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Harm minimisation for self-harm: a cross-sectional survey of British clinicians' perspectives and practises

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ABSTRACT

Objective Harm minimisation for self-harm is an alternative to preventive strategies and focuses on maximising safety when self-harming. We explored the views of clinicians on harm minimisation for self-harm to describe reported use and acceptability in clinical practice.

Design A cross-sectional study using an online survey consisting of fixed-choice and open-ended questions.

Setting Primary and secondary care practices in England, Scotland and Wales.

Participants Snowball sampling of UK-based clinicians (n=90; 67% female) working with people who self-harm and who have or have not previously recommended harm minimisation methods to patients.

Results Of the 90 clinicians sampled, 76 (84%) reported having recommended harm minimisation techniques to people in their care who self-harm. Commonly recommended techniques were snapping rubber bands on one's wrist and squeezing ice. Other techniques, such as teaching use of clean instruments when self-harming, were less likely to be recommended. Perceived client benefits included harm reduction and promotion of the therapeutic relationship. Perceived potential limitations of a harm minimisation approach for self-harm were (a) potential worsening of self-harm outcomes; (b) ethical reservations; (c) doubts about its effectiveness and appropriateness; and (d) lack of training and clear policies within the workplace.

Conclusions In our sample of UK-based clinicians in various settings, harm minimisation for self-harm was broadly recommended for clients who self-harm due to perceived client benefits. However, future policies on harm minimisation must address clinicians' perceived needs for training, well-defined guidelines, and clear evidence of effectiveness and safety to mitigate some clinician concerns about the potential for further harm.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ A wide range of clinical practitioners from different settings participated in this study, but there were very few mental health nurses or managerial staff.
⇒ This study included general practitioners who, have not been included in the limited research on harm minimisation for self-harm, despite often being the first point of contact for patients who self-harm.
⇒ The use of an anonymous, online survey may have enhanced disclosure and reduced social desirability bias.
⇒ Snowball sampling may have induced selection and non-response biases.
⇒ We did not specifically ask which self-harm methods respondents had recommended harm minimisation for, so we were unable to capture views on the acceptability of harm minimisation for specific types of self-harm.

INTRODUCTION

The UK has one of the highest rates of self-harm in Europe[1] and rates have increased significantly in the last decade.[2 3] Self-harm is the strongest risk factor for suicide[4 5] and is associated with repeat self-harm,[6] accidental death[7] and psychopathology.[8] Self-harm is defined as the intentional act of harming oneself, regardless of motivation, and includes self-injury and self-poisoning.[9] Its physical repercussions such as scarring and blood loss[10] add to the rationale of self-harm management to reduce risk and mortality. The evidence-based management of self-harm is hindered by the inconclusive evidence to support the effectiveness of psychosocial and pharmacological interventions for self-harm.[11–13] Cessation may not be realistic for individuals who use self-harm as a coping mechanism, and efforts to stop self-harm can be counterproductive, unhelpful[14] or even harmful.[15]

Harm minimisation for self-harm offers an alternative to standard preventive interventions that aim for self-harm abstinence.[16] It derives from a substance use model for which acceptability and effectiveness are evident in needle exchange programmes[17] and alcohol harm prevention.[18] The main aim of harm minimisation is to reduce harm associated with a high-risk behaviour rather than eliminating it for individuals who are unable or not ready to change. Harm minimisation techniques range from pinching oneself, squeezing ice, drawing red lines on

one's wrists and practising wound care to more contentious techniques such as providing clean blades, teaching anatomy and advice on using clean instruments.[19]

Harm minimisation is included in the National Institute for Health and Care Excellence (NICE) guidance on the management of self-harm.[9] However, this recommendation is based on a low level of evidence. No trials have been conducted to evaluate the effectiveness of harm minimisation for self-harm. Previous studies examining the acceptability of harm minimisation for self-harm suggest inpatients preferred harm minimisation strategies to preventative and controlling methods.[20 21] Meta-analyses of randomised controlled trials exploring interventions for self-harm found that abstinence approaches used by mental health professionals are ineffective[22 23] and may reduce patient trust and lead to more lethal methods of self-harm or indeed suicide.[21] Recently, there has been a push to reconceptualise self-harm recovery beyond cessation, to recognise a more non-linear process that is reported by people with lived experience of self-harm.[24] Harm minimisation, in considering the purpose of self-harm to an individual as well as ways to reduce damage, may provide a more person-centred approach than cessation approaches. Despite this, it is unclear to what extent harm minimisation strategies are currently being used across clinical settings and whether clinicians perceive them to have value.[9] To date, two studies have investigated the perspective of clinicians and their practice in relation to harm minimisation techniques for self-harm. These studies, limited to a mental health inpatient unit[25] and forensic learning disability service,[26] show that despite reported positive views there are concerns surrounding a harm minimisation approach. This has implications for implementation because clinicians are responsible for delivering interventions, and positive interactions with clinicians are an important factor in the recovery of clients who self-harm.[27]

While current guidance on harm minimisation for self-harm is quite limited,[9] scoping work for the NICE 2022 guidelines identifies this as an area to be covered in further detail, including evidence for effectiveness.[28] We must therefore gain a clearer understanding of the views and practice of different harm minimisation techniques from clinicians working with people who self-harm to identity the use and acceptability of harm minimisation techniques to those involved in collaborative care planning.

In this study, we aimed to explore clinicians' perspectives on the use of harm minimisation techniques for self-harm across a wide range of settings through an online survey consisting of open-ended and fixed questions to identify views that might represent potential barriers and facilitators in the use of harm minimisation for self-harm.

METHODS

Study design

We conducted a cross-sectional study using an online survey which collected quantitative and free-text data and used descriptive statistics and thematic analysis to describe current practice of harm minimisation for self-harm, levels of training and views on the approach.

Participants

We recruited clinicians through purposeful snowball sampling via Twitter and personal and professional networks to reach primary and secondary care clinicians (clinicians who work in mental health specialist settings). We tagged the Twitter accounts of self-harm support organisations (eg, Harmless UK, Battle Scars UK) to share the study. The survey was also disseminated to a general practitioner (GP) network through FM. The inclusion criteria were broad to include any UK-based clinician who had worked with people who self-harm, regardless of harm minimisation experience, to gather data on what could potentially facilitate or impede its use among clinicians who had not used this approach.

Researcher reflexivity

The lead author (AMH) has no clinical experience of harm minimisation in self-harm management but acknowledges broadly positive views on it. The research team consists of an MSc student (AMH), academic psychiatrist (ALP), academic GP (FM), MSc student (EB), qualitative mental health researcher (NM) and research psychologist (SLR). All members reflected on how their professional backgrounds influenced their interpretation of findings.

Patient and public involvement

No patient involved.

Survey measure

We designed an online survey (online supplemental material 3) consisting of fixed-choice and open-ended questions delivered using Opinio survey software. The survey questions were informed by existing literature, clinical expertise (ALP) and team discussions between AMH, SLR and ALP. Fixed-choice questions gathered demographic data on age, gender, occupation, length of time in current role and service type. We provided a fixed-choice list of harm minimisation techniques and asked respondents to indicate which technique(s) they had used or would be comfortable using, if any. Respondents also had the option to elaborate on techniques they were aware of but not represented among options provided. We elicited views on harm minimisation practice using open questions and free-text boxes. We provided a fixed-choice list of the types of clinical populations respondents had recommended (or were willing to recommend) harm minimisation techniques to. We also measured confidence and training in advising clients on harm minimisation for self-harm using fixed-choice questions with the option to elaborate where relevant.

To explore attitudes towards self-harm, we incorporated two statements from the Self-Harm Antipathy Scale.[29] Responses to these statements ('People should be allowed to self-harm in a safe environment' and 'An individual has

a right to self-harm') were measured using a Likert-type scale with three options: Agree, Disagree and Undecided. The survey was piloted with six clinical academic psychologists within the University College London (UCL) Division of Psychiatry to assess face validity. The final survey had 36 questions in total, with branching reducing the number of questions applicable to each respondent. It took approximately 10 min to complete. The final page signposted respondents to UCL and National Health Service NHS) support resources in case the survey caused distress. On completion, respondents had the option to enter a draw for a £20 Amazon voucher. Data collection took place between mid-July and the end of August 2020.

Data analysis

Survey responses were downloaded from Opinio into Excel. We summarised descriptive data for demographic characteristics of our sample and responses to fixed-choice questions. We conducted a thematic analysis of free-text responses to open questions which was facilitated using NVivo (V.12) and guided by the six stages described by Braun and Clarke.[30] The first stage is getting familiarised with the data through repeated reading to get immersed in it. This is followed by the generation of initial codes through organising interesting or salient extracts into meaningful groups. The third stage involves searching for themes by moving different codes into potential themes at a broader level. Next, the themes are reviewed. The fifth stage is where the finalised themes are defined and named. Finally, a report is produced to summarise findings. Analysis involved an inductive approach with no preconceived themes in mind.

Each set of survey responses was read and reread for familiarisation by AMH. The first 10 transcripts were examined for common, salient pieces of information that led to the creation of a coding framework in which the author sorted survey responses into broader levels of subthemes. Then, salient pieces of data from the subsequent 80 responses were coded based on this framework with continuous addition, renaming or removal of codes and/or subthemes. Codes were grouped together to inform potential subthemes and then combined into broad overarching themes based on subtheme similarities. The analysis process was cyclical as AMH would re-examine previously coded content and, if relevant, place them into new or revised codes. Then, an independent rater (EB) checked the codes and themes then discussed any thoughts and disagreements with AMH to enhance the validity of the analytic process by encouraging reflexivity and enhancing conceptual coherence. The coding framework was refined iteratively with the wider study team through meetings, including discussions of researcher reflexivity.

RESULTS

Sample characteristics

A total of 184 clinicians responded to the questionnaire by clicking on the survey link. As this was an open survey, a response rate could not be calculated. Of these 184 respondents, 140 people (98%) provided informed consent. Only 89 individuals (64%) completed the survey in full by answering all relevant questions. We included those who dropped out before completion if they had answered the open-ended questions relating to use of and perspectives on harm minimisation for self-harm. Therefore, responses from 90 clinicians were analysed.

Respondent demographic characteristics

Our sample (table 1) was predominantly female (67%) and almost half were in the 30–39 age range (47%). The majority (88%) worked in England, but none were from Northern Ireland. Most responses were from professionals working in the field of psychology/mental health (32%) and GPs (29%). Most respondents (79%) worked for the NHS and two-thirds (67%) of the respondents had over 2 years' experience working in their current role. The majority (84%) reported experience recommending harm minimisation techniques for self-harm.

Practice of harm minimisation (actual and hypothetical)

Of the 90 respondents, 76 (84%) reported recommending or having recommended harm minimisation techniques to people in their care who self-harm. The method most described was snapping rubber bands on one's wrist (72%) followed by squeezing ice (57%) and kicking and punching something soft (57%). Conversely, ensuring that a client had had tetanus protection (9%) and teaching anatomy for safer cutting (14%) were least reported of the fixed-choice responses. A third (27/90, 30%) of respondents reported using (or being willing to use) other methods (online supplemental material 4). Most respondents have used harm minimisation in the community setting for working age adults (53%) and children and adolescents (46%) (online supplemental material 5).

In total, 14 respondents (16%) reported not having recommended harm minimisation techniques for self-harm in their clinical practice and the majority were GPs (10/14, 71%). Of this group, most respondents reported that they would consider recommending methods such as squeezing ice, kicking and punching something soft and teaching wound care (table 2).

Perceptions of groups for which harm minimisation techniques were not appropriate

Over half (46/76; 61%) of those who had recommended harm minimisation techniques in their clinical practice and a third of those who had not recommended harm minimisation (5/14; 36%) identified no groups with whom they would avoid the practice of harm minimisation. However, those who had reservations about recommending harm minimisation to certain people indicated a range of groups (table 3). Commonly identified groups included individuals wanting to stop self-harming, children, adolescents and high-risk individuals.

Table 1 Demographic characteristics of survey respondents (n= 90)

Characteristic	Number (%)
Age	
20–29	11 (12%)
30–39	42 (47%)
40–49	19 (21%)
50–59	14 (16%)
60–69	4 (4%)
Gender	
Male	28 (31%)
Female	60 (67%)
Gender non-conforming	2 (2%)
Country of practice	
England	79 (88%)
Scotland	8 (9%)
Wales	3 (3%)
Northern Ireland	0 (0%)
Occupation	
Assistant psychologist	3 (3%)
Clinical psychologist	15 (17%)
Counselling psychologist	4 (4%)
Educational psychologist	1 (1%)
Family therapist	3 (3%)
Forensic psychologist	1 (1%)
General practitioner	26 (29%)
Healthcare assistant	1 (1%)
Mental health nurse	2 (2%)
Occupational therapist	3 (3%)
Psychiatrist	10 (11%)
Psychological well-being practitioner	1 (1%)
Social worker	3 (3%)
Support worker	4 (4%)
Other*	13 (14%)
Organisational setting	
NHS	71 (79%)
Private	5 (6%)
Voluntary sector	10 (11%)
Other†	4 (4%)
Length of time in current role, years (minimum=0, maximum=40)	
2 or less	30 (33%)
3–5	17 (19%)
6–10	16 (18%)
11–15	7 (8%)
16–20	9 (10%)
21 or more	11 (12%)
Use of harm minimisation for self-harm	
Yes	76 (84%)
No	14 (16%)

*Includes assistant clinical psychologist, counsellor, peer recovery practitioner/worker, service manager, systemic psychotherapist, trainee clinical psychologist and voluntary sector self-harm specialist.
†Includes prison service, local authority and community integrated care.
NHS, National Health Service.

Training and support

Only a minority of respondents (n=9, 12%) (online supplemental material 6) indicated that there were clear local guidelines on harm minimisation for self-harm in place within their workplaces. Slightly more respondents confirmed an awareness of national guidelines (eg, NICE) within their workplace (n=15, 20%). The remaining respondents stated that in their workplace they were unaware of national guidelines. More than half (n=44, 59%) had not had training in harm minimisation for self-harm. For those who had received training (n=30, 41%), this was in the context of dialectical behaviour therapy, core professional training, continuing professional development, self-directed training, local training by trust/organisation or delivery of training to others. The majority (n=25, 83%) had found training helpful, whereas a few (n=5, 17%) had not.

Table 2 Type of harm minimisation techniques recommended

Harm minimisation technique	Actual use (n=76)	Hypothetical use (n=14)
Pinching	23 (30%)	7 (50%)
Squeezing an ice cube for a short time	43 (57%)	10 (71%)
Snapping rubber bands on one's wrist	55 (72%)	8 (57%)
Drawing lines on one's wrist	28 (37%)	8 (57%)
Kicking and punching something soft	43 (57%)	9 (64%)
Teaching basic knowledge of medical care that is, wound care	41 (54%)	9 (64%)
Teaching anatomy such as how to cut with minimal risk and avoid major veins and arteries	11 (14%)	4 (29%)
Ensuring client has tetanus protection	7 (9%)	5 (36%)
How to use clean instruments	21 (28%)	2 (14%)
Other techniques	24 (32%)	3 (21%)

Table 3 Groups of people to avoid harm minimisation with

At risk groups identified by respondents who had used harm minimisation techniques (n=30)	At risk groups identified by respondents who had not used harm minimisation techniques (n=7)
► People with suicidal intent/high suicidal risk ► People who want to stop self-harming or are motivated to change ► People with low IQ ► People with psychosis ► People lacking mental capacity ► Children, adolescents, young people (due to concern regarding parents' judgement) ► People with learning disabilities ► People with personality disorders	► People who want to stop self-harming ► Vulnerable or high-risk people ► People with self-harm that is not perceived as 'addictive' ► Young people

Of those who did not have experience of recommending harm minimisation to clients who self-harm (n=14), more than half (n=8) were not aware of local guidelines on this. Only two respondents were aware of national guidelines on harm minimisation (eg, NICE) being implemented in their workplace, but the remainder (n=12) were unaware. Almost all those with no previous experience of using harm minimisation for self-harm (n=13/14, 93%) had received no training in the subject.

Confidence in using harm minimisation approaches

More than half (n=43/76, 58%) of those who had reported recommending harm minimisation to clients indicated they were confident in this, while 26% (n=19) were unsure and 16% (n=12) reported not feeling confident in recommending these techniques.

Personal perspectives on self-harm

The majority of those who had recommended harm minimisation to clients (n=59/72) and the majority of those who had not (n=8/14) endorsed the view that an individual has a right to self-harm. Much fewer in each group (n=42/72 and n=1/14, respectively) felt that people should be allowed to self-harm in a safe environment (table 4).

Qualitative findings

Our analysis of free-text responses generated five main themes (figure 1).

Theme 1: Client-Centred Benefits

A safer alternative that reduces harm

Respondents felt that harm minimisation was helpful in reducing physical harms such as scarring, infection, tissue damage, death, unintentional physical injuries or death, accident and emergency visits as well as other risky behaviours and in reducing the severity and incidence of self-harm. Harm minimisation allowed 'for the safe practice of a generally unsafe practice […] that gives them the same release/relief they get from self-harm' (ID 3, occupational therapist) and was felt to prove useful when 'patients are adamant on or working to reduce self-harm' (ID 42, GP). Some respondents found harm minimisation to enable therapeutic work to be done while ensuring the need to self-harm is still met in a less harmful way.

> [Harm minimisation] can enable work on underlying beliefs to be addressed - acceptance that self-harm may be essential/inevitable to moving on can seem paradoxical but other alternatives just may not be effective enough. (ID 6, psychiatrist)

Additionally, some respondents felt that harm minimisation methods offered clients a way to cope with the urges to self-harm by allowing them to experience short-term relief and calmness during distressing episodes through 'alternative forms of release which are less invasive' (ID 74, GP).

Table 4 Agreement with Self-Harm Antipathy Scale items

Respondents who had recommended harm minimisation techniques for self-harm (n=72)			
	Agree n (%)	Disagree n (%)	Undecided n (%)
People should be allowed to self-harm in a safe environment	42 (58%)	5 (7%)	25 (35%)
An individual has a right to self-harm	59 (82%)	3 (4%)	10 (14%)
Respondents who had not recommended harm minimisation techniques for self-harm (n=14)			
	Agree n (%)	Disagree n (%)	Undecided n (%)
People should be allowed to self-harm in a safe environment	1 (7%)	3 (21%)	10 (71%)
An individual has a right to self-harm	8 (57%)	3 (21%)	3 (21%)

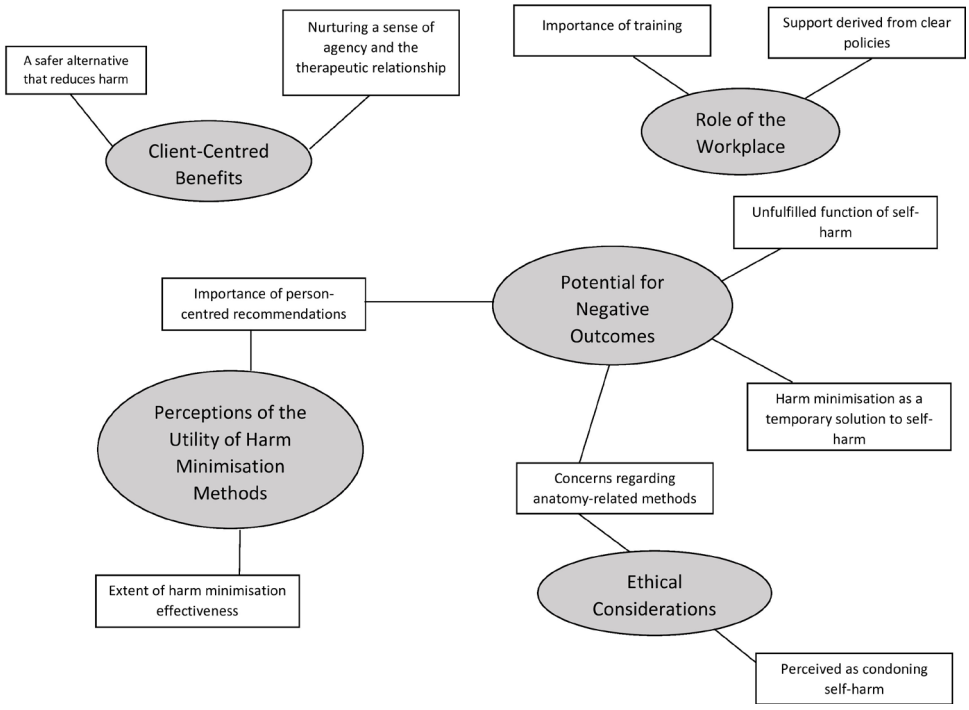

Figure 1 Thematic map summarising 5 main themes and 10 subthemes.

Nurturing a sense of agency and the therapeutic relationship

Harm minimisation appeared to offer an alternative to people who self-harm and this was believed to promote a sense of agency in clients. Harm minimisation recommendation was felt to signal to the client that the clinician is interested and understands that self-harm stems from a function unique to the individual and therefore are willing to work with the client's self-harm. There was also a sense that harm minimisation could help foster a sense of control, by learning new skills or alternatives, if accompanied by efforts to 'identify the function self-harm plays' (ID 52, GP).

In cases where harm minimisation offered clients an increased sense of autonomy, the therapeutic relationship was improved as a result due to 'an acknowledgement of their urge to harm themselves and […] Therefore, it can help the client in the moment and also foster a good therapeutic relationship' (ID 15, assistant psychologist). Some felt that having an open dialogue about harm minimisation can help validate the client's need to self-harm which develops the therapeutic relationship.

Theme 2: Potential for Negative Outcomes

Some respondents viewed harm minimisation as potentially giving rise to unintended negative outcomes. For example, one respondent was concerned about a client replacing cutting with severe calorie restriction and exercise, which was felt to be more damaging. Other respondents felt that the harm arising from harm minimisation approaches was preferred over the harm that could have been caused if the client had had no other alternatives.

> Some find these forms of harm minimisation triggering (e.g. drawing lines in red pen can make the person want to cut more). Some people have used harm minimisation techniques to the extreme (e.g. causing ice burns from holding ice cubes for too long, bruising/breaking the skin from pinging an elastic band), however the harm done in these cases is still often less severe than if the person had not used the alternatives. (ID 66, peer recovery worker)

There were also concerns that introducing harm minimisation methods to a person will 'just become another way of harming themselves' (ID 80, psychological wellbeing practitioner).

Unfulfilled function of self-harm

Despite harm minimisation techniques being perceived to have some benefits, some respondents who did not use anatomy-related harm minimisation methods felt that their clients would not receive the same release of tension with other harm minimisation methods such as squeezing ice or snapping bands. This was because they perceived those methods as not offering the desired painful stimulus needed to gain relief or to satisfy the intent to inflict harm, for example because 'it can often be unsatisfying to use something 'softer" (ID 4, occupational therapist). At best, they felt that this could render the harm minimisation method ineffective; at worst, they feared that it could contribute to further distress or frustration arising from the unmet urge to self-harm eventually leading to an even more severe act of self-harm than if self-harm were carried out initially.

Harm minimisation as a temporary solution to self-harm

Respondents described concerns over what they perceived as a misplaced focus on the client's self-harm

rather than 'engaging with the specifics of why a person is self-harming' (ID 37, social worker). Some respondents felt that if harm minimisation is practiced in the absence of therapy or without an understanding of the underlying reasons and functions of self-harm, then harm minimisation strategies 'become deliberate self-harm acts that need to be escalated to have the same effect' (ID 41, psychiatrist) and are therefore 'likely at best to be unhelpful' (ID 57, voluntary sector self-harm practitioner).

Theme 3: Ethical Considerations

Perceived as condoning self-harm

Most clinicians in this study reported that they rarely recommended techniques such as teaching anatomy, ensuring tetanus protection or teaching how to use clean instruments and this was linked to fears of being seen as condoning self-harm or 'legitimising the harming process' (ID 63, GP). There seemed to be a reciprocal relationship between concerns over advising anatomy-related techniques with concerns about giving the impression that a clinician was encouraging self-harm. One therapist explained that it made them 'wonder about the message of it's OK to cut in these places but not this place. Seems a fine line with colluding with it' (ID 83, family therapist).

Concerns regarding anatomy-related methods

Assessing risk was identified by respondents as important as this could influence the harm-minimisation methods suggested. For example, teaching anatomy was not seen as appropriate for those who were actively suicidal in case they misused this information to cause more damage or to attempt suicide. This subtheme particularly applied to data describing anatomy-related techniques that involved teaching how and where to cut safely or how to use sharp instruments, regardless of whether the clinician has recommended other harm minimisation methods.

> If you teach anatomy of which are the most 'dangerous' areas, this could provide information about how to cause harm. (ID 39, GP who did not recommended harm minimisation in their practice)

Theme 4: Perceptions of the Utility of Harm Minimisation Methods

Extent of harm minimisation effectiveness

Some clinicians who had suggested harm minimisation for self-harm deemed it unhelpful for their clients. Reasons cited included examples of clients refusing help for their self-harm, rejecting harm minimisation methods and clients' frustration at methods failing to work. However, some respondents emphasised that the utility of these approaches relied on factors such as relationship with patients, clinicians' skill and a consideration of a client's motivation for self-harm.

> Often they are most helpful when they have been thought of by the person themselves or suggested by peers, or have been developed collaboratively in a supportive relationship that recognises that one size does not fit all and that something that works for someone at one point in their lives may cease to be effective or possible at another point. (ID 57, voluntary sector self-harm specialist)

Several clinicians also felt that the setting and population played an important role and that higher risk, forensic and secondary care settings would not be suitable for the practice of harm minimisation.

> In prison one of the main reasons people self-harm is to get their needs met (e.g., to get a TV/kettle, to get a different cellmate) so often it needs to be a physical wound to be effective and other options won't achieve the same aim. (ID 26, social worker)

Several respondents felt that the utility of harm minimisation depended on the availability of resources (such as wound care supplies) and support (such as one-to-one professional support) 'at the moment of potential self-harm' (ID 8, psychiatrist). Additionally, there was a sense that recommending harm minimisation methods without considering the resources needed to use them could impact clients negatively.

> There are also adverse effects when these techniques are prescribed without discussion of whether the person has the resources to carry them out or the ability at the time of self-harm to step back and use these type of techniques. (ID 58, voluntary sector specialist)

On the other hand, GPs viewed harm minimisation as 'something to offer in the community where we have limited access to secondary care' (ID 73) and it was perceived as useful while awaiting specialist input. This communicated a perception that harm minimisation was not always reliant on the associated resources mentioned above.

Importance of person-centred recommendations

Some clinicians felt that if they recommended only a limited repertoire of harm minimisation methods, such as 'the standard techniques like rubber bands, drawing lines and ice cubes' (ID 10, assistant psychologist), without tailoring them to the individual, this could risk appearing patronising and thus cause frustration. Therefore, there was a sense that the utility of harm minimisation recommendations was dependent on whether it was delivered in a collaborative, client-led manner, taking into account the underlying reasons for why a person self-harms and whether harm minimisation techniques might be perceived as useful by the client 'as opposed to simply being given a list of options to pursue instead' (ID 87, trainee clinical psychologist).

Theme 5: Role of the Workplace

Importance of training

Those who had received little or no formal training in harm minimisation for self-harm, but instead had either taught themselves or learnt while working, expressed worries about delivering the safest or best support. A lack of training was cited by many as a contributing factor to

lacking confidence when recommending a harm minimisation approach.

However, a few respondents commented that training should be setting dependent as different environments would require different approaches that consider the limits of harm minimisation generalisability and utility. For example, a family therapist explained the reason that she felt confident in recommending harm minimisation was due to her community Child and Adolescent Mental Health Services (CAMHS) team receiving a high volume of referrals involving self-harm and a requirement to be 'familiar with this' (ID 84).

Among those who had received training, many reported that being trained was useful in learning techniques that are 'up our sleeves if we need to teach them' (ID 2, clinical psychologist), learning less-commonly known/used alternatives, improving understanding of self-harm and increasing clinician confidence in recommending harm minimisation methods.

Support derived from clear policies

Having clear policies in place was felt to be important as this support and guidance was reassuring to staff and was felt to reduce the likelihood of inappropriate recommendations relating to harm minimisation. Having clear safeguarding policies that were supported by the management chain was also felt to provide confidence in recommending harm minimisation.

> If a patient harmed themselves after I recommended one of these techniques (e.g. I encouraged them to draw on their skin and they used the pen to scratch themselves), I would probably be suspended/fired. If the [multidisciplinary team] had a policy to recommend one of these techniques and the patients found it useful, I would recommend or remind them where necessary. (ID 33, healthcare assistant)

DISCUSSION

In our national survey of clinicians working with clients who self-harm, the majority of our samples had recommended harm minimisation methods for people who self-harm, with the most cited techniques being snapping rubber bands and squeezing ice. However, there was relatively low awareness of local and national guidelines and less than half of our sample had received training in harm minimisation for self-harm. Our thematic analysis identified mixed views regarding the value of harm minimisation for self-harm. Although the perceived benefits to clients included reducing harm and developing the therapeutic relationship, we also identified some hesitation around using harm minimisation methods. Respondents expressed concerns around inadvertently causing harm instead of minimising it and appearing as colluding with the client to allow self-harm. This was particularly prominent from the data around anatomy-related methods. Furthermore, respondents conveyed a sense that when harm minimisation methods become a prescribed set of standard techniques with no consideration of the individual's reasons for self-harm, it is unhelpful at best. It appears, however, that having specific harm minimisation training for the management of self-harm and receiving support from the workplace organisation through implementation of clear policies and guidelines may facilitate effective harm minimisation use by improving confidence in tailoring harm minimisation methods to the individual.

Comparison with other studies

The mixed views on harm minimisation for self-harm in this study reflect those in the wider literature. A survey study of attitudes towards harm reduction among inpatient mental health practitioners[25] found that practitioners who had implemented a harm minimisation approach within inpatient units reported positive outcomes and an increase in perceived empowerment by patients. However, practitioners who had not used harm minimisation for self-harm expressed concerns about its potential impact on self-harm severity, managing risk, legal and ethical consequences and challenges to their moral beliefs.[25] This work suggests that concerns about risk and liability need to be balanced against the recognised potential benefits of harm minimisation methods such as wound care and damage limitation in the risk management of each individual's self-harm.[31 32] The findings of the survey study above differ from ours in that most of the clinicians in their sample had no experience of harm minimisation in practice, compared with the 84% in our sample who had used harm minimisation strategies.

Evidence shows that patients who use harm minimisation for self-harm also express mixed views. A study[33] investigating what British young people in care find helpful with their self-harm found that 34.9% identified harm minimisation as helpful but 27.8% found it unhelpful. Some respondents in our sample expressed concerns regarding the perceived potential for harm minimisation methods to cause further harm, especially anatomy-related methods. These concerns are consistent with those expressed by young people who self-harm in two other British qualitative studies.[34 35] More work is needed to further explore such concerns, also extending sampling beyond young people to adults who self-harm.

Our finding that clinicians perceived a need for clear guidelines, staff training, ensuring individualised harm minimisation advice and a well-supported workforce is consistent with previous studies in specialised settings (a forensic learning disability service and prison service).[26 36] As our study included respondents from a wide range of services, this finding may be resonant across a range of clinical settings.

Finally, we found that person-centred recommendations were viewed by clinicians as important for effective harm minimisation implementation. This accords with the original harm reduction approach described in the substance misuse field wherein users are recognised as the 'primary practitioners of harm reduction'.[37]

Strengths and limitations

We obtained data from mental health clinicians as well as GPs, who have previously been overlooked within this literature. For many people who self-harm, GPs are their first contact with formal help-seeking services and these individuals often remain the clinical responsibility of GPs.[38–41]

Our assurance of anonymity is likely to have enhanced disclosure through reduced social desirability bias, thus improving study participation over other methods. We also involved researchers from different professional backgrounds, thus increasing the credibility of the findings.[42] However, our use of Twitter and snowball sampling may have introduced selection and non-response bias, which are common in cross-sectional surveys.[43] For example, our adverts mentioned harm minimisation for self-harm and this may have led to an overrepresentation of clinicians favouring this approach. The survey also did not probe what types of self-harm clinicians usually encounter in practice; therefore, it was not possible to ascertain whether harm minimisation methods are widely applied to self-harm in general or used for specific types of self-harm. Lastly, there was a relatively low response from mental health nurses, management staff and respondents from countries beyond England, therefore limiting generalisability to those clinical groups or areas.[44]

Implications for clinical practice and policy

Our findings suggest that clinicians in primary and secondary care view harm minimisation as being potentially beneficial for clients who self-harm to reduce physical harm. In line with NICE[9] guidelines, mental health services should ensure that harm minimisation is more available as an option to clients in conjunction with therapy. In recommending harm minimisation techniques, clinicians should prioritise the client's needs and consider the function of their self-harm to empower patients to develop their own set of diverse, individualised harm minimisation techniques.

Most professionals in our sample did not report having had training in harm minimisation and many felt this contributed to their lack of confidence in implementing such approaches. To our knowledge there is no standardised training for using harm minimisation approaches for self-harm in the UK. However, some trusts have developed local training packages. In an English psychiatric hospital[45] a 25 min training session has been introduced for staff on inpatient wards, providing guidance about safe self-injury practice, opportunities to share knowledge and experiences and creating a forum for discussion and debriefing, in addition to training in formulating safe self-injury care plans. Where evaluated, those who had received the training reported feeling more confident when discussing self-harm with patients and incorporated the information into their care plans. This work suggests that training on self-harm and harm minimisation is acceptable to clinicians and should be offered to both secondary and primary care professionals, as an additional self-harm management approach. The reported concerns of some clinicians about unintentionally causing harm or being liable for harm suggests a need for clear workplace policies around harm minimisation, offering reassurance by clearly setting out safeguarding procedures, risk-monitoring practices and the clinical and legal implications of allowing a person to continue harming, although safely.

Future research

In-depth interviews with a wider range of practitioners are necessary to gain richer insights into their views, to triangulate these findings and to explore why some clinicians feel a harm minimisation approach should be avoided for certain groups of people. The willingness of clinicians to recommend more 'risky' anatomy-related methods with the prerequisite of training may be setting specific and should be explored to investigate the extent to which training improves confidence in harm minimisation use.

Future qualitative research should explore the acceptability of different harm minimisation approaches for a range of groups in community and inpatient settings, covering different age groups and ethnicities and reflecting the views of carers and practitioners. This work will inform the development of a set of trials to investigate the effectiveness of different harm minimisation approaches in specific patient groups.

Our summary of the literature has highlighted the few studies investigating the acceptability of harm minimisation approaches. A 2022 NICE evidence review[46] of harm minimisation for self-harm concluded there were no studies that met Grading of Recommendations, Assessment, Development and Evaluations (GRADE) criteria, that is, to assess effectiveness. Given these evidence gaps, future qualitative research should explore the acceptability of different harm minimisation approaches for a range of groups in community and inpatient settings, covering different age groups and ethnicities as well as reflecting the views of carers and practitioners. This work will inform the development of a set of randomised controlled trials to investigate the effectiveness of different harm minimisation approaches in specific patient groups in reducing physical damage, distress or the frequency and severity of self-harm, including any potential harms that may result from each approach.

It is also important to study whether and how training improves confidence in harm minimisation use as this may influence overall care planning. Qualitative perspectives from mental health nurses and management staff should be obtained to explore how harm minimisation for self-harm can fit into a risk management framework within clinical practice due to the prioritisation of safety and organisational reputation.[47] It is important to assess whether practitioners' sense of personal responsibility towards the client's self-harm is linked to organisational safeguarding guidelines and policies.

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