Responding to Self-Harm in Scotland Final Report

Mapping Out The Next Stage Of Activity In Developing Services And Health Improvement Approaches

The Scottish Government

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The Scottish Government
St Andrew's House
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EH1 3DG

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RESPONDING TO SELF-HARM IN SCOTLAND
FINAL REPORT

Mapping Out the Next Stage of Activity in Developing Services and Health Improvement Approaches

Background

1. Truth Hurts, the report of the UK National Inquiry into Self-harm among Young People (2006), proposed a comprehensive approach to self-harm involving both a generic focus on mental health improvement as well as behaviour specific information, training and intervention. The independent evaluation of Choose Life also recommended development of responses to non-fatal aspects of self-harm.

2. The Scottish Government made a commitment in Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-11 to improve the knowledge and understanding of self-harm in Scotland and to prepare an appropriate response. The Government said that it would work with partners to:

- agree a definition of self-harm and develop a non-stigmatising language and description of self-harm;
- increase awareness of self-harm and its determinants;
- map and assess existing training provision and projects across Scotland;
- increase our understanding of effective methods of prevention and offer guidance to those delivering both general and specific services;
- develop local and national information.

3. A National Self-Harm Working Group was established in August 2009 (see **Appendix A** for the members of the working group) to take these tasks forward and to map out the next stage of activity in developing services and health improvement approaches.

4. The Interim version of this report was developed and agreed by the Working Group and presented as a consultation document for wider engagement and input. This Final Report has been developed following that engagement, and agreed by Scottish Ministers. It is presented as a work plan

of objectives that will form the basis for more specific action during implementation.

Definitions: What is Self-Harm?

5. For the purposes of this work the National Self-Harm Working Group adopted the definition provided in the latest National Institute for Health and Clinical Excellence (NICE) guidelines on self-harm:

> **"self-poisoning or self-injury, irrespective of the apparent purpose of the act"**

Cumulative research evidence from the UK and elsewhere suggests that the majority of acts of self-harm are not intended to end a person's life (therefore not 'suicide attempts'). Attempted suicide *is* included within the scope of the adopted definition. However, throughout this report note is taken of the evidence showing that the majority of acts are at the other end of the scale, i.e. an act which enables people to cope, with the intention of staying alive.

6. We have applied three exclusions to the definition for the purposes of our work, self-harm through substance misuse (alcohol & drug), accidental self-harm and self-harm related to eating disorders, as there is already separate action in place to address these in Scotland, irrespective of whether these behaviours are motivated by self-harm. It is important to note that we do recognise the relationship that drinking, recreational drug use and eating disorders have with self-harm, and if these behaviours are co-occurring with the definition adopted here, those aspects of behaviours that fall within the definition would come under the scope of work. Examples of policies and initiatives through which these related issues are being addressed include: in the case of alcohol and drugs, Changing Scotland's Relationship With Alcohol: A Framework For Action; embedding of Alcohol Brief Interventions; establishment of Alcohol and Drugs Partnerships; The Road to Recovery:

National Drugs Strategy. In relation to eating disorders, NHS Boards continue to work towards improved access and outcomes for service users and carers based on prevention, appropriate intervention and sustained recovery in line with clinical guidance and the NHS Quality Improvement Scotland (QIS) Recommendations for the Management and Treatment of Eating Disorders in Scotland.

7. The determinants of self-harm are many and complex; however, self-harm is commonly understood as a behavioural response to, or reflection of, emotional or psychological need. It comprises two main types of behaviour, **self-poisoning** and **self-injury**.

> **Self-poisoning** includes the ingestion of a substance in excess of the prescribed or generally recognised therapeutic dose or of a recreational or illicit drug in a way that is intended to be self-harmful, rather than in connection with addiction / dependence.
>
> **Self-injury**, also referred to as self-mutilation, self-injurious behaviour, non-suicidal self-injury, is harm to the body, commonly by cutting with a sharp object, but also by burning/scalding, inserting or swallowing sharp objects, hair-pulling, biting, hitting/punching, banging (head or other body parts), scratching or jumping from height.

8. The majority of acts of self-harm are not intended to end a person's life. However, depending upon the apparent or stated purpose of the act, self-harm may be referred to by a number of terms, some of which reflect suicidal intent, if this was present. These terms include: deliberate self-harm, intentional self-harm, self-inflicted violence, parasuicide, attempted suicide and non-fatal suicidal behaviour. A self-harmful act may or, more frequently, may not be accompanied by suicidal ideation (thoughts about self-inflicted death) or suicidal intent (seriousness or intensity of wish to die), and so no assumption should be made about the extent to which any particular self-harmful act is oriented towards death ('suicidal'). The level of suicidal intent may range from being completely absent at one end of the spectrum, where

self-harm is more about coping with difficult feelings or processing emotional distress, and can at times be life-preserving; a way of averting or dealing with suicidal impulses, while at the other end of the spectrum the level of suicidal intent may be extremely high, where the aim was to die, but this was, for whatever reason, not successful.

9. While the vast majority of people who self-harm do not go on to take their own lives, people who harm themselves are at increased risk of future suicide. Estimates, based on hospital admissions for self-harm, show that the level of increased risk ranges between 0.5% and 2% after one year, which is up to 100 times higher than in the general population, rising to above 5% after five years.

Risk Groups: Who self-harms?

10. The evidence would suggest that younger people are more likely to engage in acts of self-harm than adults and that experience of a severe life event (especially interpersonal loss), trauma or symptoms of depression / anxiety are likely triggers for the behaviour in many cases. However, these generalities mask a wide variety of circumstances that are covered by the self-harm label.

11. While acknowledging that self-harm is not specific to any age, gender, ethnic group, sexuality, disability group, sector of society, or set of life circumstances and events, there may be certain groupings among all of the above where self-harm is more prevalent, and any future work would aim to be sensitive to the needs of these groups of people.

12. The Working Group commissioned a series of vignettes to illustrate the variety of circumstances where self-harm may occur, and these are set out below. These examples do not describe single individuals; rather, they are composites which draw on practitioners' knowledge of circumstances in which

people self-harm. They are for illustrative purposes only, and do not cover all circumstances in which self-harm occurs.

Composite Vignette A. A female pupil in first year at high school. She was a happy girl from a loving family. Her primary schooling was a success and she was excited about her high school career. A group of girls have started bullying her. They are sending her texts and messages on the internet telling her they are going to beat her up. She is terrified and one evening she cuts her arms and takes an overdose of her mother's pain killers. She recalls having fleeting thoughts of wanting to end it all but says her intention was not to die.

Composite Vignette B. A male in his thirties. At the age of 9 he was taken into care as his parents were abusing heroin. His life since then has mostly been in foster care, young offenders' institutions and now prison. He has a deep feeling of self hatred and when he can, he swallows pieces of broken glass or razor blades in an attempt to atone for his badness.

Composite Vignette C. A female pupil in fifth year at high school. She presented herself to the school nurse. She was upset, unhappy and admitted to recently cutting herself. She got the idea to cut herself from an internet site. The cutting helped her release a feeling of pressure. She said that she felt teachers were having a go at her for not concentrating in class and she felt under pressure from her father who was unhappy with her recent school reports. The school nurse, on reading her records, noticed she had been diagnosed with ADHD (attention deficit hyperactivity disorder).

Composite Vignette D. A male in his twenties. Since leaving school he has been on one or two short training programmes, but has been out of work for the past few years. He spends his nights drinking and his days in bed. Every few months when drunk he overdoses on whatever tablets are around. At the time he wants to die as he sees no hope. After each

overdose he ends up in A & E and is given an appointment with the mental health services. He never attends these appointments.

Composite Vignette E. A female in her forties. She is head teacher of a primary school. She is married to an architect. They have just had their first child and she has been diagnosed with post-natal depression. She feels distant from her newborn child and a failure as a new mum. The increased support from the health visitor has added to her sense of worthlessness and in order to punish herself she began cutting her thighs with a pair of scissors.

Composite Vignette F. A female in her thirties. She has been married for 15 years; her husband assaults her regularly. Following these violent episodes he apologises and promises it will never happen again and life becomes calm for a few days. She has been burning her stomach with an iron for 4 years now. No one knows. She states the pain from the burn brings about the same sense of calm that follows her assaults. She is deeply unhappy.

Composite Vignette G. A 17-year-old female. She found herself in a homeless hostel after a fall out with her family. Her mother had not believed her allegations that her stepdad had sexually abused her from the age of 12. She felt alone, angry and ashamed. At night in her room her emotional distress was keeping her awake; she swallowed 12 Paracetamol tablets to try and numb the pain she felt inside.

Composite Vignette H. A 13-year-old male. He lives at home with his mother, who left his father when he was six, due to domestic violence and his father's alcohol abuse. He experiences feelings of rage which he can't explain. He has behaviour problems at school and experiences difficulties in maintaining friendships. He started cutting his arms with a sharpener blade which helped him get rid of his anger. He doesn't want to stop as he has met friends who also cut themselves.

Composite Vignette I. A 14 year old female. She is out on a Friday night drinking with some friends. She is having a good time. Her boyfriend texts her to let her know that she is "dumped" and he is seeing someone else. She goes to her local garage and buys two packets of Paracetamol and swallows them with her vodka. She tells her friends what she has done. They call an ambulance and she is taken to A & E.

Prevalence and Incidence: What's Going On?

13. It is impossible to provide a definitive picture of the prevalence and incidence of self-harm in Scotland. While there is some evidence about the prevalence of self-harm among adolescents, no general population survey of self-harm has ever been conducted. A national investigation of non-fatal suicidal behaviour among adults (16-74 years) in Great Britain reported that 4.4% (3.6% of men and 5.3% of women) had made a suicide attempt at some time in their lives - based on a positive answer to the question "Have you ever made an attempt to take your life, by taking an overdose of tablets or in some other way?". A further 2.4% (2.0% of men and 2.7% of women) had engaged in deliberate self-harm without suicidal intent - based on a positive answer to the question "Have you deliberately harmed yourself in anyway but not with the intention of killing yourself?" (Meltzer *et al*., 2002). Disaggregated data for Scotland are not available.

14. The main source of information about self-harm in Scotland is hospital admission / discharge data. **Table 1** shows the number of acute hospital stays in NHS Scotland in 2007/08, 2008/09 & 2009/10 (provisional) where a diagnosis of intentional self-harm was recorded. A hospital stay is defined as a continuous spell of treatment in hospital and is counted against the year in which the stay finishes. During a hospital stay the patient may change consultant, change speciality or may be moved from one hospital to another. There were 13,825 stays in 2007/08, 13,402 in 2008/09 and 12,741 in 2009/10. Self-harm can occur at any age but is most common in adolescence

(among females) and young adulthood (both sexes). The peak self-harm rate – based on the hospital stay data - was found in the 20-29 age group, with risk of self-harm tending to decline with increasing age. The Scottish data on hospital-treated self-harm during the period 2007/08 – 2009/10, as set out in **Table 1,** shows a downward trend of 3% in 2008/09 and 7.8% in 2009/10, when compared with 2007/08 figures.

15. It is almost certainly unsafe to generalise from hospital data to the situation in the community at large. Many acts of self-harm do not receive medical treatment; thus, hospital attendance rates do not reflect the true scale of the problem. This is particularly true of adolescents and young adults. Fewer than 13% of episodes of self-harm among 15-16 yr olds in an English survey resulted in presentation to hospital. Moreover, at least 80% of self-harm related admissions to hospital are for self-poisoning, as people who self-poison are more likely to seek help than those who self-injure. It is estimated that, among teenagers in the general population, self-injury is more common than self-poisoning, perhaps by a ratio of 2:1. Hospital data probably also underestimate gender difference, especially in adolescence when, based on self-report studies, the evidence would suggest girls may be three times more likely to self-harm than boys.

16. A school-based survey sought to determine the prevalence of self-harming behaviour and serious thoughts of self-harm among 2008 adolescents aged 15-16 years in Scotland (O'Connor et al 2009). Presence of self-harming behaviour was defined as a positive response to the question "Have you ever deliberately taken an overdose (e.g. pills or other medication) or tried to harm yourself in some other way (such as cut yourself)?". **Table 2** presents the main results. More than one in eight (13.8%) reported at least one episode of self-harm during their lifetime, with a nearly threefold difference between girls (19.9%) and boys (6.9%). These prevalence estimates are similar to those reported in England, Ireland, Belgium, Norway, Australia and USA, and higher than those reported in The Netherlands and Hungary.

What Next: How Should We Respond to Self-Harm?

17. As set out in paragraph 1 of this document, Truth Hurts recommended *both* a generic focus on mental health improvement *and* behaviour specific information, training and intervention. Based on this, and our understanding of self-harm we suggest the following overarching **Primary Objectives** for policy:

PO1. Reduce the number of people who are experiencing psychological distress through general approaches which reduce self-harm and increase capability in people and communities.

PO2. Improve the general service response to people who are experiencing psychological distress, whether exhibited through self-harming behaviour or not, to reduce the number of people who may already self-harm or who may go on to self-harm, or who may be failing to cope in other ways.

PO3. Increase the rate of identification of people who are self-harming, both through encouraging more people to seek help and through better recognition of self-harming behaviour by professionals working in different settings, and improve risk assessment at various levels of care.

PO4. Improve the service response to people who self-harm with the objective of reducing the frequency, severity or occurrence of the self-harming behaviour, addressing the underlying causes of that behaviour and improving people's experience of care services thus assisting them in moving towards safe and positive future goals.

18. The Working Group considered that Objectives PO3 and PO4 should form the focus of dedicated action in Scotland to address self-harm. Objectives PO1 and PO2 deal with population wide approaches and responses whose implementation will also have an effect on the prevalence of self-harm. These population wide approaches include those outlined in Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011. This document recognises that our mental state is shaped by our social, economic, physical and cultural environment and may encompass spheres as diverse as, for example, housing, poverty reduction and nutrition, which can all contribute to reducing the likelihood that people will go on to self-harm.

19. The Working Group proposed that the overarching Primary Objectives should be supported by a number of **Specific Objectives**, around which specific actions will be developed to form the focus of future work:

SO1. Awareness raising and training in respect of self-harm by providing good quality and easily accessible information and training to key professional groups likely to encounter self-harm in the course of their work, such as nurses, teachers and social workers, as well as information for those engaged in self-harm and their family members and carers.

SO2. Specific training, building on accepted clinical excellence guidelines, for those professional staff, such as those in A & E or in crisis services, who are likely to be in direct contact with those who self-harm and who have an opportunity to intervene positively to reduce repeated self-harming behaviour (building on work already in place in respect of training on suicide prevention).

SO3. Stigma reduction work to increase the likelihood that those who self-harm will come forward for help and will feel confident about talking about self-harm with friends, family members and professionals / care givers.

SO4. **Clear referral pathways to enable people who self-harm or those who identify self-harm to access an appropriate service that meets their needs.**

SO5. **Guidance on information sharing, protection and confidentiality for those working with children and adults at risk where there is a concern about self-harm.**

SO6. **Extension of the Mental Health in Scotland, A Guide to delivering evidence based Psychological Therapies in Scotland "The Matrix" http://www.scotland.gov.uk/Topics/Health/health/mental-health/servicespolicy/matrixfeb2009 to include evidence base for approaches to respond to self-harm, in the context of the presumption that those requiring a clinical intervention would receive treatment within the new waiting time framework.**

SO7. **The known links between self-harm and trauma (including abuse, neglect, bereavement, loss and grief) will be considered, in the context of developing work on trauma sensitive services. This will be taken forward through the Scottish Government's clinical expert group and its planned guidance around Trauma Informed services.**

SO8. **Improvement of data in respect of self-harm in Scotland, building on existing data from hospital admissions and discharges, and reliable evidence based data from other sources. To include information about workforce skills and knowledge. The Benchmarking work in mental health is now developing more detailed information regarding individuals who self-harm and access accident and emergency, acute and psychiatric hospital settings. This work will inform the workforce skills and knowledge required to support individuals**

who self harm. The monitoring of this skills development is taking place within the NHS Education for Scotland (NES) delivery of psychological therapies programme.

SO9. Creation of a National Monitoring and Implementation Group to track progress on the separate, but related, suicide and self-harm agendas and strategies.

Next Steps

20. The objectives set out above will form a national work programme and the specific actions necessary to put them into practice will be developed.

Expected Outcomes from These Actions

21. What would be different for people who self-harm if we were achieving these objectives? Quotes and opinions gathered from stakeholders and people with lived experience of self-harm during consultation on this document:

'There will be less stigma.'
'There will be a change in attitudes from "you have a problem" to "you need support".'
'People who self-harm are treated with respect and taken seriously.'
'People will be less anxious about talking to someone who self-harms.'
'People's understanding of self-harm will be greater.'
'There will be education about how to minimise risk when you self-harm.'
'People who self-harm will have fewer barriers to getting support.'
'People will know where to go to seek help and support, feel accepted when they are there and have more options for types of support.'

Appendix A: National Self Harm Working Group: Members List

Name	**Organisation**	**Job Title**
Alana Atkinson	NHS Health Scotland	Health Improvement Programme Manager
Dallas Brodie	NHS Greater Glasgow & Clyde	Consultant Liaison Psychiatrist
Sandra deMunoz	NHS Lothian	Choose Life Coordinator
Vince Fletcher	Scottish Prison Service	Choose Life Coordinator
Nigel Henderson	Penumbra	Chief Executive
Geoff Huggins	Scottish Government	Head of Mental Health
Monica Merson	NHS Health Scotland	Head of Health and Wellbeing
Rory O'Connor	University of Stirling	Professor of Psychology
Christopher Ward	NHS Fife	Nurse Consultant
Steven Platt	University of Edinburgh	Professor of Health Policy Research
Merrick Pope	NHS Lothian	Clinical nurse Specialist in self harming behaviours
Claire Robertson	Barnardos	Team Leader
Michael Van Beinum	NHS Borders	Consultant Child and Adolescent Psychiatrist

Table 1

Number of acute hospitals stays in NHS Scotland where a diagnosis of intentional self-harm was recorded; by month for 2007/8 - 2009/10

	2007/08	2008/09	2009/10p
April	1 147	1 134	1 123
May	1 217	1 187	1 195
June	1 145	1 080	1 075
July	1 141	1 207	1 154
August	1 184	1 186	1 181
September	1 126	1 183	1 048
October	1 188	1 158	1 046
November	1 156	1 081	1 019
December	1 075	921	922
January	1 141	1 099	988
February	1 099	1 066	971
March	1 206	1 100	1 019
Yearly total	13 825	13 402	12 741

p Provisional.

Notes:

1. A hospital stay is defined as a continuous spell of treatment in hospital. During a hospital stay the patient may change consultant, change specialty or may be moved from one hospital to another.

Hospital stays are counted against the year in which the stay finishes. Please note that stays are not equivalent to the number of patients, as a person may have more than one stay in a year.

2. Up to six ICD-10 diagnoses (1 main and 5 other) can be recorded on an SMR01 record. All diagnosis positions have been used to identify cases of intentional self harm.

3. The codes used in this analysis are supplementary codes which indicate the nature of any external cause of injury, poisoning or other adverse effects. Codes used: Deliberate (intentional self-harm): X60-X84 (intentional self-harm) (see "ICD code description" worksheet for more details)

4. The policy for admitting people following self-harm may vary from hospital to hospital. For example, some hospitals may use short-stay observation units within Accident and Emergency departments to care for these patients rather than formally admitting them to hospital.

5. These figures do not include people who are seen at Accident and Emergency departments.

6. Only hospital stays where the specified codes have been recorded are counted. Hospital stays with harm coded as resulting from an accidental or undetermined (i.e. unclear whether intentional or not) cause are excluded.

Source: ISD Scotland SMR01

Reference: ISD/HIG/IR2010-01874

Date: 26/07/10

Table 2: Prevalence of deliberate self-harm (past year and lifetime) and serious thoughts of self-harm in the previous year

	No of respondents	% (No)	Odds ratio	95% CI
Past year prevalence of deliberate self-harm				
Males	917	5.1 (47)	1.00	
Females	1050	13.6 (143)	2.94	2.09-4.14
All*	1967	9.7 (190)		
Life-time prevalence of deliberate self-harm				
Males	917	6.9 (63)	1.00	
Females	1050	19.9 (209)	3.37	2.50-4.54
All*	1967	13.8 (272)		
Serious thoughts of self-harm in past year without doing so				
Males	913	8.5 (78)	1.00	
Females	1052	19.5 (205)	2.59	1.96-3.42
All*	1965	14.4 (283)		

*43 participants did not answer the deliberate self-harm questions and/or indicate sex

Source: Self-harm in adolescents: self-report survey in schools in Scotland by Rory C. O'Connor, Susan Rasmussen, Jeremy Miles and Keith Hawton The British Journal of Psychiatry (2009)

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