Title of Policy: Policy and Protocols on Self Harm **Description of the Policy:** This Policy has been developed for the staff in The Village Residence	
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1.0 What is self-harm and what does the policy cover?

The guideline has adopted the definition that self-harm is '**self-poisoning or self-injury, irrespective of the apparent purpose of the act**'. The guideline has, therefore, used a shorter and broader definition than that adopted by the World Health Organization **('an act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences'**) (Platt et al., 1992).

The guideline focuses on those acts of self-harm that are an expression of personal distress and where the person directly intends to injure him/herself. It is important also to acknowledge that for some people, especially those who have been abused as children, acts of self-harm occur seemingly out of the person's control or even awareness, during 'trance-like', or dissociative, states. It therefore uses the term 'self-harm' rather than 'deliberate self harm'.

1.1. **Common terms used to describe self-harm**

SYNONYMS

- Self-harm
- Deliberate self-harm
- Intentional self-harm
- Parasuicide
- Attempted suicide
- Non-fatal suicidal behaviour
- Self-inflicted violence

SUB-TYPES

- Self-poisoning
- Self-injury

- Self-mutilation

1.2. Methods of self-harm

The methods of self-harm can be divided into two broad groups: self-poisoning and self-injury. People who self-poison are more likely to seek help than those who self-injure (Hawton *et al.*, 2002a; Meltzer *et al.*, 2002a.

About 80% of people who present to emergency departments following self-harm will have taken an overdose of prescribed or over-the-counter medication (Horrocks *et al.*2003). A small additional percentage will have intentionally taken a dangerously large amount of an illicit drug or have poisoned themselves with some other substance. The pattern of the type of drug taken in overdose has changed in recent years, largely with changes in their availability.

Recent studies of the method of suicide suggest that people who survive a medically serious suicide attempt may well have a poorer outcome in terms of life expectancy. For example, in a prospective study of 302 people who had made a serious attempt on their life, 1 in 11 had died within 5 years, with nearly 60% of deaths being by suicide, and a greater than expected number dying by vehicular accident (Beautrais, 2003).

1.3. How common is self-harm?

Since many acts of self-harm do not come to the attention of healthcare services, hospital attendance rates do not reflect the true scale of the problem (Hawton et al. 2002a; Meltzer et al., 2002b).

1.4. Factors that are associated with self-harm

1.4.1 Socio-economic factors and life events

Self-harm occurs in all sections of the population but is more common among people who are disadvantaged in socio-economic terms and among those who are single or divorced, live alone, are single parents or have a severe lack of social support (Meltzer et al., 2002a).

Life events are strongly associated with self-harm in two ways. First, there is a strong relationship between the likelihood of self-harm and the number and type of adverse events that a person reports having experienced during the course of his/her life. These include having suffered victimization and, in particular, sexual abuse (Hawton et al., 2002a; Meltzer et al., 2002a). Second, life events, particularly

relationship problems, can precipitate an act of self-harm (Bancroft et al., 1977).

People diagnosed as having certain types of mental disorder are much more likely to self-harm. For this group, the recognition and treatment of these disorders can be an important component of care. In one survey of a sample of the British population, people with current symptoms of a mental disorder were up to 20 times more likely to report having harmed themselves in the past (Meltzer *et al.*, 2002a). The association was particularly strong for those diagnosed as having phobic and psychotic disorders. People diagnosed as having schizophrenia are most at risk and about one-half of this group will have harmed themselves at some time.

Certain psychological characteristics are more common among the group of people who self-harm, including impulsivity, poor problem-solving and hopelessness. Also, people who self-harm more often have interpersonal difficulties. It is possible to apply diagnostic criteria to these characteristics. This explains why nearly one-half of those who present to an emergency department meet criteria for having a personality disorder (Haw *et al*., 2001). However, there are problems with doing this because:

- There is an unhelpful circularity in that self-harm is considered to be one of the defining features of both borderline and histrionic personality disorder.
- The diagnostic label tends to divert attention from helping the person to overcome their problems and can even lead to the person being denied help (National Institute for Mental Health in England, 2003).
- Some people who self-harm consider the term personality disorder to be offensive and to create a stereotype that can lead to damaging stigmatisation by care workers (Babiker & Arnold, 1997; Pembroke, 1994).

1.5. Older people

Although it appears that older people are less likely to self-harm, the consequences are often more serious; it has been estimated that of every five older people who self-harm one will later die by suicide (Lawrence *et al*., 2000; McIntosh, 1992). Consistent with this, older people who have self-harmed score highly on scales that measure suicidal intent (Merrill & Owens, 1990; Nowers, 1993) and their profile resembles that of older people who die by suicide (Dennis & Lindesay, 1995). In particular, older people who self-harm have high rates of physical ill health, social isolation and depression (Draper, 1996; Merrill & Owens, 1990; Pierce, 1977).

Those with persistent depression are at particular risk of repetition of self-harm or suicide (Hepple &

Quinton, 1997).

Staff should be cognisant of the fact that some older people may deliberately self harm by refusing to eat and drink.

Other older people may self harm by eating objects such as tissues, gloves and other items. Whereby the intention may not be to self harm, the consequences of such actions could result in self harm.

Most of these foreign-object cases involve patients with Alzheimer's and other psychiatric conditions who remain unable to appreciate the dangers associated with swallowing materials that may be on hand in their rooms.

Commonly encountered swallowed foreign objects including:

- **Plastic knives and forks**
- **Food packaging**
- **Sterile gloves**
- **Pens**
- **Toothbrushes**
- **Coins**
- **Razorblades**
- **Dental implants / dentures**

What makes many of the foreign object ingestion cases particularly horrific for the patient is the fact that many of the foreign objects are extremely dangerous is the fact that many objects go undetected by staff until a problem manifests itself in the form of a severe medical complication -- such as choking or internal bleeding.

Given the prevalence in ingesting foreign materials or objects amongst Alzheimer's, dementia and psychiatric patients, staff in the Village Residence need to be mindful of this real tendency and take steps toward minimizing the chances a patient can access these materials:

- Staff should take steps towards identifying which patients have a history of ingesting foreign materials
- Medical devices should be kept under locked conditions
- Staff should remove non-edible food wrappers and coverings from meals prior to serving staff
- Staff should supervise patients with a swallowing proclivity

Due to the fact that many of these patients are simply unable to perceive the dangers associated with ingesting foreign objects, staff need to be mindful of the inherent risks associated with keeping materials accessible to their patients and implement safeguards to prevent patients susceptible to this type of behavior from accessing materials.

1.6. Repetition and suicide

Following an act of self-harm the rate of suicide increases to between 50 and 100 times the rate of suicide in the general population (Hawton *et al*., 2003b; Owens *et al*., 2002).

Men who self-harm are more than twice as likely to die by suicide as women and the risk increases greatly with age for both genders (Hawton *et al*., 2003b). It has been estimated that one-quarter of all people who die by suicide would have attended a general hospital following an act of self-harm in the previous year (Owens & House, 1994).

About one in six people who attend an emergency department following self-harm will self-harm again in the following year (Owens *et al*., 2002);

2.0. Assessment and treatment for people who self-harm

2.1. Aims and principles of treatment

As with any other treatment, the overarching aims are to reduce harm and improve survival while minimising the harm that may result from the treatment. In addition, the experience of treatment and care needs to be acceptable to service users and carers. This is especially so for people who self-harm and who may be suffering psychological, social or drug- and alcohol-related problems, which need further help after the immediate physical problems have been adequately addressed.

It is essential that service users and carers, where appropriate, are engaged effectively by clinicians in an atmosphere of respect and trust. Without this, further psychosocial assessment and referral for treatment will be difficult if not impossible.

The key aims and objectives in the treatment of self-harm should, therefore, include:

- Rapid assessment of physical and psychological need (triage)
- Effective engagement of service user (and carers where appropriate)
- Effective measures to minimise pain and discomfort
- Timely initiation of treatment, irrespective of the cause of self-harm
- Harm reduction (from injury and treatment; short-term and longer-term)
- Rapid and supportive psychosocial assessment (including risk assessment and co morbidity)
- Prompt referral for further psychological, social and psychiatric assessment and treatment when necessary
- Prompt and effective psychological and psychiatric treatment when necessary
- An integrated and planned approach to the problems of people who self-harm, involving primary and secondary care, mental and physical healthcare personnel and services, and appropriate voluntary organisations

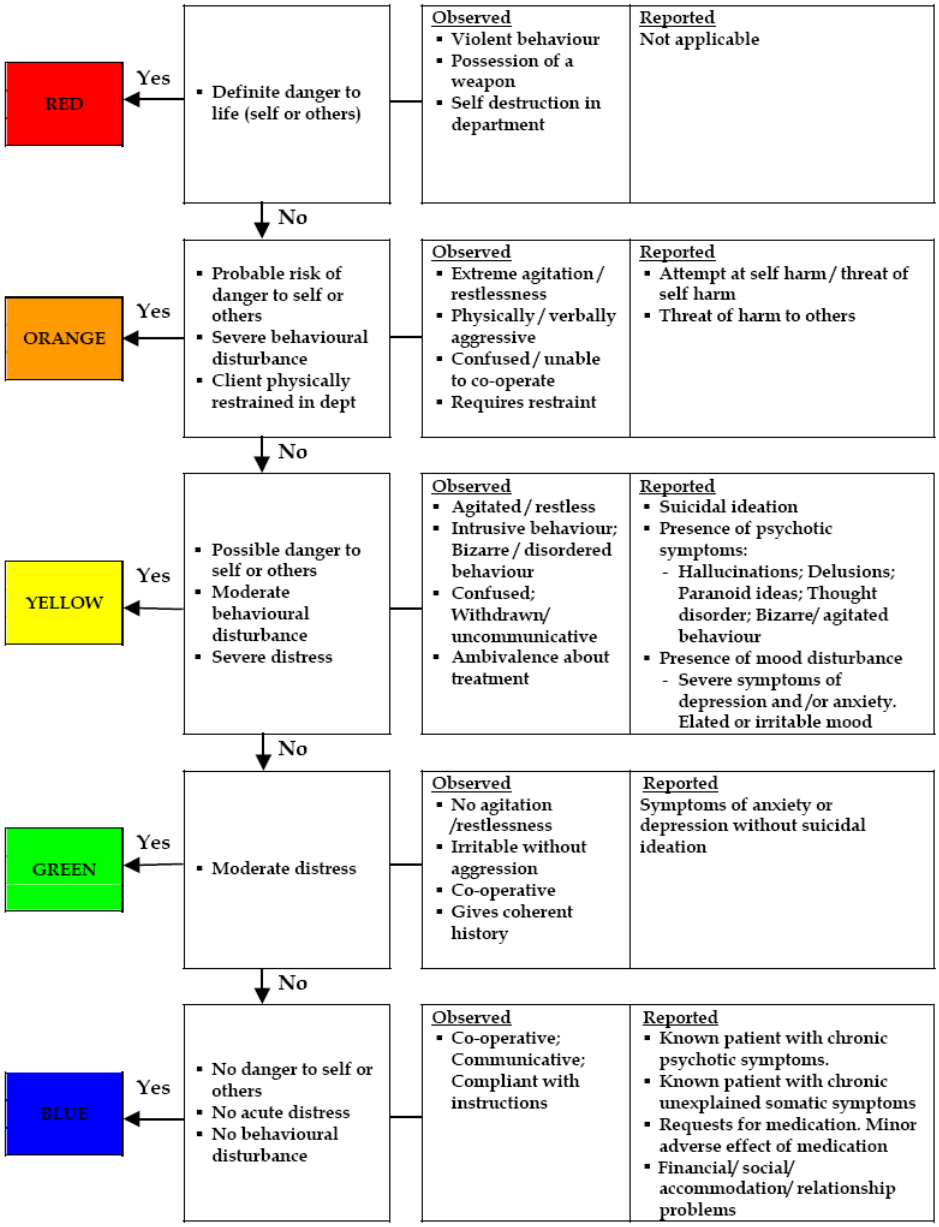
2.2. Primary care and pre-hospital environment

Primary care professionals, community-based mental health workers, ambulance staff and others come into contact with people who have self-harmed with varying frequency.

In this context, assessment and referral to the emergency department is the most common action undertaken, in particular for self-poisoning. Sometimes, self-injury (but not self-poisoning) will be dealt with in primary care without referral for further physical treatment, usually by sympathetic GPs who have already had contact with the person.

2.3. In this service any person who self harms should be referred immediately to the Medical Officer or Casualty Department in Our Lady of Lourdes Hospital. It may also be necessary to refer the person for urgent psychiatric referral and assessment.

The Following is the Triage System to be used if there is any suspicion or doubt.



Adapted from scales by Broadbent, M., Jarman, H. & Berk, M. (2002). *Improving competence in emergency mental health triage.* Accident and Emergency Nursing, 10, 155-162 and Smart, D., Pollard, C. & Walpole, B. (1999). *Mental health triage in emergency medicine.* Australian and New Zealand Journal of Psychiatry, 33 (1), 57-66

Developed by Simon Baston and the NICE self-harm guideline development group

References

National Institute of Clinical Excellence (2004) Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care available at http://www.nice.org.uk/Guidance/CG16. Downloaded 03/10/2010.