Health professionals who are assessing and treating people who self-harm should be aware of, and pay close attention to, associated physical disorders

Pathway to reduce premature death after self-harm

Self-harm is not an illness, it is an expression of personal distress. People who self-harm have an increased risk of premature death from suicide, accidental death and natural causes (Neeleman, 2001). As well as being at high risk of suicide, most patients who self-harm have psychiatric disorders; in addition, physical health problems are often poorly treated in people with mental health disorders, leading to a reduced life expectancy (Wahlbeck et al, 2011).

People who self-harm are more likely than the general population to die prematurely

Current advice

The National Institute for Health and Care Excellence has produced a pathway on self-harm (tinyurl.com/NICE-SH-pathway), which brings together related NICE guidance and products associated with the issue in a set of interactive topic-based diagrams.

New evidence

A cohort study (Bergen et al, 2012) investigated premature death in 30,950 people who attended six accident and emergency departments in England after self-poisoning or self-injury between 2000 and 2007. The causes of premature death and years of life lost were assessed and compared with the general population. Associations with socioeconomic deprivation were also tested using participants' residential post codes.

The median follow-up period was six years, during which time 1,832 of the participants died. Death from all causes was higher in people who had self-harmed than in the general population. This equated to about 31 years of life lost by each person. Twenty-five times more people who had self-harmed died of accidental poisoning than would be expected in the general population, intentional self-harm increased 19 times, and death from undetermined intent was 24 times higher than expected.

Deaths due to natural causes were also generally greater than expected in people who had self-harmed. Deaths due to diseases of the digestive system were 7.5 times higher than expected, which may have been associated with increased prevalence of alcohol problems in this group than in people dying of other causes. Deaths due to mental and behavioural disorders were 7.5 times higher than expected; 87% of these were due to psychoactive substance use. All-cause mortality increased with each quartile of socioeconomic deprivation.

The researchers concluded that clinicians who are assessing and treating self-harm should be aware of the need to pay close attention to physical disorders in people who self-harm. Additionally, assessment of people who present with self-harm should include inquiry into physical health, risky behaviour, psychosocial needs and risks of further self-harm or suicide. **NT**

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BOX 1. **COMMENTARY**

The research by Bergen et al (2012) is an important reminder that this group of people continues to experience significantly increased death rates compared with the general population. The findings demonstrate that, not only has this increased risk been maintained, but that it may have increased compared with the results of previous studies in the UK. The authors suggest that improvements in cause-specific mortality in the UK population might not have occurred to the same extent in people who self-harm, which is a plausible interpretation.

For practitioners, a history of self-harm should encourage active consideration of both physical and mental ill health. For UK health services, this work provides evidence that, after two decades of guidance on the treatment of self-harm, this group of patients is still disadvantaged.

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