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Effects of the COVID-19 pandemic on self-harm

There has been extensive discussion, some of it data-based¹ but much of it speculative, on the effect of the COVID-19 pandemic on suicide. Since death by suicide requires thorough investigation by professionals, such as coroners, collecting timely data on these deaths is challenging. Self-harm, an important public health concern in its own right, often precedes suicide, and can be used as a proxy outcome to identify how the pandemic has affected population mental health.

People who have self-harmed might present to different parts of the health-care service. Presentation to the emergency department is common, but comprehensive UK-wide data on self-harm in this setting are scarce. However, local analyses of hospital activity can be informative. An examination of clinical records in one large provider of mental health services in England, UK, showed a 40% decrease in self-harm referrals to liaison psychiatry in the 6 weeks after the lockdown, followed by an increase in referrals to previous levels.² This reduction is consistent with data from our own long-established self-harm monitoring systems.³ Individuals might also present to primary care with self-harm. A study of 1500 general practices in the UK using the Clinical Practice Research Datalink found that the recorded incidence of self-harm was 38% lower in April, 2020, than the rate expected on the basis of previous years.⁴ This decrease was particularly marked in women, people younger than 45 years, and those from the most deprived quintile of practices.

The reduction in self-harm presentations to health-care services could be a result of public health messages to protect the National Health Service (NHS), anxieties about contracting the virus, or reduced access to services. These findings might also reflect a genuine decrease

in community incidence. Longitudinal community data are scarce. Findings from the UCL COVID-19 Social Study, a large UK panel survey, showed that rates of self-harm have remained fairly constant since the UK lockdown, with 2–4% of people indicating they had self-harmed in the previous week. If the community incidence of self-harm has not decreased but there has been a substantial decline in health service use then this could indicate that people are seeking help elsewhere. Some charities and third sector organisations have reported a substantial increase in activity. Public Health England investigated the use of both telephone and online support services, but the findings were variable.

There is no indication that the pandemic has caused self-harm rates to increase in the UK. This finding is consistent with international data on suicidal behaviour,⁵ but important caveats apply. The pandemic is an ongoing and evolving situation. The rates of self-harm might yet increase because the wellbeing of many people has undoubtedly been affected. Data are sparse and any effects will not be uniform. At present, the reduction in the use of health-care services is perhaps the most important finding because self-harm often occurs at a point when an individual is in crisis or distressed. The consequences of reduced clinical contact at this time are unknown. Going forward, the evidence and the key principles of care for self-harm have not changed. Health-care services need to be made accessible, high quality assessments must be made available, and people who self-harm should be able to access the interventions they need.

NK chaired the National Institute for Health and Care Excellence (NICE) guidelines for self-harm (longer term management) 2012 and the NICE Quality Standards on self-harm 2013; and is the topic adviser for the new NICE guidelines for self-harm. NK and LA work with NHS England on national quality improvement initiatives for suicide and self-harm. LA chairs, and NK and KH are part of the Department of Health and Social Care's National Suicide Prevention Strategy Advisory Group for England. NK, KH, KW, and CC are investigators on

the Multicentre Study of Self-Harm in England, UK. The views expressed in this article are the authors' own and not those of the Department of Health and Social Care, NHS England, National Institute for Health Research or NICE.

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For more on the UCL COVID-19 Social Study see <https://www.covidsocialstudy.org/results>

For more on the Public Health England data see <https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-report>