



Southern
Community
Welfare Inc.

DELIBERATE SELF INJURY PROJECT

REPORT 2009-10

2009 - 2010

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Disclaimer: Every individual and organisation working with young people who deliberately self injure has varying responsibilities (including duty of care) and must make informed decisions about their policies. This report is intended to inform about observations we have made. It does not seek to determine specific policy.



During 2009-2010, Southern Community Welfare (SCW) conducted a targeted project on the issue of Deliberate Self Injury (DSI). The Sutherland Shire Council generously funded this project through a '2009 large community grant'. The following report outlines the activities and outcomes of this 'DSI project'.

The overall aim of Southern Community Welfare's 2009 DSI project was to facilitate an improved understanding of, and response to, young people struggling with deliberate self injury, particularly within the community of Sutherland Shire (in southern Sydney). Using a community approach, the project sought to canvas the needs and issues of various groups including young people struggling with DSI themselves, family members, friends, people working in schools and those working in the health and welfare sector.

The project was divided into three distinct components:

- (1) DSI community consultation
- (2) DSI support group for young people
- (3) DSI webpage

The details of activities undertaken in each of these three sections of the DSI project - their aims, their challenges and their outcomes - are the focus of this report. Throughout the report we have deliberately included many direct quotes, anecdotes and subjective information. Rather than labouring facts and figures, our intention is to canvas some of the subjective experiences – positive and negative, helpful and unhelpful - of those who have been affected by DSI.

Deliberate self injury has been a particular interest of our service for many years, which over time has been expressed through providing individual counselling for DSI, community education nights, professional development seminars, and producing written materials on DSI for various groups. A major part of the current project has seen us pilot a DSI support group, the first of its kind in NSW. This has been a significant and rewarding step for our service in seeing a group of young people discover means to begin releasing the grip of DSI on their lives.

We sincerely hope that the information contained herein is of interest and benefit to the Sutherland Shire community, other communities throughout Sydney, and beyond. Self-injury, in many forums, continues to be a difficult topic to discuss. It is confronting. For some it may seem hard to understand. For some it is very close to home. It is our intention that this report will contribute to those discussions that are already underway, and that it may open up spaces where a discussion is yet to begin. Most of all we long to see that acceptance, understanding and encouragement would follow and surround the people we know, and the many, many others, who carry with them scars on the inside.

The Southern Community Welfare Team

EXECUTIVE SUMMARY

DSI Community Consultation

Young People with DSI

- Many of those who struggle with Deliberate Self Injury have a complex mental health profile including multiple diagnoses.
- Deliberate Self Injury is perceived as a coping strategy by many young people who struggle with DSI.
- The reasons for self-injuring are many and varied between young people. Even one individual may have a variety of reasons or purposes for DSI.
- Peer group pressure or influence was not seen to be a significant reason for DSI in the young people we surveyed.
- Helpful treatment strategies are specific to each individual. Those treatment strategies that some young people found helpful were the same strategies that others found unhelpful. Being coerced to stop DSI was generally regarded as an 'unhelpful' strategy by young people.
- Support and acceptance characterised helpful ways for people to respond to young people with DSI. Degradation and negative judgements characterised unhelpful responses to young people with DSI.
- Young people frequently have both positive and negative experiences with professionals in regards to DSI.

Friends and Family of Young People with DSI

- DSI can have complex and varied effects on a friend/family member's relationship with a young person struggling with DSI. It can commonly have some effects that strengthen the relationship as well as strain the relationship.
- The most common way in which family or friends found out about a friend/family member's DSI was through seeing the injury.
- Shock, confusion, helplessness, guilt, sadness and anger were common emotional responses to finding out about a loved one's DSI.
- Family and friends had many and varied concerns about how to support the young person with DSI.
- Helpful websites, a friends/family support group, and a DSI information talk were rated by most participants as potentially beneficial resources for supporting the young person with DSI.

Professionals Working with Young People and DSI

- The top three issues that professionals rated as challenges for young people in the Sutherland Shire struggling with Self Injury were:
 - 1) Family relationship issues
 - 2) Lack of understanding from family
 - 3) Comorbid mental health issues
- Professional concerns about working with young people struggling with DSI focused around concerns for the young person's wellbeing, how to effectively manage the situation, and the professional's personal response to the distressing situation.
- All professionals indicated a belief that they or their service would benefit from specific training in working with DSI clients.
- 25.6% of professionals indicated that they did not know where they would refer young people with DSI in the Sutherland Shire.
- 95% of professional participants stated that they believed it is important or very important to collaborate with other services in managing a DSI client. However, no participants indicated that they believe Sutherland Shire services currently collaborate 'very well', and only 14.3% believe they do so 'well'.
- Professionals rated the top three most helpful interventions for young people with DSI as being individual counselling, collaborative case management and DSI support group.

Schools and Young People with DSI

- The top three issues that school staff participants rated as challenges for young people in the Sutherland Shire struggling with Self Injury were:
 - 1) Lack of understanding from family
 - 2) Family relationship issues
 - 3) Lack of understanding from peers
- School staff noted professional difficulties when working with young people and DSI. These related to concerns about the student's wellbeing and education, concerns about managing the situation, concerns about their personal response and concerns about the broader school response.
- All participants indicated a belief that DSI training would be beneficial for either him/herself or his/her school. Topics of particular interest were: options for schools in supporting students with DSI, understanding DSI, and recognising signs of DSI.

DSI Support Group for Young People

- At the Mid Group Evaluation, most participants self-reported that the social/emotional peer support was the part of the group that they were most enjoying and finding most helpful. Trends in the raw data scores obtained at the Mid-Group Evaluation suggest that the intensity of participants' depression, anxiety and stress had decreased (averaged across participants) between Pre-Group and Mid-Group.
- At the End of Group Evaluation, participants (on average) self-reported both the social/emotional support and the 'teaching' (predominantly CBT-based) content of the program to be 'most helpful'. They also indicated that strategies, tools and techniques suggested in the program were 'helpful'. Trends in raw data scores obtained at the End of Group Evaluation suggest that the intensity of participants' depression, anxiety and stress had decreased (averaged across participants) between Pre-Group and End of Group.
- At the 4 Month Follow Up Evaluation, all participants self-reported positive effects of the group on their mental health and wellbeing, use of helpful coping strategies, social support, and frequency of deliberate self injury (DSI). Some participants also reported positive changes related to work/study. Trends in raw data scores obtained at the 4 month Follow Up suggest that the intensity of participants' depression, anxiety and stress had decreased (averaged across participants) between Pre-Group and 4 Month Follow Up, and that mental wellbeing had continued to improve between End of Group and 4 month Follow Up.
- All support group participants stated that they would recommend the group to other individuals who self injure.

DSI Webpage

Additional resources were added to the Southern Community Welfare website. In particular, the following downloadable documents:

- Factsheet for parents and guardians
- Factsheet for friends
- Factsheet for Males
- Factsheet for Healthcare Workers
- Factsheet for Teachers
- Creating a school self injury policy

PART ONE: DSI COMMUNITY CONSULTATION

The DSI community consultation consisted primarily of surveys investigating the experience of four different groups with an interest in deliberate self injury amongst young people. These groups were:

- a. Young people who have struggled (or continue to struggle) with DSI.
- b. Family members and friends of young people who have struggled (or continue to struggle) with DSI.
- c. People employed in secondary schools (teachers, school counselors etc).
- d. Health and welfare professionals working with young people.

The aim of the community consultation was to gain more detailed information about the nature of self-injury, particularly in the Sutherland Shire community. It is hoped that the results will add to the current collective of community knowledge about DSI. In this way, we anticipate that it will provide a stronger voice for those who have struggled (or are currently struggling) with deliberate self-injury, enable greater understanding of the difficulties faced by the four different groups surveyed, inform programming and funding for deliberate self-injury programs, and provide insight into needs within the community (in relation to DSI) that are not currently being met.

(a) Young People struggling with DSI

Participants in Young People Survey

Ten young people participated in our survey, all of whom were female. They ranged in age from below 16 to over 30 years of age, with the 16-18 years age bracket representing the highest proportion of respondents. 50% of participants were school students at the time of completing the survey, and other participants had various other vocational arrangements including higher education, full or part time work, and working at home as a mum. Eight out of 10 participants resided in the Sutherland Shire, and 8 out of 10 lived with their parents. All participants had self-injured at some time during their life.

Ideally we would have had a higher number of participants for this survey. After extensive advertising through local media, community noticeboards, community organisations, health and welfare services as well as other existing contacts - over several months - we collected only ten responses. We expect that this is related to the highly private nature of self injury as well as clinical considerations surrounding duty of care for young people in completing such a survey. Please note that due to the low number of participants, any figures quoted should not be considered as population statistics or as representative in general of young people struggling with self-injury. Rather, they represent the experiences of the ten respondents.

Mental Health

Based on the self-report measure used, 100% of participants reported having experienced both anxiety and depression. Many indicated that the depression and anxiety had been ongoing from a young age, and had severely impacted on their day-to-day functioning. Nine out of the 10 participants reported experiencing further mental health complications on top of the depression and anxiety. Four young women reported difficulties with obsessions or compulsions, four reported post-traumatic stress, four reported having struggled with an eating disorder, three reported Bipolar Disorder. Other mental health complications, or diagnoses, mentioned by some participants were Borderline Personality Disorder, Conversion Disorder and temporary psychosis. Nine out of the 10 respondents reported having had suicidal thoughts at some time during their life, and 5 reported that they had attempted suicide at least once. These self-report results suggest that many young people struggling with DSI have a complex mental health profile.

Deliberate Self Injury

Only one participant stated that DSI is no longer a current issue in their life. The mean age for the onset of self-injury was 13.2 years of age (responses ranged from 12-16 years of age). All participants had experienced DSI for over one year and 60% had been affected by DSI for more than 5 years. The reasons for self-injuring were many and varied between the young people. Even one individual may have a variety of reasons for their DSI.

All respondents indicated that DSI had helped them to cope. In attempting to understand the purpose of DSI, it is interesting to note that all the young people in this survey conceived of Deliberate Self Injury primarily as a coping mechanism rather than a primarily self-destructive act. In free-response questions, 8 of the 10 respondents referred to the way in which DSI helped them to release, manage or escape from strong emotions. One response read:

(I injured as) a distraction from difficult/painful family situations, it provided a release of built up emotions and feelings...I was able to see something physically wrong with me, which sort of justified in my mind feeling hurt.

Self-hatred and low self-esteem were the next most commonly mentioned reasons for deliberate self-injury, with one response reading:

I couldn't handle being myself anymore. I hated myself and I wanted to punish myself.

Other functions of DSI that young people referred to were: to feel physical pain rather than emotional pain, to justify the emotional pain, to gain control, to feel alive, to try to "fix everything", and to distract themselves from their circumstances. One response in particular highlighted the way in which DSI acted as a coping mechanism, stating:

I'm still here!

A few responses hinted at the fact that the respondent recognised DSI had helped them in the short-term, but had negative long-term consequences. For example one young woman wrote:

At the immediate (it helped me to cope) - but has in the long run been extremely detrimental.

Circumstances or situations that were reported as triggers to DSI reactions included: a sense of being isolated, lonely or rejected, family conflict, abuse, and believing that people wanted bad things to happen to them.

Other Young People

Peer group influence was not seen to be a significant reason for DSI in the young people we surveyed. The only participants who indicated that they were part of a peer group in which DSI was common, indicated that this peer group was treatment-related. In other words, none of the ten participants reported having been influenced by a peer group to self-injure. In fact, the responses indicated that their peers have been either concerned and supportive, or alternately, lacking in understanding about DSI and unhelpful. One young person commented:

people always tell you to stop like it's easy and you're some kind of small child. People don't understand why we do it.

Nine people rated DSI as a “very important” issue for young people at the moment (the other person rated it as “important”), with most responses reflecting a belief that young people are not well enough informed about DSI, and the ensuing stigma has an isolating effect.

it is so much more common than most people realise and because society does not feel comfortable talking about it, the people who struggle with it feel even more alone

Recovery

All the young people surveyed said that they had attempted to stop or reduce their self-injury. Talking to either friends or professionals who understand was the most commonly listed helpful thing that the young people had done in an attempt to stop or reduce DSI. One girl stated:

[The biggest help was] having someone who I could talk to about it and didn't shame me but understood that it was something deeper and helped me understand that.

Many other techniques were mentioned as having been helpful in the recovery process. Distraction was mentioned by a few people, including watching TV or movies. Many included creative and expressive pursuits such as listening to music, drawing and journaling. A couple mentioned exercise. Two people indicated that drawing on themselves with a red texta had been a helpful step in reducing self-injury. One person said that being on their own was helpful. Two people referred to techniques that may be considered low-level self-injury, but that had helped them in reducing the severity of their injury (holding ice in the hand and flicking a rubber band on the wrist). Cognitive-Behavioural techniques including putting off the injury for a set time combined with distraction, or thinking about the consequences of the injury were mentioned by a couple of people. Medication, education and self-motivation for change were also noted.

Interestingly, the things that young people listed as impediments to recovery were remarkably similar to the list of things that other people had found helpful. For example: listening to music, holding ice, flicking a rubber band, self-soothing alternatives, watching TV, cognitive distractions and talking to friends and family (the latter may be people who do not understand the issue, the respondent did not make an indication about this). The similarity of these lists suggests that different people have markedly different responses to common treatment suggestions for DSI, and finding helpful options is an individual process. Additional unhelpful alternatives to self-injury listed were being told or “made” to stop, by friends, family or professionals, having all sharps removed, hospitalization, or pretending it didn't exist. As noted at the outset of the report, this information is not intended to dictate policy, but provide a reference point for information.

The role of other people

Of the ten survey participants, all reported that at least one other person knew about their self-injury. This was expected, since most of the participants were informed about the survey through another person (either a professional worker or social contact).

Participants were asked what other people have done that was helpful for them. Common themes that ran through these responses included listening, encouraging, validating feelings, sitting with them when they felt unsafe, seeking help, understanding and looking ‘under the surface’ of the injuries to see the person beneath. One response read:

My best friend lets me tell him about it. He doesn't freak out or judge or tell me to stop. He simply listens to me and I feel better. It calms me that he doesn't yell at me or judge me or say mean things. He never uses it against me.

Participants mentioned several particularly unhelpful responses to their DSI. These included yelling, ridiculing, putting down, telling them to commit suicide, telling them to get over it, removing self-injury items, talking to other people about it, keeping a watch on them at all times and generally lacking understanding. Support and acceptance characterised helpful ways for people to respond to young people with DSI; Degradation and negative judgements characterised unhelpful responses to young people with DSI.

Participants were asked if they would like anyone else to know about their self injury who doesn't know already. Two respondents said they would like others to know and named these people as their husband or boyfriend. When asked what would prevent people from telling others, responses centered around concerns about others seeing them differently, people reacting in an unwanted way, or the shame and embarrassment for the young woman within herself. One person also stated that "they don't need to know".

Young people who responded to the survey noted several things that they wish their family/friends/support people knew about self injury. Since this is their message to their community, we have included all nine responses in full text, as they were originally written.

That it's not disgusting. Like someone who smokes or drinks. I'm addicted and yes I hurt myself and sure there'll be long term scars but it wont kill me slowly like smoking or drinking. In the end I'll be ok but now i need this to cope.

That people who self-harm do not do it to seek attention.

that they knew more basic education about what it is and why people do it,

why people self-injure, that they are not crazy, its not for attention

it shouldn't be scary, they are feeling alone and want people to help and support them

It's just a coping strategy, not a good one – but nothing strange about coping strategies, everyone has one.

Understand

Why people do it.

That it's not something that you can just stop.

Professional Support

All ten participants said that they had sought professional assistance at some stage for their self-injury. It is relevant to note that most participants found out about the survey through professionals, and therefore there is an obvious bias in the sample for this response. Services accessed included psychologists, counsellors, school counsellors, psychiatrists, telephone counselling, hospital crisis teams and a specialist depression service. All but one participant said they would look on the internet if they wanted to find a professional support service for DSI. The next highest response was 60% of participants who said they would go to a GP.

One respondent indicated that she had never had a positive experience with a professional in regards to DSI. The other respondents indicated they had experienced positive consultation(s) or therapeutic relationships with professional(s) regarding DSI. Comments made included:

Psychologist put me in (a) better general mood. School gets me out of dysfunctional home environment.

one professional who was just very accepting of what I was going through, non-judgemental and didn't make me feel stupid or crazy.

Told that I did a great job of surviving and now it's time to learn new ways of handling life's stresses. i wasn't shamed or made to feel bad.

Unfortunately 60% of respondents stated that they had had at least one negative experience with a professional in regards to DSI. Those who had experienced negative treatment made comments such as:

I felt like I was being judged all the time.

stitches without any numbing aids been told i was childish, told i cut the wrong way – to die you should cut the other way.

"I don't understand why you just can't stop it"

Told I was attention seeking

A Dr at the hospital told me how stupid I was for doing this and that I shouldn't be allowed to work with children.

Things that the young people stated they would like professionals to know about self injury included:

That we're normal people just trying to cope. Not freaks or people trying to "fit in"

that its not just attention seeking - there has to be something going on underneath for someone to get to the point of self harming.

If I had something else that worked I would do it. It's a cry for help.

It appears common for young people to have both positive and negative experiences with professionals in regards to DSI.

Opinions regarding a DSI Support Group

Participants were asked about any benefits they could imagine receiving from attending a DSI support group, or, what they would like to get out of it. The majority of responses had very strong similarities. Almost all responses referred to being with people who understand through shared experiences and, in this way, being comforted by the knowledge that they are not alone. Two responses referred to the benefit of finding ways to recover. Based on these responses, the participants appear to value understanding as a high priority, and it would be interesting to know whether they believe the understanding would be a means to the end of recovery or an end in itself. Further questions that were not asked in this context which may be of clinical interest include, 'What do young people struggling with self-injury perceive 'recovery' to be' (i.e. cessation of DSI, healthy self-value, alleviation of depression etc), and 'what would young people see as the goal of treatment'.

We expected that some young people would have reservations or concerns about joining a DSI support group. When asked about this young people noted that some concerns would be getting ideas from other people either about how to self injure or how to hide injuries, being triggered (to self-injure) by the group, feeling judged by other people, carrying other people's burdens and feeling as though their own concerns are trivial compared to others'.

Responses were highly mixed when asked about whether they would be interested in attending a DSI support group, although all showed some degree of interest. 30% responded “Yes, *definitely interested*”, 30% responded “*Probably interested*”, 30% responded “*Not sure*” and 10% responded “*Probably not interested*”. None of the participants responded “*No, definitely not interested*”. Factors that respondents reported would increase their likelihood of attending a DSI support group included group members being all of the same gender, group being run by a professional, a rule that details of self-injury are not to be discussed in the group, and group members being of a similar age. It seems that although the support of like-minded peers may be generally regarded as potentially helpful, various concerns are also linked to this type of support.

(b) Family members and Friends of young people struggling with DSI

Participants in Friends and Family Survey

Eleven friends or family members participated in the community consultation survey (9 female, 2 male). These people ranged in age from the 18-25 year age bracket up to the 65+ years age bracket. 10 out of the 11 people lived in the Sutherland Shire, and 2 of the 11 people had engaged in self injury themselves at some time in their life. 2 of the participants indicated that they had engaged in a considerable amount of work or study in the area of DSI (i.e. 9 had not engaged in any work or study related to DSI).

Mental Health

Participants were asked about the mental health status of the people they know who self injure. depression (81.8% reported that their friend/family member experiences this), anxiety (63.6%) and suicidal thoughts (54.5%) were the most commonly cited issues that friends and family members had noticed in the young people they know who struggle with DSI.

Relationship with the Young Person with DSI

The two most common ways in which family members or friends found out about a young person’s DSI was through seeing an injury (72.7% of participants had found out in this way) or the young person telling them (63.6%). *Note: Participants were able to select more than one response, for example when they know more than one person with DSI. Hence the figures do not equal 100%.*

Participants were asked about their initial reaction to finding out about their friend/family member’s DSI. Their responses included:

shocked that a beautiful young girl would want to harm herself, couldnt believe that it happened to normal people like me, i thought only scary people that took drugs etc cut themselves

sadness - my sense of having failed them. Confusion - how to best help them, give them space and privacy but also be available - support and nurturing. Also hurt and frustration when I walked in on a cutting episode.

I got a text message at work from my daughter telling me she was cutting herself. I went cold all over.

Why? How can I help? How serious is the person?

These responses show some of the variety of emotions experienced by support people - shock, confusion, helplessness, guilt, sadness and anger appear to be common for family and friends when they initially hear of the DSI. Interestingly, however, a notably different response came from a participant who had struggled with DSI him/herself. This participant responded “*understanding. want to help. knowing how hard it is to deal with*”.

Participants were asked whether DSI has affected the relationship between him/herself and the friend/family member struggling with DSI. Respondents described both positive and negative effects of DSI on their relationships.

Strengthened the relationship. In some circumstances, learning of the young person's DSI had been difficult, but served to increase trust, understanding and communication in the relationship. For example:

made us closer. though it is testing and hard and puts strain on the relationship. its a good opportunity to take care of them and love them.

More sympathetic to her.

It was difficult - mixed communication but we stayed focused on clear emotions and expression, acceptance of each other, eventually building high levels of trust and love..

Strained the relationship. In some circumstances, learning of the young person's DSI had decreased trust, exacerbated communication difficulty, and caused support people to be hyper vigilant for signs of self injury, for example:

It made me want to tiptoe around them, not anger them or upset them out of fear they'd self harm.

I tend to watch her more closely

We don't speak about it currently. Am hesitant to raise the subject and be seen to be prying.

I treat them more fragile.

i now find it hard to trust them and a bit anxious that if i say or do the wrong thing and make them upset that they might cut again

Supporting a Young Person with DSI

Participants were asked what things they would like to better understand about DSI. Four out of the 11 respondents wanted to know why a young person would self-injure. Four other respondents were interested in learning ways to better support their friend/family member, two of whom were specifically interested in discouraging the person they support from self-injuring. Two respondents indicated that they felt they had a good understanding, and one was interested in the brain mechanisms involved in DSI.

Participants were asked to rate their confidence in supporting those they know who self-injure (1=No confidence, 3=Some confidence, 5=High confidence). Ten people responded to this question and indicated varying degrees of confidence, ranging from low confidence (4 responses of '2') to high confidence (2 responses of '5'). When asked about what they find most difficult in supporting their friend/family member, responses were widely varied and included the following issues:

- The young person's reluctance to address the issue
- Worry about doing or saying the 'wrong thing'
- Breaking trust through telling other necessary people
- Seeing the scars
- The situation becoming worse rather than better

- Not knowing when or what the next trigger (for DSI) might be
- Raising the issue after a period of not speaking about it
- When the young person shuts their support people out
- Low level of trust in the relationship

Participants were asked what types of supports they would find useful in supporting their friend or family member with DSI. Responses were as follows:

- Helpful websites (63.6% of respondents indicated that this would be useful for them)
- Family/friends support group (63.6%)
- DSI information talk (54.5%)
- Family therapy (36.4%)
- Counselling – *for the support person* (36.4%)
- One-on-one discussion with a professional (36.4%)
- Case meetings with professionals or schools (27.3%)
- One respondent added that their friends and family members are great supports for them.

Family and friends of young people with DSI noted that they had sought information about DSI from a variety of sources including friends/family members (40%), GPs (40%), hospitals (30%), youth or social workers (10%) and psychologists (10%). However, the most commonly accessed source was the internet (70%). No respondents indicated that they had accessed information from a school.

Opinions regarding a DSI Support Group

Participants in the friends and family survey were asked about the benefits they could imagine for young people in attending a DSI support group. 80% of respondents suggested that a benefit would be participants knowing they are not alone in their struggles as well as making new friends, that is, the interpersonal and social aspects of support that a peer group would provide. Other responses included recognising and managing triggers and finding options other than self-injury. As documented in Part Two of this report, these responses closely reflect benefits that participants did report receiving from the SAFE DSI support group run through Southern Community Welfare. Respondents to the survey were asked about concerns they may have about a DSI support group, which tended to centre around unhelpful relationships being formed in which DSI would be fostered and increase. No participants in the pilot SAFE DSI group reported a negative outcome such as this.

(c) Professional Services

Participants in Professionals Survey

Participants in this section of the community consultation were 51 professionals who work in various mental health or welfare support services. Participants were recruited through various professional networks. Services that respondents worked in included: counsellor (27.5%), church-based youth service (19.6%), youth drop-in (15.7%), youth refuge (7.8%), hospital mental health (7.8%), family support service (5.9%), drug & alcohol service (5.9%), street outreach (5.9%), community health (3.9%), hospital emergency department (2.0%), general church ministry (2.0%), homelessness

service (2.0%), mental health outreach (2.0%), private psychology practice (2.0%), education (2.0%), and carer respite (2.0%). These services represented a range of services from the government-funded (45.1%), not-for-profit (41.2%), private (19.6%) and voluntary (9.8%) sectors. *Note: Participants were able to check more than one classification for their service and role if applicable, hence figures do not add to 100%.* Roles that participants held within each service included youth worker, social worker, psychologist, counsellor, case worker, case manager, support worker, nurse, manager, pastor/minister, youth liason, teacher, volunteer and occupational therapist.

Participants were asked to approximate how many clients they have worked with in 2008 - mid 2009 (approx 18 month time period) who struggled with deliberate self injury. 18.4% of respondents worked with no DSI clients, 24.5% worked with 1 to 2 DSI clients, 20.4% worked with 3 to 5 DSI clients, 26.5% worked with 5 to 10 DSI clients, 6.1% worked with 10 to 20 DSI clients and 4.1% worked with more than 20 DSI clients. Those professionals who had not worked with any DSI clients during 2008-2009 did not complete the next section of the survey.

The issue of Deliberate Self Injury

Participants were asked to comment on changes that they or their service had perceived within the issue of DSI over the past 5 years. Although many participants did not make a comment on this issue, there were some common themes amongst those who did comment. Several responses indicated that they had not perceived any significant changes. Several others commented that the issue of self injury had become less taboo, less secretive and more commonly discussed amongst peers. Some respondents indicated a belief that the incidence of self injury had increased and/or changed over recent years – some saying that it has appeared to be less related to extreme suicidal behaviour. It was also noted that increases or changes in DSI may at least partly reflect a greater understanding of staff about DSI, as well as clients being more willing to discuss DSI.

DSI Clients

Professionals were asked to rate up to 5 of the biggest challenges that they perceive for young people in the Sutherland Shire who are struggling with DSI, from a list provided. Responses to this question were as follows:

- Family relationship issues (61.9% professional respondents indicated they believed this was in the top 5 challenges)
- Lack of understanding from family (59.5%)
- Comorbid mental health issues (42.9%)
- Lack of understanding from peers (28.6%)
- Lack of understanding from school (28.6%)
- Comorbid drug & alcohol issues (23.8%)
- Difficulty accessing services – including personal factors causing apprehension in accessing services such as embarrassment or fear of a lack of understanding (23.8%)
- Lack of understanding from professionals (19.0%)
- Lack of services (16.7%)
- Accomodation issues (9.5%)
- Peer pressure to self-injure (9.5%)
- Difficulty accessing appropriate medical care for injuries (7.1%)

Some respondents additionally noted that a big challenge for young people with DSI in the Sutherland Shire is stress and perceived pressure placed upon them. This option was not included in the original list.

Working with DSI Clients

Professionals were asked about their experiences of working with young people who self injure. Participants were asked how confident they feel in working with this client group. 2.3% responded 'no confidence, 25.6% responded 'little confidence', 39.5% responded 'somewhat confident', 18.6% responded 'confident' and 14.0% responded 'very confident'. The top three emotions that professionals said would describe their feelings about working with DSI clients were concerned, hopeful and sad.

Participants in the professionals survey described a wide variety of professional difficulties, struggles and fears that they have experienced in working with DSI clients. Some of their responses were:

Concerns about the young person's wellbeing

The fear that they will escalate the behaviour and as a result put their life at risk

Concern that it may be quite some time before self injury is not a part of their life

If it gets to the addictive stage it is hard to break the cycle, it seems to become the only coping strategy

Professional concerns about managing the situation

I can only help in certain aspects and quite often it must be a team effort to help a client.

Maintaining rapport and trust following disclosure of self harm to parents, doctors, hospitals etc

I find it difficult to keep families focused on needing to treat other issues when they are scared about the self-harm and want that to be the only focus of treatment.

we are not trained...[in] how to deal with these patients.

when attempts to work openly alongside other service providers is not reciprocated and My biggest difficulty is knowing who to refer on to with some reliability.

Making sure I recommend correct treatment/ the consequences that could follow if I am wrong in my analysis

That I would miss an obvious sign and find them in a very bad way.

not letting [others involved] overreact

Concerns about personal response

Seeing the extreme injuries that can be presented.

The magnitude of the variety and the depth of concern noted in these responses highlights the importance of meaningful and effective support for professionals working with DSI clients.

Participants were asked about the training they had received for working with DSI clients. 33.3% of respondents indicated that they had received no specific training in deliberate self injury. A further 27.8% indicated that they had received very little training or only self-directed learning. Some responses did not give specific details, but few participants indicated that they had been involved in more than one or two specific workshops on DSI.

Participants were asked to indicate whether they believed their service would benefit from specific training in DSI. All respondents indicated that they believed this would be helpful for their service. When asked about the specific areas of training they believe would be helpful, the following topics were all rated as potentially beneficial:

- Recognising signs of DSI (61.0% of respondents believed this would benefit their service)
- Understanding DSI (58.5%)
- Working collaboratively with schools and other services (56.1%)
- Protective and risk factors for DSI (48.8%)
- Working therapeutically with DSI (46.3%)
- Medical management of DSI (29.3%)

The majority of respondents indicated that they currently receive support in working with DSI clients through avenues such as individual supervision (55.3%), group supervision/debriefing (28.9%) and ad hoc support from peers or managers (47.4%). Only 10.5% indicated that they receive DSI-related professional training (which appears consistent with results reported above). Interestingly, when asked about the professional support that they think would be *ideal* for professionals working with DSI clients, 73.2% responded that DSI-related professional training would be beneficial – and furthermore, this figure was higher than for individual supervision (65.9%), group supervision/debriefing (58.5%) and ad hoc support from peers or managers (24.4%). These responses appear to indicate that there is an unmet need, or desire, for DSI-related professional training, at least within many of the services represented in this survey.

Professionals were asked about whether they would refer a young people to another service if DSI was their primary presenting problem. In this circumstance, 35% of respondents indicated that they would not refer or would be unlikely to refer, and 65% indicated that they would be likely or would almost certainly refer. However, when asked what service they would refer such clients to, 25.6% of participants indicated that they would not know where to refer DSI clients within the Sutherland Shire.

95% of professional participants stated that they believed it is important or very important to collaborate with other services in managing a DSI client (no participants said that it was 'not important'). However, no participants indicated that they believe Sutherland Shire services currently collaborate 'very well', only 14.3% believe they do so 'well', 46.4% believe they do so 'adequately', 35.7% believe they do so 'poorly', and 3.6% believe they do so 'very poorly'. The picture painted by these responses suggests that greater and/or more effective collaboration between local services is desired by many professionals. Participants were then invited to comment on how they believe collaboration between services could be improved. Some of the responses included:

MHPN (Mental Health Care Plan – obtained through a GP to see a psychologist) is a very good start

Greater involvement from school counsellors and a breakdown of barriers between school counsellors (as public servants) and psychologists as private practitioners.

Earlier involvement of all stakeholders in care planning

better access on general wards to mental health services.

As a pastor I'm very aware of the lack of connection with other churches and services which exists. It would be helpful to have a centrally managed organisation, (even if it was only a website for practitioners and pastors etc), which could act as a means of organising a network for the purposes of providing and advertising further training, and for allowing people to ask questions and find answers.

Allocation of a particular person as the 'case manager', and all significant correspondence to be discussed with them.

Professionals were asked about the type of services that they believe would benefit those young people who self-injure. Of the list of suggestions, the top three responses were DSI individual counselling (82.5%), collaborative case management (80%) and DSI support group (65%).

When asked about whether they would refer DSI clients to a well-managed support group, 80% of respondents said that they would be likely or almost certain to refer. However, professionals noted a number of questions they would have about the group format, including:

- Whether young people would share self injury methods, support one another's destructive behaviours, or collectively feel more helpless.
- Whether young people with DSI would be willing to speak about their difficulties in a group setting (It was suggested that some clients would only be comfortable sharing one-on-one)
- Whether the group was empirically supported / researched.
- Who was running it – i.e. credibility of the professional
- Whether the group would address issues underlying the DSI
- Whether the group would support the young person's faith or lifestyle
- Whether the client was able to get to the group (transport etc)

Please see Part Two of this report for a description and findings from the pilot DSI support group facilitated by Southern Community Welfare.

(d) Schools

Participants in Schools Survey

Participants in the schools survey were 42 staff working in a range of secondary schools (71.4% government, 26.2% private or independent, 2.4% working across all schools in the region), in various roles including class teacher, faculty head teacher, welfare teacher, year advisor/coordinator, school counsellor, school chaplain, teacher librarian and school-link coordinator (mental health). 78.6% of participants work in schools within the Sutherland Shire. Permission was granted by the DET NSW for government-employed teachers to participate in this survey.

DSI and Young People

School participants were asked to rate the top five challenges that they believe young people with DSI face in the Sutherland Shire. Responses were as follows:

- Lack of understanding from family (64.5% participants rated this in the top 5 issues)
- Family relationship issues (58.1%)
- Lack of understanding from peers (51.6%)
- Comorbid mental health issues (48.4%)
- Peer pressure to self-injure (25.8%)
- Comorbid drug and alcohol issues (22.6%)

- Difficulty accessing services – including personal factors causing apprehension in accessing services such as embarrassment or fear of a lack of understanding (16.1%)
- Lack of understanding from school (12.9%)
- Lack of understanding from professionals (9.7%)
- Lack of services (6.5%)
- No challenges (6.5%)
- Accommodation issues (3.2%)
- Difficulty accessing appropriate medical care for injuries (3.2%)

This list is quite similar to the order of responses given by participants in the professional services survey, with three notable distinctions:

- 1) School respondents rated peer pressure as a more prevalent issue than did professional services respondents
- 2) Professional services rated lack of understanding from school as a more prevalent issue than did school respondents
- 3) A small minority of school respondents indicated that some young people with DSI face ‘no challenges’ – presumably referring to students who experiment ‘superficially’ with DSI.

School participants were asked whether they had noticed any changes in DSI over recent years. These responses are subjective and situationally bound, but the results are interesting nonetheless. Needless to say, every school is likely to experience its own pattern of self-injury cases. Several participants mentioned that they had noticed a decrease in the last couple of years compared to a particularly large number of cases they were aware of around 2004-2005 (some linked this to the higher prevalence of the ‘emo’ culture at that time). Several participants also mentioned that the prevalence of incidences seems to rise and fall over different years, some participants suggesting that this was strongly linked to peer group influence (i.e. one case may lead to several other cases within the one peer group as peers experiment). One participant mentioned that students with DSI also congregate together for support. Other respondents perceived the overall incidence of DSI to have risen or not changed. Some respondents referred to the greater awareness and understanding of DSI amongst adolescents, which had corresponded to more openness to inform staff and seek support for their friends with DSI.

Response to DSI in Schools

School staff participants were asked to estimate over the course of 2008-mid 2009 how many students they were aware of within the school who struggled with DSI. 17.5% responded ‘none’, 40.0% responded ‘1-2 students’, 32.5% responded ‘3-5 students’, 7.5% responded ‘5-10 students’ and 2.5% responded ‘10-20 students’. Participants were asked to estimate the proportion of DSI cases within the school that the school is made aware of. Of course, in responding to this question one can only make an educated guess, but interestingly responses ranged from ‘The school would know of almost all cases of DSI’ through to ‘the school would know of only a small proportion of DSI cases’. 97.3% of respondents indicated that there are likely to be cases of DSI within the school population (whether they are many or few) that the school is not aware of. One respondent commented that very few students offer this information to the school, and more commonly friends report incidences or injuries are seen.

Participants were asked: ‘If a student revealed that they were self-injuring, how would the school normally respond?’ Major themes running through these responses were:

1. Inform a staff member in a higher position (such as deputy principal, head of welfare or principal) who in many cases would take over management of the case.

2. Make a referral to the school counsellor who may additionally refer to external support services in cases of high risk.
3. Those managing the case would consider whether a DOCs (child welfare) referral would be appropriate.
4. Some responses indicated that parents would be informed automatically, and others indicated that parents would be informed 'if appropriate'. A school counsellor noted that a decision about whether to inform parents would partly depend on the student's age and assessed level of risk.

School staff participants were asked to rate their confidence in supporting students who self-injure. 9.4% responded 'not confident', 34.4% responded 'little confidence', 34.4% responded 'somewhat confident', 12.5% responded 'confident' and 9.4% responded 'very confident'. Some participants also made further comments such as:

[I'm] really not sure what to say, try not to judge, would benefit from some support literature and courses

As year advisor it is possible that I would need to support a student who self-harms, however, we are given no training in how to deal with them. We just refer them to the Counsellor but often don't hear anything back from them or get any tips for future action.

I do not understand this issue at all

Often DSI in the school context is equated with suicidal risk. DSI is still a taboo subject for many.

When asked how they feel about supporting students with DSI, it is interesting that the top three responses were the same as for those working in professional service roles, that is, concerned (82.8%), hopeful (37.9%) and sad (27.6%). Two participants commented that their lack of understanding about DSI made it difficult for them to empathise with students in this situation.

School staff indicated that they experience various professional difficulties, struggles and fears in regards to DSI. These can be grouped into four general categories:

Concerns about the student's wellbeing and education

- How to support the student whilst maintaining their dignity
- That it could lead to suicide (intentional or unintentional)
- Lack of receptiveness to teaching (mind otherwise occupied)

Concerns about managing the situation

- Issues around breaking confidentiality, i.e. rapport versus duty of care
- Saying the wrong thing
- Lack of time to talk with the student or unable to provide enough support
- Lack of qualifications
- Some students unwilling to talk openly to teachers

Concerns about personal response

- Hearing about or seeing injuries is distressing
- Emotionally draining and easy to feel personally involved (rather than simply professionally)

Concerns about the broader school response

- Lack of understanding about DSI by some staff (e.g. DSI is the same as suicide ideation)
- Schools' actions can appear at odds with therapeutic treatment at times

- How to support the student's peers well
- How to support the student's parents well

School staff participants were asked about any training they had received specifically about DSI. The school counsellors who responded to this question indicated that they had received a substantial amount of professional development in this area. Out of the non-counsellor school staff, one out of 19 respondents (a year advisor/coordinator) indicated that s/he had received significant DSI-specific training. The other 18 non-counsellor respondents to this question indicated that they had received little or no DSI-related training and information they had obtained was through personal reading or experience.

School staff participants were asked to indicate the specific areas they believe that they, or their school, would benefit from receiving training in. Responses were as follows:

- Options for schools in supporting students who self-injure – 75.9% indicated this would be beneficial
- Understanding DSI – 72.4%
- Recognising signs of DSI – 72.4%
- Protective and risk factors for DSI – 69.0%
- Working collaboratively with support services – 44.8%
- Creating support plans and referrals for DSI – 41.4%
- No training – 0.0%

Each of the percentages for training options are relatively very high, suggesting that many school staff would like additional broad training in DSI. Comments that some participants made included a suggestion that DSI –specific training would be particularly useful for year advisors, deputies, welfare coordinators etc. Another participant commented that “Anything would be good!”. 100% of participants indicated that DSI training would be helpful for either themselves or their school. Taken together, these results suggest that school staff want further training for themselves or their school in DSI, and they believe that this is very limited at present.

PART TWO: DSI SUPPORT GROUP FOR YOUNG PEOPLE

A pilot support group was run for young people who were attempting to end the cycle of self-injury in their lives. The aim of the group was to facilitate a safe and supportive space for young people struggling with DSI to begin to move towards more healthy means of coping. We chose to use the SAFE in OZ (Self Abuse Finally Ends) program as the foundation for our group. SAFE in OZ Consumer Recovery Program is designed to support and educate about the process of ending self injury, and decrease isolation for those trapped in this behaviour. It encourages group members to discuss their thoughts, feelings and behaviours that contribute to their self-injury, with the purpose of discovering and developing more helpful coping strategies, realistic thought processes, emotional regulation techniques and self-soothing behaviours. Furthermore, the group provides a safe and supportive environment in which people may share experiences both with professionals and other consumers, who will empathise, understand, and encourage one another to make healthy and safe life choices. It is a strict policy of the SAFE program that specific details of injuries or injuring methods are not discussed between group participants.

The program is divided into 11 modules throughout which the following topics are covered:

- Understanding self-injury
- Ending self-injury
- Goal setting
- Anger
- Self-affirmation
- Assertiveness and boundaries
- Helpful and unhelpful thinking
- Emotions and self soothing
- Messages from childhood
- Triggers
- Relaxation
- Support resources
- Choices and change

The pilot DSI support group at Southern Community Welfare was coordinated by two facilitators and a support consultant: Rachel McKinnon (Registered Psychologist), Karen La Motte (Counsellor) and Karlyn Johns (DSI project coordinator/case manager). Advertising for the group began in May 2009. Flyers and emails were distributed through the Sutherland Shire Youth Network, local Area Health teams, church youth leaders and other professionals working with young people (e.g. private psychologists, GPs). Prior to the start of the group, interested young people completed an individual intake interview with one of the facilitators to assess the young person's suitability for the group. Seven young people started the program, and five completed it.

Pre-Group Interview

Prior to the start of the group all potential participants were interviewed by one of the group facilitators. Only information relating to people who started in the support group is included. Group participants were all female and ranged from 17 to 24 years of age, with 20 years of age being the average. Six out of the 7 young women who started the SAFE program were using self-injurious behaviour as a current coping mechanism at the time of the outset of the group. One had recently stopped using self-injurious behaviour, but had frequent thoughts or urges to injure again. The age at which participants recalled first self-injuring ranged from 11 to 18 years of age, with 14 years of age being the average. Methods of self-injury reported included cutting, burning, overdosing, head-banging, picking, self-deprivation of food, scratching, hair-pulling, interfering with wounds and other

deliberate risk-taking behaviour. All participants stated that in addition to self-injury they had experienced some form of compulsive difficulty or disorder, many of which related to eating (either under or over eating). Five participants reported having struggled with alcohol abuse (either past or present), and two reported having struggled with other drug abuse (licit or illicit). All participants expressed a resolve to overcome self-abuse, a commitment to be honest with herself and others (whilst maintaining safe boundaries), and an intention to attend every group session.

Mid-Group Evaluation

Following session 6 (of 12), group participants were invited to complete a mid-program evaluation. Several prompting questions were asked, and responses have collated here under the three major themes that were commented on by participants: content of the program, strategies, techniques and tools, and support offered within the group.

Content of the program

Participants commented that the content of the group was not too difficult but challenging at times, in particular emotionally challenging at times. Participants reported that they were able and willing to complete the homework activities most of the time, though this was more difficult for participants who were completing concurrent studies. On the whole participants indicated that they were satisfied with the program content.

Strategies, techniques and tools

At the time of the mid-group evaluation, few participants commented on the helpfulness of strategies, techniques or tools. Although a couple of comments reflected some participants finding the strategies learnt to be helpful by this point, the following quote reflects the sentiment expressed by some other participants in relation to strategies:

I find it difficult in some ways (to use the tools and strategies offered in the program), but my psychologist said....it's just mental barriers I have to break through

Interestingly, group members' opinion of the strategies, tools and techniques largely changed as the group went on. It is likely that more strategies were learnt or used in the second half of the group. It is also likely that these strategies became more helpful with encouragement and practice, and therefore the benefits began to be seen later on in the process. There was, however, evidence at the mid-group evaluation that the foundations for new cognitive processes and behavioural patterns were beginning to be established, as these two comments reflect:

When I leave the group I know that self-injury is at the front of my mind but I'm also in the headspace to strategise and try and discover things about my (mental) illnesses etc.

I've tried distraction techniques and putting it off. Lots of the time I used them but still self harmed – yesterday for the first time I used a technique without self harm

Support (social and emotional) offered within the group

On the basis of the mid-group evaluation and informal feedback during the group, the facilitators became aware that social and emotional support was one of the key program elements that participants were both enjoying and finding helpful at this stage in the process of overcoming self injury. Comments that were made included:

I think most of us need to vent and that's one reason why the group works so well for me

I usually (feel) a lot better (more emotionally safe and supported) than when I came

End of Group Evaluation

In the last session of the program, the young women who completed the group were given a questionnaire about the effect of the SAFE program on their resolve to overcome self-injury.

Participants were asked whether they would recommend the program to other individuals who self-injure. All participants responded "Yes".

They were asked to rate the program content, support offered and strategies provided in the group as "Most Helpful", "Helpful" or "Not Helpful", with the option of making an additional comment.

Content of the program.

Average response - "Most Helpful".

Some comments made were:

you get to see what's going on inside your head in front of your face on paper

it's been really good for my self esteem and my coping strategies

Support (social and emotional) offered within the group.

All responses - "Most Helpful".

Some comments made were:

Having a group was the best thing I've ever done because you can discuss things amongst the group and it may answer questions that you or someone else has

Excellent facilitators

Helps trying not to SI (self-injure) and make it till class next week

Strategies, techniques and tools.

Average response - "Helpful".

One participant commented that the group has caused her to think about self-injury more often, and this has been difficult, but noted that she still remained free of self-injury.

Two open-ended questions were also included:

What positive behaviour changes have occurred since being part of the program?

Some comments made were:

I've tried to be more realistic with my responses and reactions to situations

Socially – (having) deep and meaningful (conversations)

Have not self-injured for a while

What important things have you gained from being part of this program?

Responses included:

To be assertive not aggressive

To step back from situations and analyse it / To think about the trigger

Friendships

Positive self-talk

Red texta on my leg instead [i.e. helpful non-harmful strategies]

4 Month Follow-Up Evaluation

Approximately four months after the final group session, the participants who completed the program were sent a follow up questionnaire about the ongoing impact of the group. Four responses were received for this 4-month follow-up. Self-report prompting questions asked participants to comment on the ongoing effect of the group on their general mental health/wellbeing, their self-injury and any other areas of their lives. Responses fell into five general categories.

1. Mental Health and Wellbeing

All participants commented on the positive impact of the group on their general mental health and well being. Some comments included:

My self esteem and general mood has improved DRAMATICALLY since 12 months ago.

I am learning (trying) to stand up for myself more and be assertive. I don't think I hate myself so much, often I don't hate myself at all. I can appreciate the good/positive things in life and I feel really lucky for everything I have. People have literally commented that I am a different person recently, and much happier. I think the long term effects have been greater than what I gained in the short term.

2. Coping Strategies

All participants commented on the positive impact of the group on their choice of coping strategies. One participant wrote:

I have better coping skills and am less emotionally involved. I am doing [positive] things that I neglected for a long time

If I have a problem I look through my notes and work through whatever it is that's ailing me, without resorting to self-harm...I'm constantly talking to people about the program...

3. Social Support

All participants commented on the positive impact of the social support in the group. In particular, participants commented on the value of ongoing social support and friendships with other group members (which continued post-group). Some participants mentioned that the group normalised some of their experiences – it allowed them to recognise that they are not on their own, and that other people go through very similar emotions and thought processes.

4. Self-Injury

Out of the four respondents, all stated that they still have thoughts or urges to self-injure, the frequency of which ranged from every couple of days to once a month. At four months post-group:

- One participant had remained self injury-free since prior to the start of the group.
- One participant stated that she had not self injured since towards the end of the group (approximately the past 5 months).
- Two respondents stated that their self-injury had reduced compared to pre-group.

Comments included:

I can resist it better, I can put it off... Once I used a less harmful alternative instead of my usual injuring.

Even when I get urges, I can work out why and positively act against those urges in a way that benefits me.

5. Other Areas of Life

Two participants commented that the group had a positive effect on their work and study. In particular that they felt less stressed by work and believed that they could cope more effectively.

Mental Health and Wellbeing: Depression, Anxiety and Stress

As an additional measure of changes in mental health and wellbeing, participants' scores on the Depression, Anxiety and Stress Scale (DASS-42) were tracked prior to starting the group, in the middle session of the group, in the last session of the group and 4 months after the completion of the group. The following are the average scores for Depression, Anxiety and Stress of the responses received by participants at each stage. Unfortunately not all participants completed the DASS at each data collection stage.

DASS Scores	Depression	Anxiety	Stress
Pre – group (n=4)	32	28	31
Mid – group (n=4)	19	18	24
End – group (n=3)	21	19	26
Post - 4 mth follow-up (n=4)	17	15	20

Statistical analyses have not been performed on the raw data obtained due to the low number of participants which does not allow for strong conclusions to be drawn. Since not all group members participated in each stage, it is also important to assume that there is a margin of sample bias error. In other words, these figures are not intended to represent statistical information, but can be considered rather as quantitative observations. Descriptions and discussion regarding some perceived trends follow below.

Pre Group to Mid Group

Between the start of the group (Pre) and the 6th session (Mid), average scores on each of Depression, Anxiety and Stress declined. Statistical analysis would be required to determine the statistical significance of these results. However, preliminary observation of the raw scores suggests that the intensity of participants' depression, anxiety and stress decreased (averaged across participants) from pre-group to mid-group. This trend in the data corresponds with participants' self-reports of improved mental wellbeing during the course of the group. There is some preliminary evidence to suggest that the intensity of participants' depression, anxiety and stress was decreased (averaged across participants) from pre-group to mid-group.

Mid Group to End of Group

The scores for Depression, Anxiety and Stress slightly increased between session 6 (Mid) and session 12 (End) (though they remained lower than the average scores at the Pre test). While it is noted that this difference may not be statistically significant, the facilitators' clinical observations indicated that group participants were generally apprehensive about the completion of the group. Reasons for this included worrying that the progress they had made may not continue without the support of the group, as well as general disappointment about not continuing to meet regularly with the other group members.

End of Group to 4 Month Follow Up

The Follow Up scores are of particular interest as they refer to the ongoing effects of the group. 4 months after the completion of the group, average scores for Depression, Anxiety and Stress continued to be lower than the Pre scores. Furthermore, Follow Up scores were also lower than both the Mid and End scores. Although we cannot determine statistical significance, the trend of the raw data suggests that gains in mental wellbeing (depression, anxiety and stress) made during the group were maintained up to (at least) 4 months following the completion of the group program, and participants' mental wellbeing may have continued to improve in the 4 months after the completion of the group. Further research into the SAFE program involving a greater number of participants and statistical methodology could provide more confident conclusions.

PART THREE: DSI WEBPAGE

The DSI webpage is an extension on Southern Community Welfare's website to provide detailed, specific information regarding deliberate self injury for various groups of people in the community.

As the final part of this project we attempted to provide access to information that had been requested of us throughout the DSI project. Many people have told us of difficulties in accessing reliable and non-triggering DSI information on the internet. In particular:

- Up-to-date educative information on DSI for individuals who self injury, their family members, their friends, other service providers and the general public.
- Specific information for teachers and schools in regards to providing a safe and supportive place for young people struggling with DSI.

During the community consultation phase of the DSI project (as outlined above), 63.6% of family and friends who participated expressed that they would benefit from helpful DSI websites. Additionally, 43.8% of participants in the schools survey indicated they had little or no confidence in supporting a student who self injures and 75.9% indicated a belief that their school would benefit from training in options for schools in supporting students who self-injure. The information that is now available on our webpage is intended to address some of these needs.

Our DSI team decided upon fact sheets as an easy-to-use web-based communication tool which could provide specific information for various relevant community groups. As we researched this concept, we discovered that a UK-based organisation, 'First Signs' (www.firstsigns.org.uk/) had develop such fact sheets, very much along the lines we had envisioned. Our team agreed that the 'First Signs' fact sheets were highly appropriate for our purposes, as well as generalisable to the Australian context. Hence, we sought and received permission from 'First Signs' to allow access to these fact sheets from our website. The following DSI topics are covered:

- Factsheet for parents and guardians
- Factsheet for friends
- Factsheet for Males
- Factsheet for Healthcare Workers
- Factsheet for Teachers
- Creating a school self injury policy

Please visit www.scw.org.au/Services_DSI_Facts.aspx to view these factsheets through our website.

Other DSI information available on our website includes:

- Information about upcoming DSI educational and support services offered by Southern Community Welfare.
- Some local newspaper articles related to DSI.
- A link to the SAFE in OZ website – the organisation that produced the program used in the DSI support group.
- Downloadable DSI brochures and booklets, one of which specifically addresses the needs of young people who wish to seek help and support.
- Crisis counselling numbers.
- Information about DSI community services we are familiar with that are based in other states of Australia.
- Links to other helpful DSI websites.

- Suggestions for helpful books on DSI.
- Frequently asked questions about DSI.
- Public access to this report.

Please visit www.scw.org.au to access our DSI-related web pages.

Reported compiled by

Rachel McKinnon

Psychologist

B. Psyc (Hons), Grad Dip Ed, PG Dip Soc Hlth, Associate MAPS