Dual harm: the importance of recognising the duality of self-harm and violence in forensic populations.

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Individuals displaying both self-harm and violent behaviour are common within most institutional settings, especially within prison or inpatient settings. However, there is a paucity of clinical guidance for the provision of effective care, with practices often emphasising the differences, rather than the similarities between these behaviours (1). There is a growing awareness of the relevance and importance of recognising 'Dual Harm' (as described (2)) with emerging evidence that can guide both our research and practice. Nevertheless, a lack of clarity remains around whether those who dual harm should be understood through a self-harm framework or a violence framework, or, as I will argue, seen as a distinct group which requires greater attention.

There is an accepted association within the literature between harm to self (either as self-harm or suicidal behaviour) and engaging in harm to others. Although significant overlap is reported across community, psychiatric, prison and school settings, little direct attention has been given to those who exhibit both behaviours and the prevalence, distinct characteristics or needs (3).

There have been difficulties in confirming the prevalence of dual harm within the general population. A recent large-scale study suggested a rate of 2.9% amongst adolescents(4) but amongst those with a history of self-harm, 29-35% will also engage in violence (3,4). Identifying prevalence has been easier within institutional settings with early studies on US psychiatric inpatients reporting a prevalence of nearly one-quarter (23%); with over half (53%) of those who self-harm also exhibiting violent behaviour (5) Recent UK studies suggest a custodial population prevalence of between 11 and 16% in men (2,6) and somewhat lower in women (7). Markedly, both studies identified that between 40 and 60% of those with a history of in-prison self-harm also had a history of institutional violence, similar to psychiatric samples. The presence of dual harm is especially raised within institutional and custodial populations. Interestingly, across settings and sex, the presence of violence amongst those who self-harm is consistently high, at one-third in community samples, rising to over half in institutional populations.

The relevance of dual harm on improving safety and security

Beyond simply an overlapping group, dual harm represents a significant safety and health improvement opportunity. Although the rates of self-harm, suicide and violence are widely reported (8-10), currently few, if any, official figures report on dual harm. However, we may want this to change as their impact can be broad, especially within forensic populations. For example, recent research (6) reported that 56% of over 4000 misconduct incidents from one prison were accounted for by the 11% of the dual harm population. This exaggerated impact suggests we should focus on early intervention, a task which requires join-up across services.

The benefits of integrated early intervention which crosses behavioural boundaries are clear, from intervening with self-harm in the prevention of an escalation of risk to self (e.g. suicide,(11)) to its development into violent behaviour (i.e. early self-harm doubles the risk of a later violent offence, (12). When considering potentially fatal outcomes, we now know that dual harm uses more lethal

self-harm methods (4,6,7,13) with over 6% of suicides having a violent conviction (14). The development of integrated and focussed intervention could significantly improve overall safety and stability far beyond the boundaries of a singular harm. However, addressing the raised risk of death or serious harm requires understanding of the distinct identifiers and needs of this group and to face challenges posed by current practice and policy.

Improving assessment for dual harm

Given the prevalence and their impact on services and society, there is surprisingly little known about the characteristics and behaviours of this group, beyond those who tragically engage in homicide-suicide. Thankfully, a duality of fatal behaviour is extremely rare, and usually occurs in a specific interpersonal context and as such, this sub-group is not a specific focus of this commentary. Nevertheless, in keeping with this broader consideration of dual harm, individuals who undertake homicide-suicide are considered distinct from those who engage in either homicide or suicide (15)

The integration of distinguishing features for dual harm may improve our assessments and aid identification and address risk development. Currently, the most consistent factor is a high behavioural versatility. Dual harm engage in very high levels (3-6 times) of disruptive and maladaptive behaviours (e.g. firesetting, disorder or criminal damage (2,6,7) compared with all other groups, which likely reflect limitations in self-regulation (4,12). Furthermore, this versality has been demonstrated in the range of methods used to self-harm (6,7,13) and may account for those who do utilise method substitution (16).

We also know that antisocial personality disorder (ASPD) appears over-represented amongst dual harm populations (4,17). Furthermore, the presence of early substance dependence (4,18) indicates a potential area for early intervention.   However, the mixed relationship between current substance use and recent dual harm within prison populations (2,6,7) suggests this may be best framed as a stable dynamic factor than an explanatory one, a finding in keeping with homicide-suicide (15). Emerging evidence amongst adolescents suggests dual harm having greater experience of violence in early childhood, early contact with the criminal justice system and a higher rate of psychotic symptoms although no difference in their contact with mental health services (4,14).

The distinctiveness of factors in this group could aid assessment or intervention focus for dual harm; utilising the breadth of maladaptive behaviour or SH method, ASPD traits, early substance dependence or psychosis (pre-18) or violence victimisation (pre-12).   However, this suggests that dual harm may initially present to a range of services (e.g. social services, substance use or criminal justice agencies), emphasising the need for all services to routinely assess the risk of harm to both self and others.

Facing the conflicts and challenges

A major challenge to confirming risk factors for dual harm has been the separation of violent and self-harm behaviours in both the academic and practice arenas, compounded by its distinction into the government arenas of 'justice' and 'health' (2). This separation is based upon outcome, rather than cause, with the fields diverging and leading to conflicts within practice. In most settings, violence is met with punishment and containment to protect others; with self-harm requiring care and compassion to protect the client (6) However, the known relationship between these behaviours makes this distinction unsustainable.

The main practice challenge with dual harm, is that the clinician must balance the risks posed to others alongside those posed to client themselves when making judgements regarding access to

services.   The decision to not expose staff or co-patients to a potential risk of harm may affect the provision of effective care and intervention for a dual harm patient in crisis. The complex needs of this group coupled with the higher risk of suicide and lethal self-harm in this group requires equivalent, robust and sustainable alternatives.

 Furthermore, evidence suggests that exclusion may lead to exceptional rates of punishment and isolation in this group, potentially due to the assumption that they need containment. Compared with violent men who do not self-harm, men who dual harm spend, on average, 40% longer in prison and over twice as many days under segregation or similar highly restrictive regimes (6,13) with little evidence of therapeutic intervention. Furthermore, this raises procedural difficulties whereby those in prison at raised risk of self-harm should only be placed in segregation under 'exceptional circumstances' (7,19) and therefore, the effective management of this group remains obscured.

Conclusion

People who dual harm make an impact, especially within forensic and institutional settings with around half of those who self-harm also expressing violence, with those who dual harm accounting for most of the wider disruption. This is a distinct and complex group and we require our research and practice to turn its lens to understanding and integrating the distinct characteristics and needs of this complex population into the development of effective assessment, intervention and management.   A conceptual move towards the integration of dual harm into everyday practice could have a significant impact on fatal incidents but also overall safety and stability within many settings (20,21). Routine assessments should cover both self-harm and violence, as separate behaviours but also as potentially linked. Integrating the wider implications of dual harm (e.g. potential for lethal self-harm, behavioural variability, experience of isolation and punishment and early life events) into staff training could improve care and risk management approaches. Finally, effective management requires greater cross-risk case management and cross-disciplinary decision making, which within criminal justice settings, this requires the routine and active participation from both health and justice colleagues.

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