SUICIDE & SELF-HARM

Researched and written by
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This report covers both suicide and self-harm, and is intended to be informative about prevalence and trends to a wide audience. However, the figures available for self-harm (often referred to as deliberate self-harm) and self-injury are unreliable; hence this section takes a more discursive approach to the issues, with the aim of informing people about preventative measures which can also act to prevent suicide.

The analysis of the different risk factors presented in this report can add to our understanding of suicide and suicide trends, but there is a limit to the extent to which they can explain or account for changes in an individual's risk of suicide. The likelihood of a person taking his or her own life will depend upon a combination of both risk and protective factors within their own immediate environment.

Nevertheless, the analysis of risk factors does provide us with evidence concerning the effects of major changes to the availability of methods, for example, the reduction in suicides that followed the change to North Sea gas (referred to in section 4). It can also provide ideas about where to target suicide prevention measures.

Eleanor Dace
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SECTION 1: SUICIDE

Introduction

Suicide accounts for 400,000 years of life lost before the age of 75 years. The reduction of suicide and undetermined deaths has been identified by both the current and the former Government as a measure for targeting mental illness. The 1992 Green Paper, ‘Health of the Nation’, set a target of reducing the rate by 15% by the year 2000, i.e. from 11.1 per 100,000 population in 1990 to no more than 9.4. It also specified a 33% reduction in the suicide rate for people with severe mental illness, from the estimate of 15% in 1990 to no more than 10%.

In 1998, the Government issued a Green Paper, ‘Saving lives: Our Healthier Nation’, which again identified a reduction in suicide and undetermined deaths as a target for mental illness. It stated that the rate would be reduced by a further one sixth by the year 2010.

Furthermore, the National Service Framework for Mental Health Services, launched by the Government in September 1999, identified the prevention of suicide as one of its seven standards. It stated that:

Local health and social care communities should prevent suicide by:

- promoting mental health for all, working with individuals and communities (Standard one)
- delivering high quality primary mental health care (Standard two)
- ensuring that everyone who has a mental health problem can contact local services via the primary care team, a helpline or an A&E department (Standard three)
- ensuring that individuals with severe and enduring mental illness have a care plan which meets their specific needs, including access to services round the clock (Standard four)
- providing safe hospital accommodation for individuals who need it (Standard five)
- enabling individuals caring for someone with severe mental illness to receive the support which they need to continue to care (Standard six).

and in addition:

- support local prison staff in preventing suicides among prisoners
- ensure that staff are competent to assess the risk of suicide among individuals at greatest risk
- develop local systems for suicide audit to learn lessons and take any necessary action.

REFERENCES

Suicide Statistics

Official statistics tend to be based on coroner's verdicts and are likely to underestimate the true extent of suicide. They are also based on country of birth, and so are inconclusive on people of minority ethnic origin born in the UK. Most analyses of suicide trends include ‘undetermined deaths’ which are deaths where there is inconclusive evidence about the intent to die. These are now widely accepted as being suicides.

In 1998, there were 5,905 suicides in the UK; this equates to approximately one suicide every 90 minutes.\(^5\)

A recent analysis of the official suicide figures for England and Wales revealed a decrease in suicide rates for both males and females between 1990 and 1997; this is in contrast to the previous trends where male suicide was seen to be on the increase.\(^6\)

In Scotland, there were 649 deaths from suicide in 1998; 486 men and 163 women.\(^7\) This is 50 more than in 1997. If undetermined injury, accidental or purposely inflicted is added, the figure rises to 878 in 1998, compared with 874 in 1997.

In Northern Ireland, there were 173 deaths from suicide and accidental poisoning in 1998; 128 men and 45 women.\(^8\) This is compared with 163 in 1995.

Seasonal Differences

Figures for England and Wales show high levels of suicide in Spring and early Summer, most notably March, April, May and June.\(^9\) There is also a peak in January. Research as to why this is so is inconclusive.

<table>
<thead>
<tr>
<th>Age ranges</th>
<th>Suicide and self-inflicted injury</th>
<th>Undetermined injury</th>
<th>Suicide and self-inflicted injury</th>
<th>Undetermined injury</th>
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</thead>
<tbody>
<tr>
<td>Under 1</td>
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<td>1-14</td>
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<td>11</td>
</tr>
<tr>
<td>15-44</td>
<td>1667</td>
<td>868</td>
<td>344</td>
<td>258</td>
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<tr>
<td>45-64</td>
<td>787</td>
<td>350</td>
<td>235</td>
<td>148</td>
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<td>65-74</td>
<td>183</td>
<td>70</td>
<td>97</td>
<td>63</td>
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<tr>
<td>75 and over</td>
<td>188</td>
<td>61</td>
<td>110</td>
<td>61</td>
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<tr>
<td>TOTAL</td>
<td>2826</td>
<td>1380</td>
<td>788</td>
<td>551</td>
</tr>
</tbody>
</table>

Source: Mortality Statistics: Cause, Office for National Statistics Series DH2 no. 25.
**Age and Gender**

**Men and Women**

More than three times as many men as women kill themselves every year. For example, in England and Wales, there were 5,545 suicides and undetermined deaths in 1998; 4,206 by men and 1,339 by women. Male suicides peaked in 1988 and began to fall in 1992. Female suicides fluctuated during the 1980s, but are now falling. In Scotland, the male suicide rate has continued to rise. Female suicides have fallen although there was a slight increase in 1998. Rates for men and women in Northern Ireland continue to fluctuate.

Explanations for the difference in male and female suicide rates are inconclusive. Official statistics suggest that men are more likely to use more violent and therefore ‘successful’ methods of suicide such as hanging and asphyxiation by car exhaust fumes. Women are more likely to overdose with drugs, which can be more unpredictable. (Further consideration of different methods will be addressed in a later section.) Furthermore, women are at greater risk of suicide in the first year after childbirth.

**Children and Young People**

Research has often focused on the high suicide rate among young people, which has risen over the last two decades and is one of the main causes of death for this age group. Young men are at particular risk. For example, the suicide rate for men aged between 15 and 24 years rose by 64% between 1984 and 1994.

It has been suggested that the real rate of suicide among children and young people may be up to three times the official recorded level. Possible reasons for this disparity include uncertainty about the circumstances of the death, an unwillingness to use the label of suicide when it involves a child – often for the sake of the family, and the constraints of registration policy and practice. For example, when undetermined deaths among children and teenagers (15 to 19 year-olds) are added to the number of suicides, the overall rate is double. Since it is now widely accepted that undetermined deaths often constitute suicide, this age group is at particular risk. Research looking at suicides by young people (under 25 years old) found that the most frequent methods used were hanging and carbon monoxide poisoning and that co-proxamol (paracetamol and dextropropoxyphene) was the most frequently used drug in overdoses. This research went on to reveal a relationship with self-harm prior to actual suicide. For example, nearly 45% of people who had killed themselves had harmed themselves in some way: more than half had done so on a number of occasions, and 80% within the last year. However, only 22.4% were receiving care from mental health services. (The relationship between self-harm and suicide will be discussed in more detail in a later section.)

**REFERENCES**


This research highlights not only the importance of good quality services for people who self-harm, but also that suicidal ideas should be taken seriously. It also raises questions around the availability of drugs such as co-proxamol which is currently a prescription-only drug. Furthermore, research has suggested that young people, both male and female, make more frequent visits to their GPs prior to their suicide. This has implications for GP training.

Another study identified some of the common characteristics of people aged under 35 who had killed themselves. Significant factors included acute and severe mental disorder, ‘rootlessness’ and social withdrawal, and chronic and recent interpersonal problems.

Suicides by students have also attracted some attention. Students can experience a great deal of anxiety and depression concerning their examinations, financial worries, and uncertainty about their future. Measures for preventing student suicides include careful induction upon arrival at university, means of alleviating academic stress and worries, and readily available and closely associated student counselling and psychiatric services.

Older People

For several decades, the focus has been on the suicide rate amongst young men. However, older people are more likely than younger people to ‘complete’ their suicide attempts. For example, in 1998, 16% of all suicides were people aged 65 or over. This may partly be due to the increased likelihood of having prescribed medication. Furthermore, depression, which may lead to suicide is often associated with physical pain or illness and living alone which are more likely to occur in old age. Depression may also be accepted as part of old age, or overlooked in favour of physical complaints or dementia. For example, in a sample of older people with depression, GPs only recognised 51% as having depression. The risk rises for those over 75 years of age, particularly for older men who have the highest rate of suicide in any demographic group. Research suggests that this figure will increase.

Suicide attempts are often overlooked in older people, and yet they are strong predictors of completed suicide in the near future. Therefore, attempted suicide and self-harm in older people, particularly when it occurs for the first time in old age, should result in a referral to mental health services or some form of specialist care as soon as possible.

REFERENCES


The recent decline in male and female suicide rates is true for all age groups. Some trends can be related to particular initiatives such as the increase in catalytic converters, which led to a reduction in the number of people who use car exhaust gas as a method. Also, the fall in suicide between 1963 and 1975 may reflect the reduction in the availability of barbiturates and poisonous domestic gases.

However, the reduction in the use of some methods may have actually led to an increase in the use of other methods. For example, the rise in hanging by young men and poisoning with car exhaust may partly be due to the move away from overdoses and to methods which are more lethal. This may be reflected in the rise in suicide by young men, particularly as this trend coincides with a 45% rise in car ownership by young men. Having said this, the 300% increase in suicide in both genders by car exhaust gas exceeds the overall increase in car ownership. A raised awareness of this as a potential method may have added to the increase.

In older people, self-poisoning is the most common method of suicide. Again, this may reflect the greater availability of medication prescribed for medical problems.

### Suicide and undetermined injury by method

<table>
<thead>
<tr>
<th>Method</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poisoning</td>
<td>779</td>
<td>615</td>
</tr>
<tr>
<td>Gases (mainly car exhaust fumes)</td>
<td>518</td>
<td>50</td>
</tr>
<tr>
<td>Hanging and suffocation</td>
<td>1738</td>
<td>290</td>
</tr>
<tr>
<td>Drowning</td>
<td>195</td>
<td>96</td>
</tr>
<tr>
<td>Firearms and explosives</td>
<td>122</td>
<td>3</td>
</tr>
<tr>
<td>Jumping</td>
<td>120</td>
<td>24</td>
</tr>
<tr>
<td>Cutting and piercing</td>
<td>76</td>
<td>14</td>
</tr>
<tr>
<td>Other</td>
<td>720</td>
<td>258</td>
</tr>
</tbody>
</table>

Suicide and Social Deprivation

Research suggests that suicide is associated with poverty, poor social conditions, unemployment and violence, particularly among young men. Furthermore, men in unskilled employment are more than twice as likely to kill themselves compared with other men in the population.

Between 1975 and 1990 there was a rise in unemployment and violence amongst males, a trend which reflects the rise in male suicide during the same period. Other social trends within this period include a rise in the number of people living alone, an increase in properties being repossessed and homelessness. All may lead to, or at least contribute to, increased loneliness and isolation, creating a greater risk of suicide. There was also an increase in illegal drug use and alcohol consumption, both of which are associated with suicide. This period also saw the HIV/AIDS epidemic, which had a huge impact on young gay men which may have contributed to the rise in young male suicide.

Trends in women's lives may also have affected men's mental health. They include the growing independence of women, with women marrying later, being more likely to be working mothers, with the rate of 'lone mothers' doubling from 9 to 18%.

Why then did the suicide rate begin to fall in the 1990s, when such social factors still existed? It has been suggested that other factors, such as a healthier economy, a fall in unemployment, an improved response by professionals to suicidal thoughts and more developed approaches to suicide prevention, particularly for women and older people, played a role.

Geographical Variation

Suicide rates vary across geographical areas and levels of urban density.

Female suicides (15 to 44 years of age) have fallen in all countries in the UK, except for in Scotland where suicides within this group have risen by 12%; this is 70% higher than the UK rates taken as a whole (1994-1996). Furthermore, suicides among women aged 45 and over are higher in Scotland than in the rest of the UK.

Male suicide rates continue to increase in areas of high deprivation. Local authorities with significantly high suicide rates are in Wales and the North West, all areas with high social and economic deprivation. For example, the rate for men between 15 and 44 years of age, is 35% higher in Wales than in England (1994 -1996). Authorities with the lowest rates are in central and southern England.
Places with the highest suicide rates include Manchester, Hastings, Copeland and Carmarthenshire. Manchester in particular has the highest rate across all ages and across both genders.

Places with the lowest rates include South Herefordshire, Tonbridge and Malling, mid-Bedfordshire and Purbeck in Dorset.

Professions Associated with Suicide

The differing rates of suicide among occupational groups is thought to be linked to the level of access to the means of suicide, the level of occupational stress experienced, and the degree of isolation. For example, the risk is particularly high for farmers and vets.

It has been suggested that the higher risk of suicide in farmers may be related to their easy access to dangerous methods for killing themselves. For example, an analysis of methods used by farmers revealed that firearms were involved in 40% of cases, hanging in nearly 30%, carbon monoxide in 16.4%, poisoning in 8% (over half of which involved agricultural or horticultural poisons). There were considerably more deaths due to firearms compared with men in the general population. Hanging was also somewhat more frequent.

During this study, there was a reduction in firearm death rates following changes in legislation regarding their use. Interestingly, the rate of suicides among farmers began to fall, although this was followed by a rise in suicides by hanging.

People in Contact with Mental Health Services

Suicide is more prevalent amongst people who are known to experience mental health problems or mental illness, compared with the rest of the population. For example, an average primary care group with a population of 100,000 would have about 10 suicides each year, two or three of which would have been in contact with mental health services in the last year. Also, one study revealed that 20-25% of people who had died of suicide had presented to a general hospital after episodes of self-harm in the year prior to death.
A National Confidential Inquiry into suicide and homicide by people with mental illness found the following:

- 24% of suicides were by people who had been in contact with mental health services in the last year; half of these people had had contact with mental health services in the week prior to suicide.
- The most common diagnoses were depression, schizophrenia, personality disorder, and alcohol or drug dependence.
- 22% of suicides occurred in the year following the onset of the illness.
- 63% had a history of self-harm.
- 16% of this group were inpatients in a psychiatric hospital at the time of their death.
- 24% killed themselves within three months of being discharged from inpatient care.

People who are inpatients are thought to be at particular risk, although there is very little reliable evidence around the possible risk factors or their predictive power. One study found that the rate of suicide in psychiatric in-patients was 13.7 per 10,000 admissions. Predictive factors used were a planned or actual suicide attempt, recent bereavement, the presence of delusions, chronic mental illness, and a family history of suicide. However, even using this analysis, only two of the patients who killed themselves had a predicted risk of suicide above 5%.

Furthermore, research has suggested that two thirds of people who kill themselves have not received specialist psychiatric care in the previous year. A study in Greater Manchester found that 70% of people who had killed themselves and who were in touch with mental health services had had their level of care reduced in the month immediately prior to their death, of which 27% could be considered to be at a high predictable risk of suicide. Only 1 in 3 had a designated keyworker (this became a statutory requirement in 1991). This reduction in care usually occurred at their ‘final’ appointment in the community, at which time they were thought to be well. This study has important implications for aftercare and its termination when a person is viewed as ‘clinically recovered’. It is suggested that care should be maintained beyond this point.

**Depression**

The lifetime risk of suicide for people with a diagnosis of affective disorders such as manic depression and depressive disorders is estimated to be 15%. However, the calculation method has been criticised; the actual rate may be as low as 6%.

### REFERENCES


Research suggests that people with a diagnosis of depression are at particular risk of attempted suicide. A survey of 2,000 people with manic depression revealed that 47% had made at least one suicide attempt during the course of their manic depression. This is a worrying figure when viewed with research which suggests that previous attempts are a strong predictor of a ‘completed suicide’. Related factors include being female, having a family history of manic depression, alcohol misuse, and a delay between first admission and diagnosis.

**Schizophrenia**

People with schizophrenia are thought to be at a high risk of killing themselves, particularly people with long-term schizophrenia. A study in the United States suggested that 40% of people with schizophrenia report suicidal thoughts; between 20-40% attempt suicide, and 9-13% end their lives by suicide. However, more recent research has suggested that earlier estimates have been influenced by the use of outdated calculation methods and statistics, as mentioned earlier. The lifetime risk of suicide is usually quoted as 10% for schizophrenia. However, this is based on data from 1921-1975 and on outdated calculation methods. The recalculated lifetime risk for schizophrenia is 4%.

**Addiction**

Research suggests that people with addictions have a higher rate of suicide. For example, one study looked at suicide trends among people registered as having an addiction, across a 25 year period. Although the suicide rate was declining amongst this group, the rates were still significantly higher than the rate within the general population.

These findings have important implications for people using prescribed drugs, particularly anti-depressants. More caution is needed around the prescribing of such drugs without a clear diagnosis of depression, and more care around prescribing levels. There also needs to be greater collaboration between GPs, community mental health teams and specialist substance misuse services, and for all addiction assessments to include an assessment of suicide risk.

The majority of mortality statistics are available by country of birth rather than by ethnic origin; consequently most studies only refer to people born elsewhere, such as the Indian subcontinent, Africa and the Caribbean, and exclude the large proportion of Asian and African Caribbean people born in the UK.
Ethnicity and Suicide

People born in the Caribbean have low rates of suicide and attempted suicide compared to the remaining population. Asian women have high rates of suicide and self-harm compared to white UK and African Caribbean women. Young Indian married women are particularly at risk, whereas Asian men and older people have relatively low suicide rates. The picture is more complex than this; it has been shown that suicide rates vary between different ethnic groups from the Indian subcontinent. It is thought that family and marital pressures and conflicts, together with a lack of support or appropriate services, go some way to explain the high rates of both suicide and self-harm among Asian women.

Research carried out in the United States suggests that suicide rates for young lesbians and gay men may be considerably higher than rates for heterosexual young people. A report commissioned by the US Government concluded that lesbian and gay youth were two or three times more likely to attempt suicide than other young people, and that they may account for 30% of suicides in young people. Other US studies have suggested that as many as 40-50% of young lesbians and gay men have attempted suicide. There is a growing body of research which suggests that the same is true in the UK.

Suicidal thoughts, suicide attempts, acts of self-harm and actual suicides are thought to be more common among young lesbians and gay men, as a result of homophobia and the associated feelings of isolation. Age is an important factor in the lives of lesbians and gay men, since it is when young people are in the process of coming to terms with their sexuality that they are particularly vulnerable to isolation and stigma among their friends and families. Ways of coping with these feelings may include self-harm, alcohol abuse, and eating distress, and may result in suicide.

For many years, psychiatry has classed ‘homosexuality’ as a mental disorder. Whilst this has ceased to be the case in recent times, the legacy of this approach undoubtedly persists. Some of the theoretical models underpinning counselling and psychotherapy, for example, still regard homosexuality as abnormal or as a sign of incomplete development. Until this is no longer the case, and until legislation prohibiting discrimination on the grounds of sexual identity is passed, it would seem unlikely that lesbians and gay men will feel entirely safe about consulting mental health services when in distress.

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There is considerable research to suggest that the prison population is at greater risk of developing mental health problems compared with people of a similar age and gender in the community, and are therefore at an increased risk of suicide. Furthermore, prisoners are less likely to have their mental health needs recognised, and are less likely to receive psychiatric help or treatment.

It has been estimated that a prisoner is up to seven times more likely to kill him/herself compared with someone living in the community. In 1997, there were 70 suicides (67 men and 3 women) in prisons in England and Wales. This is a 40% increase since 1990, and a 159% increase since 1983.

Research has focused on the remand population (approximately 20% of the total prison population), who are thought to be at particular risk, compared with both the sentenced population and the population generally. In 1997, 39% of prison suicides were by prisoners on remand. Remand can be a particularly stressful experience due to the level of uncertainty, the proximity of the offence, the experience of the prison environment which is often characterised by overcrowding, staff shortages, changes in the prison population, and also the stress of being away from family and friends.

Prisoners with a history of mental health problems are at a greater risk of suicide. Research has shown that 22% of prison suicides are associated with a diagnosis of severe mental illness. In 1997, the Department of Health commissioned the Office for National Statistics (ONS, formerly the OPCS) to carry out a large scale survey of psychiatric morbidity in the prison setting. In this survey, a large number of prisoners reported having had 'suicidal thoughts'. 46% of male remand prisoners said that they had considered suicide in their lifetime, 35% in the last year, and 12% in the week prior to interview. The rate for females on remand was even higher.

Furthermore, 27% of male remand prisoners had attempted suicide at some point in their life, 15% in the last year, and 2% in the week prior to interview. The high level of past suicide attempts suggests that suicide is not necessarily a result of the prison situation alone.

Women, both sentenced and on remand, reported higher rates of suicidal thoughts and attempts compared with male prisoners. For instance, over a quarter of female remand prisoners had tried to kill themselves in the year before interview; this is twice the proportion of male remand prisoners.

The ONS survey also highlighted issues around access to mental health care, the lack of which may influence suicide rates. For example, a relatively small number of prisoners reported receiving help for their mental distress in prison, as opposed to

**References**

58. Estimate used by the Howard League for Penal Reform, 1995.
when they were in the community. The level of help was correlated with the type of mental health problems, with those with a psychotic diagnosis or more severe form of neurosis being more likely to have received help. A significant number of prisoners reported being refused help for their mental health problems whilst in prison; this included medication, counselling and an appointment with a psychiatrist. Interestingly, nearly 10% of prisoners said that they had refused offers of help. A weak association was found between the length of stay in prison and use of mental health services, with prisoners being more likely to receive help if they were in prison for longer.

The risk of suicide is particularly high for young prisoners, especially young people on remand. Yet, there has been a substantial rise in the number of young people held on remand, from 1,068 15 and 16 year olds in 1991, compared with 17,000 in 1995. Furthermore, an Inquiry found evidence of bullying, self-mutilation, attempted suicide, and officially sanctioned violence.

Below are a number of possible strategies for preventing suicide:

- Targeting high risk groups e.g. young people, older people, people with mental health problems and prisoners
- Restricting the availability of the means of suicide
- Setting a standard for media reporting and fictional portrayal of suicides
- School programmes for equipping young people with effective problem-solving skills
- Helping school staff to detect ‘at risk behaviour’, such as mental distress and deliberate self-harm
- Increased access to effective crisis intervention.
SECTION 2: SELF HARM, SELF-INJURY AND ATTEMPTED SUICIDE

Introduction

The term ‘deliberate self-harm’ (often abbreviated to DSH by health care professionals) is generally used to cover all acts of self-harm, self-injury and attempted suicide. This can be misleading, as it can encompass a range of different acts and motivations to act, not all of which involve the intention to die. However, there is a strong association between attempted suicide, self-harm and suicide, which implies that all incidents of self-harm should be treated with care and attention.

An estimated 100,000 people per year are referred to hospitals in England and Wales for self-harm, mainly involving drug overdoses or self-injury. Recorded incidents of ‘deliberate self-harm’ are three to four times more common in women than in men, and more common in younger adults.

Suicidal motivation varies considerably among people who overdose. Whilst some people who harm themselves in this way may not be suicidal, there will be others who have survived a serious attempt at killing themselves. The outcome of an overdose is unpredictable. The intention to die may be minimal in cases which prove fatal due to misjudgment of the dose or drug used, particularly in the case of paracetamol which can cause death in relatively small amounts due to its delayed effect on the liver.

Attempted Suicide

Attempted suicide is a strong predictor of death through suicide among people with mental health problems. It is estimated that around 1% of people who attempt suicide go on to kill themselves within a year of an attempt, a rate which is 100 times the rate of suicides among the general population. Approximately 3-5% of people who attempt suicide kill themselves within the following few years, and an estimated 40-50% of people who kill themselves are thought to have made previous attempts. Also, one study revealed that 20-25% of people who had died of suicide had presented to a general hospital after episodes of self-harm in the year prior to death.

All of the evidence available highlights the value and importance of providing adequate care and follow-up to people who have survived a suicide attempt, when instituting suicide prevention measures. The Health Advisory Service makes some recommendations for dealing with deliberate self-harm and assessing suicide risk. They recommend that adequate psychosocial assessments should be offered to all people attending hospital accident and emergency departments following incidents of deliberate self-harm. This is not only because of the risk of subsequent suicide, but also because the degree of risk presented is not a reliable indication of the degree of psychological distress present.

REFERENCES

Self-Harm and Self-Injury

‘It is about trying to create a sense of order out of chaos. It’s the visual manifestation of extreme distress.’ Maggy Ross

A great many people, both men and women, hurt themselves in various ways (such as cutting, burning, scratching or bruising) as an expression of distress and often as a means of coping with that distress. It is very difficult to estimate the numbers of people who self-injure with any accuracy, because of the considerable under-reporting of what can be a wholly private event. Estimates vary between 400 and 1400 per 100,000 population per year. It has been suggested that one in 600 people injure themselves sufficiently to need hospital treatment.

It is generally believed that self-injury is twice as common among women as it is among men, although this is based on the visible numbers of people being treated in hospital or other health care services. Statistics on self-injury are very unreliable, however, because of the many people and injuries treated at home without recourse to health care services or professionals. A survey of women who self-injured found that 90% of the women had cut themselves and a third had inflicted blows or scalded themselves. 74% had begun self-injuring during childhood or adolescence and 69% had been injuring themselves for more than five years.

Self-injury can become habitual – as it becomes a way of coping with difficult feelings (see below), but for many people it may be something that they do only when in a period of distress and may only become visible to others when it is extreme and out of control.

Self-injury can be the result of distress caused by previous abuse, whether physical, mental or sexual in nature. However, to assume that some form of abuse has taken place is unhelpful and there may be a number of other possible factors involved. Some people hear voices that provoke them to self-injure, and for some it is closely associated with eating distress, or alcohol misuse. There is considerable evidence to suggest that people frequently injure themselves when detained or imprisoned (in prison, special hospitals and secure units, or in psychiatric hospitals), where control over their own life and environment has been removed. Cause and effect is unclear: some people may have been injuring themselves prior to detention and increase it when detained, whereas others may start self-injuring for the first time in this situation.

An important underlying theme is a deep sense of worthlessness or low self-esteem, which can silence the expression of emotions and drive them inside until such time as they explode in self-injury. A vital factor to remember about self-injury is that, for many people – although they may wish to stop doing it – it remains a way of coping with those feelings they cannot express. Self-injury can be a means of avoiding or preventing suicide, and it can be a way of life for many people. The injuries can

REFERENCES
release feelings of self-hatred, anger and anxiety, and can provide a means of self-punishment or of taking control.

‘It gives a physical face to pain that cannot be treated or removed by others and might otherwise extinguish life.’
Louise Pembroke

Responses to Self-Injury

Responses to self-injury, from society and from health care professionals, are influenced by the taboo and misunderstanding surrounding it. While many forms of self-harm in its broadest interpretation, are socially acceptable (such as smoking, dangerous sports, alcohol) the image of someone causing themselves visible pain and injury is difficult for many people, both inside and outside the health care professions, to understand. Often, because a person has done this to themselves, it is thought that they are to be blamed for the time and resources taken to care for them afterwards. Many people fail to get beyond this common perception and to see the person as someone in distress trying to cope with difficult feelings and experiences.

Frequent self-injury commonly results in a diagnosis of ‘borderline personality disorder’, a term that includes behaviours described as impulsive and self-destructive. This is of some concern due to current policy trends which target people given a diagnosis of personality disorder. The term is a controversial one, as it is not a diagnosis that leads to any obvious treatment – in fact it can be used as a means of labelling someone as untreatable.

A common misperception is that the person who self-injures is ‘attention-seeking’ or manipulative, and yet the majority of self-harm goes unnoticed by anyone other than the person who has done it. It is a curious fact that ‘attention-seeking’ behaviour is used as a pejorative term when in reality the person who self-harms may very well need attention in the form of care and treatment.

These attitudes often lead to punitive and inappropriate care both in psychiatric wards and in accident and emergency departments. People have reported being stitched without anaesthetic, and being refused treatment altogether. In psychiatric wards and secure units, people may be punished for their self-injury by silence, isolation or anger in an attempt to stop the injuring. The underlying aim of most treatment approaches is to stop the behaviour, but the irony is that punitive responses frequently result in more self-injury. A common approach is in fact an

REFERENCES


77 For further reading, see Babiker and Arnold (1997) op cit; Pembroke, L.R. (1994), op cit.
explicit 'no-self-harming contract' whereby the person commits themselves not to harm again in order to continue receiving treatment or services.

"the doctor was very angry and stitched my wrist with no anaesthetic. It was like he wanted to teach me a lesson but instead he taught me that I could withstand even more pain than I thought."^{79}

One of the reasons for these inappropriate approaches to people who self-harm, is that self-injury gives rise to difficult feelings in health care staff, and these feelings have become institutionalised into the statutory treatment and management approaches to self-harm. Like many other people associated with someone who self-harms, medical and nursing staff may feel distressed, frightened, angry, sick. Acknowledging these feelings and improving awareness of the prejudice and stereotypes associated with self-harm, through better education and training, and clinical supervision, can only help in improving the quality of the service for both service users and staff.

"for many people self-harm is an essential coping mechanism, and we have no right to demand that people stop it, unless we have something better to offer them." Dr Phil Thomas^{79}

Information and training – some of which must be from people who self-harm – can help staff to understand that the fact that someone frequently returns to their care with evidence of self-injury does not represent a failure for staff. Responses in Accident and Emergency departments can be crucial in determining the way in which someone copes with their self-harm. Acceptance of the person and of their distress and an attempt to understand what underlies the self-harm are far more beneficial, as are good physical care for the injury and a non-judgemental approach. Listening and talking to the person can make an enormous difference to their feelings of worth and self-esteem.

Contracts with patients that require them not to harm themselves take away their control and create conditions conducive to repeated self-harm. Although it may be challenging to staff to allow people access to the means of self-harm whilst in their care, this can help people to retain responsibility for their behaviour and to negotiate boundaries and helpful responses. Staff and patients often share the same goal of harm minimisation, and working together to achieve this can be far more beneficial than one imposing upon the other.

REFERENCES

Self-Harm: Good Practice Guidelines for Staff

- Work with the person: listen and accept them and their self-harm
- Find ways of dealing with your own feelings about self-harm, whether through clinical supervision or team work
- Do not make stopping self-harm a goal of treatment
- Do not withhold treatment or care as a condition of stopping self-harm
- Provide good physical and nursing care for wounds
- Encourage people to learn alternatives to self-harm and to manage it themselves
- Learn from people who self-harm – through training and information
SECTION 3: FURTHER HELP AND RESOURCES

**Self-Help and Self-Management for Self-Harm**

The National Self-Harm Network has taken an active approach towards training and recommending guidelines for the care of people who self-harm in A&E departments. The Network has also looked in some detail at self-help and self-management approaches towards self-harm, aiming towards the minimisation of harm.

One of the first steps in the self-management of self-harm is information about basic anatomy and physiology and wound care, so that people can understand the extent of their harm and the risks associated with it. Ways of avoiding infection are also important for someone to understand, since an infected wound can cause a need for professional care some time after the original harm has taken place.

The National Self-Harm Network’s ‘Hurt Yourself Less Workbook’ takes the reader through a number of exercises to encourage them to think about such things as: feelings before, during and after self-harm, risk factors and trigger factors to self-harm, ways of taking care of oneself emotionally as well as physically. It takes the reader through their past and experience of life-events to enable them to understand the factors in their life that may have predisposed them to self-harm, and when and why it started. A new publication from the National Self-Harm Network’s ‘Cutting the Risk’ addresses issues of risk reduction, self-care and managing scars. Written by survivors and professionals attending the risk reduction conferences organised by the Network, this publication is aimed primarily at people living with self-harm, but is a useful resource for people working with people who self-harm.

Ultimately people who self-harm need respect and understanding, and help in working with their behaviour and finding alternative ways of dealing with difficult feelings and experiences. Many people do want to stop harming themselves, but a vital half-way point is self-acceptance and the acceptance of others; self-harm is a strategy for living and people who self-harm are often doing the best they can to survive.

**Mental Health Foundation Publications about Suicide**


Other Resources

Life Matters: A simple guide to important life skills. RMAAS publications: Guildford.
ISBN 1 903165 00 8
Tel: 01483 452754

This book is a self-help approach to developing and maintaining lifeskills. It is a step-by-step guide to help people to get the most out of life. It is particularly useful for people who feel alienated, isolated, stressed and/or depressed.
ORGANISATIONS

**Bristol Crisis Service for Women**
PO Box 654
Bristol BS99 1XH
Helpline: 0117 925 1119  Friday and Saturday nights 9pm-12.30am
Website: www.users.zetnet.co.uk/BCSW/

**Depression Alliance**
35 Westminster Bridge Road
London SE1 7JB
Tel: 020 7633 0557
Website: www.depressionalliance.org

**Depression Alliance Scotland**
3 Grosvenor Gardens
Edinburgh EH12 5JU
Tel: 0131 467 3050

**Eating Disorders Association**
First Floor, Wensum House
103 Prince of Wales Road
Norwich NR1 1DW
Helpline: 01603 621 414 (9am - 6.30pm Mon-Fri)
Youth Helpline (18 years and under): 01603 765 050 (4pm-6pm Mon-Fri)
Recorded message about eating disorders: 0906 302 0012
Website: www.edauk.com

**Manic Depression Fellowship**
Castle Works
21 St George's Road
London SE1 6ES
Tel: 020 7793 2600
Email: mdf@mdf.org.uk
Website: www.mdf.org.uk

**Manic Depression Fellowship Scotland**
7 Woodside Crescent
Glasgow G3 7UL
Crisis Line: 0141 331 0344
Email: manic@globalnet.co.uk
Mental Health Foundation
20-21 Cornwall Terrace
London, N W 1 4Q L
Tel: 020 7535 7400
Fax: 020 7535 7474
E-mail: mhf@mhf.org.uk
Website: www.mentalhealth.org.uk

Mental Health Foundation Scotland
5th Floor
Merchant’s House
30 George Square
Glasgow G 2 1EG
Tel: 0141 572 0125
Email: scotland@mentalhealth.org.uk
Website: www.mentalhealth.org.uk

Mind
Granta House
15-19 Broadway
London E15 4BQ
Mind Information Line: 0345-660163 (9.15am-4.45pm Mon - Fri)
Email: email@mind.org.uk
Website: www.mind.org.uk

Mind Cymru
3rd Floor, Quebec House
Castlebridge
Cowbridge Road East
Cardiff CF1 9AB
Tel: 01222 395123

National Self-Harm Network
PO Box 16190
London N W 1 3W W
Email: info@nshn.org.uk

National Schizophrenia Fellowship
30 Tabernacle Street
London EC2A 4DD
Tel: 020 7330 9100
Fax: 020 7330 9102
National Advice Service: 020 8974 6814
E-mail: info@london.nsf.org.uk
National Schizophrenia Fellowship (Scotland)
Claremont House
130 East Claremont Street
Edinburgh EH7 4LB
Tel: 0131 557 8969
Email: info@nsfscot.org.uk
Website: www.nsfscot.org.uk

NSF @ease website resource
@ease c/o NSF
30 Tabernacle Street
London EC2A 4DD
Tel: 020 7330 9100
Fax: 020 7330 9102
Email: info@at-ease.nsf.org.uk
Website: www.at-ease.nsf.org.uk
This is a new mental health resource for young people under stress or worried about their thoughts and feelings.

The Samaritans
10 The Grove
Slough SL1 1QP
Tel: 01753 532713
Helpline: 08457 909090
Website: www.samaritans.org.uk

Scottish Association for Mental Health
Cumbrae House
15 Carlton Court
Glasgow G5 9JP
Tel: 0141 568 7000

Young Minds
2nd Floor, 102-108 Clerkenwell Road
London EC1M 5SA
Parents Information Service: 0800-018-2138 (Freephone)
Email: enquiries@youngminds.org.uk
Website: www.youngminds.org.uk
THE MENTAL HEALTH FOUNDATION
The Mental Health Foundation is the UK’s leading charity working for the needs of people with mental health problems and people with learning disabilities. We aim to improve people’s lives, to reduce stigma surrounding the issues and to promote understanding. We fund clinical research, social research and community projects. We provide information on mental health issues for the general public and healthcare professionals. We aim to maximise expertise and resources by creating partnerships between ourselves and others including Government, health and social services.