to predict in a specific individual. As Sarker (2013, p. 297) points out, although the actuarial risks are well established there is no algorithm that can identify the actual risk of suicide in a specific individual. Although the risks may be obvious with hindsight, the very “obvious” nature of such risks is an illusion. For example, based on the use a routine risk assessment, 60 per cent of suicides are assessed as low risk and only 3 per cent of those categorised as high risk actually commit suicide (Allen, 2013).

Furthermore, even when assessment makes use of formal measures designed to assess suicide risk the situation does not improve. The NICE guidance relating to self-harm (National Collaborating Centre for Mental Health, 2012) has recognised this fact and warned against the routine use of such measures in clinical practice. Recent research (Quinlivan et al., 2017) has confirmed the empirical basis of this advice.

At this point it is pertinent to return to the paper by Newton-Howes (2018), he concluded that the ability to predict suicide in a clinically meaningful timeframe is in fact not possible (Newton-Howes, 2018, p. 20). In spite of this, both experts in Rabone made use of risk calculations. They provided numerical assessments of the risk of suicide using percentage scores to indicate the level of risk and how the degree of risk changed during the events prior to Miss Rabones death. Evidence was accepted by the court that suggested a high degree of predictability was possible in the assessment of suicide risk (Rabone v. Pennine Care NHS Foundation Trust, 2010).

This points to the possibility that the law may interpret risk in a different way than the health professional. If this position was replicated in other legal cases then this could have implications for undertaking therapeutic activities that may incorporate a high level of risk. This very point is made by Horton (2010) in his analysis of the Savage case. He argues that risk management strategies are increasingly subject to legal scrutiny. Making use of the work of Luhmann, Horton argues that different professionals make use of different modes of communication and this means they have different ways of looking at the same phenomena and will process similar events differently (Horton, 2010, p. 581). As Horton points out, evidence in court is only meaningful if it is objective and follows legal rules. Risk will therefore be interpreted in terms of tort, human rights or criminal law for example, and a judge may struggle to interpret formulations of risk such as those used by a health professional, which do not follow legal rules. This could have important clinical implications.

Risk, Rabone and the implications for harm minimisation

The law has a significant influence on the normative environment in which any activity is undertaken and organisations must adapt based on legal decisions (Edelman, 1999, p. 1402). This poses the practitioner with a real problem given the fact that to implement harm minimisation safely, the health professional needs to be clear that the person who self-injures does not pose an active suicide risk. This would be unproblematic were suicide and self-injury quite distinct phenomena. In reality the relationship between suicide and self-injury is complex and
distinguishing between the two is not easy. This means that the health professional is faced with a serious clinical conundrum. As Sarker (2013, p. 296) asks, how is it possible to differentiate between a patient who is actively suicidal from a patient who wishes to self-injure for different reasons. In spite of the courts perspective risk assessment can never be an exact science. If risk cannot be assessed in an accurate way, then it is not possible to provide an objective measure on which to base a decision about the threshold at which the risks associated with harm minimisation techniques become acceptable. What constitutes an unacceptable level of risk should ideally be an objective decision; in reality it is a subjective judgement (Craddock, 2004, p. 325). Thus, the clinical team proposing to allow a person to continue to self-injure has no objective threshold by which to judge the acceptability of the risks being proposed. There is no place on a sliding scale of probabilities, which marks the point where harm minimisation techniques become appropriate or inappropriate.

Harm minimisation thus presents a number of problems. First, there are risks to the patient if the approach is not implemented safely as serious harm or even death could be the outcome. Second, the limitations in terms of both the validity and the reliability of the assessment tools available to the health professional prevent objective decision making, so it is difficult to differentiate between suicide and self-injury without suicidal intent. Third, if this is then combined with an institutional requirement to avoid blame, litigation and reputational damage then an innate cautiousness may be inevitable. Given the pressure to ensure that every decision and intervention is clinically and legally defensible, the easiest way to achieve this is to err on the side of caution. This may result in foregoing the adoption of harm minimisation approaches on the basis that it is difficult to square the circle in relation to permitting self-injury and allowing harm in a situation where suicide could be a potential outcome. Unfortunately, this may not prevent harm from coming to the patient as adoption of more restrictive types of intervention may also be problematic.

As has been noted, in a hospital setting the normal approach to dealing with self-injury is to try and prevent it occurring. Such an approach can in its most extreme form be highly restrictive; including for example searches of the person and their possessions, removal of harmful objects and the use of continuous observation. Individuals may in some circumstances be detained under the Mental Health Act and therefore subject to restrictions on their movement and subject to enforced treatment. These initiatives bring with them their own set of problems and Sullivan (2017) has described this in terms of the “paradox of preventative practice”. He argues that the means used to try and prevent self-injury produce a confrontational rather than therapeutic relationship that exacerbates rather than contains the risks.

Self-injury has for some people a positive coping function and if this is removed then both their distress and desire to self-injure may increase. This leads to a situation where individuals attempt to self-injure covertly, in more dangerous ways, or even attempt suicide. For example, patients who when living at home may self-injure through cutting their skin inflicting only minor injuries, may when admitted to hospital use methods such as hoarding medication to overdose or using clothing to ligature. Both are difficult to control and can be fatal. This may occur in spite of high levels of observation. This leads Sullivan (2017) to conclude that the actions taken to prevent harm may in fact be more harmful than the original behaviour itself.

Now it is clear that when a person’s actions may lead to harm, then action should be taken to reduce that harm. However, the action taken must be proportional to the seriousness of the situation. Moreover, it must have a reasonable chance of achieving its aim. The argument supporting harm minimisation, in this situation, is that by respecting the individual’s autonomy and by developing a more therapeutic relationship, the likelihood of reducing the chance of serious harm or even death is reduced. Furthermore, the interventions used are both proportionate and necessary, as the approach constitutes the least restrictive form of intervention and the least harmful way of achieving the therapeutic goals agreed with the patient.

It may be argued that the risk of suicide overrides all other considerations. Unfortunately, this could be detrimental for some individuals. Whilst there is no doubt that the risk of suicide is increased in those who self-injure, there is also some evidence that there are some people who may injure themselves, not because they wish to die, but in order to provide relief from a situation that threatens to overwhelm them (National Collaborating Centre for Mental Health, 2012).
Although it is difficult at times to differentiate between the two, this does form part of routine clinical practice. Even if harm minimisation is not a consideration, the use of restrictive interventions in all situations where suicide may only be a possibility cannot be justified. Although when suicide occurs its impact is significant it must be remembered that such occurrences are rare. Most individuals admitted to hospital will not end their lives through suicide. It is therefore important not to over use coercive forms of intervention that are neither proportionate nor necessary. A risk adverse approach may lead to lost opportunities to reduce self-injury and lead to an increase in the risk of harm. Moreover, it may increase the risk of suicide in the longer term. The right approach is surely to consider the issue on a case-by-case basis, as no two cases of self-injury are the same. What is required in a given situation depends on the nature of that situation and in some situations harm minimisation may constitute a realistic therapeutic option. In these circumstances the law, health care organisations, regulators and society more generally need to recognise that this may be the only option. Progress is not always risk free.

Conclusion

This paper has considered the implications of using harm minimisation techniques when working with people whom self-injure and provided an argument for why its use appears limited within inpatient environments. It has been argued that a preoccupation with risk and an increasingly legalised clinical environment has been perceived by many health professionals as associated with accountability and blame. This has contributed to a cautious mind-set amongst many health professionals, which has resulted in the development of a risk adverse approach to care. This paper has illustrated how this process may affect the adoption of harm minimisation approaches particularly given the relationship between self-injury and suicide. It has been argued that the adoption of more restrictive forms of intervention used in the pursuit of safety may also bring with them their own difficulties.

In the final analysis, harm minimisation approaches include a number of complex and sophisticated interventions that require an environment in which there are the skills, knowledge and experience available clinically to implement the approach, as well as the will to contain the anxiety that such an approach may produce in both individual clinicians and the wider organisation. This is an environment where health care professionals are able to innovate and to take risks and to engage in meaningful therapeutic activity, sometimes in challenging circumstances. It has to be conceded that this is not the position in many mental health units where opportunities for real therapeutic engagement are limited. In the final analysis harm may be a step too far for most health care organisations. This is a situation that must change, people who self-injure deserve better and heightened concerns about relatively rare events accompanied by concerns about legal liability, regulatory action and reputation must work with and not against the patient’s interests. It is important that demands for accountability do not become overly burdensome and fail to work in the interests of the patient. A process that would be assisted by the completion of research studies providing more empirically based analysis of the benefits or otherwise of harm minimisation approaches in this area of clinical practice. This would then promote more informed decision making at a clinical, managerial and organisational level.

References


Bawa-Garba v. General Medical Council (British Medical Association and others intervening) (2018), EWCA Civ 1879.


Bolam v. Friern Hospital Management Committee (1957), 1 WLR 582.

Bolitho v. City and Hackney Health Authority (1997), 3 WLR 1151.


Fanning, J. (2013), “Risk and the Mental Health Act 2007: jeopardising liberty, facilitating control”, Thesis submitted in accordance with the requirements of the University of Liverpool for the Degree of Doctor of Philosophy (PhD), University of Liverpool, Liverpool.


General Medical Council (2013), Good Medical Practice, GMC, London.


R v. Adomako (1994), 3 WLR 288 HL.

Rabone and another (Appellants) v. Pennine Care NHS Foundation Trust (Respondent) (2012), UKSC 2.

Rabone v. Pennine Care NHS Foundation Trust (2010), UKSC 2.

Reynolds v. The United Kingdom (App.No 2694/08) (2012), 437 ECHR.

R (Secretary of State for Justice) v. HM Deputy Coroner for the Eastern District of West Yorkshire (2012), EWHC 1634 (Admin).


Savage v. South Essex Partnership NHS Foundation Trust (2010), EWHC 865 QB.


Further reading


About the author

Patrick Joseph Sullivan has a professional background in mental health services dating back to the 1970s. He is currently a Postgraduate student at the University of Manchester undertaking a PhD in Bioethics and Medical Jurisprudence. His research interest is the ethical and legal implications of using harm minimisation approaches with people who self-injure. He has previously published papers on this subject in the Journal of Medical Ethics and Clinical Ethics. Patrick Joseph Sullivan can be contacted at: Patrick.Sullivan-2@postgrad.manchester.ac.uk

For instructions on how to order reprints of this article, please visit our website: www.emeraldgrouppublishing.com/licensing/reprints.htm
Or contact us for further details: permissions@emeraldinsight.com