Psychological management following deliberate self-harm

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Recent trends in the epidemiology of suicidal behaviour

There are approximately 4,000 suicides in England and Wales each year. This is equivalent to one death every two hours. The overall rate of suicide in Britain has fallen slightly over recent years, but the rate among young people increased considerably during the 1980s. Suicide is now the third most common cause of death in people aged 15–30. About half those who die by suicide have a past history of non-fatal deliberate self harm (DSH). It has been argued that by providing a high standard of care to these patients the national rate of suicide could be reduced[1].

Paracetamol and other analgesics are the most commonly used substances in overdose and 40% of cases also involve the consumption of alcohol. The majority of episodes of DSH that are treated by medical services present initially to accident and emergency departments (AED). Over 90% involve self-poisoning and 30–50% of patients require a brief admission for further medical treatment[2], resulting in over 200,000 admissions to British hospitals each year. One-fifth of those who have an episode of DSH repeat the act during the next year, and 1% die by suicide – a rate of suicide 100 times that of the general population[3].

The rate of DSH in Britain is currently 3 per 1,000 per year. This results in over 100,000 admissions to hospital each year, making DSH the most common reason for acute medical admission among women aged under 60. The rate of DSH was formerly far higher in women than men, but rates in men have increased over recent years and the male to female ratio is now 1:1.2. DSH in the elderly is less common, although a higher proportion of elderly patients state that at the time of the episode their intention was to kill themselves.

Patients who present following an episode of DSH usually have multiple social and personal problems. Experiences of childhood sexual abuse[4] and other sources of trauma in early life are common, as are current worries about unemployment, physical illness, relationship problems, etc. An important minority of patients also suffers from depression, schizophrenia and other treatable mental disorders. Attempts to identify factors that have motivated an episode of DSH are difficult to obtain through retrospective enquiry. While some patients clearly hoped to effect a change in the attitude or behaviour of others, a greater number state that they had wanted to escape a difficult situation, and a third group asserts that it was their intention to end their life[5].

Key Points

- **In the year following an episode of deliberate self-harm (DSH) 20% of individuals repeat the act and 1% die by suicide**
- **DSH is the most common reason for a medical admission among women aged under 60**
- **Medical teams have a responsibility to ensure that an initial psychosocial assessment is completed**
- **High quality care depends on a clear plan for patient management that is agreed with the mental health liaison service**
- **Duty to care and patient autonomy both need to be considered when managing the unco-operative patient**
- **Specialist intervention is of benefit to patients and may reduce the likelihood of repetition of suicidal behaviour**

Psychosocial assessment: the role of general medical staff

Prior to the 1980s the responsibility for conducting psychosocial assessment lay entirely with psychiatrists. In response to the large increase in rates of DSH in the 1960s and 1970s, together with research that showed that medical and nursing staff could be trained to conduct psychosocial assessments, this procedure changed. In 1984, a government circular stated that automatic referral of patients to psychiatric services was no longer appropriate, and standards for initial assessment by general medical staff were developed[6].

In addition to providing physical care of the patient, general medical staff were asked to:

- detect immediate suicide risk
- detect the presence of severe mental illness
- ensure that the patient is referred for specialist assessment.

This assessment takes place in the AED for many patients, but an important minority does not receive an assessment before being transferred to an inpatient ward.

Research conducted following this change has revealed that these initial assessments are often absent or incomplete[7]. It has been suggested that poor training and negative attitudes to patients who harm themselves are

responsible for this deficit. Two strategies have been used in an attempt to improve the quality of assessments:

1 The use of scales for the assessment of suicidal behaviour[8].
2 The provision of specific training for staff[9].

Both strategies improve the quality of patient assessments. Scales such as the SAD PERSONS scale (Table 1)[10] combine demographic and clinical risk factors for subsequent suicide, and provide a brief and efficient way of structuring an initial assessment.

Table 1. Items included in the SAD PERSONS scale.

S	Sex (male)
A	Age (<19 or >45 years of age)
D	Depression/hopelessness (patient describes depression, decreased concentration, appetite, sleep or libido)
P	Previous deliberate self-harm (having made one or more previous attempts)
E	Excessive alcohol/drug use
R	Loss of rational thinking (treatment for psychosis, organic brain syndrome, etc)
S	Separated, widowed or divorced
O	Organised or serious attempt (ie well thought out/left suicide note, changed will)
N	No social supports (ie no close/reliable family, friends or job)
S	Stated future intention to self-harm (or ambivalent about repetition)

The further management of patients

In most instances, the initial psychosocial assessment is followed by referral to a specialist team, which may include psychiatrists, mental health nurses and social workers. Specialist assessment is considered necessary for all children and older people admitted to hospital after an episode of DSH. Whatever system is agreed for managing these admitted patients, it should be in keeping with guidelines laid down by a local group of general medical and psychiatric staff who should also oversee the operation of these arrangements.

Hawton and Catalan[11] suggested that further psychosocial assessment needs to address five questions (Table 2). In addition to speaking to the patient, the observations of ward staff and other informants are important in completing the assessment. Subsequent management will depend on what is uncovered during the interview, and might include:

- inpatient or outpatient treatment of an underlying mental disorder
- referral for assessment and treatment of a drug or alcohol problem
- input from social services to address a particular social problem.

Some general strategies may also help to prevent the repetition of self-harm, including limiting the availability of the means of self-harm (such as throwing out unused tablets from the person's home) and involving others such as the patient's partner in future care. A brief exploration of how the patient copes when in crisis, and a discussion about alternative strategies for coping is also helpful (eg how to contact emergency psychiatric services, ringing the Samaritans (0345 90 90 90) or other helplines).

Table 2. Questions that need to be addressed as part of the psychological assessment.

1 What were the patient's intentions?
2 Does the patient still want to die?
3 What are the current problems?
4 Is there a psychiatric disorder?
5 What resources are available to the patient?

There is substantial variation in the proportion of patients who receive further input from mental health services following their discharge from hospital, but the majority do not receive any such input[12]. One reason for this is uncertainty about the effectiveness of follow-up treatment. Although brief psychological interventions have been demonstrated to reduce levels of psychological distress and the extent of social problems, their effects on preventing repetition of suicidal behaviour are less clear[13]. A recent systematic review[14] of interventions following DSH recommended further evaluation of 'problem solving therapy' – a form of cognitive behavioural therapy for which considerable, but not statistically significant, reductions in the rate of repetition of DSH have been reported. A statistically significant reduction in the rate of repetition has been demonstrated among patients who receive 'dialectical behaviour therapy'; a simplified version of this treatment is currently undergoing further evaluation.

Medico-legal considerations

An important minority of patients who present to medical services following an episode of DSH are unco-operative with medical treatment and seek to leave the hospital before their assessment and treatment have been completed. Such patients have a higher rate of repetition of suicidal behaviour[15]. Concern for patient autonomy is paramount in these circumstances, but doctors and others managing patients also have to be aware of their duty to care. Two factors need to be considered when managing this situation:

1 If the patient is suffering from a mental disorder, there may be grounds for treating them under the powers of the Mental Health Act. Where this is the case, an urgent psychiatric assessment should be sought. Where there is no evidence that the patient is mentally disordered, the patient's capacity to make decisions needs to be assessed (Table 3).
2 Patients who are acutely confused because of self-poisoning or intoxication with alcohol or drugs may lack capacity. In these circumstances,

Table 3. Assessing capacity.

A patient lacks capacity if unable to:

- comprehend and retain information on the proposed treatment, including its indications, main benefits and the consequences of non-treatment
- believe the information
- use the information and weigh it up as part of the process of arriving at a decision

treatment under common law may proceed if it is considered essential to preserve the patient's life[16]. The new Human Rights Act, which came into effect on 1 October 2000, may affect the management of patients who do not have capacity[17].

While the situation is complex, problems associated with managing non-consenting patients emphasise the need to conduct an initial psychosocial assessment, including an examination of the patient's mental state, at the earliest opportunity.

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