



The topic of self-harm has been poorly conceived, inadequately described and, in consequence, is widely misunderstood. The three major questions facing professionals and service users alike are:

■ What do we mean by self-harm?

■ Can we separate it from suicide?

■ How do we work safely with people who self-harm and when should we intervene (or not) when a person is at the point of self-harming?

To resolve and clarify these areas I will describe a tool that I have developed.

In 2002, in a bid to explore whether workers, carers and users have shared goals in risk assessment, I set up a series of focus groups. It emerged that 'keeping the person safe' was a common concern. However, the participants had very different views about when safety becomes a priority, and, indeed, what 'being safe' means.

I believe that the concepts of safety and risk are intertwined; we shouldn't consider one without the other. In practice, the issue of risk tends to receive too much attention, while safety is comparatively neglected. The literature – much of it written by people who harm themselves – often emphasises reducing harm, keeping safe and managing risk, but this message has not always filtered through.

Confusion over terms

Because this topic is so poorly understood there is much confusion over the terms self-harm, self-injury, deliberate self-harm and suicide. If we overemphasise preventing negative outcomes, we can lose sight of the need to maintain the safety of the person who harms him or herself. We may also neglect to ask: 'Is our practice actually reducing harm?'

A more helpful approach would be to assess risk and safety together with the person who commits acts of harm. The client could be

Much of the confusion that surrounds the terms self-harm and suicide can be cleared up with aid of a tool developed by Mike Smith

accompanied by someone who knows him or her well. Over the past two years I have piloted a new assessment tool with 50 people who harm themselves. Almost all (90 per cent) of the staff felt that this assessment accurately reflected the risk posed by their client and all (100 per cent) of the clients felt it reflected the risks they faced.

Staff found the tool helped them to focus on the 'real issues', while the clients applauded its focus on safety and appreciated that the tool separated the various domains relating to self-harm more accurately than others.

Self-harm or suicide?

In theory suicide and self-harm are easy to separate, but in practice it can be a little harder, and many professionals confused them. However, it is not rocket science: suicide is a deliberate act with direct intent to end one's own life.

The tool includes a simple question that most people find helpful in separating suicide from self-harm. 'These things that you do, do you do it to feel better or to end all of your feelings?' Obviously people who want to feel better are more likely to be self-harming and people who want to end all feelings can be assumed to be suicidal until further information can exclude or confirm this.

Self-harm is a little harder to define: it can take many forms, and the only salient feature, in my experience, is intent. The intent may be to feel better, to cope, but it is clearly without direct intent to die.

Of the people who self-harm that I work with, many (60 per cent) say that they are unclear about their intent when we first meet. However, they stress that they do

not have a direct intent to die. Being unclear, ambiguous or ambivalent intent is not a direct intent to die and so, clearly, the person is not directly suicidal.

Self-injury is defined in DSM-IV (APA 2000) as the 'deliberate damaging of body tissue without the direct intent to end life'. Most of the people I work with who self injure believe this definition highlights tissue loss and the amount of physical damage, when this may actually be less relevant and less risky.

Harm is a much wider concept and I have come to define it as follows: self-harm is a 'repetitive, harmful act or omission to the self whose direct intent is not to end life'.

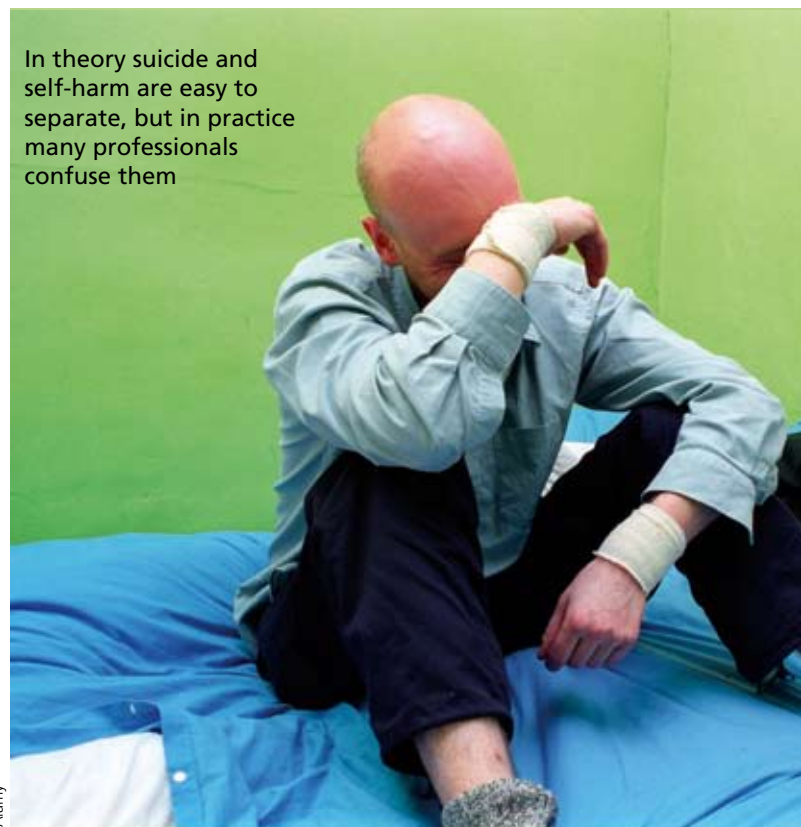
Some people commit a single act of self-harm and do not come to attention of the mental health services. I have not been able to test this tool with such people, as they do not come to my attention. I can, however, see the benefits of discussing the five domains of self-harm

with people after their first episode of self-harm to help them to identify their suicidal feelings.

Most of the people with whom I work have cut themselves. While some are also co-morbidly suicidal, the two emotions are readily separable. They are best treated as separate entities because people usually self-harm for one reason, but could be suicidal for an unrelated reason.

The tool is based on considering the five domains outlined below. The person using the tool reaches a judgement based on the guidance notes provided on risk and safety for each domain. The judgement is scored from 0-5 (0

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being the extreme of safety and 5 being the extreme of risk). At the conclusion of the five domains we again consider all the information and make a further simple judgement, overall, about current risk and safety that informs the plan for working together. Fifty-five people were approached to help pilot the tool; 50 agreed to participate and respond. They ranged in age from 16 to 53 years.

The five domains

The five broad domains that characterise self-harm can help to predict risks among, and protect the safety of people who self-harm.

1. Intent People who are clear that they intended to stay alive would have a low score; which people who are ambiguous, or unclear, or have the possible intent to die have a higher score. This can be harder to judge with certain populations; I have found that adolescents and people new to mental health services tend to offer a less clear description of their intention when

they overdose or use a ligature. However the discussion around intent does appear to be useful for both parties.

2. Directness How directly linked are the person's life experiences and emotions to current self-harming? People who can relate their experiences of their self-harm to their life experiences and themselves, and who are receiving support with those experiences, may be safer than people who can see no link or have no explanation for why they self-harm.

Self-harm is obviously a multi-levelled, personal experience and substitution should also be considered. For instance, people may use one form of self-harm, consciously or otherwise, to prevent another form of self-harm. Similarly, self-harm may be a part of bargaining with the self, others or psychotic experiences. The more directly the person is able to relate these experiences to the self, the safer the person is rated. The level of personal distress that the person is currently experiencing may also be considered here.

3. Potential lethality Many forms of self-harm, despite having no direct intent to end life, can be lethal. In my own experience of working with people who harm themselves by cutting, many cut in ways that are less risky for themselves. But some people, especially those who are impulsive or emotionally explosive, may cut in a more potentially lethal way. The use of ligatures and poisoning is potentially more lethal, although each case must be appraised individually.

4. Control and distress Many people have a high degree of control over when and how they self-harm, and over the intensity/severity used. They may be judged to be safer than those who demonstrate little or no control, or who feel that their harm is inevitable and it may have a compulsive nature. People may demonstrate control when taking precautions to keep themselves safe or to hurt themselves less. Control

can also be significantly affected by current levels of distress and social circumstances. Therefore these factors should also be considered when assessing a person's ability to control what is happening.

5. Repetitiveness The frequency of the incidents of self-harm and any escalation is the final domain to consider. Obviously frequent potentially lethal self-harm is exponentially more risky than infrequent and rare potentially lethal self-harm. This area, however, has to be seen together with all the other domains and is an example of why all the domains cannot be separated. This also further shows the complexity of judgement and the importance of considering risk together with people who self-harm as they are the experts in their own experiences and, after all, it is mostly their safety and risk we are considering. For example, someone who does significantly life-threatening things (such as hanging by ligature) once a year may well feel more of a risk than the person who does something less potentially lethal but more often (e.g. cutting without large blood loss or significant tissue damage). This demonstrates the need to focus on joint judgement and not arbitrary thresholds.

Judgement

In reaching a judgement I consider with the client the overall scores for all five domains and we jointly agree the level of risk and safety in their current self-harm. Obviously more guidance is available within the tool on each of the domains than can be described here, but there are avenues for dialogue and discussion which should underpin the process of assessing risk and safety.

This information is used to develop a plan of how to reduce risk or maximise safety in each domain. We also separate out self-harm and suicidal feelings in care plans and involve loved ones or friends, as necessary, in our decisions.

Further results

None of the clients in the pilot study died in the year the work was

done. Not all of them had a mental health worker and some people were not known to the mental health system and approached me directly. While scores varied greatly across the 50 participants, in all cases, where applicable, both workers and clients found the tool helpful in considering risk.

Many professionals (64 per cent) indicated in written feedback that they felt that they had always been conservative when considering risk. They found existing risk assessment tools were unhelpful because they mainly highlighted the fact that the person had self-harmed at some time in the past and nothing else. Perhaps more worryingly, 60 per cent of mental health professionals interviewed confused suicide and self-harm. The mental health workers said the concept of para-suicide was unhelpful and confusing. I am now looking at the clinical significance of scoring the judgements to ascertain whether there are markers suggesting that reducing risk and increasing protection may be appropriate when supporting the person to manage his or her self-harming behaviour. It may be that seeing beyond the self-harm is helpful ■

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References

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A full copy of the pilot Self Harm Assessment of Risk/Safety (SHARS) is available by email from: mikesvoice@aol.com

