

Self harm

Ten percent of Australian 14- to 15-year-olds report that they have self-harmed in the previous 12 months (Australian Institute of Family Studies, 2017) and 24% of women and 18% of men aged 20-24 report self-harming in their lifetime (Robinson, McCutcheon, Browne, & Witt, 2016). Rates of hospitalised self-harm for Indigenous people are three times higher than the rates for other Australians (Burgess, Christian, & McIntyre, 2017). Estimates suggest that 25% of people who present to the emergency department repeat self-harm within six to twelve months (Bilén et al., 2013; Saunders & Smith, 2016). However, the group of people who deliberately self-harm and present to hospital are diverse; predicting repetition is difficult (Bilén et al., 2013).

Screening tools for predicting which individuals will deliberately self-harm with and without suicidal intent are not distinguished in this research review. This follows from concerns that it is not possible to clearly distinguish these two categories; suicidal intent is often ambivalent, and non-suicidal self-injury is a strong risk factor for suicide attempt (Brunner et al., 2014). Most studies included in this review either did not distinguish the two categories or focused on self-harm without suicidal intent. It should be noted that older adults are more likely to be self-harming with suicidal intent than other age groups (Morgan et al., 2018).

There is no evidence that risk assessment scales are effective in reducing risk of self-harm. The review of assessment scales we conducted (presented in the resources section of this tip sheet, p. 4) showed that scales commonly fail to accurately predict repeat self-harm. Most scales performed no better than clinician or patient ratings of risk and some performed considerably worse. The findings support existing clinical guidelines not to use risk classification scales in isolation to predict future risk. Risk scales may be useful as tools which help structure assessments, provide prompts for factors to consider in ensuring crucial items are not missed and to help elicit relevant information.

Triggers and warning signs for self-harm

- Scars, often in patterns
- Fresh cuts, scratches, bruises, bite marks or other wounds
- Wounds that don't heal or get worse over time
- Keeping sharp objects on hand/hidden (e.g. razors, knives, needles, glass shards, bottle caps)
- Wearing long sleeves or long pants, even in hot weather
- Avoiding sports/other activities where one might have to change clothes in front of others
- Frequent reports of accidental injury
- Difficult relationships with friends or partners
- Breakdown of a relationship
- Behavioural and emotional instability and impulsivity
- Difficult feelings, such as depression, anxiety, anger or numbness
- Statements of helplessness, hopelessness or worthlessness
- Difficulties at school (e.g. not doing well academically, pressure at school, exam stress)
- Difficulties at work
- Being bullied, either at home, school or work
- Loss of a job
- Worries about money
- Misusing alcohol or drugs
- A crisis or recent difficult life event (e.g. death of a loved one, recent abuse or violence)
- Talking about self-injury (mentioning peers who engage in self-harm)
- Past self-harm
- Poor physical health (especially in older adults).

(de Cates & Broome, 2016; Garisch & Wilson, 2015; Mars et al., 2014; Morgan et al., 2018; Oginni, Robinson, Jones, Rahman, & Rimes, 2018; Stanford, Jones, & Loxton, 2017; Xavier, Pinto-Gouveia, Cunha, & Dinis, 2017).

Cultural awareness

The consumer may present in such a way that would typically indicate symptoms of self-harming behaviour, but cultural issues may provide a better explanation.

Self-harming behaviours, such as cutting and burning, are fundamentally different to ritualistic, culturally accepted Aboriginal ceremonial or grieving practice. For example, if the consumer presents with superficial cuts to their forearms following the death of a family member, this could be part of 'sorry business' which is part of the ceremony related to grieving, which includes 'sorry cuts'.

Responding to self-harm

Key practice recommendations:

1. Ensure prompt access to emergency care. This involves service management within hospital settings for prioritising the medical and mental health assessment of people presenting with deliberate self-harm.
2. Ensure prompt access to mental health assessment. Every person presenting for emergency care for deliberate self-harm should have a comprehensive mental health assessment. The minimum requirements for the assessment are described in the paragraph below these recommendations.
3. Encourage treatment engagement and follow-up attendance. Identify distress that is amenable to change.
4. Teach new coping and problem-solving skills. When compared to standard after-care, certain cognitive therapies (e.g. Cognitive Behavioural Therapy, Mentalisation Based Therapy, Dialectical Behaviour Therapy) have been effective in reducing deliberate self-harm.
5. Treat underlying mental disorders.

Assessment following self-harm

- Ask about any thoughts and plans regarding further self-harm.
- Compile a detailed review of current and past episodes of self-harm behaviour.
- Assess current psychosocial stressors and support available from others.
- Document any current alternative means of dealing with ongoing stressors.

Items to include in the care plan for self-harm

- An assessment of the consumer's mental state. The presence of self-harming behaviours indicates that the priority for

care should be around safety and strategies that will help the consumer cope (e.g. when the consumer feels like self-harming, they should seek out a support person to talk with about their problem).

- Risk factors should be documented (static and dynamic):
 - Is the consumer safe in their home environment?
 - Are there enough supports in place?
 - Is there a responsible carer/family member around at all times?
- The consumer's goals or achievements should be incorporated (positively worded).
- Set small, achievable goals, to avoid overwhelming the consumer. Address the most acute issues first. For example, address the self-poisoning or cutting first, as this can be potentially life threatening.
- The consumer and their family's views should be considered and included.
- Divide the care plan into sections which show the role of everyone involved in the consumer's care. This gives the consumer a sense of support and safety and gives all parties a sense of ownership in the recovery process.

Continuity of care

- Consumers presenting with self-harming behaviours should be followed up due to the need for ongoing assessment for severity of symptoms (e.g. assessment of ongoing self-harming, ongoing support with behavioural treatments in the community).
- Services that provide treatment for people who have self-harmed should arrange after-care using psychological or psychosocial interventions aimed at reducing repetition of deliberate self-harm.
- When someone is discharged from an inpatient setting it is important to make contact at the earliest possible opportunity to offer support, monitor self-harming behaviours, and monitor the living environment and supports.

Post-hospital strategies for people presenting with self-harming behaviours

- When the person feels the urge to self-harm, encourage them to talk to someone

they trust. If they do not feel comfortable talking to a friend or family member, refer them to their GP, a counsellor, teacher or Lifeline (13 11 14).

- Encourage the person to think about when they do and don't self-harm. Is there a particular time, place or feeling that makes self-harm more likely to occur? Also identify the circumstances when self-harm is least likely to occur. Recognising things that

trigger self-harm can help the person avoid those situations.

- Encourage the person to distract themselves when they feel the need to self-harm. It can help to wait 15 minutes and see if the urge goes away.
- Use sensory strategies. Encourage the person to focus on other things such as taking some deep breaths, taking a shower, holding an ice cube, reading a book or having something to eat or drink (non-alcoholic). Sensory approaches may help regulate their emotions and keep them busy in a positive way.
- Ask the person if they would consider keeping a diary to express their emotions. This can help them vent their feelings and cope better with negative thoughts. It can also help the person identify the feelings that lead to self-harm.
- Provide the person with information about self-harm from reputable sources such as Lifeline and Beyond Blue (links to websites are included below).

Strategies not recommended for managing self-harming behaviours

- There is no evidence that 'no self-harm contracts' are effective in reducing self-harm behaviours, rather they can actually be detrimental (Edwards & Harries, 2007; Edwards & Sachmann, 2010).
- Evidence available from a small number of randomised controlled trials (RCTs) shows that pharmacological treatment does not reduce the risk of repetition of self-harm or has an unfavourable risk to benefit ratio (Royal Australian and New Zealand College of Psychiatrists, 2016).

Resources

Table 1: Risk assessment tools for predicting self-harm

Tool/sample	Description	PPV ^a	NPV ^b	Time frame
Manchester Self-Harm Rule (MSHR) (Cooper, Kapur, & Mackway-Jones, 2007) → presented at ED with self-harm	<p>Patients who have any of the below factors are classified as being high-risk of repeat self-harm:</p> <ul style="list-style-type: none"> • history of self-harm • previous psychiatric treatment • current psychiatric treatment • benzodiazepine taken as overdose. 	21%	96%	6 months
Global clinical assessment	A clinician assessed likelihood of repeat self-harm, without a risk assessment tool, on the same sample as utilised to test the MSHR.	22%	92%	6 months
ReACT Self-Harm Rule (Steeg et al., 2012) → presented at ED with self-harm	<p>*Supersedes the MSHR</p> <p>A self-harm presentation was classified as higher risk if at least one of the following factors was present:</p> <ul style="list-style-type: none"> • recent self-harm (in the past year) • living alone or homelessness • cutting as a method of harm • treatment for a current psychiatric disorder. 	30%	91%	6 months
Comparison of risk screeners (Steeg et al., 2018) → presented at ED with self-harm	Compared the predictive accuracy of the Manchester Self-Harm Rule (MSHR), ReACT Self-Harm Rule (ReACT), SAD PERSONS Scale (SPS) and Modified SAD PERSONS Scale (MSPS) in an unselected sample of patients attending hospital following self-harm.			See lines below
MSHR	Described above.	31%	95%	6 months
ReACT	Described above.	33%	91%	6 months
SADPERSONS (SPS)	<p>The score is calculated from ten yes/no questions, with one point for each affirmative answer:</p> <p>S: Male sex A: Age (<19 or >45 years) D: Depression P: Previous attempt E: Excess alcohol or substance use R: Rational thinking loss S: Social supports lacking O: Organised plan N: No spouse S: Sickness</p> <p><u>Scoring</u> 0–4: Low risk 5–6: Medium risk 7–10: High risk.</p>	34%	72%	6 months

Tool/sample	Description	PPV ^a	NPV ^b	Time frame
Modified SADPERSONS (MSPS)	<p>The score is calculated from ten yes/no questions, with points given for each affirmative answer as follows:</p> <p>S: Male sex → 1 A: Age 15-25 or 59+ years → 1 D: Depression or hopelessness → 2 P: Previous suicidal attempts or psychiatric care → 1 E: Excessive ethanol or drug use → 1 R: Rational thinking loss (psychotic or organic illness) → 2 S: Single, widowed or divorced → 1 O: Organized or serious attempt → 2 N: No social support → 1 S: Stated future intent (determined to repeat or ambivalent) → 2</p> <p><u>Scoring</u> 0-5: May be safe to discharge 6-8: Probably requires psychiatric consultation >8: Probably requires hospital admission.</p>	32%	74%	6 months
Comparison of risk screeners (Quinlivan et al., 2017) → presented at ED with self-harm	Assessed the predictive utility of the MSHR, ReACT, SPS and MSPS.	13-40%	70-94%	6 months
Clinical and patient global evaluation of risk scales	<p>Clinician global evaluation of risk scale → 1 question which asked the respondent to estimate the likelihood of repeat self-harm within 6 months on a 1-10 Likert-type scale (e.g. "How likely do you think it is that the patient will repeat self-harm within the next 6 months?"). 1 = extremely unlikely and 10 = extremely likely. 0-5 = low risk; 6+ = high risk.</p>	47%	85%	6 months
	<p>Patient global evaluation of risk scale → 1 question which was identical to the clinical evaluation of risk, except it asked the patient to rate their likelihood of repeat self-harming.</p>	44%	83%	6 months
Barratt Impulsiveness Scale (Patton, Stanford, & Barratt, 1995)	30-item questionnaire assessing impulsiveness; 0-96 = low risk; 97+ = high risk.	42%	70%	6 months
Short-Term Assessment of Risk and Treatability (START) (O'Shea & Dickens, 2015) → secure psychiatric patients	<p>20 items need to be scored twice on a 3-point scale (0 = no/minimal strength/vulnerability, 1 = moderate strength/vulnerability, 2 = high strength/vulnerability); once in terms of risk factors and once regarding protective factors. Need to be trained to use this tool and then trained raters derive the self-harm specific risk estimate to determine low, medium or high risk. → Too time-consuming for busy, front-line staff and only predicts self-harm risk for females.</p>	55%	87%	3 months
Clinician risk assessment (Murphy, Kapur, Webb, & Cooper, 2011) → presented at ED with self-harm	A mental health nurse assessed the likelihood of repeat self-harm, without using a risk assessment tool.	25%	-	12 months

^a Positive predictive value (PPV) = the probability that patients classified as high risk of self-harming do subsequently self-harm.

^b Negative Predictive Value (NPV) = the probability that patients classified as low risk of self-harming do not subsequently self-harm.

For clinicians

RANZCP Reference guide for the management of deliberate self-harm: Key points and recommendations from the RANZCP clinical practice guideline

https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/deliberate-self-harm-reference-guide.aspx

Resources for helping consumers with self-harm are available at Orygen

<https://www.orygen.org.au/Training/Resources/Self-harm-and-suicide-prevention>

Aboriginal and Torres Strait Islander cultures and deliberate self-harm

<https://healthinonet.ecu.edu.au/learn/health-topics/social-and-emotional-wellbeing/self-harm-and-suicide/>

For consumers

Lifeline: Self-harm <https://www.lifeline.org.au/get-help/topics/self-harm>

Beyondblue: Self-harm and self-injury <http://resources.beyondblue.org.au/prism/file?token=BL/1302>

Orygen: [https://www.orygen.org.au/ Coping with self-harm: a guide for parents and carers](https://www.orygen.org.au/Coping-with-self-harm-a-guide-for-parents-and-carers)
[Self-Harm: Sorting Fact from Fiction](https://www.orygen.org.au/Self-Harm-Sorting-Fact-from-Fiction)

Calm Harm app: <https://calmharm.co.uk/>

ReachOut: Self-harm <https://au.reachout.com/tough-times/self-harm>

Project Air: Fact Sheets (see Self-Help) <https://www.uow.edu.au/project-air/resources/fact-sheets/>

The Truth about Self-Harm – A free-to-download booklet for consumers and carers

<https://www.mentalhealth.org.uk/publications/truth-about-self-harm>

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