Self-Harm: assessing risk and managing patients

Faculty of Liaison Psychiatry Annual Residential Conference

London
May 2015

Nav Kapur
Centre for Suicide Prevention
University of Manchester
Outline

1. Context
2. Risk assessment
3. Managing self-harm
Outline

1. Context
2. Risk assessment
3. Managing self-harm
Self harm

Self-poisoning or self-injury irrespective of apparent motivation or medical seriousness
Terminology

Non-suicidal self-injury v. attempted suicide: new diagnosis or false dichotomy?

Navneet Kapur, Jayne Cooper, Rory C. O’Connor and Keith Hawton

Summary

Non-suicidal self-injury (NSSI) is a term that is becoming popular especially in North America and it has been proposed as a new diagnosis in DSM-5. In this paper we consider what self-harm research can tell us about the concept of NSSI and examine the potential pitfalls of introducing NSSI into clinical practice.
Scope

Number of episodes and persons presenting to general hospitals with self-harm

<table>
<thead>
<tr>
<th>England</th>
<th>~ 250,000 episodes/yr (175,000 persons)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>~ 300-500 per 100,000/yr</td>
</tr>
<tr>
<td>Repetition (1 year)</td>
<td>21%</td>
</tr>
</tbody>
</table>

Source: Multi-Centre Self-harm Project 2015
Self-harm in England

Claim that youth self-harm is at an 'epidemic' level

Interview by Chris Smith, words by Jimmy Blake
Newsbeat reporters

5 June 2013 | Health
Self-harm in England

Figure A: Age-standardised person-based rates of self-harm in males and females aged 15+ years in three centres (Oxford, Manchester, Derby) combined

http://cebmh.warne.ox.ac.uk/csr/mcm/news.html
Self-harm and suicide

- 50%+ of those who die by suicide have a history of self-harm
- Risk of suicide increased 30-50 fold in the year after self-harm
Self-harm and suicide

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Life expectancy in men who self-harm vs the general population

Bergen et al 2012, Lancet
Services for self-harm

Proportion of patients discharged home from ED

Kapur et al 1998, BMJ
Services for self-harm

Proportion of patients who received a psychosocial assessment

<table>
<thead>
<tr>
<th>Location</th>
<th>Proportion</th>
</tr>
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<tbody>
<tr>
<td>Leeds</td>
<td>70%</td>
</tr>
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</tr>
<tr>
<td>Manchester</td>
<td>30%</td>
</tr>
<tr>
<td>Nottingham</td>
<td>50%</td>
</tr>
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</table>
Variations in self-harm services

Hospital

(Cooper et al BMJ Open 2013)
Service user experience

`They wouldn't touch me... they looked at me as if to say `I'm not touching you in case you flip on me”... they didn't actually say it, it was their attitude...‘

`The last time I had a blood transfusion the consultant said that I was wasting blood that was meant for patients after they'd had operations or accident victims. He asked whether I was proud of what I'd done...'  

(Taylor et al 2009, BJPsych)
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Risk
The problem with risk assessment: Assessment of risk prior to suicide

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</tr>
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<td>3,368</td>
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Table 2: Social and clinical characteristics of Inquiry suicide cases (continued)

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<tr>
<th>Behavioural features</th>
<th>Number (6,203)</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>History of self-harm</td>
<td>4,124</td>
<td>68</td>
</tr>
<tr>
<td>History of violence</td>
<td>1,291</td>
<td>22</td>
</tr>
<tr>
<td>History of alcohol misuse</td>
<td>2,631</td>
<td>44</td>
</tr>
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<td>History of drug misuse</td>
<td>1,789</td>
<td>30</td>
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<td>548 (16.6)</td>
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(Kapur et al BMJ 2005)
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*(Kapur et al. BMJ 2005)*
# Risk tools and scales

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<th>SAD PERSONS</th>
</tr>
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<tr>
<td>(10 items)</td>
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</table>

- S Sex
- A Age
- D Depression
- P Previous Attempts
- E Ethanol Abuse
- R Rational Thinking Loss
- S Social Support Lacking
- O Organised Plan
- N No Spouse
- S Sickness
Risk tools and scales to predict suicide after self-harm:
• Positive Predictive Value less than 5%
• So they are wrong 95% of the time
• And they miss suicide deaths in the large ‘low risk’ group
UK NICE Guidelines (2011):

Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.

Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.

Risk assessment tools may be considered to help structure, prompt, or add detail to assessment.
What are we doing?

What risk tools are used by mental health services?

- SAD PERSON SCALE: 2
- Suicide Intent Scale: 1
- Pierce Suicide Intent Scale: 1
- Structure Proforma (local): 22
- Computerised assessment system: 2
- CPA (forms or based on): 6
- Risk Assessment Matrix: 1
- CARSO: 1
- Initial Screening Assessment tool: 1

Quinlivan et al BMJ Open 2014
Outline

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   Psychological interventions
   Doing simple things well
   Guidelines and other things
Interventions for self-harm

Distribution of time to repeat self-harm after index
censored at 1 year

(Kapur et al J Clin Psychiatry 2006)
What works?

Psychological interventions and repeat self-harm

1.4 Per protocol repetition (last follow up)

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Experimental Events</th>
<th>Total</th>
<th>Control Events</th>
<th>Total</th>
<th>Weight</th>
<th>Risk Ratio M-H, Random, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>BROWN2005</td>
<td>13</td>
<td>45</td>
<td>23</td>
<td>40</td>
<td>13.0%</td>
<td>0.50 [0.30, 0.85]</td>
</tr>
<tr>
<td>DUBOIS1999</td>
<td>8</td>
<td>43</td>
<td>10</td>
<td>41</td>
<td>6.5%</td>
<td>0.76 [0.33, 1.74]</td>
</tr>
<tr>
<td>GIBBONS1978</td>
<td>27</td>
<td>200</td>
<td>29</td>
<td>200</td>
<td>14.6%</td>
<td>0.93 [0.57, 1.51]</td>
</tr>
<tr>
<td>GUTHRIE2001</td>
<td>5</td>
<td>58</td>
<td>17</td>
<td>61</td>
<td>5.3%</td>
<td>0.31 [0.12, 0.78]</td>
</tr>
<tr>
<td>HAWTON1987</td>
<td>3</td>
<td>41</td>
<td>6</td>
<td>39</td>
<td>2.8%</td>
<td>0.48 [0.13, 1.77]</td>
</tr>
<tr>
<td>SALKOVSKIS1990</td>
<td>3</td>
<td>12</td>
<td>4</td>
<td>8</td>
<td>3.3%</td>
<td>0.50 [0.15, 1.66]</td>
</tr>
<tr>
<td>SLEE2008</td>
<td>26</td>
<td>40</td>
<td>21</td>
<td>33</td>
<td>21.8%</td>
<td>1.02 [0.72, 1.44]</td>
</tr>
<tr>
<td>STEWART2009</td>
<td>3</td>
<td>23</td>
<td>2</td>
<td>9</td>
<td>1.9%</td>
<td>0.59 [0.12, 2.95]</td>
</tr>
<tr>
<td>TYRER2003a</td>
<td>84</td>
<td>213</td>
<td>99</td>
<td>217</td>
<td>30.9%</td>
<td>0.86 [0.69, 1.08]</td>
</tr>
</tbody>
</table>

Total (95% CI)  675 648 100.0% 0.76 [0.61, 0.96]

Total events 172 211

Heterogeneity: Tau² = 0.03; Chi² = 11.36, df = 8 (P = 0.18); I² = 30%

Test for overall effect: Z = 2.35 (P = 0.02)
What works?
The problem with randomised trials …..
Doing simple things well
Doing simple things well

Psychosocial assessment
Observational data on 35,938 individuals presenting with self-harm to 3 centres in England, comparing repetition in those receiving vs not receiving specialist assessment (adjusted for baseline characteristics)

(Kapur et al 2013)
How do they work?

The assessment itself
The main thing was that [psychiatrist] did look as if he actually cared, that's it, and he wanted, he really wanted to help me, and so that was a very positive thing” (P4)

Access to aftercare
[I'm] hugely grateful that I've got the help, it's made a whole world of difference [yeah], I'm getting regular phonecalls, people are phoning me, keeping me informed, my care people are coming, I know that within the next couple of weeks, I will have the support I need” (P10).

(Hunter et al 2013)
But do guidelines make a difference?

National clinical guidelines

Self-harm

The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care

Issued: July 2004

NICE clinical guideline 16
www.nice.org.uk/cg16
But do guidelines make a difference?

National Clinical Guidelines:

Change in self-harm service provision in 31 hospitals in England (2001/2 vs 2010/11)

(Cooper et al 2013)
But do guidelines make a difference?

National Clinical Guidelines:

Change in global quality scores for self-harm services in 31 hospitals in England 2001/2 vs 2010/11.

Median Quality Score (IQR):
11.5 (10-14) in 2001/2 vs 14.5 (11.5 -16) in 2010/11
NICE guidelines 2012

SELF-HARM
THE NICE GUIDELINE ON LONGER-TERM MANAGEMENT
NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH
The NICE self-harm pathway covers:

- Planning of services
- General principles of care for people who self-harm
- Assessment, treatment and management
- Long-term treatment and management.
Implementing guidance

**Commissioning and Benchmarking Tool**

For the two main stages of treatment likely to change - psychosocial assessments and psychological interventions - you can model the costs of commissioning these services in different settings by entering activity data into the blue cells. The table below relates specifically to psychosocial assessments, while the number of psychological interventions required can be modelled on the next worksheet. The proportion of people who receive a psychosocial assessment can vary widely, so these figures (cell D13:H13) may need to be adjusted to reflect local circumstances. A change in service provision can be modelled by increasing the percentage who receive an assessment over the five year period.

### Activity commissioned: Psychosocial Assessments

<table>
<thead>
<tr>
<th>Patients eligible for assessment</th>
<th>Current</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion who receive an assessment</td>
<td>346</td>
<td>346</td>
<td>346</td>
<td>346</td>
<td>346</td>
</tr>
<tr>
<td>Assessments commissioned</td>
<td>67%</td>
<td>73%</td>
<td>79%</td>
<td>84%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>232</td>
<td>252</td>
<td>272</td>
<td>291</td>
<td>311</td>
</tr>
</tbody>
</table>

### Recurrent cost element

<table>
<thead>
<tr>
<th>Recurrent cost element</th>
<th>Current year</th>
<th>Year 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>Unit cost (£)</td>
<td>Units</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
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**Unit Costs**

- MHCOM05 - Children and Adolescent Other Services: 222, 0, 222
- MHCOM09 - Other Specialist Mental Health Services: 137, 0, 137

[http://www.nice.org.uk/usingguidance/commissioningguides/SelfHarm.jsp](http://www.nice.org.uk/usingguidance/commissioningguides/SelfHarm.jsp)
NICE quality standards

NICE quality standards are a set of specific, concise statements

They set out markers of high-quality, cost-effective patient care.

Quality standards will be reflected in the new Commissioning Outcomes Framework and will inform payment mechanisms and incentive schemes.
NICE self-harm Quality Standards – June 2013

1. People are treated with compassion, respect and dignity
2. They receive an initial assessment of physical health, mental state, social circumstances and risk of suicide.
3. They receive a comprehensive psychosocial assessment.
4. They receive the monitoring they need to keep them safe.
5. They are cared for in a safe physical environment.
6. Collaborative risk management plan are in place.
7. They have access to psychological interventions.
8. There is a transition plan when moving between services.

http://publications.nice.org.uk/quality-standard-for-selfharm-qs34
Implementing guidance

Improving outcomes and supporting transparency

Part 2: Summary technical specifications of public health indicators

Updated November 2013
Implementing guidance

Department of Health

Improving outcomes and supporting transparency
Part 2: Summary technical specifications of public health indicators
Updated November 2013

The indicator will have two elements:

2.10i Attendances at A&E for self-harm per 100,000 population
2.10ii Percentage of attendances at A&E for self-harm that received a psychosocial assessment
Depression Care Effort Brings Dramatic Drop in Large HMO Population’s Suicide Rate

Tracy Hampton, PhD

While physicians and other health care workers may not be able to predict which of their patients will attempt suicide, they can implement preventive strategies that markedly lower the risk of such tragedies. Now, one pioneering program has demonstrated the importance of pursuing 2 key approaches at once: carefully assessing patients for risk of suicide and adopting measures to reduce the likelihood that a patient will attempt suicide.

The example comes from a quality-improvement initiative that succeeded in substantially bringing down the rate of suicide in a population of about 200,000 members of a large health maintenance organization (HMO). Through the second quarter of last year, the Perfect Depression Care program of the Behavioral Health Services (BHS) division of the Henry Ford Health System resulted in 9 consecutive quarters without any suicides, a dramatic contrast to the annual rate of several awards, including the Joint Commission’s Ernest Amory Codman Award and the Gold Achievement Award from the American Psychiatric Association.

“I believe we have a model that is applicable to most health care settings and that could dramatically improve the care of patients with depression and other major mental disorders that raise the risk of suicide,” said neuropsychiatrist C. Edward Coffey, MD, Henry Ford Health System vice president and CEO of BHS, a large integrated mental health and substance abuse system that includes 2 inpatient hospitals and 10 clinics serving southeastern Michigan and adjacent states.

ZERO SUICIDES

The Perfect Depression Care Initiative was one of 12 national demonstration projects (and the only mental health

JAMA 2010

BBC News 19.1.2015
Helping young people and parents

self-talk.org

Self-harm: experiences of parents

Watch parents and carers share their experiences of having a child who self-harms, on the award-winning website healthtalk.org. Research by The University of Oxford.

“I’m just thinking ‘why is my little girl doing this? What did I do?’”

“Just remain hopeful and strong and realise that nothing stays the same”
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Summary

1. The role of risk assessment needs some thought
2. Make evidence based interventions available
3. Develop and implement guidelines
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