

key points

SELECTED BY

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Self-harm is best defined as ‘any act of self-poisoning or self-injury carried out by an individual irrespective of motivation’. With a 10.5% lifetime risk, self-reported self-harm is common in the community and 5.6% have made a suicide attempt. A significant proportion of self-harm episodes are without suicidal intent.

Self-harm can occur at any age but is most common in young people. Prior self-harm is the key risk factor both for repeated self-harm and also for subsequent suicide. The presence of depressive symptoms predicts repeated self-harm, as does any history of psychiatric illness. Men are at a higher risk of suicide following self-harm.

Assessment of self-harm (actual or planned) should include: details of pre-planning; final acts; the event itself; what happened afterwards; as well as broader psychosocial risk factors. Patients should be asked to reflect on the episode to consider whether they regret it, or whether they are likely to repeat it. Patients should be screened for depression, anxiety, psychosis and history of self-harm. Physical illness and substance misuse increase risk.

Referral to secondary care community mental health teams should be considered for patients who present in primary care with a history of self-harm and a risk of repetition. Patients with continuing thoughts or serious intent of self-harm, where supportive or protective factors cannot be identified, may need urgent referral to secondary care. Prediction of further episodes of self-harm is notoriously difficult. Some clinicians may find the use of standardised rating scales, such as the SAD PERSONS scale, a useful way to identify patients who warrant referral and further assessment.

There is currently insufficient evidence to recommend any pharmacological prevention of self-harming. Problem-solving therapy showed promising results when compared with placebo but larger studies are required to corroborate findings. Dialectical behaviour therapy combines a psycho-education programme, aspects of cognitive behaviour therapy and mindfulness and has been effective in reducing self-injury behaviour in adolescents and adults with borderline personality.

Many self-harm episodes are triggered by life events and psychosocial stressors, such as housing, relationship, employment or financial problems. Documenting these in a care plan or letter can improve communication between healthcare professionals and ensure the patient feels their problems have been acknowledged. Any underlying mental disorder should be followed up and treated, in particular, efforts should be made to encourage patients to address alcohol and substance misuse behaviour.

The GP should provide long-term continuity of care, and maintain a holistic awareness of a patient’s life events enabling discussion of the patient’s emotional problems at an early stage with the aim of intervening before a crisis.