

INVITED
COMMENTARY

The challenges of managing self-harm effectively

INVITED COMMENTARY ON... SELF-HARM IN ADOLESCENTS[†]

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SUMMARY

This commentary discusses how much we appear to know about self-harm and the circumstances in which it may occur but how little we really know about what works in managing it. It reviews how suggestions for its management conflict with what we know about self-harm and the outcomes of young people. The challenge appears to be how better to identify those at risk of further self-harm and to train frontline staff in this, so that at-risk individuals may be referred to specialist services. Perhaps there is also a need to review the evidence for what actually works in reducing repetition of self-harm.

DECLARATION OF INTEREST

None.

Having read Wood's (2009, this issue) article, I was left wondering how much we appear to know about self-harm and the circumstances in which it may occur, but how little we really know about what works when trying to manage it. There may be several reasons for this situation. There is no doubt that self-harm raises concern in most professionals that come across it, but so much of it is a 'one-off' occurrence that it does not need managing as such. For many, is a risk assessment the intervention to make and is it enough?

Clinical approaches to self-harm in young people

There is now some good evidence that most young people who self-harm are not mentally ill (Hawton 2008); instead, self-harm is usually related to life problems and is generally of low suicidal intent. Anyone who has undertaken on-call or self-harm work for any length of time would likely agree that this reflects clinical experience. It then raises the question as to why, despite all this, every young person who self-harms warrants a mental health assessment.

Psychiatrists often come under pressure for medicalising everyday life: is self-harm an example

of this? If self-harm in young people is related to life problems, should there be more involvement of Social Services to help young people? There is a tendency for non-mental health professionals to hear the term 'self-harm' and immediately assume that this falls under the remit of mental health services. Perhaps mental health professionals should be challenging this perspective given the evidence above. All doctors should be able to undertake a basic psychiatric history and risk assessment. If, as Antipodean guidelines suggested (Australasian College for Emergency Medicine 2000), risk was categorised as immediate, serious or lesser, a more measured response might be made. This position was also supported by Hawton & James (2005), who stated that all young people who have self-harmed in a potentially serious way should be assessed in hospital either by a child and adolescent psychiatrist or specialised mental health professional, although 'serious' self-harm was not defined. This is in contrast to the 'one-size-fits-all' approach advocated by the National Institute for Health and Clinical Excellence (National Collaborating Centre for Mental Health 2004) that all children or young people who have self-harmed should be admitted overnight.

Reducing the risk of repetition

Hawton & James (2005) stated that 30% of young people who self-harmed reported previous episodes. Repetition appears to be most likely where there is significant psychosocial disadvantage or mental health problems. This would suggest that we need a more multidisciplinary approach to managing self-harm. For those where the psychiatric risk has been assessed as low, should other services be more actively involved to prevent further self-harm? The argument that early intervention, sensitive management and, where necessary, prompt referral to specialist services will improve management of this complex behaviour (Nursing Times 2008) contrasts with that of Burns et al (2005), who found that the evidence base for treatments designed to

reduce the repetition of self-harm in adolescents is very limited.

Is there such a low rate of repetition for most young people who are assessed (Hawton 2008) because of the involvement of mental health services? Perhaps we are sympathetic to the distress that young people experience, and the opportunity to be heard and reassured prevents further self-harm episodes. It is difficult to consider how we could measure whether the effect of the assessment process itself perhaps has a beneficial therapeutic effect.

The challenges faced

As an experienced child psychiatrist, I was disappointed to find that very little has changed in how we respond to self-harm in that there is still little good evidence of how those that do repeatedly harm themselves can be effectively treated (Burns 2005). Is it time to review the terminology, as 'cutting' and 'overdoses' fall under the self-harm umbrella but most cutting probably does not even present to services? I wonder whether we need to do more to identify those episodes of self-harm that are potentially serious, and to target resources; the challenge is how. Many in primary care services would currently struggle to identify the episodes that are serious and those that are not. Maybe in addition to assessing individuals at greater risk of further self-harm, child psychiatrists and other mental health professionals should also be doing much more to educate parents, teachers and others who see children and young people in their everyday lives. Non-specialist professionals and parents may need help to consider all the issues surrounding self-harm and understand that mental health problems are not common in young people who self-harm but that many social issues

are. Also, how much of self-harm is learnt from friends and family and perceived as a 'normal' coping response?

Wood (2009) concludes that the challenge for professionals is to identify those young people at risk of death. I would suggest that the challenge is far greater. I do not believe that we will ever prevent young people from using self-harm as a coping mechanism. However, the fact that it remains such a common response to acute distress without suicidal intent suggests that we still have a long way to go in supporting young people through adolescence in ways that resonate with them. This may be an ideal opportunity to involve young people in helping us come up with some solutions, as to date we are still struggling.

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