



Self-Harm in Manchester 2008-2009

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The Manchester Self-Harm Project

Self-Harm in Manchester

January 2008 - December 2009

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Note: This report is based on combined data from three Emergency Departments (EDs): Manchester Royal Infirmary at Central Manchester University Hospitals NHS Foundation Trust, North Manchester General Hospital at Pennine Acute Hospitals NHS Trust, Wythenshawe Hospital at University Hospital of South Manchester NHS Foundation Trust, and data from the Manchester Mental Health and Social Care Trust. Data on ED presentations at each individual Emergency Department are available on request.

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Summary of findings

Rates of self-harm in Manchester

The rate of self-harm in Manchester has been declining steadily since 2003. Overall rates have continued to decline in 2008 and 2009.

Rates among females aged 25 to 34 declined significantly between 2008 and 2009, continuing the downward trend since 2003. The 15 to 19 age group had the highest rate in 2008/09 combined for both males and females.

However, the rate of self-harm has increased for some male age groups:

- A significant increase in the self-harm rate amongst males aged 35+ between 2008 and 2009
- A more marked increase in the rate for males aged 55+ between 2008 and 2009 than in previous years (rates for males aged 55+ have been increasing gradually since 2003)
- In 2008 and 2009 males aged 15 to 24 had the highest rate of self-harm among males overall

Demographic characteristics of self-harming individuals

59% of the cohort was female. 69% of individuals were single and 20% lived alone. 14% of individuals were from BME (Black and Minority Ethnic) groups; 6% South Asian and 3% Black.

40% of individuals were unemployed, an increase of 5% since our previous report (Dickson et al., 2009).¹

Precipitants to self-harm:

The most frequently cited precipitating factor was relationship problems with a partner. Since the last report (Dickson et al., 2009) there has been a rise in the proportion of individuals reporting that the self-harm was a response to problems with alcohol/substance misuse, money, employment and mental health issues.

Clinical characteristics of self-harming individuals

Repetition of self-harm:

- In 2008 19% of individuals re-presented with an episode of self-harm within 12 months (allowing a 12 month follow-up period into 2009)

¹ The previous MaSH report covers the two-year period September 2005 to August 2007.

- 64% reported previous self-harm in their lifetime and 33% reported self-harm within the past year

Alcohol and substance misuse:

Clinicians identified 36% of individuals as currently misusing alcohol (46% of males and 30% of females). 18% were identified as misusing drugs (25% of males and 13% of females).

Characteristics of self-harm presentations

Method of harm:

- 71% of episodes involved self-poisoning with drugs²; of these:
 - 60% used analgesics
 - 25% used antidepressants
 - 26% used other drugs (including street drugs)
- 19% involved self-cutting
- 9% involved self-injury other than self-cutting (a rise of 4% since the previous report) (Dickson et al., 2009)

Time of presentation:

Presentations were most frequent on Saturday through to Monday (46% of all presentations) and peaked between 10pm and 2am (27%).

Management by ED staff:

- 53% were admitted to a medical bed
- 21% were referred straight to psychiatric services
- 19% were either discharged or self-discharged without a referral

Management by psychiatric staff:

- 34% of all presentations were assessed by mental health specialists; of these:
 - 29% were referred to their GP (as the only referral)
 - 25% were referred to mental health services (including outpatients, community drug/alcohol teams, day hospital, duty psychiatrist)
 - 12% were referred to other organizations (e.g. social services, counseling, voluntary organizations)
 - 7% were admitted to a psychiatry ward/unit

² More than one type of drug may be involved for each episode.

1. Introduction

This report presents findings from the Manchester Self-Harm (MaSH) Project for the years 2008 and 2009.

The MaSH Project collects data on self-harm presentations to Emergency Departments (EDs) in Manchester. 'Self-harm' is defined as '*intentional self-poisoning or self-injury irrespective of motivation*' (Hawton et al., 2003).

The MaSH Project is collaboration between the University of Manchester and four NHS Trusts:

- **Manchester Mental Health and Social Care Trust;** which includes mental health liaison teams covering the three EDs

Three Emergency Departments located at:

- **Manchester Royal Infirmary**
Part of Central Manchester University Hospitals NHS Foundation Trust
- **North Manchester General Hospital**
Part of Pennine Acute Hospitals NHS Trust
- **Wythenshawe Hospital**
Part of University Hospital of South Manchester NHS Foundation Trust

The aims of the MaSH Project are to:

- Monitor rates of self-harm
- Evaluate and inform clinical services
- Provide evidence on which service development and training may be based
- Provide an infrastructure for research on patterns of self-harm, clinical management and risk factors
- Inform and make recommendations on national suicide prevention initiatives

The Manchester Self-Harm Project collaborates with self-harm monitoring centres in Oxford and Derby, through the Multicentre Study of Self-Harm in England (Bergen et al. 2010). Multicentre monitoring is an integral component of the National Suicide Prevention Strategy for England (DoH 2002).

1.1 Data collection

The MaSH Project collects data on presentations of self-harm to the three participating EDs. When a patient presents to the ED, a brief assessment form (the MaSH form, Appendix 1) is completed by the treating medic.

Table 1: Information collected from self-harm presentations

Patient Data	Management Data
Sociodemographic characteristics, Psychiatric history, Details of the self-harm, Precipitating events, Mental state, Suicidal intent	Risk assessment, Communication with GP, Follow-up arrangements

When no MaSH form is received, information is obtained from electronic records and medical notes held at the three hospitals. In addition, information from paper and electronic psychiatric assessments is collected for patients seen by a mental health specialist. During this report period, data from psychiatric assessments were also obtained from electronic notes.

1.2 Numbers of self-harm episodes and individuals

Patients presenting to the ED with self-harm may have re-attended with one or more repeat self-harm episodes during the reporting period. In Sections 2, 3 and 4 we present results based on an individual's first episode during the study period for which data was available. Section 5 shows findings based on all episodes.

The total number of episodes, and the number of individuals accounting for these, is shown below (Table 2).

Table 2: Episodes and individuals presenting to the three hospitals

All Study Hospitals	2008	2009
Episodes	3152 (F:M 1807:1345)	3262 (F:M 1747:1515)
Individuals	2424 (F:M 1415:1009)	2479 (F:M 1350:1129)

2008: F:M ratio (individuals) = 14:10. 23% of episodes were repeat presentations of self-harm in 2008.

2009: F:M ratio (individuals) = 12:10. 24% of episodes were repeat presentations of self-harm in 2009.

Since 2006 the ratio for the number of individuals presenting per year had been around 14 females to every 10 males. In 2009 this ratio converged to 12 females for every 10 males.

1.3 Numbers of self-harm presentations treated and assessed

After presenting to the ED, not all patients will wait to be treated. Among those who do receive treatment in the ED, not all will receive a psychosocial assessment by either ED or psychiatric staff (Table 3).

Table 3: Numbers of treated and assessed episodes

All Study Hospitals	2008	2009
Treated	91% (2856/3152)	94% (3064/3262)
Psychosocial assessment (by ED and/or psychiatry)	56% (1777/3152)	53% (1740/3262)

2008: In 9% (296) of presentations patients did not wait for treatment.

2009: In 6% (198) of presentations patients did not wait for treatment.

In 2008 and 2009 self-harm presentations by males, and those that involved self-injury by cutting or other self-injury, were less likely to receive a psychosocial assessment. This is corroborated by our multicentre research (Kapur et al., 2008).

2. Rates of Self-harm in Manchester

2.1 Self-harm rates by sex and age

Table 4: Annual rates of self-harm per 100,000 population in Manchester 2007 to 2009³

	2007	2008	2009
Overall	427	404	397
Females	518	493	449
Males	337	318	349

The overall rate of self-harm has decreased since 2007. This was accounted for by a decrease in the female rate, although female rates remained consistently higher than male rates of self-harm. The self-harm rate for males has fluctuated over the three year period and increased from 2008 to 2009.

The overall decrease masks an increase in rates for some age and sex groups (see Section 2.2).

Sex and age differences

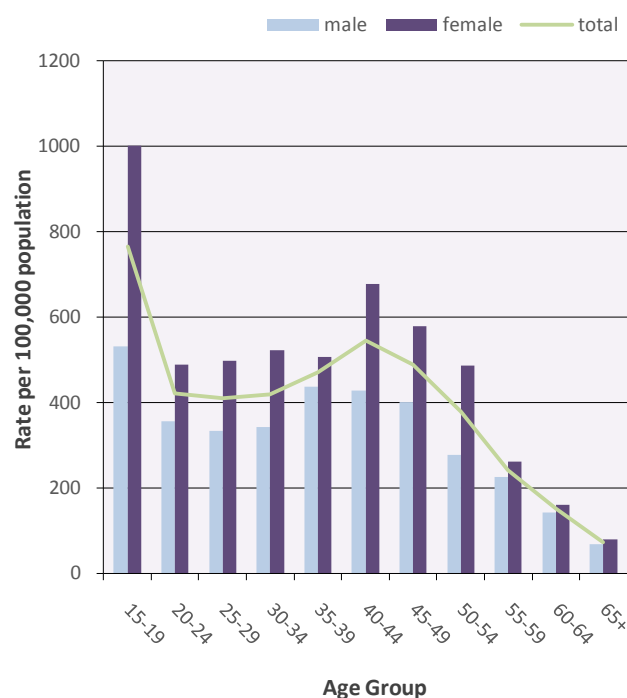
Female self-harm rates were higher than male rates across all age groups. The female rate was highest for the 15-19 years age group, with the rate of self-harm equivalent to around one percent of the population.

For males the rate was also highest in the 15-19 year group, though was around half that of females in the same age group. This is a change since the previous report where the highest rate was for males between 35-39 years.

The 40-44 year group had the second highest rate of self-harm.

³ Rates per 100,000 populations are based on the index (first chronological) episode in each year for individuals 15 years and over, presenting to any of the three Manchester Emergency Departments, following self-harm (including patients who did not wait for treatment) who resided within the City of Manchester Postcode area. The rates for previous years have been adjusted for this report in line with revised ONS population estimates.

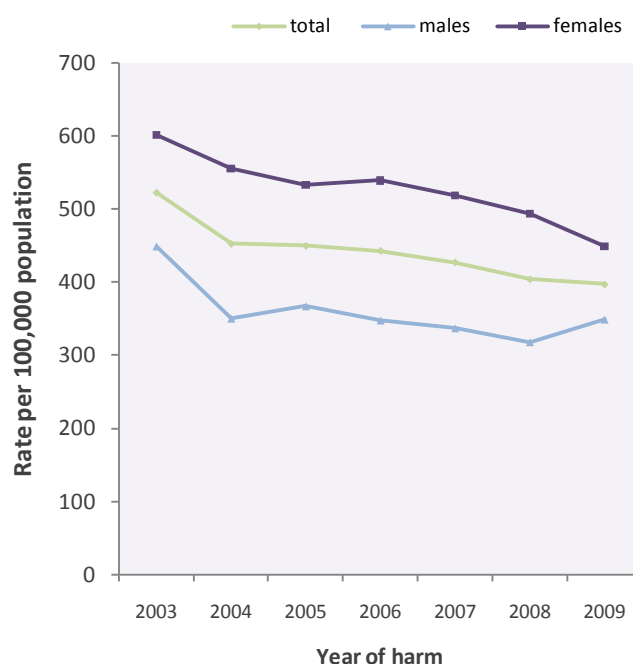
Figure 1: Average rates of self-harm in Manchester per 100,000 population aged 15 years and over in 2008 and 2009



2.2 Seven year trends in self-harm rates in Manchester

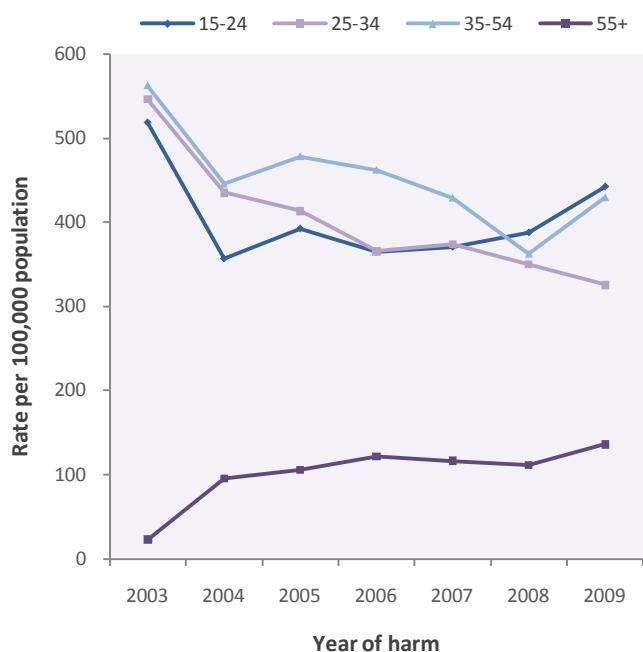
Up to 2008, rates of self-harm were steadily declining for both sexes, matching trends seen in multi-centre self-harm data (Bergen et al., 2010). Since 2008 this trend appears to be reversing for males, although a significant linear trend is seen only in males aged 35+; an increase of 19% (p = .04) (Figure 2b).

Figure 2a: Rates of self-harm by sex 2003 to 2009



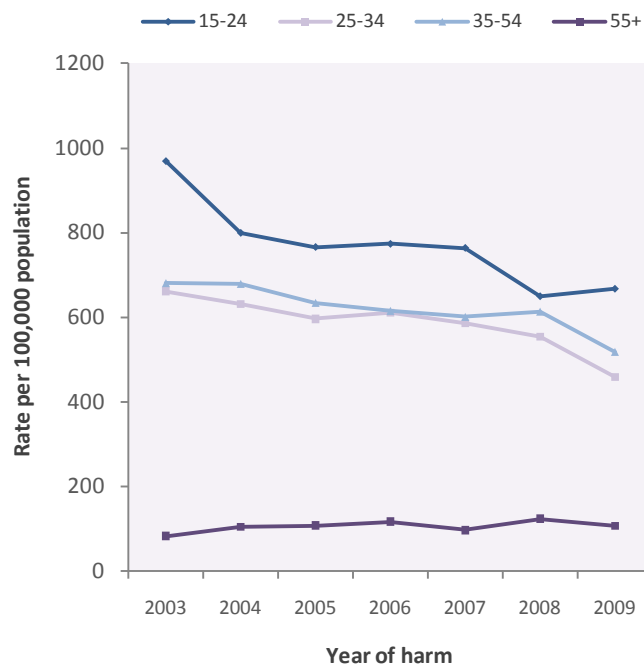
The rate of self-harm among young men (ages 15 to 24) increased by 14% between 2008 and 2009. This rise was not statistically significant, but because it may indicate an emerging trend, we explored the characteristics of this group in more detail. The proportion of males aged 15 to 24 reporting a history of self-harm decreased from 71% in 2008 to 54% in 2009, suggesting an increase in those attending with a first ever self-harm episode. There were increases in the proportions reporting self-harm as a response to housing problems (8% in 2008 to 15% in 2009) and financial problems (12% to 17%). The proportion that is unemployed in this group remains high (41% in 2008 and 44% in 2009). The proportion citing self-harm due to mental health problems decreased (15% in 2008 to 6% in 2009) as did those reporting drug problems (39% to 31%) and alcohol problems (38% to 32%).

Figure 2b: Male rates self-harm by age group 2003-2009



There has been a steady rise in the rate of self-harm in the 55+ age group since 2003; a total increase for males and females of 32% from 2003 to 2009 with a significant linear trend ($p < .001$). This is mainly accounted for by a rise in the rate for males.

Figure 2c: Female rates of self-harm by age group 2003-2009



Rates among females aged 25 to 54 declined significantly between 2008 and 2009 (a decrease of 16%, $p = .05$), continuing the downward trend since 2003 (Figure 2c).

Published research

Monitoring of self-harm across three centres (Oxford, Manchester and Derby) concluded rates of self-harm were decreasing over the period 2000-2007, paralleling a downward trend in suicide in England (Bergen et al., 2010); specifically, male rates declined by 25% and females by 13% between 2000 and 2007 in Manchester.

Reasons as to why the downward trend in rates seen in the previous report have not been maintained in some age/sex groups in the present period of study remain open to conjecture. A possible explanation for the increased rate in older males may include the economic crisis and downturn in 2008 (Hawton et al., 2007).

3. Social and Demographic Characteristics of Self-Harming Individuals

4581 individuals presented with self-harm in the two year study period.⁴

3.1 Age and gender

Table 5: Age and gender

Gender (n = 4,575)	%	Mean Age (n = 4,570)
Male	41	30 years, ranging between 9 and 93 years
Female	59	

Females made up 59% of the individuals and males 41%. The mean age was 30, ranging between 9 and 93.

3.2 Marital status

Table 6: Marital status (n = 4,204)

Marital Status	%
Single	69
Partnered	21
Separated/Divorced	9
Widowed	2

⁴ Demographic characteristics are calculated using the individual's first chronological episode during the study period where data was available.

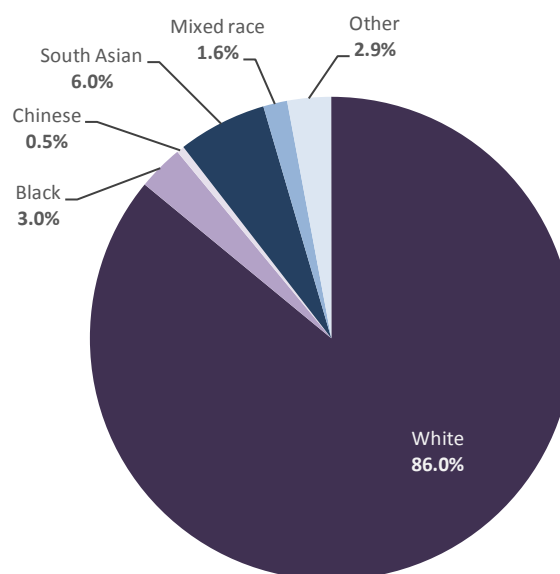
3.3 Living arrangements

Table 7: Living arrangements (n = 2,369)

Living Arrangement	%
Partner/Spouse	28
Parent/Sibling	24
Alone	20
Friends/other relatives	10
Homeless/Hostel/Lodgings	9
Children only	8

3.4 Ethnicity

Figure 3: Ethnicity (n = 3,879)



In the present study period, BME (Black and Minority Ethnic) groups accounted for 14% of the Manchester self-harm cohort. The largest BME groups were those of South Asian (Indian, Pakistani or Bangladeshi) origin (6%), and Black individuals (3%).

This compares to population estimates (ONS, 2007) for Manchester, where 24% of the population are made up of BME groups (11% South Asian, 6% Black, 3% mixed race and 4% Chinese or other).

Table 8: Percentage of females within ethnic group in the self-harm cohort

	% Female within group
Mixed Race (n = 62)	77
South Asian (n = 231)	67
Black (n = 118)	64
Chinese (n = 19)	58
Other (n = 114)	57
White (n = 3,335)	56

Around two-thirds of individuals from both the South Asian and Black BME groups were female (67% and 64% respectively), compared to 56% of the White group.

Published research

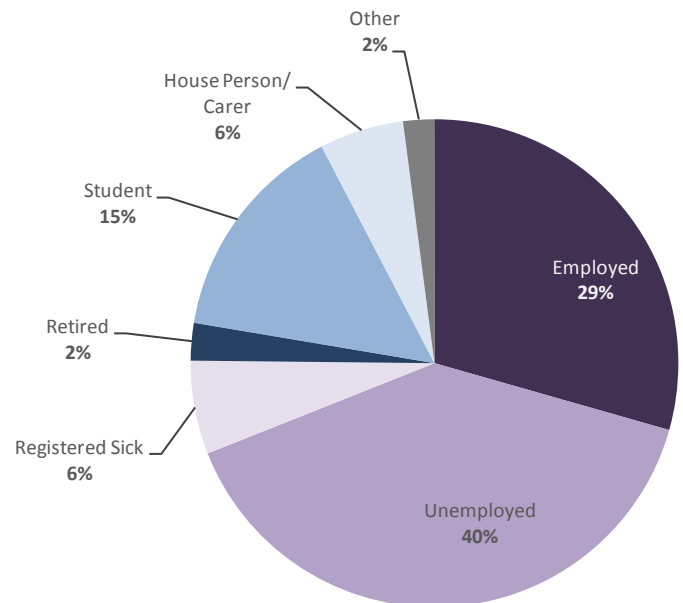
Cultural differences in the experience of psychological and social distress (Kirmayer, 2001) may contribute to the differential between white and other ethnic groups presenting to the Emergency Department for treatment.

Multicentre research by Cooper et al. (2010) found that BME groups were less likely to receive psychiatric assessment and follow-up than the white group, having presented for treatment. Young black females (aged 16 to 34) were found to have higher rates of self-harm than white females in the same age group.

3.5 Employment status

40% of the individuals who self-harmed were registered unemployed. This is an increase of 5% since the previous report. Of the total number unemployed in the present study period, 25% had been unemployed for 26 weeks or more.

Figure 4: Employment status (n = 3,467)



3.6 Precipitants of self-harm

Information on factors precipitating the self-harm episode was recorded for 2375 individuals; 52% of all individuals and 91% of those with a psychosocial assessment.

59% of individuals reported more than one precipitant, 57% of females and 60% of males.

The most frequent precipitating factor for both sexes was interpersonal problems with a partner.

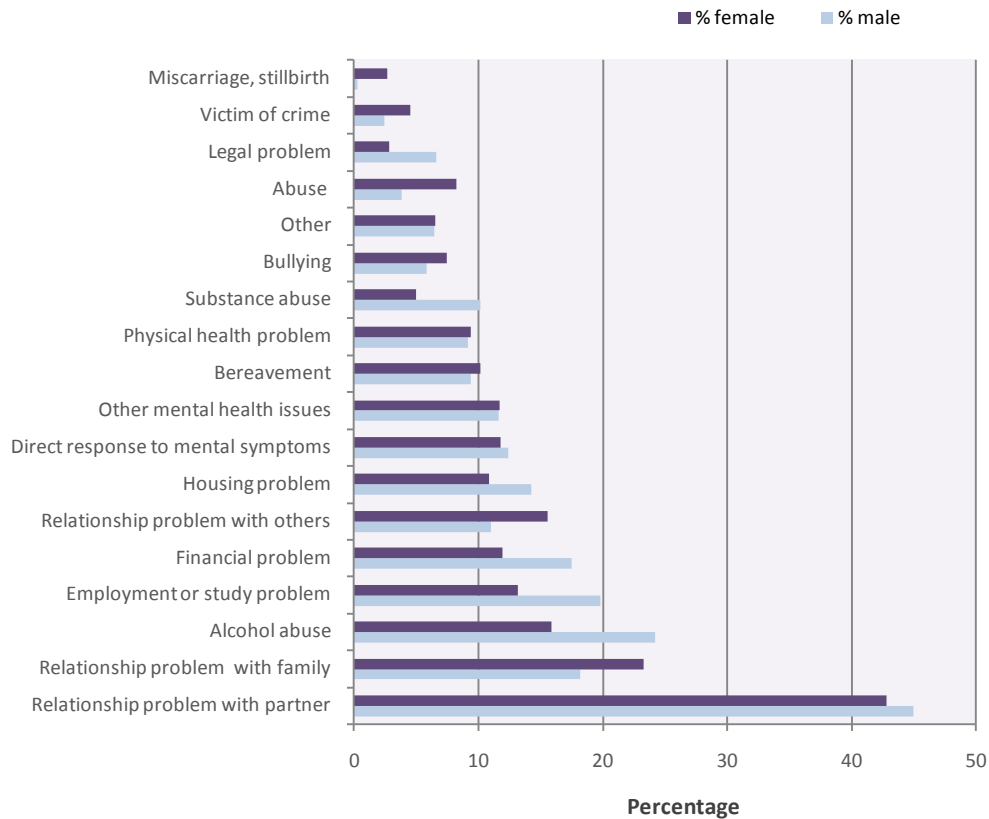
Females were more likely to report relationship problems with family, with 'others' and problems due to abuse (physical, mental or sexual), and males were more likely to report problems with substance/alcohol misuse, money, housing, employment and the law, in line with our previous report (Dickson et al., 2009).

There has been a rise in both sexes reporting self-harm as a response to alcohol and substance misuse, 'other' mental health issues, employment problems and financial problems compared to the previous report (Dickson et al., 2009).

Published research

Our multicentre study of ethnic differences in self-harm (Cooper et al., 2010) found that South Asian females were more likely than White females to report relationship problems with their partner or family. Black females were more likely to cite housing problems as precipitating the self-harm.

Figure 5: Precipitants of self-harm for individuals (n = 2,375)



4. Clinical Characteristics of Self-Harming Individuals

Current and previous psychiatric treatment

Details of psychiatric treatment were available for 52% (2385) of all individuals.

Of these, 48% were currently receiving psychiatric treatment, including from their GP. Around one in six (17%) had received psychiatric treatment in the past but were no longer doing so.

4.1 Repetition of self-harm

Percentage of repeat episodes

Between 1st January 2008 and 31st December 2009, 4581 individuals presented with 6414 episodes of self-harm. 29% of these episodes were repeats. 33% of male episodes and 27% of female episodes were repeats.

6 month repetition rate

3,612 individuals presented between 1st January 2008 and 30th June 2009 (allowing all individuals a six month follow up period). 14% (15% of males and 13% of females) re-presented within 6 months of the first episode.

12 month repetition rate

2,422 individuals presented between 1st January and 31st December 2008 (allowing all individuals a 12 month follow period). 19% of individuals (21% of males and 17% of females) re-presented with an episode of self-harm within 12 months of the first episode.

Self-reported previous self-harm

Information was available for 53% (2429) of individuals. Asked if they had self-harmed previous to this episode, 64% responded that they had self-harmed, with or without medical treatment, on a least one previous occasion.

Table 9: Self-reported previous self-harm by sex

	% Males (n = 993)	% Females (n = 1436)
Any previous self-harm	62	66
Self-harm within last 12 months	34	33
Self-harm more 12 months ago	28	31

Published research

Our multicentre research (Lilley et al., 2008) found that those who had self-cut were more likely to have self-harmed previously and to repeat self-harm, compared to those where self-cutting was not involved in the self-harm episode. However, switching method of harm between episodes was common, particularly amongst those who first presented with self-cutting.

4.2 Alcohol and substance misuse

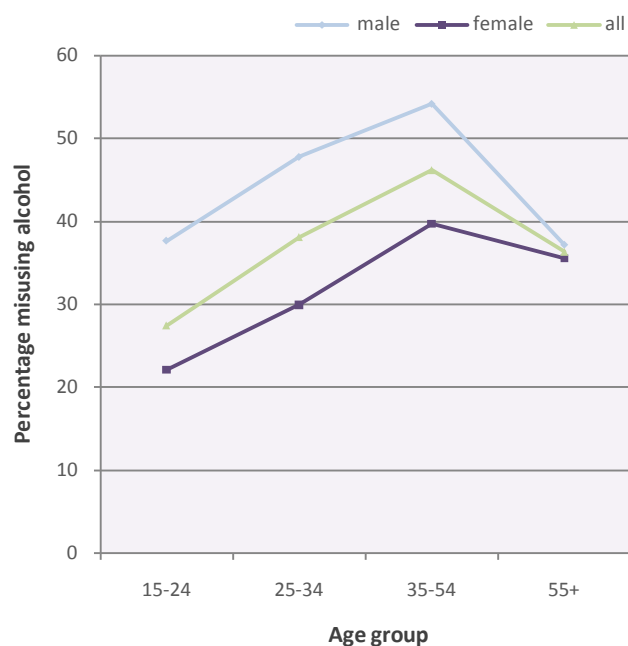
Alcohol

Details of alcohol consumption at the time of self-harm were available for 49% (2228) of all individuals.

58% of these individuals had drunk alcohol in conjunction with the self-harm episode (64% of males and 54% of females).

Details of alcohol use in general were recorded for 50% (2286) of individuals. Alcohol misuse is here defined as drinking 7 or more units per day, or harmful use as regarded by a mental health clinician.

Figure 6: Alcohol misuse by individuals by sex and age group



Overall, 36% of individuals were defined as currently misusing alcohol (46% of males and 30% of females). These percentages represent an increase of 3% for males and 5% of females since the previous report.

Alcohol use was highest in the 35 to 54 years age group for both males and females.

Substance misuse

Information about substance misuse was available for 50% (2305) of individuals. 25% of males and 13% of female were classified as misusing drugs (use on a regular basis or classified as harmful use by a mental health clinician).

In contrast to alcohol misuse, drug misuse was more common in age groups under 35, with 19% using drugs in the 15-19 age group rising steadily to 28% in the 30-34 age group and falling in the groups aged over 35 years.

4.3 Evidence of mental disorder: clinical impression at the time of assessment

Information about the presence or absence of psychiatric disorder was available for 41% (699/1722) of individuals who received a psychiatric assessment. 4% were assessed as showing no evidence of psychiatric disorder at the time of assessment.

Table 10: DSM Axis* for the 670 individuals where a diagnosis was available

DSM Axis	%	Disorder
Axis I	16	9% Alcohol and or Drug Dependence 4% Schizophrenia 2% Severe Depression 1% Bi-Polar Disorder
Axis II	4	3.9% Personality Disorder 0.4% Learning Difficulties
Axis IV	74	33% Depression 35% Misuse of Alcohol and or drugs 5% Anxiety or Stress Disorder 0.5% Dysthymia

*DSM (2000)

5. Characteristics of Self-harm Episodes and their Management

5.1 Method of harm

Method of harm was recorded for 6405 (99.9%) episodes at the three Emergency Departments.

Table 11: Method of self-harm (n = 6,405)

	% Total	% Males	% Females
Self-poisoning (drugs)	71	68	74
Self-cutting	19	19	18
Other self-injury	9	11	6
Self-poisoning (other substance)	2	2	1

The most common method of self-harm was self-poisoning with drugs, and the second most common was self-cutting.

There was a decrease of 7% since the previous report (Dickson et al., 2009) in the number of episodes involving self-poisoning with drugs. This was accounted for by:

- An overall rise of 4% for 'other' self-injury; a 5% increase for males and 3% for females
- An increase of 2% for self-cutting in males (from 17% to 19%)

Self-injury other than cutting was used in 9% (547) of episodes. The most common form of 'other' self-injury was hanging or strangulation (24%).

Table 12: Methods of self-harm: Other self-injury (n = 547)

	% Total	% Males	% Females
Hanging / strangulation	24	26	20
Hit self or something	18	21	13
Jumping from height	13	13	12
Traffic related	10	11	9
Swallowing foreign body	10	8	14
Burning self	4	3	7
Carbon monoxide	2	3	2
Drowning	2	2	2

Males were more likely to use an 'other' method of self-injury. In particular, males were more likely than females to use hanging/strangulation and hitting an object/self. Females were more likely to swallow a foreign object.

Published research

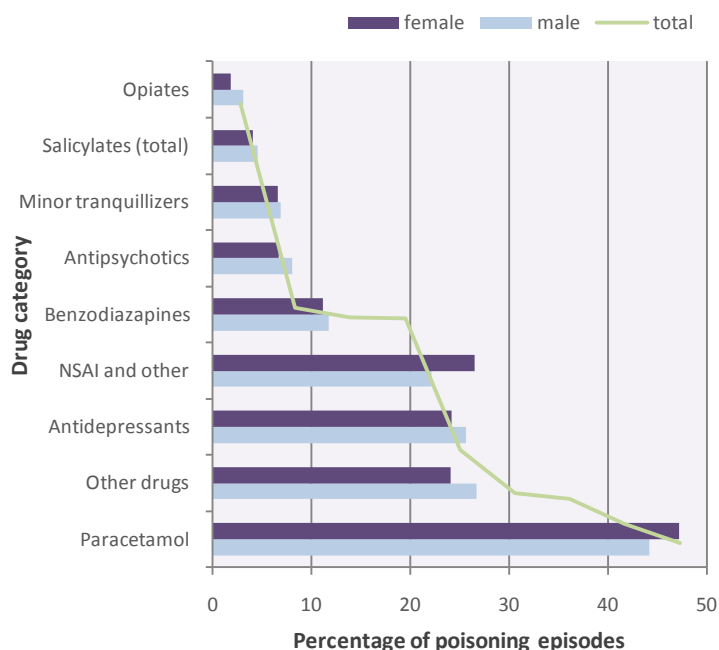
A significant rise in other methods of self-injury (i.e. excluding self-cutting) between 2000 and 2007 was found in our multicentre research (Bergen et al. 2010).

5.2 Drugs taken in self-poisoning

71% (4569) of all episodes involved self-poisoning with drugs.

The type of drug used was known for 97% (4450) of all self-poisoning episodes. 60% of these involved the use of analgesics (pain killers). Where analgesics were taken, three quarters (76%) involved the use of paracetamol compounds.

Figure 7: Substances used in self-poisoning episodes 2008-2009⁵



The most commonly used drug type for self-poisoning in males and females continues to be paracetamol and its compounds, accounting for 46% of self-poisoning episodes. This is a decrease of 6% since the previous report (Dickson et al., 2009).

As a percentage of episodes involving analgesics, opioid analgesics were used in 16% compared to 11% in the previous report (Dickson et al., 2009), although the overall proportion remains small.

Drugs other than analgesic and psychotropic medication were included in the 'other drugs' category, which also included street drugs. Following paracetamol, the three most commonly used types of drugs were 'other drugs' (26%), antidepressants (25%) and NSAIs (non-steroidal anti-inflammatory) drugs (25%).

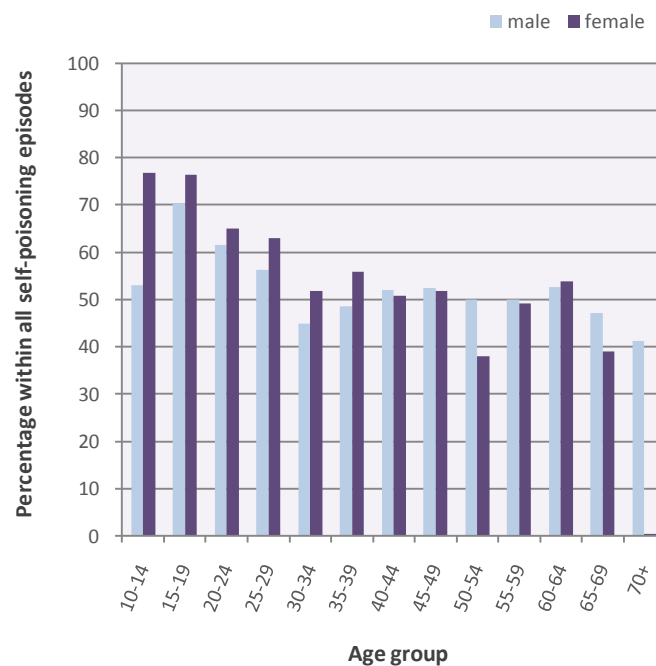
Published research

The relative toxicity of antidepressants when taken in overdose (Hawton et al., 2010) was found to vary markedly between drugs in SSRI, tricyclic (TCA), SNRI and NaSSA categories.

The withdrawal of co-proxamol prescriptions in 2005 was associated with a significant increase in prescribing alternative analgesics, mostly paracetamol compounds but also codeine (Hawton et al., 2009). However, further multicentre research (Hawton 2011) found no evidence of an increase in self-poisoning episodes involving other analgesics during the co-proxamol withdrawal phase (2005 to 2007).

Figure 8 below shows the proportion of self-poisoning episodes where analgesics were used, by sex and age groups. When younger people self-poisoned, they were more likely to use analgesics, particularly females aged 10 to 19.

Figure 8: Percentage of self-poisoning episodes involving analgesics by age and sex

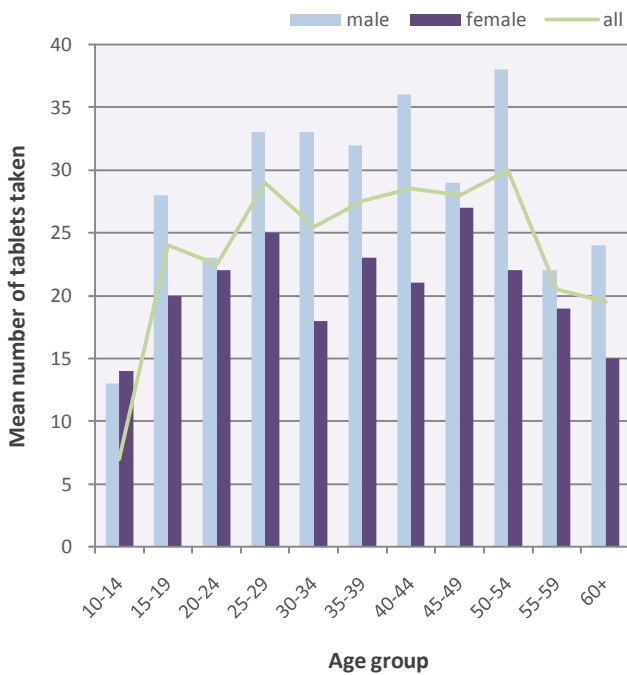


Number of tablets taken in self-poisoning episodes involving paracetamol (and compounds)

For episodes involving paracetamol the mean number of tablets taken was 25 (range 1-300). The mean was higher for males (30 compared to 22 for females).

⁵ More than one type of drug may be involved for each episode.

Figure 9: Mean number of tablets taken for self-poisoning episodes involving paracetamol compounds, by age group and sex

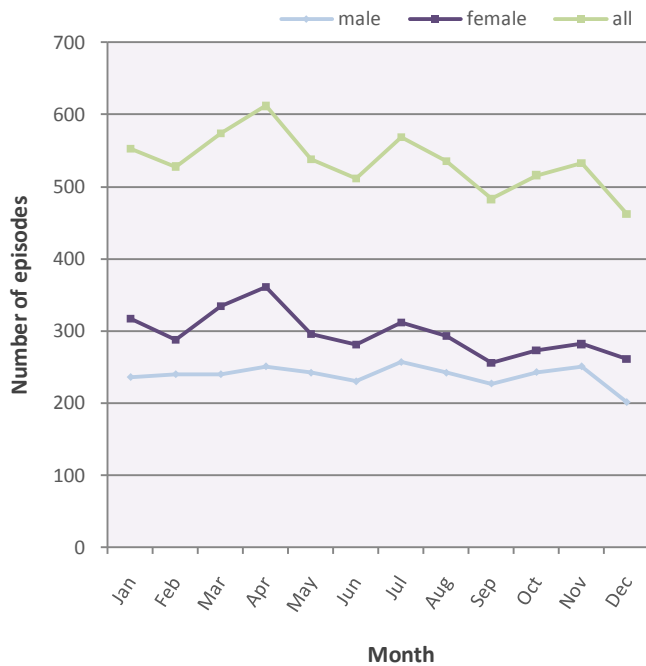


Overall the mean number of tablets was greatest in the 50-54 years age group (mean = 30) and the 25-29 years group (mean = 29).

5.3 Service data

Month of presentation

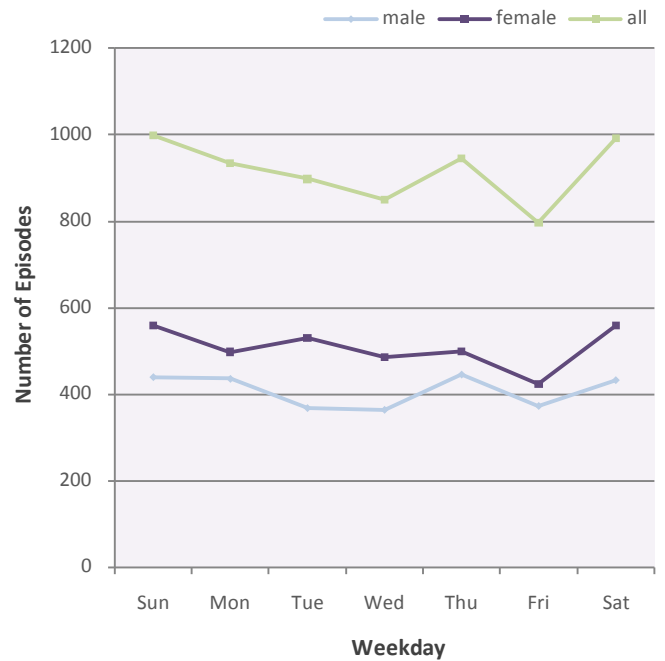
Figure 10: Month of presentation 2008-2009 (n = 6,414)



Peaks in the number of presentations were seen in April, July and November for both sexes. The April peak was more apparent in females, and the July peak in males.

Day of the week of presentation

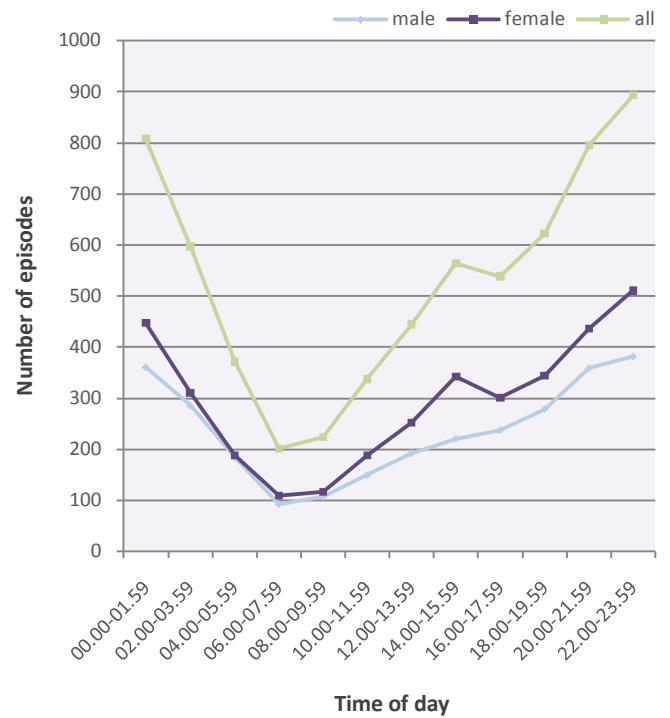
Figure 11: Day of presentation 2008-2009 (n = 6,414)



Presentations were most frequent on Saturday through to Monday (46% of all presentations). The lowest number of presentations was on a Friday.

Time of presentation

Figure 12: Time of day of presentation (n = 6,402)



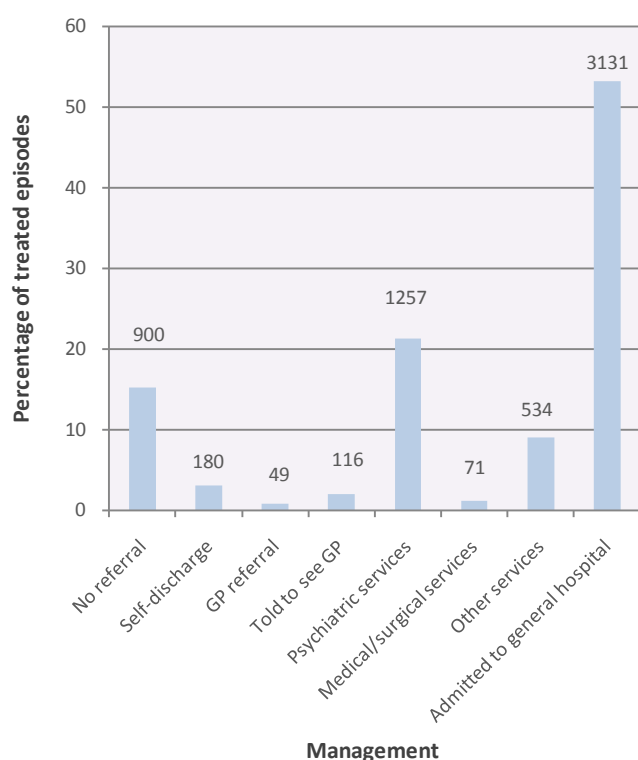
60% of presentations were between 6pm and 4am peaking between 10pm and 2am (27%) and declining from this time to a low of 6% between 6 and 10am.

5.4 Management of episodes by Emergency Department and psychiatric staff

Management of self-harm episodes by Emergency Department staff

Management in the ED was known for 92% (5887) of all episodes. In 494 (8%) episodes, patients did not wait for treatment. The grade of ED staff was known for 5520 (86%) episodes. 67% were treated by SHOs, 23% by registrars and 7% by consultants.

Figure 13: Referral of episodes by Emergency Department staff⁶



The majority of self-harm episodes resulted in admission to a hospital bed and/or referral to psychiatry:

- 53% of self-harm episodes resulted in being admitted to a hospital bed (including beds in Clinical Decision Units)
- 21% of episodes were referred straight to psychiatric services
- 19% were either discharged or self-discharged without a referral

Amongst episodes that resulted in a medical admission 44% received a psychosocial assessment completed by a member of psychiatric staff. This is a decrease of 12% since the last report (Dickson et al., 2009).

⁶ Each case may be referred to more than one service.

Management of episodes by Mental Health Specialists

A total of 2198 episodes (34% of all presentations) were assessed by Mental Health Specialists⁷. 67% were assessed by nurses and 30% by SHOs. Management was known for 2183 (99%) of these episodes.

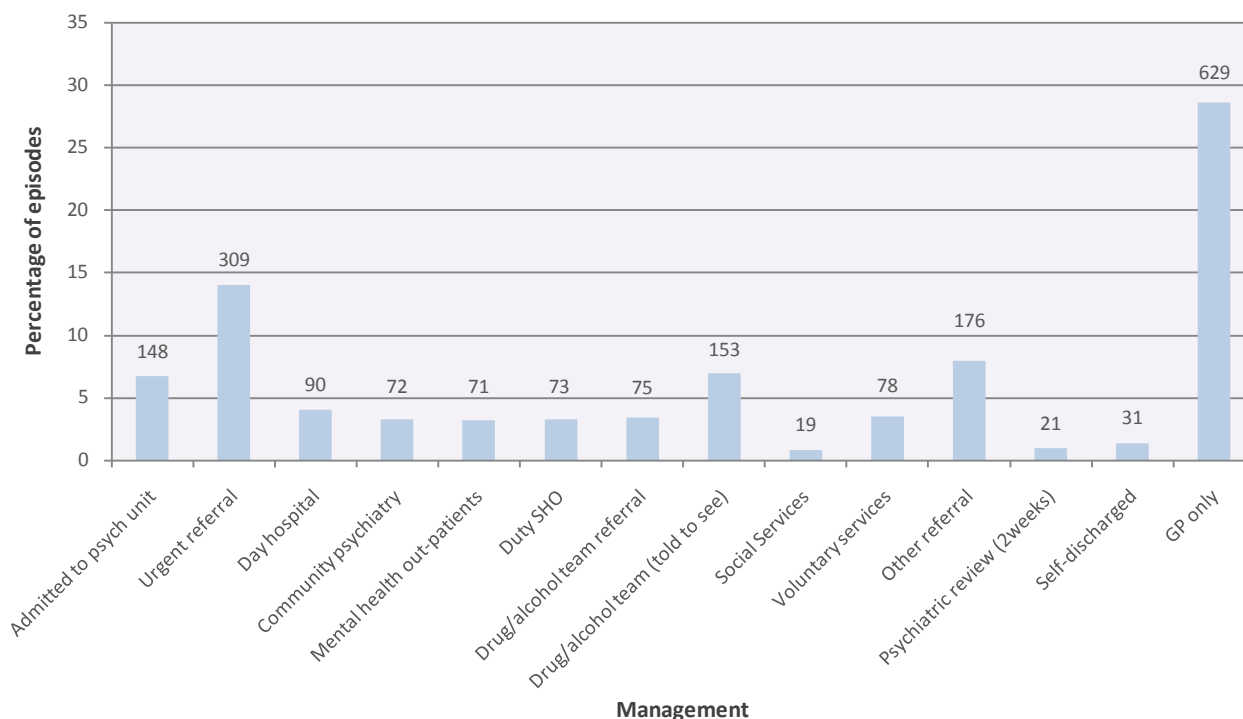
Management by mental health specialists included the following:

- 25% of episodes were referred to Mental Health Services, including outpatients, duty psychiatrist, day hospital, community drug and alcohol teams and psychiatric review
- 7% (148) of episodes resulted in admission to a psychiatry ward or unit; 8 of these admissions were made under provision of the Mental Health Act (2007).
- 14% of episodes had an urgent referral; almost all of which were to a Crisis Team
- In 12% of episodes other referrals were made, including to voluntary organisations (such as 42nd Street), social services and counselling
- In 29% of episodes, a referral to the patient's GP was the only formal referral

The GP was informed of the self-harm episode in 50% of cases where a Mental Health Specialist had completed a psychosocial assessment.

⁷ This may be an under ascertainment of the total assessment rate due to the introduction of electronic risk assessment forms during the reporting period.

Figure 14: Referral of episodes by psychiatric staff⁸



Published research

MaSH data was analysed (Cooper et al., 2008) to assess communication between secondary and primary services following self-harm episodes, as recommended in NICE guidelines. The patient’s GP was informed of the self-harm in around two-thirds of episodes, suggesting NICE guidance is only partially being met.

Both NICE guidelines (NICE, 2004) and the Royal College of Psychiatrists (RCP 2004) emphasise the need for all patients who self-harm to receive psychosocial assessment. Factors associated with a decreased likelihood of assessment include unemployment, being young, self-cutting, attending outside normal working hours and self-discharge (Kapur et al., 2008).

Rates of assessment, offers and uptake of brief psychodynamic interpersonal therapy following self-harm (Murphy et al., 2010), offered by a specialist team providing assertive follow-up in the community were investigated. Although the rate of completion of therapy was not high (around half completed all sessions), nearly three-quarters of those offered therapy attended at least one session.

MaSH data was used to compare psychosocial assessments carried out by mental health nurses and psychiatrists (Murphy et al., 2011). There was strong agreement between assessor types in the factors associated with high risk assessment, and the accuracy of predicting the risk of repetition was similar in both groups. However, following an assessment of high risk, psychiatrists were much more likely than nurses to admit people for inpatient treatment.

A multicentre research study comparing the management and outcomes of self-harming individuals in relation to repetition of self-harm and suicide following self-harm is currently in progress.

⁸ Each case may be referred to more than one service.

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Further research by the MaSH Project/Multicentre study of Self-harm in England

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Appendix – MaSH Assessment Form

Manchester Self-Harm Assessment Form	
<p>1. Patient Details</p> <p>A&E Number: ID No: H: NK:</p> <p>NHS No: DISTRICT No: Postcode: Date of birth: Date of presentation: Time of presentation (24hr): If not assessed please give reason:</p>	<p>Conscious level (GCS=) <input type="checkbox"/> Alert <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unconscious</p> <p>Nature of the act: Premeditated? <input type="checkbox"/> Yes <input type="checkbox"/> No Tried to avoid discovery? <input type="checkbox"/> Yes <input type="checkbox"/> No Suicide note? <input type="checkbox"/> Yes <input type="checkbox"/> No Wanted to die during incident? <input type="checkbox"/> Yes <input type="checkbox"/> No Further details of circumstances:</p> <p>MAIN precipitant(s) of self-harm: <input type="checkbox"/> Yes <input type="checkbox"/> No If the precipitants are known, what are they? Relationship problems (partner or boy/girl friend) <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship problems (parents/siblings) <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship problems (with others) <input type="checkbox"/> Yes <input type="checkbox"/> No Bullying/intimidation <input type="checkbox"/> Yes <input type="checkbox"/> No Bereavement <input type="checkbox"/> Yes <input type="checkbox"/> No Housing problem <input type="checkbox"/> Yes <input type="checkbox"/> No Employment or study problem <input type="checkbox"/> Yes <input type="checkbox"/> No Legal problem (eg. criminal charge) <input type="checkbox"/> Yes <input type="checkbox"/> No Victim of crime <input type="checkbox"/> Yes <input type="checkbox"/> No Physical health problem <input type="checkbox"/> Yes <input type="checkbox"/> No Miscarriage, stillbirth <input type="checkbox"/> Yes <input type="checkbox"/> No Financial problems <input type="checkbox"/> Yes <input type="checkbox"/> No Direct response to mental symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No Drug abuse or misuse <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol abuse or misuse <input type="checkbox"/> Yes <input type="checkbox"/> No Other mental health issues <input type="checkbox"/> Yes <input type="checkbox"/> No Abuse (physical/mental/sexual) <input type="checkbox"/> Yes <input type="checkbox"/> No Other (specify) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2. Self-harm Details</p> <p>Date of harm: Time of harm (24hr):</p> <p>Was alcohol taken within 6 hours prior to this attempt? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many units?</p> <p>Method of harm: <input type="checkbox"/> Self-poisoning drugs <input type="checkbox"/> Self-poisoning other <input type="checkbox"/> Self injury (cutting or piercing) <input type="checkbox"/> Other (drowning, asphyxiation, CO poisoning etc)</p> <p>Further Details: For drug poisoning specify type and number of tablets, for all remaining methods give details of attempt.</p>	<p>3. Risk Factors for Suicide</p> <p>Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Marital status: Q. Are you married or living with a partner or do you regard yourself as separated, widowed or single? <input type="checkbox"/> Single <input type="checkbox"/> Separated/divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married/partnered</p> <p>Ethnic Origin: (Tick most likely classification) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Indian/Pakistani/Bangladeshi <input type="checkbox"/> Chinese <input type="checkbox"/> Mixed <input type="checkbox"/> Other</p>
<p>4. Current Mental State</p> <p>Symptoms of depression: Feels depressed <input type="checkbox"/> Yes <input type="checkbox"/> No Looks depressed <input type="checkbox"/> Yes <input type="checkbox"/> No Sleep disturbance <input type="checkbox"/> Yes <input type="checkbox"/> No Appetite disturbance <input type="checkbox"/> Yes <input type="checkbox"/> No Hopelessness <input type="checkbox"/> Yes <input type="checkbox"/> No Suicidal thoughts <input type="checkbox"/> Yes <input type="checkbox"/> No Suicidal plans <input type="checkbox"/> Yes <input type="checkbox"/> No Hallucinations/delusions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Clinical Impression</p> <p>How potentially lethal was this attempt? <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High</p> <p>What is the likelihood of further attempts? <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High</p> <p>What is the chance that further attempts will be lethal? <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High</p> <p>6. Management Plan</p> <p>What was the outcome? (tick appropriate box(es)) Discharged, formally referred to GP <input type="checkbox"/> Yes <input type="checkbox"/> No Discharged, told to see GP <input type="checkbox"/> Yes <input type="checkbox"/> No Discharged, no referral <input type="checkbox"/> Yes <input type="checkbox"/> No Self-discharge <input type="checkbox"/> Yes <input type="checkbox"/> No Referred to psychiatric services (including alcohol and drug team, specialist mental health team) <input type="checkbox"/> Yes <input type="checkbox"/> No Referred to medical or surgical services <input type="checkbox"/> Yes <input type="checkbox"/> No Referred to other services (specify) <input type="checkbox"/> Yes <input type="checkbox"/> No Died <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Further details of management follow up: (include referrals to assessment and decision units) General hospital admission requested? <input type="checkbox"/> Yes <input type="checkbox"/> No General hospital admission achieved? <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric referral offered but patient refused? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Living circumstances: (tick first applicable box) Q. <i>Whom do you normally live with</i> <input type="checkbox"/> Homeless <input type="checkbox"/> Alone <input type="checkbox"/> With spouse/partner <input type="checkbox"/> Parent/sibling <input type="checkbox"/> With friends/other relatives <input type="checkbox"/> Hostel resident/lodgings <input type="checkbox"/> Dependent children only <input type="checkbox"/> Other (including prison etc - please specify)</p> <p>Employment: Q. <i>Are you employed at the moment?</i> <input type="checkbox"/> Employed (including part time) <input type="checkbox"/> Registered unemployed <input type="checkbox"/> Registered sick <input type="checkbox"/> Retired <input type="checkbox"/> Student (including schoolchildren) <input type="checkbox"/> Housewife/husband (including child care) <input type="checkbox"/> Other (including prison etc - please specify)</p> <p>Duration of unemployment: (if reg. see ask...) Q. <i>About how long have you been unemployed?</i> <input type="checkbox"/> Up to 26 weeks <input type="checkbox"/> Over 26 weeks <input type="checkbox"/> Not applicable</p> <p>Previous self-harm: (tick all appropriate boxes) Q. <i>Have you harmed yourself deliberately in the past?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes, in the last 12 months <input type="checkbox"/> Yes, more than 12 months ago <input type="checkbox"/> GP <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient</p> <p>Current psychiatric treatment: Q. <i>Are you currently having any help with mental problems?</i> <input type="checkbox"/> No <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> GP Other (specify)</p> <p>Previous psychiatric treatment Q. <i>Have you previously had any help with mental problems?</i> <input type="checkbox"/> No <input type="checkbox"/> Last 12m <input type="checkbox"/> >12m ago</p> <p>Current alcohol use: (average units per day) Q. <i>How much do you normally drink per day?</i> <input type="checkbox"/> 0 <input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7+</p> <p>Current substance use (regular): (including cannabis) Q. <i>Do you use street drugs at least once weekly?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Assessed by (BLOCK CAPITALS)</p> <p>Name: Signed: Speciality: Date of assessment: Time of assessment (24hr): Grade of assessor: <input type="checkbox"/> Consultant <input type="checkbox"/> SHO <input type="checkbox"/> Registrar <input type="checkbox"/> ENP <input type="checkbox"/> Other (specify)</p>	<p>Official use only: ID No: H: NK:</p>

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