CHAPTER SEVEN – SELF HARMING BEHAVIOURS

Helping the Consumer to Prevent Self-Harm

Aiming to Achieve the Five Cs

**Consumer and carer**
Self-harm is a behaviour and not an illness. People sometimes self-harm to deal with distress or to let people know they are in distress. This can sometimes be described as "a cry for help". There is no one cause for self-harming behaviour. Some people think that self-harming is just "an attention seeking" behaviour. This belief is unfounded and makes little of self-harm and the distress the consumer is feeling at the time. During initial contact and assessment good communication is essential for the health professional/worker in establishing engagement. Consumers exhibiting self-harming behaviours may require constant reassurance due to low mood, feelings of worthlessness and an inability to cope.

It is important not to inflict judgmental views on the consumer due to possible issues of shame and guilt and the threat of future reluctance to engage. Being non-judgmental also requires that service providers be uncritical of factors affecting many consumers over which they have little control. For example: in the case of a consumer with a long standing history of sexual abuse as a child, superficial cutting may be a learned behaviour as a means of coping as a result of poor support or treatment of the traumas they experienced in their childhood.

As discussed in previous sections, carer involvement is important. However we do have to recognise the consumer's right to confidentiality and obtaining consent prior to engaging a carer is vital. Consent can be overridden in situations where a consumer or carer may be placed at significant danger due to risk factors relating to mental impairment. For example: a consumer in crisis, engaging in self-harming behaviours, may not meet the criteria for an in-patient setting/admission however ongoing continuance of this behaviour could increase the risk of death by accident. Therefore in some situations, it is vitally important that there is carer/family involvement to ensure the consumer is safe and to remove potential items of harm. Based on context of the community (eg communities in crisis) it may be hard to distinguish a reliable carer/family member and emphasis to the importance of seeking an appropriate (suitable/reliable) other is essential.

**Context of community**
As discussed in previous sections, there needs to be continuous and effective consultation and collaboration between consumers, carers, service providers, elected leaders and community members. This is vital in developing culturally appropriate healing strategies that meet the traditional and spiritual needs of Indigenous people.

When working in Indigenous settings, we must aim to listen and learn from the people we are working with to understand about local history, issues and living conditions. The consumer may present in such a way that would in other circumstances indicate symptoms of self-harming behaviour but due to cultural issues could provide a more logical explanation.
Examples are:

- consumer presents with superficial lacerations (cuts) to their forearms following the death of a family member. It is not uncommon in some Indigenous communities for people to express their grieving through self-injury in the form of “sorry cuts”.
- Certain questions or the manner in which they are asked by the health professional/worker may be seen as inappropriate in cultural terms. Direct questioning may be seen as rude.
- Where it is necessary to address sensitive issues (eg women’s business) open the discussion by acknowledging that it might be seen as intrusive and explain why it is necessary to ask such a question.

Remember to respect cultural and health beliefs and recognise the historical and cultural factors that affect people’s health and wellbeing. Acknowledge and utilise the local community’s expertise and work in partnership. The health professional/worker should not impose their own cultural bias on others and should encourage and support local solutions.

**Continuity of care**

It is vitally important that consumers presenting with self-harming behaviours are followed up on a regular basis due to the need for ongoing assessment for severity of symptoms. Examples would be assessment of ongoing self-harming or suicidal ideation, ongoing support with behavioural treatments (medication treatments are not usually used) in the community.

Health professionals/workers should be aware that consumers who have spent time in an in-patient setting with self-harming behaviour and are discharged back into the community still need intensive follow-up.

In-patient admissions for consumers may deal with reducing risk factors and provide a safe environment while establishing the consumer on an appropriate form of treatment. This does not mean that other symptoms of the behaviour are not still present on discharge. These behaviours may be triggered for the consumer by being back in the environment that represents the original trauma.

When a consumer is discharged from an in-patient setting it is important to make contact at the earliest possible opportunity. There are a number of reasons for this:

- The health professional/worker can offer immediate support and reassurance to the consumer. Some people who self-harm often have problem-solving difficulties and they find it hard to ask for help. They may have particular problems remembering how they solved a similar problem before. This may lead to feeling a loss of control and trigger further self-harming behaviour. Thus immediate contact is vitally important to prevent this from occurring.
- The health professional/worker can obtain a true picture of the consumer’s mental state and perform a risk assessment. Some risk factors may alter from in-patient to community settings. For example, the consumer may feel isolated and unsupported in a community setting compared to the in-patient setting thus heightening the re-occurrence of self-harming behaviours.
- It allows an assessment of the living environment and supports in place.
- Contact with the consumer’s carer/family can be established offering support to carer/family, providing information on the behaviours and determining the issues and concerns that family/carers may have.
- It is important to determine the consumer’s degree of insight as this has a bearing on ongoing care, treatment and level of follow-up/intervention.
• Drafting of a community Care Plan must commence at the earliest opportunity. This should incorporate the consumer/carers’ perspective, primary health care staff, the local mental health team and local organisations that may be involved in the consumer’s care (e.g. ATODs, Life Promotions Officer, Sports and Recreation Officer.) However this will depend on available resources.

Continuity of care is essentially an ongoing activity that is performed on a consistent basis for a consumer while there is a need for support. Emphasis should also be placed on continuity of care in relation to preparing and empowering the consumer in aspects of their care. The opportunity for consumers to take control of these aspects of care is vitally important. Sharing responsibility requires a willingness on the part of the health professional/worker to view continuity as a partnership where all parties share control.

A Care Planning document is seen as an important part of managing this process and should be completed in consultation with the Multidisciplinary team, the consumer and the carer/family. The Care Plan offers a structured approach for all involved parties and can be updated as goals and treatment issues change.

**What the Care Plan should incorporate for self-harm:**

- Assessment of consumer’s mood and mental state. This can be used to determine the stage of treatment/recovery the consumer is at and can also determine if there are any underlying symptoms of mental illness (e.g. depression or schizophrenia). The presence of self-harming ideas indicates that the immediate focus of care should be around safety and employing strategies that will help the consumer cope. (e.g. When the consumer feels like harming themselves, they agree to will seek out a family member to talk about their problem, ring the health centre and/or look at the list of problem solving solutions in their notepad).

- It should be developed or altered accordingly relating to risk factors: whether that be a consumer’s risk to self, others or risk from others. Is there a risk of self-harm? Is the consumer safe in their home environment? Are there enough support mechanisms in place? Is there a responsible carer/family member around at all times? However it should not focus solely on risk factors and just because there are no risk factors does not mean that there is not an ongoing underlying problem.

- The Care Plan should incorporate positively (avoid negative comments) the consumer’s goals or achievements. Focus on strengths rather than weaknesses. Portray highlighted problems in a positive manner (For example: Sally has contacted the health centre when feeling like self-harming and has talked about her problems with staff; she is encouraged to continue doing this over the next one month period).

- It should be concise and to the point using simple language that the consumer and carer can understand. Avoid clinical jargon (Instead of: Sally will attempt to engage in alternative coping strategies prior to resorting to self mutilation, try: Sally will speak to a support person if she feels like self-harming).

- Place emphasis on achievable goals as overloading the consumer with too many goals may be overwhelming for their stage of recovery. Take the treatment phase one step at a time, with the most acute issues being addressed first. Avoid overwhelming the consumer with a long list of issues that may need addressing even if these issues are important in the consumers overall care. With self-harming behaviour it is important to address the acute crisis issues first - self-poisoning, overdosing and cutting - as some of these can be potentially dangerous or life threatening.
- Use realistic time frames and ensure the Care Plan is regularly updated emphasising the consumer's achievements (positive reinforcement of these is important so that the consumer is aware of the progress being made). For example: Sally will aim to stop her bad feelings of self-harming behaviours over the next two days. This is not achievable and the consumer who is likely to have problem solving difficulties is being placed under undue pressure.

- Ensure that the consumer/carer/family view is considered and realistic concerns for all parties are included in the document. For example: the consumer's mother states that Sally’s presentation at interview with the mental health nurse is incongruent (different) with how she is at home. Sally informs us that there are no issues currently; she denies self-harming behaviours and suicidal ideation. Sally’s mother informs that she threatens to harm herself on a daily basis at home; she made superficial cuts to her forearms yesterday and has threatened to take an overdose of tablets recently.

- Also ensure the Care Plan is split into sections emphasising the role of each individual involved in the consumer's care. This gives all involved parties a sense of ownership in the recovery process, gives the consumer a sense of support and safety and reinforces to the consumer that they are not alone. For example: the consumer will participate in regular 1:1 sessions with the mental health nurse. The carer will offer the consumer support with daily activities. The health worker will visit the consumer at home every three days for a chat and to provide further medications. The mental health nurse will follow up with the consumer on a weekly basis.

- A copy of each Care Plan should be made available to all involved parties and a copy should be kept in the consumer's file.

The frequency of visits/supportive follow-up for the consumer (daily weekly, fortnightly, monthly etc) may be determined by a whole range of factors. These factors should indicate either increased or lower occasions of service dependant upon the effect they have on a consumer’s mental health. Please refer to Chapter 5 for a list of these factors.

Ideally a consumer should have regular follow-up if any or all of these factors have been identified as prominent issues in their Care Plan. However where intense follow-up is necessary care and understanding should be given not to alienate the consumer. The emphasis should be on rapport building in a non-intimidating environment with awareness of some consumers' beliefs about shame and stigma attached to mental illness.

**Checking for change**

Utilisation of outcomes measures can be very beneficial in the ongoing care of the consumer and the direction taken based on the outcomes scores. The outcome measures should be used as the basis for determining the course of care and high scoring areas should be addressed in the Care Planning document. It is also important that the consumer/carers understand the principles surrounding the measurements and that these are used, taking into consideration cultural issues relating to Indigenous consumers. It is also important to remember that health professionals/workers who use the measurement tools must first have formal training in the area to ensure that they have a full understanding of the concepts involved. Clarification should be sought at any point where a health professional/worker has difficulty understanding or scoring a particular item.
This can be done by:
- Liaising with another worker who has outcomes training;
- The local mental health clinician/worker; and
- The Zonal Outcomes Coordinator/Educator.

Whenever completing outcomes measures with Indigenous consumers, it is extremely important to be guided by the four principles identified in Chapter Three. Principle one reminds you to involve additional informants in your assessments that lead to outcomes ratings. Remember that carer/family involvement plays a big part in providing you with greater understanding of the consumer’s experience based on the additional information and insight that they can provide. You are also expected to utilise the expertise of the Indigenous health worker or mental health worker when completing assessments.

When using the outcome measures to assess a consumer presenting with self-harming behaviour it is always important to keep in mind certain specific issues. Some of these are:
- Self-harm.
- Excessive alcohol consumption can also alter a consumer’s presentation and it is virtually impossible to obtain a clear picture of a consumer’s mental state. Alcohol consumption can cause impulsive behaviours or acts, sometimes manifesting themselves in self-harming behaviour and/or suicidal ideation. Where there may be increased risk for the consumer while intoxicated, this usually (not always though) resolves when the consumer is sober. However it is vitally important to ensure that the consumer remains safe while intoxicated or withdrawing until further assessment can be performed when the consumer is not under the influence. There is every chance that the consumer’s frequent alcohol intoxication may be a self medicating strategy for an underlying mental health problem or a previous traumatic event.
- A consumer presents with superficial lacerations (cuts) to their forearms following the death of a family member. It is not uncommon in some Indigenous communities for people to express their grieving through self-injury in the form of “sorry cuts”. It is important that the health professional/worker determines whether this act was one of non-accidental self-injury as part of a mourning ritual or an act of self-harm relating to personal issues. Carer/family members and an Indigenous health/mental health worker must be consulted to determine if this behaviour is consistent in form, intensity and duration with socially and culturally acceptable behaviours of that community.

Any information/data collected from the outcomes measures relating to the consumer’s care is confidential and it is important to reassure the consumer that all information obtained is not disclosed or used inappropriately.

**Considered clinical care**

With the Fifth “C” it is important that clinicians should consider, but not be limited to, the recommendations. The guidelines are not absolute and should not necessarily be interpreted as standards of practice. Mental health professionals care for patients with self-harming behaviour in many different settings, some of which are isolated and highly challenging, where it may not be feasible to apply all of the recommendations.
Self-harm: a Guide for Primary Care Workers, Consumers and Carers

These guidelines are an adaptation of the “Guide to Treatment for Consumers and Carers” by Jonine Penrose-Wall, Zoe Farris and Priscilla Berkery for the Royal Australian and New Zealand College of Psychiatrists. It was written in association with people recovered from self-harm and those working with them. It is intended as a general guide only and is not as a substitute for clinician advice.

About self-harm
Self-harm is a behaviour and not an illness. People self-harm to cope with distress or to communicate that they are distressed. It includes self-poisoning and overdoses, minor injury, as well as potentially dangerous and life threatening forms of injury. It does not mean body piercing, getting a tattoo, unusual sex or the recreational use of drugs and alcohol. Some people who self-harm are suicidal at the time. Others report never feeling suicidal. This guide is for and about adults who have engaged in self-harm. It aims to inform them of the best possible assessment, treatment and support and what to expect of services intended to reduce self-harm and its related suffering.

Self-harm is more common among younger people. In any year, more than 25,000 people are admitted to hospitals in Australia as a result of self-harm. Thousands more are treated in emergency departments but these cases are not included in the statistic above. Self-harm accounts for approximately 10% of all hospitalisations of young people aged 15 – 19 in New Zealand, 92% of them being due to self-poisoning. Usually, more women than men self-harm. Women more commonly take overdoses than men. Overdose is the most common form of self-harm in both Australia and New Zealand.

Indigenous people in Australia are twice as likely to die by suicide as non-Indigenous people and young Aboriginal men are at the highest risk – over three times more likely than young non-Indigenous men. Hanging is by far the most common means of suicide for both Indigenous men and women and often occurs as an impulsive act associated with intoxication and/or interpersonal conflict. While death from suicide is ten times more common among Indigenous men than Indigenous women, non-fatal self-harm is more common among women – as it is in the wider society.

Self-harm is always serious. It can cause disability and death. It is also serious because it means that a person is seriously emotionally distressed at the time of the injury.

What causes self-harm?
There is no one cause for self-harm. However, research suggests that some people seem to be more at risk than others are. These include:

- Those under stress or in crisis, and those who have self-harmed before;
- Those with mental disorders (e.g., anxiety, depression or schizophrenia);
- Those who misuse alcohol or other substances or have these addictions;
- Those who have experienced childhood trauma or abuse; and
- Those who have debilitating or chronic illness.
Is it just attention seeking?
Some people think that self-harm is “just attention seeking”. This attitude is unhelpful and it trivialises self-harm and the distress the person is feeling at the time.

This attitude does not take into account that people who self-harm have genuine difficulties coping. People who self-harm often have problem-solving difficulties and they find it hard to ask for help. They tend to have memories that over-generalise from experience and forget how they solved a similar problem in the past. They get stuck when trying to solve a current problem. This can lead to frustration and to feeling out of control. For other people, self-harm may indicate that they are experiencing symptoms of mental illness (eg major depression or schizophrenia).

Why should I get help for self-harm?
Of those who present to a hospital after self-harm, about half will never attend with the problem again. Others attend hospital again after repeating self-harm. This increases the chance of the behaviour becoming a habit as a response to distress.

Research shows that 1% of those who self-harm die by suicide within the first year of going to hospital with the problem. Some people die by accident after self-harm because of the seriousness of their injuries or the substance they took.

About half of all people who attend hospital after self-harm do so only once. Treatment teaches you new coping skills.

How do I get professional help?
It is important to get help whenever you have thoughts of self-harm. The primary care centre of the hospital is often the first place to get help. You do not have to be physically sick to get help. It is OK to talk to clinic staff about your feelings, problems, lifestyle and your overall wellbeing.

You can ask the primary care staff to arrange for you to meet with a mental health professional trained in providing treatments to reduce self-harm. The clinic staff can also work jointly with you and a mental health professional in the longer term.

In towns and cities you can also contact mental health services directly – free public mental health services are listed in the front pages of the phone book. They have “crisis teams” or “crisis and assessment teams”. Many also have workers who specialise in helping young people. Often, they will come to you and some are contactable 24 hours a day, at least by telephone. You can also call a help-line. These are also listed in the phone book and in many public phone boxes. They can’t provide “therapy” over the phone, but can help you over the initial crisis of feeling out of control, alone and unsafe. Their purpose is support and referral.

What will happen if I go to the hospital?
If you have already injured yourself, it is likely you will end up in the hospital emergency room. Here, staff will treat any injuries, assess you physically and mentally, make sure the parts of your body are working as they should, and will organise for you to get specialist help.

Can the hospital or clinic help me find mental health care?
It is an important job of the hospital or clinic to link you with a mental health worker for assessment and treatment after self-harm and find other support. For example:
- Staff may talk to a family member or friend to decide whether or not you will be safe to go home - this is to see what support you have if you leave hospital;
They may contact your local doctor to discuss the idea of you seeing him or her for counselling after you leave hospital; and

They may introduce you to, or give you the name of a mental health professional who can work through the problems that led you to harm yourself.

Some people are admitted to hospital after self-harm. Usually this is to treat a mental illness where the person cannot be treated at home. However most mental health care is provided on an outpatient basis in your community.

**Can I help myself?**

About one-half to two-thirds of people who self-harm do not keep appointments with health professionals. The steps toward helping yourself include:

- Decide to keep appointments;
- Work with the health and mental health staff;
- Find out about their training and skills so that you can have confidence in the treatment they offer; and
- Always remind yourself of the positive skills you have and build on these.

**Keeping the first appointment is a step toward helping yourself.**

**How effective are treatments for self-harm?**

It is difficult to prove that treatments work and research has not shown any approach to be clearly successful in specifically reducing self-harm. However, the main focus of treatment should be to deal with any underlying mental health problems.

**Treatment Goals**

- Treat associated mental illness;
- Prevent future self-harm;
- Improve coping skills;
- Reduce distress;
- Prevent suicide;
- Extend the time between self-harm;
- Reduce injury severity; and
- Help your family to help you.

**Treating depression**

Antidepressant medication should only be used by people if actually depressed and should be taken exactly as prescribed. SSRIs are a class of anti-depressant medication that are effective for treating depression. Some people can feel agitated on SSRIs and should report this to their doctor. It was once thought that SSRIs prompt suicidal feelings. However it has been shown not to increase suicidal behaviour.

**Treating bipolar disorder**

Lithium is a mood stabilising medication for bipolar disorder - a kind of mood disorder. It has side effects and can become toxic over time. A doctor must monitor it regularly. It has been shown to reduce self-harm in those with bipolar disorder and some people diagnosed with some sorts of personality disorder. It should only be taken if prescribed.

**Psychological treatments**

Cognitive behaviour therapy (CBT), Problem Solving Therapy (PST), Dialectical Behaviour Therapy (DBT) and Interpersonal Therapy (IPT) are all forms of psychological treatment with proven effectiveness for helping people with depression, anxiety disorders and other mental health problems. There are no side effects. There
is some research to show they may help people reduce risk for self-harm. Health professionals need special training to use these treatments.

**What other things may help?**
Coupled with looking after yourself and your relationships, and thinking positively about the future, most agree it is possible to overcome self-harm in time. It is recommended that you use the recommended research-based treatments for any mental disorder you might be experiencing and get help to cope with stress.

Some people have found the following to sometimes be helpful:
- Attending support groups for people with similar problems;
- Reading books about other peoples’ recovery;
- Continuing activities that are positive in your life and to be hopeful about the future;
- Continuing positive relationships and observing the coping styles of other people; and
- Reading information on the internet that advises on how to get the most out of mental health care.

**Help Lines and Referral Services**
If you wish to talk to someone about deliberate self-harm the most useful contact is your primary care service.
- To find out what mental health services are available in your area look in the “Emergency Health and Help” section of your local White Pages.
- If you need to talk to someone urgently please call:
  - Lifeline Australia 13 11 14
  - Just Ask Mental Health Information and Referral Service 1300 131 114
  - Kids Help Line 1800 55 1800
- Your state or territory association or foundation for mental health. Contact details can be found in the phone book.
Adult Deliberate Self-Harm: a Guide for Clinicians

These guidelines are an adaptation of the “Summary Australian and New Zealand Clinical Practice Guidelines for the Management of Adult Deliberate Self—Harm”, published in Australasian Psychiatry by Philip Boyce, Greg Carter, Jonine Penrose-Wall, Kay Wilhelm and Robert Goldney for the RANZCP Clinical Practice Guideline Team for Deliberate Self-Harm (Boyce, Carter et al 2003) which are themselves based on the RANZCP full guidelines (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Deliberate Self-harm 2004). NH&MRC-defined levels of evidence for each suggestion are recorded in the text and information regarding these is published elsewhere (Boyce, Ellis et al 2003; Boyce, Ellis et al 2003) and includes a description of the guideline development process. Consumer guidelines have also been developed. While the levels of evidence are retained in this document the reader is referred to the original documents for full referencing.

Overview
This guideline covers self-harm regardless of intent. It is an evidence-based guideline developed from a systematic review of epidemiological, treatment and medico-legal literature. All patients presenting after deliberate self-harm should be comprehensively assessed to detect and treat mental disorders, alcohol and other drug problems and personality disorders. Immediate management aims to ensure safety from further self-harm, assess and treat injuries, prevent disablement and death as a result of injuries or poisoning, and manage suicide risk by ensuring prompt psychiatric referral and mobilising social supports. Psychological management aims to detect and treat underlying mental disorders, reduce distress and enhance coping skills and thereby, reduce repeat episodes and habituation of self-harm. Managing suicide risk is a continuous responsibility and suicide vulnerability may persist long-term in some patients. There is little firm guidance from the literature on treatment efficacy to guide ongoing psychiatric management. The mainstay of psychological care remains the treatment of underlying mental health disorders. Cognitive—oriented therapies and problem-orientated approaches appear promising for reducing repeated self-harm for most patient groups but no single treatment has confirmed superiority. There is no one recommended pharmacological treatment specifically to reduce self-harming behaviours.

Introduction
Deliberate self-harm (including self-injury and self-poisoning with or without suicidal intent) is a common and serious health problem. Engaging patients in treatment and providing effective services are challenges, particularly in light of the need to screen for and manage suicide risk in this diverse patient group. This summary is intended for use by clinicians. Research shows [III-2] that improved service organisation, if sustained with staff education and supportive management, can reduce barriers to accessing specialist mental health care by these patients. International reviews and existing clinical and service development guidelines on deliberate self-harm (see comprehensive version) report that clinician and patient attitudinal barriers, fragmentation in the organisation of mental health services, and less than optimal links between specialist and primary care pose barriers to effective care.
Definitions
Deliberate self-harm is defined as an act of intentional self-poisoning or self-injury, irrespective of the apparent purpose of the act. Self-injury includes a wide variety of behaviours: self-mutilation; cutting; jumping from heights; attempted hanging; car crashes that are deliberate; and burning. Self-poisoning refers to an overdose of medications or the ingestion of other substances. Self-mutilation usually refers to self-harm where non-suicidal intent at the time of the injury is clear. This does not include culturally informed and socially sanctioned behaviours involving self-injury as occurs in some tradition-oriented societies in association with mourning and other rituals.

Overview of deliberate self-harm
Although it evokes strong negative feelings in some health professionals, repeat deliberate self-harm is a relatively infrequent problem with a low base rate of presentations. Furthermore, between 41 and 70% of adolescents and adults who present with an index episode of deliberate self-harm do not attend follow-up treatment. This hampers the further development of an evidence base for individualised treatment approaches. The mainstay of treatment is the detection and management of underlying mental disorders and the prevention of further episodes. Most current knowledge about the patient population is based on non-Indigenous hospital studies and little is known about deliberate self-harm in the wider Australian or Indigenous populations. In hospital samples, psychiatric disorders are present in >50%. Drug and alcohol abuse, personality disorders and physical illness are all over-represented. Elevated rates of suicide attempts have been demonstrated among those with childhood sexual abuse histories. Intoxication with alcohol and other substances is common prior to self-harm and may confound diagnosis and complicate assessment and management. Patients may be difficult to engage in a therapeutic alliance. Although the majority harm themselves only once, management requires providing assessment to the large numbers of persons presenting with varied needs. Services must determine management approaches that are feasible to deliver. Mental health teams must be able to direct long-term effort toward those at most risk of repeat episodes. Public health approaches are used in combination with clinical service delivery approaches.

Overview of the clinical epidemiology: rates of deliberate self-harm
Notwithstanding the lack of comparable definitions and outcomes, hospital registration studies in Australia and New Zealand in 1997/1998 and in 1998/1999, report the rate for self-harm between 73 and 159 per 100 000. This is likely to be an underestimate. The most common form of deliberate self-harm is self-poisoning, which accounts for between 73 and 84% of all hospitalised cases. Deliberate self-harm is more common among women and the highest rate is among men aged 25–34 and women aged 15–24. Risk of repeat is highest in the first 3–6 months and declines slightly after, but remains high for a significant proportion of patients in the long-term, with a cumulative rate of approximately 10% at 10 years. Patients presenting with deliberate self-harm experience higher death rates from other causes.

The completed suicide rate is twice as high in the Indigenous compared to the non-Indigenous population with the highest rate being for males aged 25 to 34 (83 per 100,000, 3.5 times higher than for non-Indigenous males). The highest rate for females is for those aged 15-24, being 20 per 100,000 (6 times the rate for non-Indigenous females in this age group). Hanging is by far the most common means of suicide, accounting for two thirds of both Indigenous male and female deaths compared to 30% and 21% for non-Indigenous males and females. Suicide has increased dramatically over the last three decades from rates that were very low.
This increase was initially in urban and town settings but suicide now occurs across urban, rural and remote communities. Indigenous self-harm tends to be impulsive (often associated with intoxication and interpersonal conflict) and public. Whereas completed suicide is much more common among Indigenous males compared to females (rates some ten times greater), as in the wider community non-fatal self-harm is more common among Indigenous females (Hunter 2005 [in press]). A study based on interviews with 183 youth in Western Australia found 30% at high to very high risk of depression, 40% at risk of suicide, and 40% at risk of impulsive behaviour (Westerman 2003).

Assessment

Initial acute management

Hospital management involves treating the effects of the injury or poisoning through coordinated multidisciplinary care. Once stabilised, the patient must have a comprehensive mental health assessment including information from relatives, primary care practitioners, or those attending with the patient collected and documented. Acute management involves:

1. engaging and establishing a therapeutic alliance with the patient and relatives;
2. identifying and treating underlying mental disorders where present;
3. comprehensive assessment of risk of harm to self and others;
4. psychosocial assessment;
5. initiating treatment planning with patient, family and other health services;
6. documenting the assessment status of the person’s safety between transitions of care and at discharge from the hospital; and,
7. including longer-term goals such as enhancing resilience and promoting adaptive coping strategies. It is essential that every patient has a complete assessment and mental health services should be organised to make this possible. There is evidence that patients not assessed have higher rates of repetition and completed suicide [III].

Conducting the comprehensive assessment

A comprehensive assessment will not be complete until the patient’s cognitive function has returned to normal; in particular, following an overdose of medications that can impair cognition. The patient interview should be conducted in a safe and secure environment and there is a need to balance privacy, dignity and security considerations [V]. As a minimum, it should include initial and ongoing assessment of mental state, detection of mental disorders; and assessment of risk of harm to self and others. This should include:

1. eliciting any thoughts and plans about further self-harm;
2. the detailed review of current and past episodes of self-harm behaviour;
3. assessment of the patient’s current social circumstances, and any alternative means of dealing with ongoing stressors; and
4. assessment of current psychosocial stressors and available support from others.

Clinicians should also follow policy and procedures advised by their employing organisation where these policies are current and appropriate. Numerous risk assessment protocols for measuring suicidal risk have been evaluated. These facilitate clinician recall of the domains of risk to cover and those recommended by local hospital policy should be completed clearly in the patient’s file. Even with validated risk assessment tools, no single tool is sufficient and assessment efficacy remains a problem.
All patients presenting after deliberate self-harm should be given a comprehensive psychiatric assessment. Mental health services should be involved as soon as possible. The key management approach includes coordination between the medical and mental health teams. Acute management should include risk assessment, mental health assessment, psychosocial assessment as well as an assessment of the availability of local services. Regardless of whether their role is short-term or long-term, health professionals should aim to form a therapeutical relationship, respecting the patient’s predicament and seeking to understand the problems they have. Eliciting guarantees of safety from the patient or developing “no self-harm contracts” are not sufficient as sole management strategies and are not recommended. Clinicians should not rely upon one risk assessment protocol as a sole management strategy. Clinical judgement and effectively engaging the patient is the mainstay of providing quality care to a highly distressed person. Any documented risk assessment form completed should, however, be placed in the patient’s notes.

Issues

**Acute management**

Key medico-legal considerations include:

1. assessing “competence” of the patient for providing informed consent to treatment;
2. facilitating informed consent;
3. ensuring clinician knowledge about appropriate mental health legislation;
4. ensuring “duty of care” for patient safety during episodes of care and during transfer to other settings; and
5. attending to concerns about confidentiality (risks to safety mean that confidentiality cannot be preserved, but the patient should be consulted wherever possible regarding what is said and to whom). Protocols should specify lines of responsibility and how to access senior medical clinicians for assessment, second opinions and treatment planning. These protocols should ensure that support is provided to family members.

**Ongoing care**

Identifying and treating underlying mental disorders where present is the mainstay of preventing or reducing the severity of future self-harm. Patients may appear to reject help from health professionals and may be difficult to engage. Many will not return for appointments. Dysfunctional coping styles and chaotic help-seeking by some of these patients can compromise therapeutic efforts and require a work environment supporting clinician reflection and awareness and thereby enabling sustained engagement.

Clinicians need to develop appropriate strategies for support that could include supervision, peer discussion and training specific to the management of patients who self-harm. Clinicians should assess the extent to which family members and significant others, where appropriate, can act as treatment allies particularly where there is a risk for suicide. A high index of suspicion for suicide is always prudent and helping carers manage this risk is essential. Treatment should be delivered in an atmosphere of optimism for recovery from any present mental disorder, and of optimism that change toward positive problem-solving and coping styles can be achieved.
Current treatment evidence
The goals of services provided to patients following self-harm are to increase the patient’s resourcefulness and positive coping, to prevent repeat episodes or habituation, to reduce distress to patients and relatives, and to prevent suicide. For those few patients with habitual self-harm, it aims to prolong the period between episodes of self-harm and reduce injury severity. Any present mental disorders should be treated according to recognised evidence-based treatment guidelines. Treatment planning should be collaborative with the patient and take into account patient preferences. Both psychological and pharmacological treatments have been evaluated. The following is an evidence summary concerning treatments evaluated to reduce self-harm specifically and are synthesised into six key practice recommendations.

1. **Ensure prompt access to emergency care**
The key issue is service management within primary care and hospital settings for prioritising the medical and mental health assessment of patients presenting with deliberate self-harm.

2. **Ensure prompt access to mental health assessment**
All patients presenting for emergency care following an episode of deliberate self-harm should have a comprehensive mental health assessment. A properly trained health professional, ideally a mental health professional, should conduct this assessment. The minimum requirements for the assessment have been described in the section on conducting the comprehensive assessment.

3. **Encourage treatment engagement and follow-up attendance**
It is essential to engage the patient for assessment of risk and to detect potential mental health problems, psychosocial disadvantage or distress that is amenable to change.

4. **Teach new coping and problem-solving skills**
When compared to standard after-care, certain cognitive oriented therapies have been found promising in reducing morbidity associated with deliberate self-harm.

5. **Treat underlying mental disorders in those who self-harm**

**Patients with mood disorders**
Limited evidence is available on the role of antidepressants and antipsychotics, and there is reported caution about the role of anxiolytic medications for reducing self-harm specifically. Tricyclic antidepressants are not recommended for patients at risk for self-harm due to safety in overdose concerns. Selective serotonin reuptake inhibitors (SSRIs) are thereby recommended for most patients. The SSRIs are indicated only if the patient is currently depressed. In general, treat depression assertively and exercise caution about the potential lethality of any prescribed medications. Considerable evidence indicates that lithium, other mood stabilisers and anticonvulsants are effective in the treatment of depression among patients with bipolar disorder. Thus these drugs play a key role in the management of the disorder and probably in the reduction of the very high risk (15–20% die by suicide) of suicide among these patients.

**Patients with schizophrenia and other psychotic disorders**
A multicentre, randomised international trial comparing atypical antipsychotics recently reported that clozapine reduced repeat self-harm in hospitalised patients with past self-harm histories when compared with olanzapine.
Patients with personality traits and disorders
Dialectical behaviour therapy has been shown to reduce self-harm in patients with borderline personality disorder and histories of multiple self-harm episodes.

Patients with alcohol and substance misuse
Coexisting alcohol and/or other substance misuse should be addressed and where appropriate specific dual diagnosis interventions utilised.

Avoid approaches where there is evidence of harmful effects
There is caution in the literature about contracting people not to self-harm because this approach may be applied unskilfully, or it may be over-relied upon as a sole management strategy. There is some evidence that certain approaches (such as recovered memory treatment with people who have a history of childhood trauma [III-3]) can increase the risk of self-harm.

A general management principle is to assist entry of the patient to mental health services in a streamlined and well-organized intake process that is known to all medical and non-medical disciplines within the health service. Clinicians should take into account usual standards for culturally sensitive engagement with patients after self-harm from Maori, Pacific Islander, Aboriginal and Torres Strait Islander and other cultural or age groups. The management of comorbidity underpins much clinical management of deliberate self-harm. Comprehensive assessment includes the assessment of substance misuse and/or addiction, and treatment planning should ensure management or referral for management of substance misuse issues.

Conclusion
Our review confirms previous findings that there are promising but no proven superior therapies for reducing deliberate self-harm in all patient groups. However, this is a highly diverse population and further research on specific subgroups is needed. An evidence base is emerging for reducing risk in some clinical subgroups and in how to engage patients in treatment and reduce their distress by better service organisation and responsiveness.