

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

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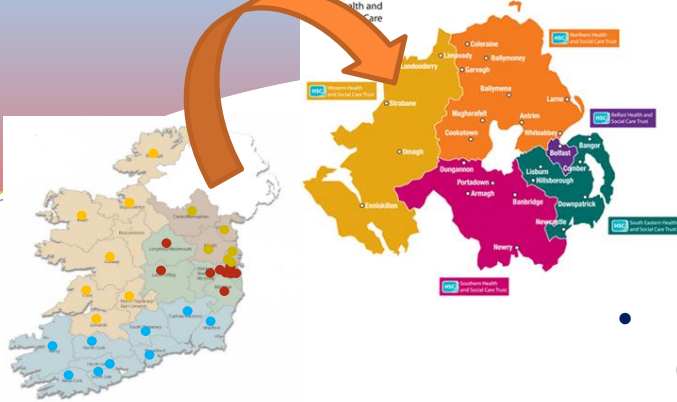


World Suicide Prevention Day Forum
AISRAP, Griffith University, Brisbane, 10th September 2019

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



#ValeAllison



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*)



RESEARCH ARTICLE

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

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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).

OPEN ACCESS

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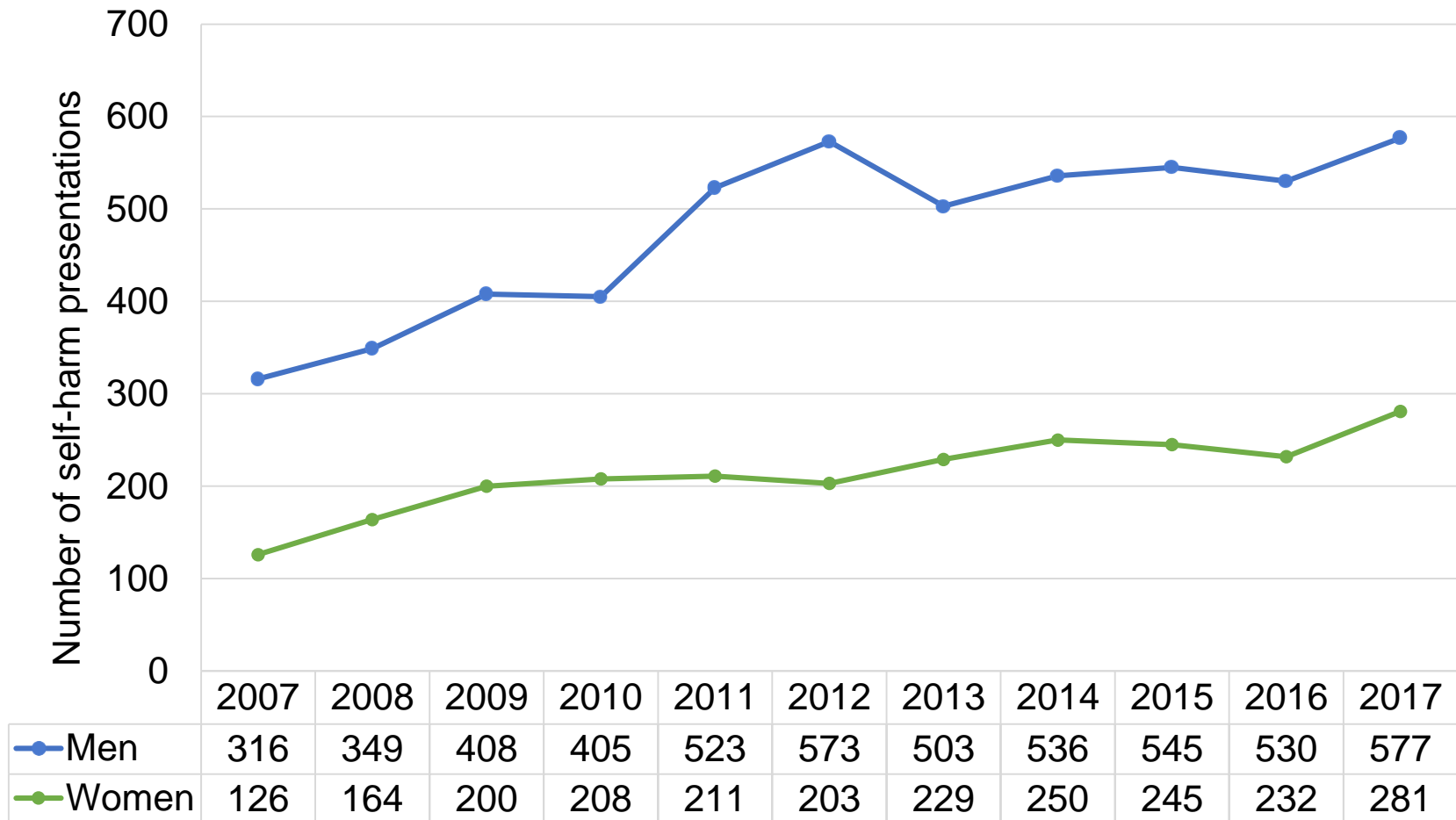
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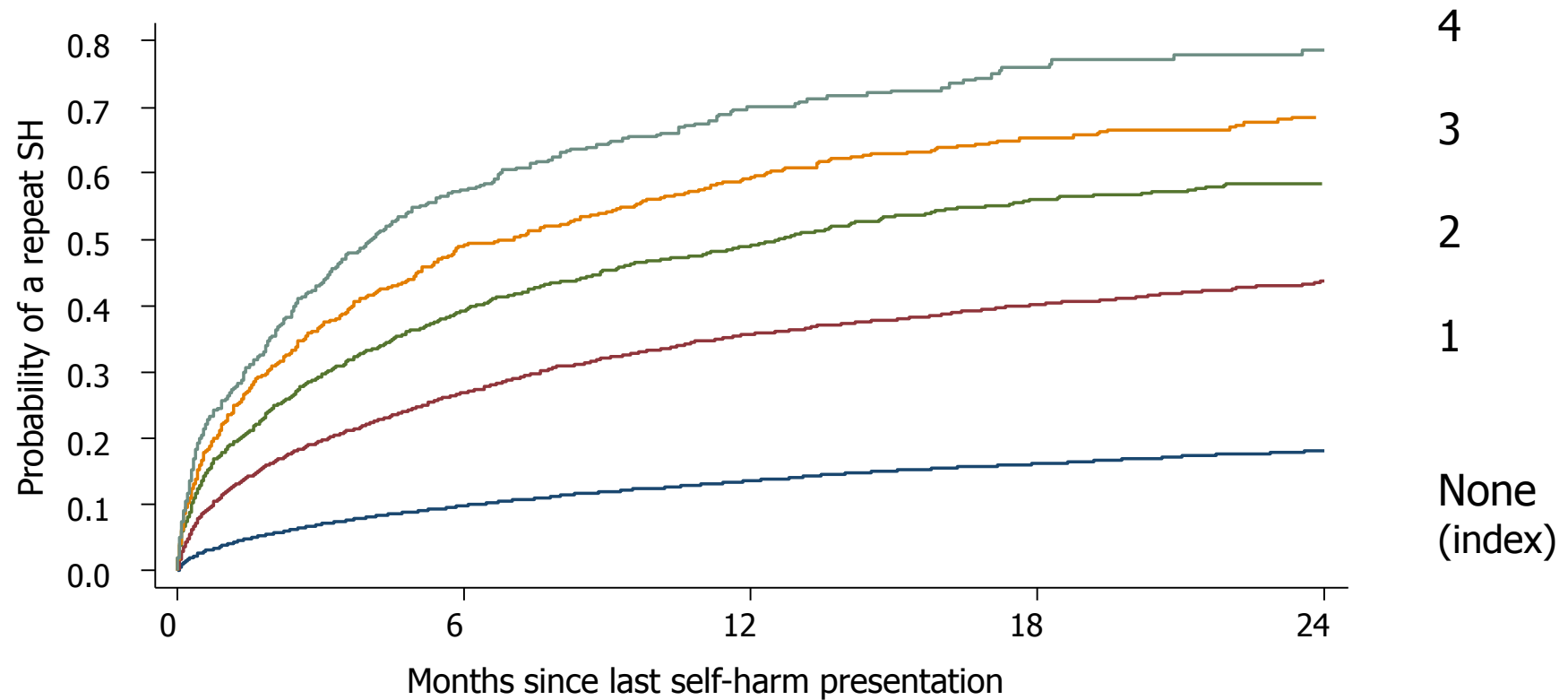
Data Availability Statement: The data used in this manuscript comes from the National Self-Harm Registry Ireland and contains sensitive patient information. As a result, access to this data set is restricted and facilitated by the National Suicide Research Foundation. All data requests may be made to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

Funding: The National Self-Harm Registry Ireland is funded by the Irish Health Service Executive's National Office for Suicide Prevention.

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



Repetition by number of previous self-harm presentations



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

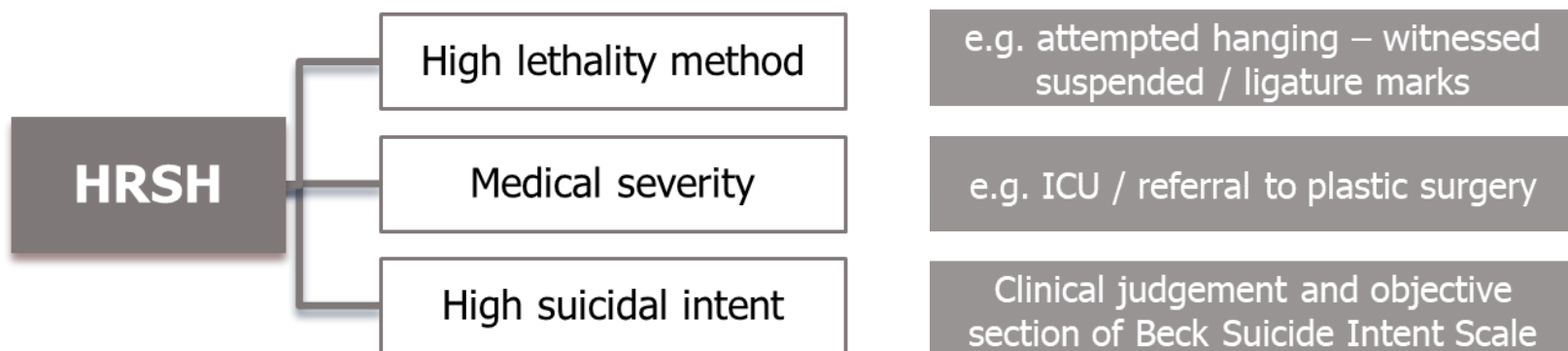
Objectives:

- 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)

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%)

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**

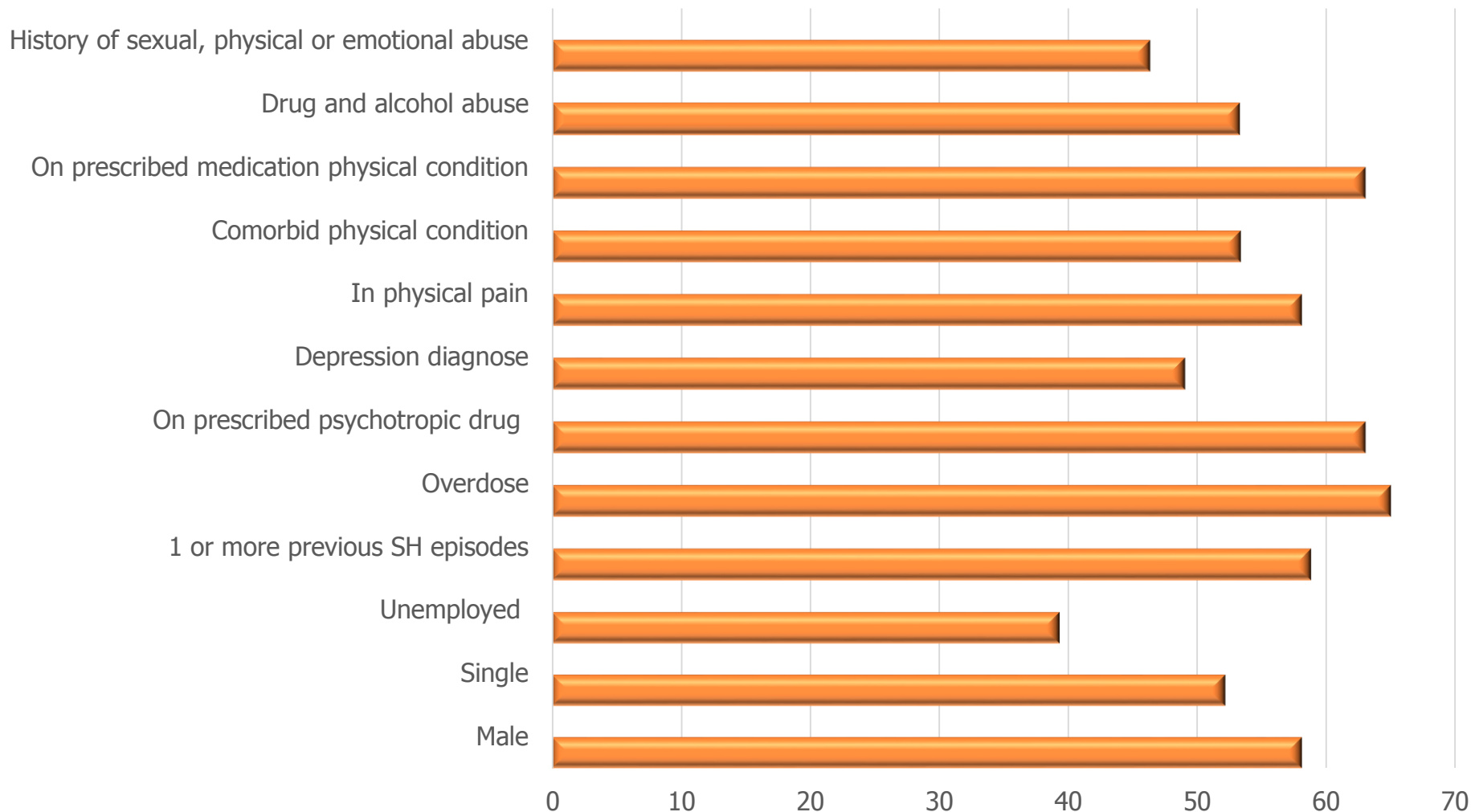
N=135
Consecutive cases
(incl. 2 fatal acts)

Study
2

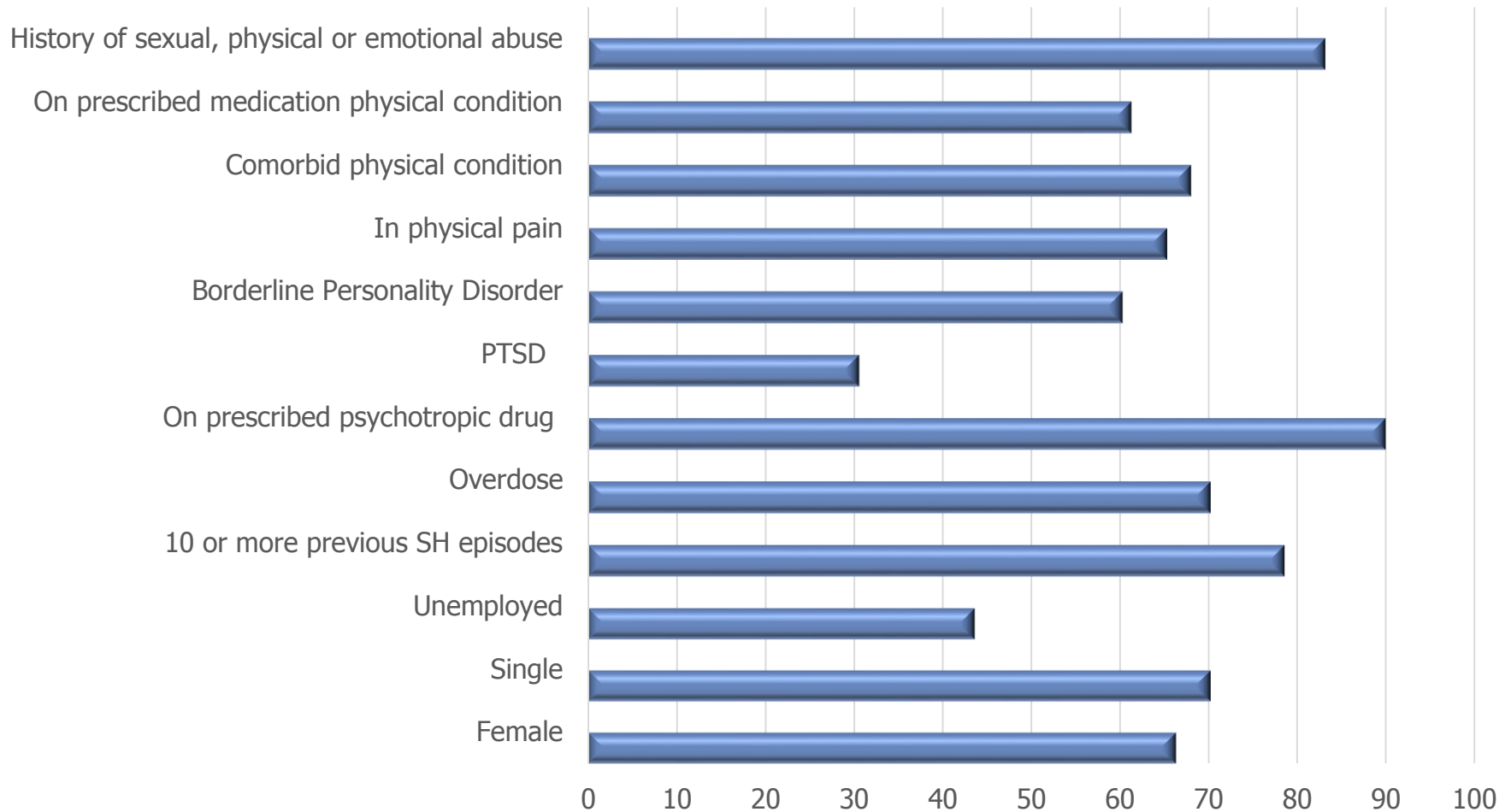
Baseline
semi-
structured
(n=32)

**6 month follow-up
semi-structured
interviews (72%)**

High-Risk Self-Harm



Major Self-Harm Repeaters



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%

Evidence based interventions

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)

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

Kath Houtman, Katerine G Miller, Tamaris L Taylor, Sushil K Datta, David Gurevitz, Philip Heywood, Caren Treanor, Kristin van Heeringen

Summary

Background: Self-harm (intentional acts of non-fatal self-poisoning or self-injury) is common, particularly in young adults aged 15–30 years, often repeated, and strongly associated with suicide. Effective treatment of individuals who self-harm is therefore important. We have undertaken a Cochrane systematic review and meta-analysis of the effectiveness of psychosocial interventions for self-harm in adults.

Methods: We searched five electronic databases (Cochrane CENTRAL, Studies and References, CENTRAL, MEDLINE, Embase, and PsycINFO) between Jan 1, 1998, and April 29, 2015, for randomised controlled trials of psychosocial interventions for adults after a recent (within 6 months) episode of self-harm. Most interventions were assessed in single trials. We report results for interventions for which at least three randomised controlled trials comparing interventions with treatment as usual have been published and hence might contribute to clinical guidance. The primary outcome was repetition of self-harm at the conclusion of treatment and at 6, 12, and 24 months' follow-up analysed, when available, with the intention-to-treat method. If this was not possible, we analysed with all available case data.

Findings: We identified 29 non-overlapping randomised controlled trials with three independent trials of the same intervention. Cognitive-behavioural based psychotherapy (CBT, comprising cognitive-behavioural and problem-solving therapy) was associated with fewer participants reporting self-harm at 6 months (odds ratio 0.54, 95% CI 0.34–0.85; 12 trials, n=1117) and at 12 months' follow-up (OR 0.45–0.86, ten trials, n=2232). There were also significant improvements in the secondary outcomes of depression, hopelessness, suicidal ideation, and problem solving. Patients receiving dialectical behaviour therapy (in three trials) were not less likely to repeat self-harm compared with those provided with treatment as usual at 6 months (odds ratio [OR] 0.59, 95% CI 0.16–2.15; n=267; three trials) or at 12 months (OR 0.65–2.47; n=72; two trials). However, the secondary endpoint of frequency of self-harm was associated with a significant reduction with use of dialectical behaviour therapy (mean difference -13.32, 95% CI -36.48 to -0.95). Four trials each of case management (OR 0.78, 95% CI 0.45–1.30; n=108) and sending regular postcards (OR 0.47, 95% CI 0.42–1.23; n=177) did not reduce repetition of self-harm.

Interpretation: CBT seems to be effective in patients after self-harm. Dialectical behaviour therapy did not reduce the proportion of patients repeating self-harm but did reduce the frequency of self-harm. However, aside from CBT, there were few trials of other promising interventions, precluding firm conclusions as to their effectiveness.

Funding: National Institute for Health Research.

Introduction

Self-harm (non-fatal intentional acts of self-poisoning or self-injury irrespective of the extent of suicidal intent) has been a growing problem in most countries over the past 40 years. In the UK, there are now estimated to be more than 200 000 presentations of self-harm to general hospitals each year.¹ Self-harm requires the use of considerable hospital resources in both developed² and developing countries. Self-harm is most common in younger people between 15 years and 30 years of age.^{3–5} Unlike suicide, self-harm usually occurs more frequently in women than men, although the female-to-male ratio appears to have narrowed over the past decade. The sex ratio also decreases over the lifespan.

Self-harm is often repeated, with 15–25% of individuals who present to hospital with self-harm re-presenting after a repeat episode within a year, although the risk of repetition is lower in adults of older age (older than 50 years).⁶ A history of self-harm is the strongest risk

factor for suicide across a range of psychiatric disorders.⁷ Repetition of self-harm further increases the risk of suicide.^{8,9} Given the size of the problem of self-harm, the frequency with which it is repeated, and the risk of subsequent suicide, it is important that effective treatment interventions are developed for this patient population. We previously published a systematic review and meta-analysis¹⁰ of both psychosocial and pharmacological treatment studies across the age spectrum in 1998, which was subsequently updated in an official guideline in 2012.¹¹ We have also done a major update of this review in conjunction with the Cochrane Collaboration.¹² In this Article we have focused on the results of psychosocial interventions for self-harm in adults investigated in a minimum of three independent trials compared with treatment as usual, because these data permitted meta-analysis, the results of which are likely to have clinical implications.

www.bmj.com/content/350:g001111
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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





World Suicide Prevention Day
Working Together to Prevent Suicide
September 10, 2019



World Suicide Prevention Day
Cycle Around the Globe

10th SEPTEMBER 2019 – 10th OCTOBER 2019

REGISTRATION OPENS
August 2019

<https://www.charityfootprints.com/iasp/>
An event run by the International Association for Suicide Prevention



IASP 2019
DERRY LONDONDERRY

**BREAKING
DOWN WALLS
BUILDING
BRIDGES**

17-21 September 2019



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