Identifying subgroups of self-harm: Implications for assessment and treatment

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Dedicated to Allison Milner,
1st May 1983 - 12th August 2019

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Background

- Limited research into subgroups of people who self-harm; different methodological approaches within existing research
- Existing clinical guidelines and guidance documents for the assessment and management of self-harm (NICE, 2013; BPS, 2012) have limited focus on clinical subgroups of self-harm and tailored treatment approaches
- Emerging evidence about people who self-harm and who do not benefit from evidence based interventions – hidden subgroups?
- Based on the National Self-Harm Registry Ireland, 39% of patients presenting to emergency departments due to self-harm do not receive a psychiatric or psychosocial assessment and 15% leave the hospital without a next care recommendation *(Arensman et al, 2018)*

PLOS ONE

RESEARCH ARTICLE

Recommended next care following hospital-treated self-harm: Patterns and trends over time

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Data Availability Statement: The data used in this manuscript comes from the National Self-Harm Registry Ireland and contains sensitive patient information. As a result, access to this data set is restricted and facilitated by the National Suicide Research Foundation. All data requests may be made to the National Suicide Research Foundation (info@nsrf.ie).

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Abstract

Objective

The specific objectives of this study were to examine variation in the care of self-harm patients in hospital settings and to identify the factors that predict recommended next care following self-harm.

Methods

Data on consecutive presentations to Irish emergency departments (EDs) involving self-harm from the National Self-Harm Registry Ireland from 2004 to 2012 were utilised. Univariate and multivariate regression analyses were performed to assess the associations between patients' clinical and demographic characteristics, and recommended next care received.

Results

Across the study period a total 101,904 self-harm presentations were made to hospital EDs, involving 63,457 individuals. Over the course of the study there was a declining number of presentations resulting in patient admission following attendance with self-harm. Recommended next care varied according to hospital location, with general admission rates ranging from 11% to 61% across administrative health regions. Multinomial logistic regression identified that the factor which most strongly affected next care was the presenting hospital. Being male, older age, method, repeat self-harm, time of attendance and residence of the patient were all identified as influencing care received. Psychiatric admission was most common when highly lethal methods of self-harm were used (OR = 4.00, 95% CI, 3.63–4.41). A relatively large proportion of patients left the ED without being seen (15%) and the risk of doing so was highest for self-harm repeaters (1.64, 1.55–1.74 for those with 5+ presentations).

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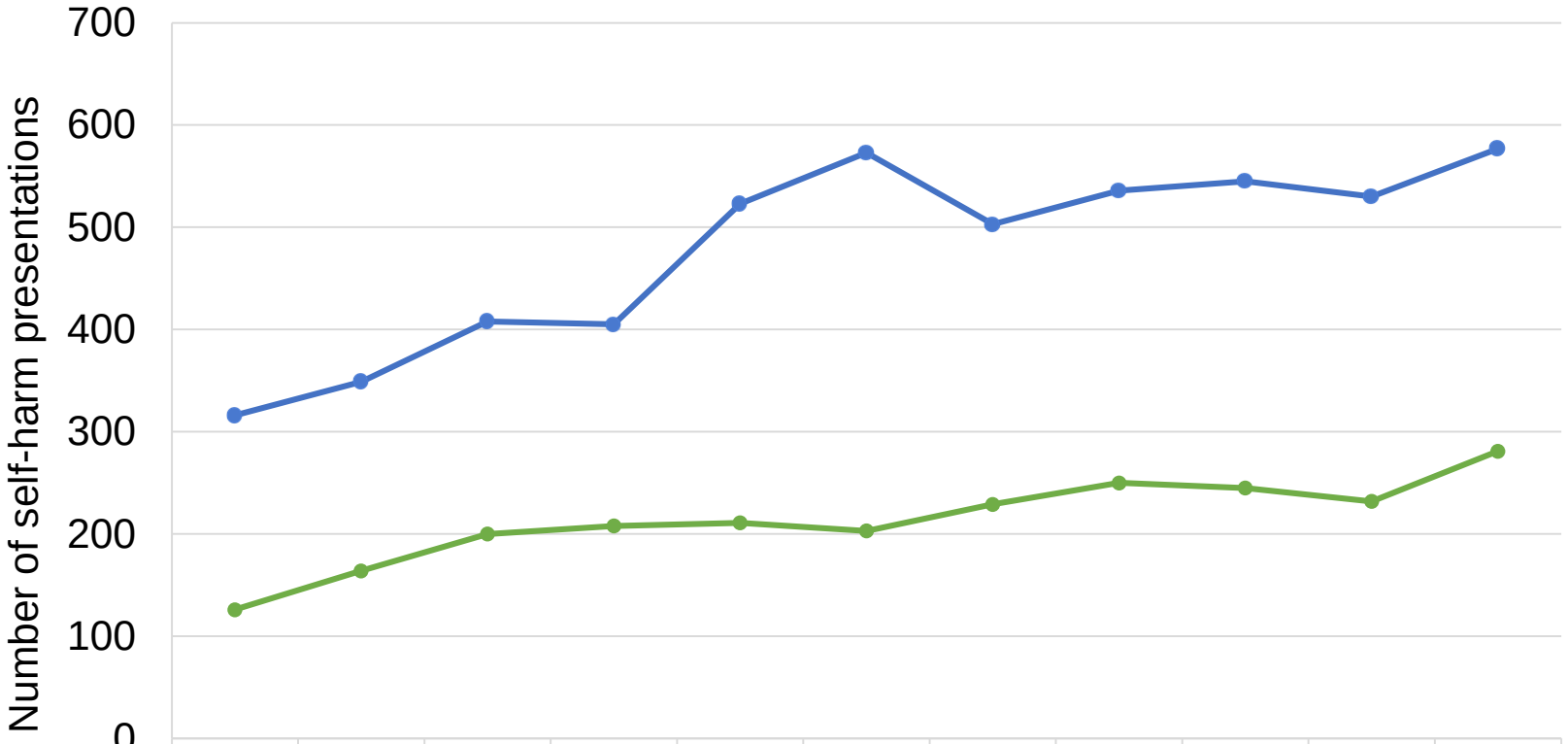
Increasing trend of self-harm acts involving highly lethal methods among males and females (rates/100,000)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Men	316	349	408	405	523	573	503	536	545	530	577
Women	126	164	200	208	211	203	229	250	245	232	281

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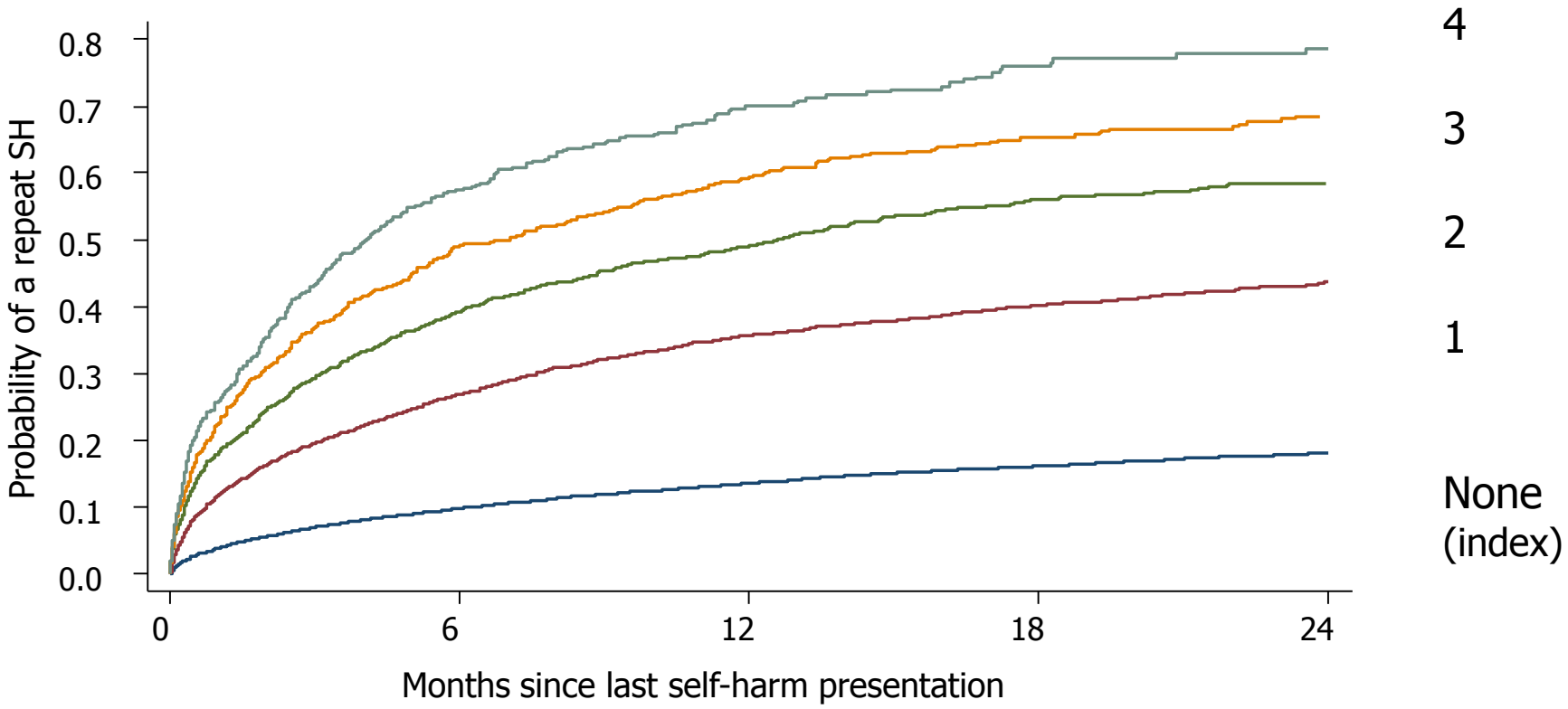
Repetition by number of previous self-harm presentations



Improving Prediction and Risk Assessment of Self-Harm and Suicide (IMPRESS)

Objectives:

- Further investigate predictive risk factors associated with repeated self-harm among high risk groups of self-harm patients

- To develop a programme for the assessment and management of self-harm procedure for repeated self-harm and suicide for use in a general hospital setting

➢ Prospective design involving in-depth semi-structured interviews following an index self-harm presentation to general hospital (baseline) and 6 months follow-up

Population: 2 high risk groups

- **High risk self-harm (HR):** self-harm presentations of high lethality and/or high level of suicidal intent)
- **Major repeaters (MR):** self-harm presentations by patients who have a history of 5 or more previous self-harm presentations)

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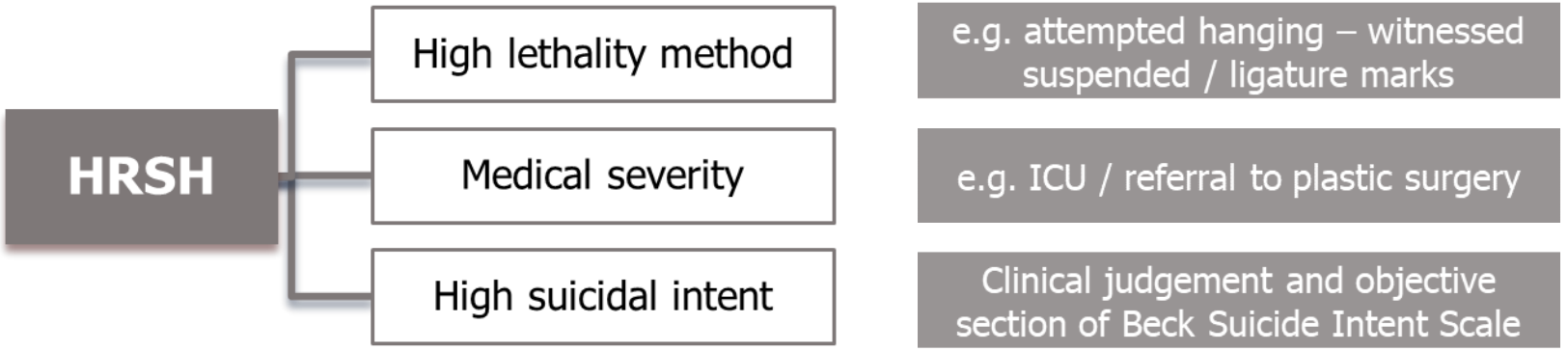
Methods: Recruitment and response of patients with high risk self-harm



3 Hospitals:
High rate city hospitals

Data collection: 28 months

Study 1	**Psychiatric and psychosocial assessment data**	**N=355** Consecutive cases (incl. 9 fatal acts)
Study 2	Baseline semi-structured (n=106)	**6 month follow-up semi-structured interviews (56.5%)**

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Methods: Recruitment and response of patients with major self-harm repetition

MR — Pattern of self-harm repetition

5 or more previous episodes of self-harm

3 Hospitals
High rate city hospitals

Data collection:
22 months

Study 1	**Psychiatric and psychosocial assessment data**	**N=135** Consecutive cases (incl. 2 fatal acts)
Study 2	Baseline semi-structured (n=32)	**6 month follow-up semi-structured interviews (72%)**

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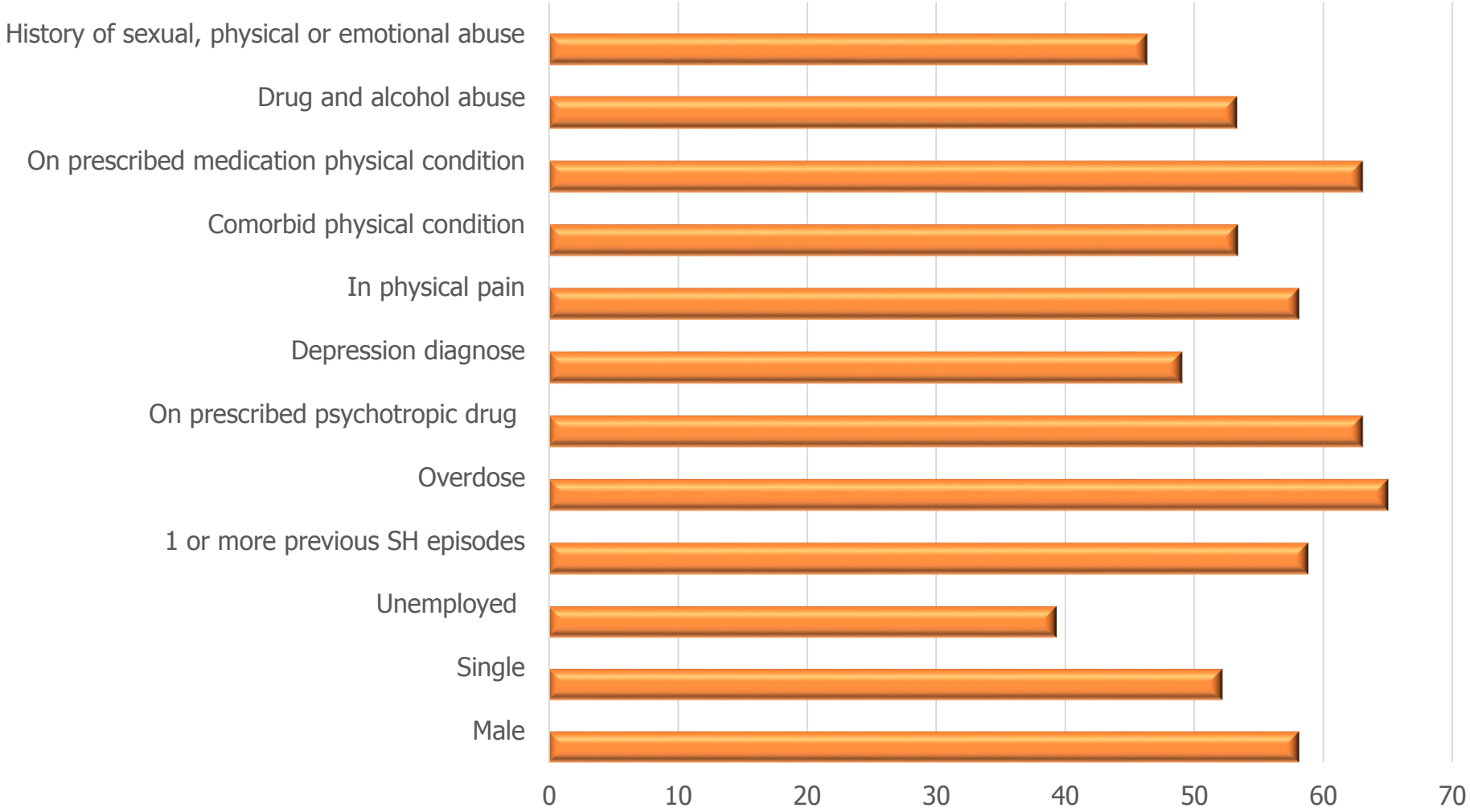
High-Risk Self-Harm



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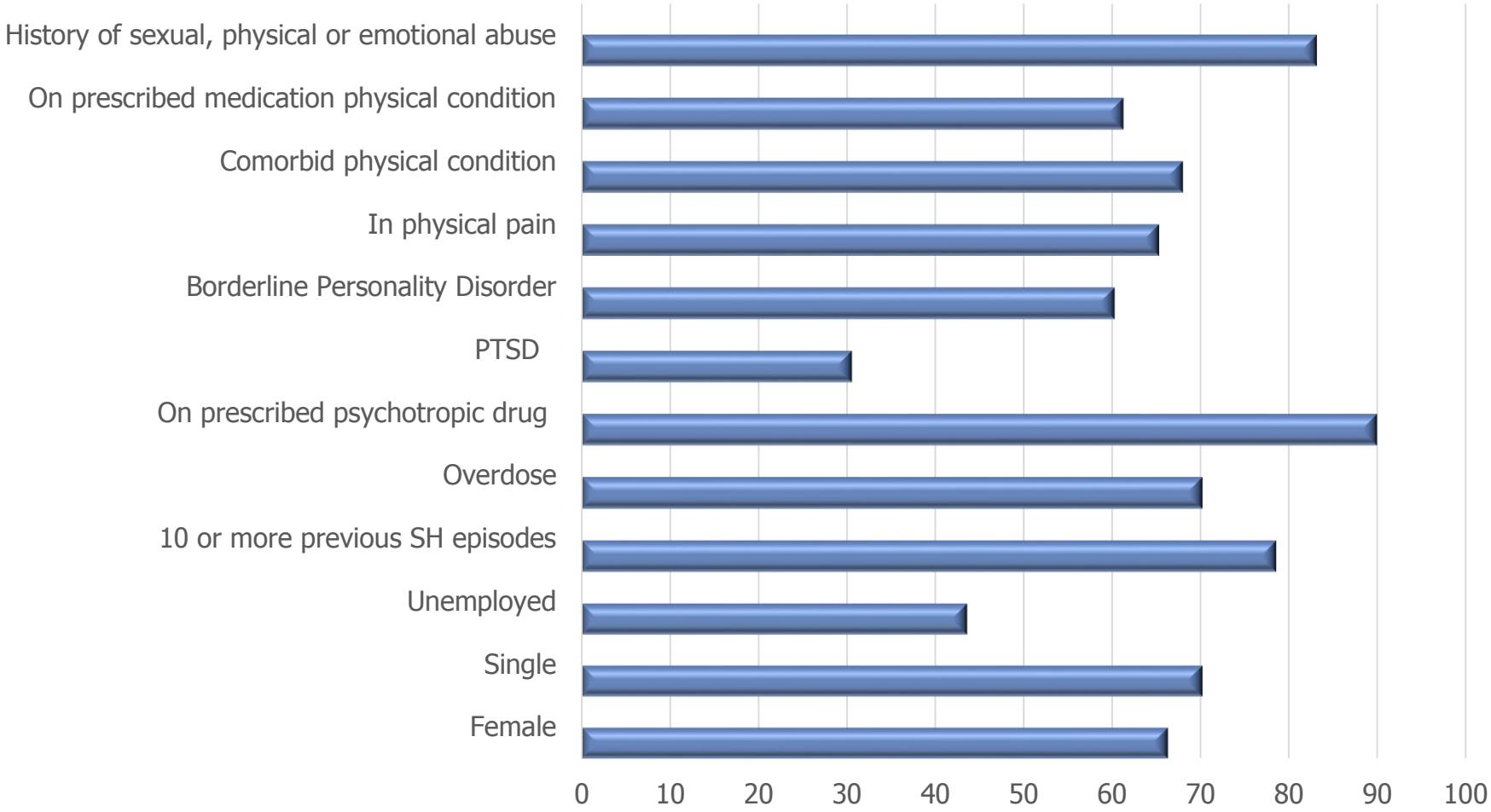
Major Self-Harm Repeaters



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Experience of physical and sexual abuse

High Risk Self-Harm

- Among the participants, **46.2%** had a history of physical, sexual or emotional abuse. Among this subgroup, **22.9%** reported one or more experiences with childhood sexual abuse or sexual assault at adolescent age.

Major Self-Harm repeaters

- Over **80%** of participants had a history of physical, sexual or emotional abuse. Among the participants who reported an abuse experience, the majority **(71%)** had experienced childhood sexual abuse and **80.6%** had experienced sexual assault at adolescent age.

Comparing major repeaters versus those with high risk self-harm on physical comorbidities and pharmacological treatment

Common physical comorbidities:	**MR**	**HRSH**
• Asthma	20%	8%
• Metabolic diseases	20%	19%
• Orthopaedic problems	16.6%	19%
• Chronic pain	46.6%	51%
Pharmacological treatment:		
• Antipsychotics	50%	20%
• Antidepressants	50%	61%
• Anxiolytics	26.6%	35%
• More than one psychotropic drug	73.3%	48%

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Evidence based interventions


Articles

Psychosocial interventions following self-harm in adults: a systematic review and meta-analysis

Summary

Introduction

Internationally consistent evidence:

- Dialectical Behaviour Therapy, in particular among women
- Cognitive Behaviour Therapy

Growing evidence:

- Problem-Solving Therapy
- Internet-based psychotherapeutic interventions for mild to moderate mental health problems

➢ DBT among men who engaged in high-risk self-harm has not yet shown consistently positive effects in reducing repeated self-harm and suicide

(Goodman et al, 2016)

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But…… not everybody is able to benefit from the evidence based interventions:

Reduced impact of DBT when:

- People suffer from severe PTSD. Increased repetition of self-harm during treatment

- Higher levels of dissociation throughout DBT treatment

- Greater severity of PTSD is associated with lower likelihood of self-harm cessation during DBT *(Harned al, 2010; Barnicot and Priebe, 2013)*

Advanced training: Self-Harm Assessment and Management for Self-Harm in General Hospitals(SAMAGH)

Core Components
Knowledge based training via E-learning
(to be completed in the week prior to skills training)

E-learning modules

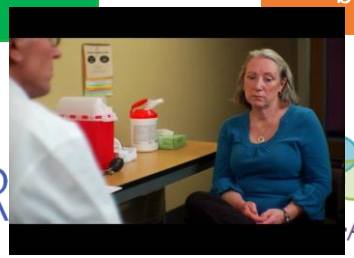
Module 1- Extent of self-harm and suicide, risk and protective factors
Module 2- Evidence informed assessment and management procedures
Module 3- Working with self-harm patients
Module 4- Subgroups of people who self-harm & evidence based treatments
Module 5- Self-care

Biopsychosocial assessments, referral pathways, safety planning (1/2 day)

Module (1/2day)
Simulation training
Skills training module
Self-harm repeaters

Module (1/2 day)
Simulation training
High risk self-harm behaviour

Module (1/2 day)
Simulation training
Challenging presentations and behaviour



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