Self-harm is defined as “self-poisoning or injury, irrespective of the apparent purpose of the act” (NICE July 2004) http://guidance.nice.org.uk/CG16/niceguidance/pdf/English/download.dspx and can encompass a range of behaviours:

- cutting
- hair pulling
- strangulation
- burning
- banging
- inserting/ingesting sharp or harmful objects/substances.

This guideline focuses on self-harm that is an expression of psychological distress.

This guideline excludes self-harm behaviours that are socially or culturally sanctioned. This guideline also excludes eating disorders, drug and alcohol misuse and risk taking behaviours.

The underlying reasons for self-harm behaviour can be complex and varied, but it is often linked to a history of trauma, abuse, neglect or disturbed family relationships. Similarly, the functions of self-harm behaviour can be varied and can change over time. Typically, self-harm behaviour is a way of coping with or expressing difficult feelings or a way of ‘speaking the unspeakable’. It can also be a way of regulating interpersonal closeness, a re-enactment of trauma, a way of ‘cleansing’ or re-connecting with the real world, or a form of stimulation – releasing endogenous opioids.

Prevalence rates for self-harm behaviour have been estimated to be 400 per 100,000 population but this varies considerably in terms of gender and age, and is one of the top five causes of acute medical admissions in the UK. A UK hospital study found that approximately 300 per 100,000 males aged between 15 and 24 years and 700 per 100,000 females of the same age were admitted to hospital following an episode of self-harm. Another study found annual rates of 800 per 100,000 for 12 to 24 year olds. Community studies show higher rates than hospital studies and it is well known that much self-harm behaviour goes undetected. The available evidence suggests that self-harm is not common in children under the age of 11.

Self-harm behaviour is strongly associated with risk of suicide, with between 0.5% and 1% of people who attend A&E following self-harm dying from suicide in the following year, rising to 4% to 5% in the longer term.

The risk of suicide following an episode of self harm varies greatly in terms of gender and age:

- **Men are twice as likely to subsequently die by suicide than women.**
- **The risk of suicide increases greatly with age for both men and women.**

**Escalation in frequency and/or severity is also an indication of increased risk.**
General principles

- Although self-harm is associated with a range of psychiatric disorders (depression, psychosis, underlying organic disorders) the diagnosis most frequently associated with recurrent self-harm is borderline personality disorder.

- Most self-harm may not be an indication of psychiatric/personality disorder, and is commonly an indication of psychological distress.

- In the event of a disclosure of self-harm, observation of a suspected self-harm injury, or presentation for treatment for a self-harm injury, people should be treated with the same care, respect and privacy as any other patient, and health care professionals should take account of the likely distress associated with self-harm.

- **If an urgent referral to an emergency department is deemed not necessary the person self-harming should be assessed for risk to assess the need for an urgent mental health referral.** They should be assessed to determine their mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness.

- The psychosocial assessment should include an evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment. It should also include identification of the main clinical and demographic factors associated with risk of further self-harm and/or suicide, and identification of key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.

- Always ask the service user to explain in their own words why they have self-harmed.

- The psychosocial assessment should be undertaken with the service user alone to maintain confidentiality and allow discussion about issues that may relate to family/carers, including abuse.

- Offer the choice of male or female staff for the psychosocial assessment and treatment. If this is not possible, explain why and write it in their notes.

- On completion of the psychosocial assessment the assessment should be clearly recorded in the patient’s notes and details passed on to the relevant mental health service for rapid follow up.

- People who present with self-harm but wish to leave before the psychosocial assessment and in whom diminished capacity and/or the presence of a significant mental illness is established, should be referred for an urgent mental health assessment. Appropriate steps should also be taken to prevent the person leaving the service.

- **In most circumstances, people who have self-poisoned should be urgently referred to the nearest accident and emergency department.** If in doubt whether to refer, discuss with the accident and emergency department or ring the Poisons Information Service: 0870 600 6266.

- **Arrange for an appropriate person to supervise the service user if being transported to any referral organization where:**
  - there is risk of further self-harm
  - the person is reluctant to attend, and/or
  - the service user is very distressed
Special considerations for children and young people under the age of 16

- For children and young people (under the age of 16) who self-harm special attention should be paid to the issues of confidentiality, the young person’s consent, parental consent, child protection, the use of the Mental Health Act in young people and the Children Act.

- All children and young people who have self-harmed should be considered for admission and assessed fully before discharge or further treatment is initiated.

- Children and young people who have self-harmed should be assessed by healthcare practitioners experienced in the assessment of children and young people who self-harm.

- Initial management should include advising carers of the need to remove medication and other means of self-harm from a child or young person who has recently self-harmed.

- Any young person under the age of 19 being referred should be referred to the CAMHS service.

Special considerations for older adults

**All acts of self-harm in people over 65 should be regarded as evidence of suicidal intent until proved otherwise.** Given the high risk amongst older adults who have self-harmed, consideration should be given to admission for mental health risk and needs assessment, and time given to monitor change and levels of risk.

All people over the age of 65 who have self-harmed should be assessed by healthcare practitioners experienced in the assessment of older people who self-harm. Special attention should be paid to the potential presence of depression, cognitive impairment and physical ill health.

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**Stepped Care**

A stepped care approach should take account of the degree of risk of suicide a person presents, with those presenting with the lowest risk being managed by the GP or within the primary care team, and those presenting with a high risk being referred to mental health specialists and, if necessary, inpatient care. In terms of the GP, practice nurse or primary care team:

- Information on alternative coping strategies, self-help books and organisations should be provided.

- For people whose self-harm is clearly a coping strategy without evidence of any suicidal intent, counselling or brief psychological interventions should be considered.

- Following assessment and treatment of self-harm in primary care, where appropriate the outcome of the risk and needs assessment, and full details of the treatment provided, should be forwarded to the appropriate secondary mental health team at the earliest opportunity. Inform other relevant staff and organisations of the outcome of this assessment.

If person is considered a high risk to themselves, advice should be obtained from the CMHT or out of hours duty psychiatrist for the relevant age group.
People who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment.

Discuss reasons for self-harm and alternative coping strategies.

When prescribing drugs to people who have previously self-poisoned, people who are at risk of self-poisoning, or people who live with someone at risk of self-poisoning:
- always prescribe drugs that are the least dangerous in overdose
- prescribe fewer tablets at any one time or shorter prescriptions

For children and young people (under 19) consider general treatment principles for Child & Adolescent Depression. http://www.rwstgp.org.uk/guidelines/local
guidelines/Child_Adolescents_depression_guidelines.pdf