Psychiatric and Physical Illness Comorbidity among Individuals with Frequent Self-Harm: A mixed methods convergent parallel study

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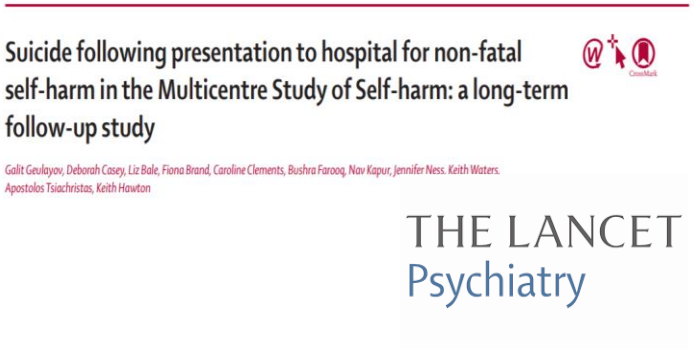
Background

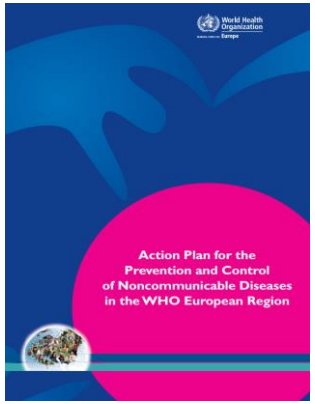
- Patients attending hospital for self-harm are at high risk of suicide
  - In the year after hospital discharge for nonfatal self-harm, **suicide was 55.5 times higher** than in the general population, and represented 35.9% of all suicides

- WHO European Action Plan for the Prevention and Control of Noncommunicable Diseases 2016-2025
  - Knowledge gaps in relation to **comorbidity between mental disorders and major noncommunicable diseases**

- SDG 3.4 requires states to adopt the following aim: 'By 2030, to reduce by one third premature mortality from non-communicable disease (NCDs) through prevention and treatment and promote mental health and well-being'

- Need to improve ***early identification*** and ***intervention*** among people who engage in self-harm in accordance with ***Connecting for Life, 2015-2024*** *(DoH, 2015)* and ***Sharing the Vision*** *(DoH, 2020; 2022)*





Gap area and Priority: Early identification of risk of self-harm among people with chronic physical diseases

MHAINTAIN

Systematic Review

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Steroid-induced mental disorders in cancer patients: a systematic review

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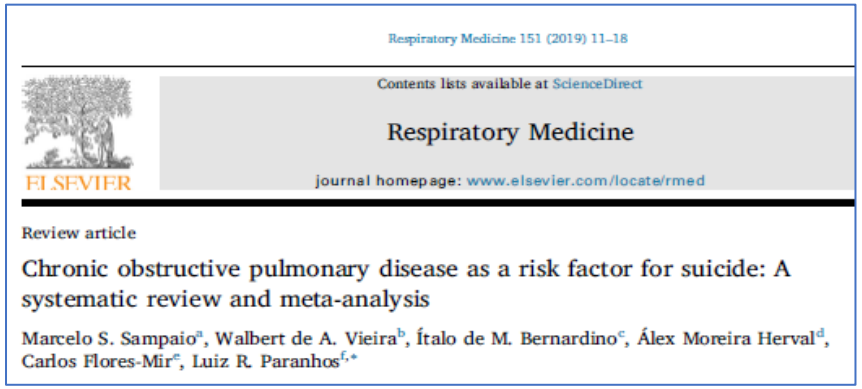

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Review article

Chronic obstructive pulmonary disease as a risk factor for suicide: A systematic review and meta-analysis

Marcelo S. Sampaio[a], Walbert de A. Vieira[b], Ítalo de M. Bernardino[c], Álex Moreira Herval[d], Carlos Flores-Mir[e], Luiz R. Paranhos[f,*]

"the worst thing about worrying is that you do end up with further worry, anxiety, a whole process of thoughts that lead you down a path to depression and suicidal thoughts, basically" ***LE***

"My mood swings became worse, I couldn't accept these changes in my health, I attempted suicide several times for this. It all became too much, really" ***LE***

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CUH Ospidéal na hOllscoile Corcaigh Cork University Hospital

NSRF National Suicide Research Foundation

UMASS University of Massachusetts Medical School

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Physical and mental illness comorbidity among individuals with frequent self-harm episodes: A mixed-methods study

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Examine the sociodemographic, and clinical profile of MRs.

Examine the sociodemographic and physical and mental disorders variables with violent or potentially violent self-harm methods (VPVSM)

Explore the participants' experience of engaging in frequent self-harm episodes.

Methods

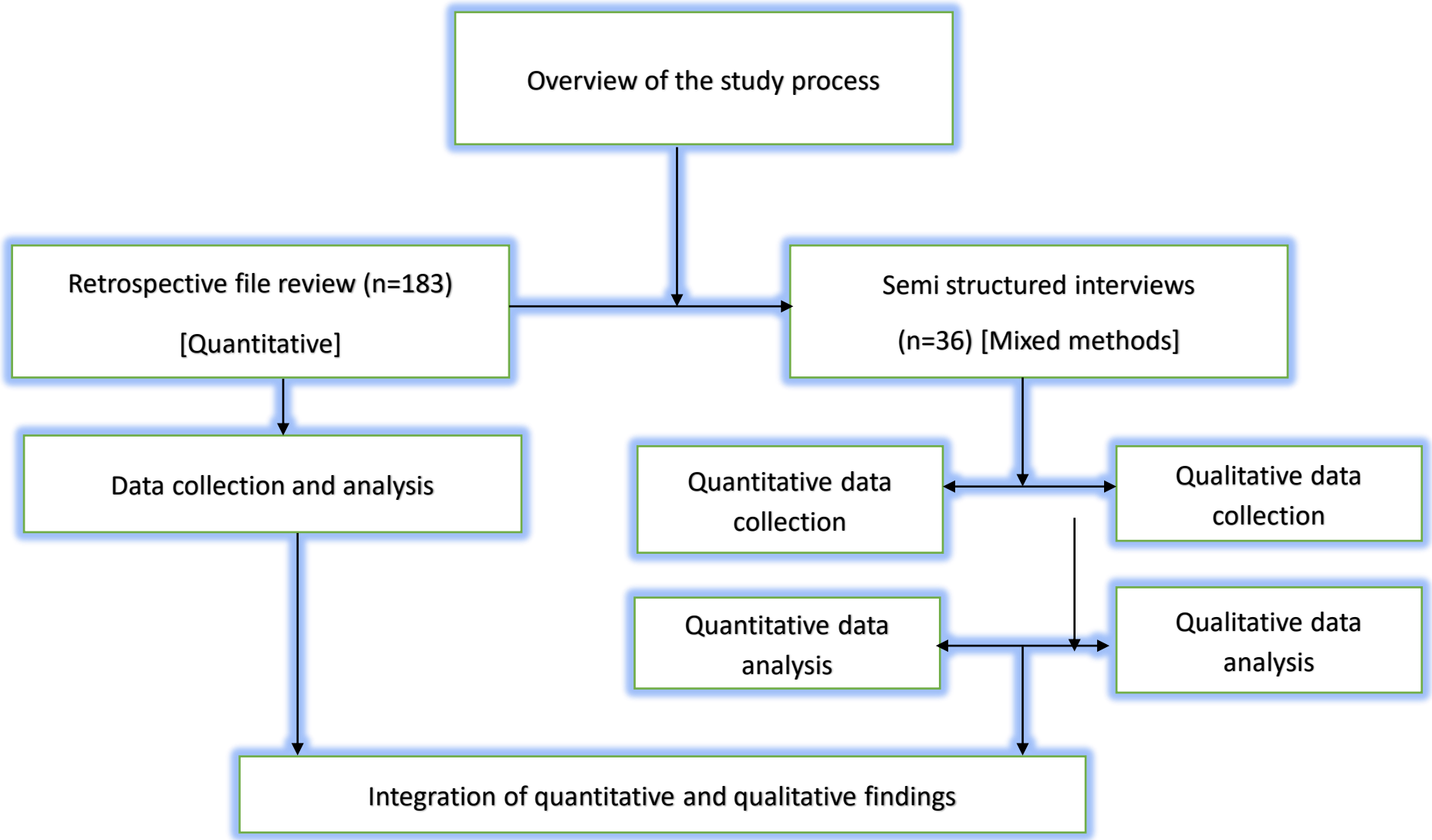
The study included consecutive cases of MRs presenting to Emergency Departments across three general hospitals in the Republic of Ireland, between March 2016 and July 2019.

During this period, the research team identified 191 MRs, eight were excluded given that either no or an incomplete, biopsychosocial assessment was available in the file, resulting in 183 cases being included in the study.

From the consecutive MRs identified through file reviews (n = 183), 36 MRs were consented to participate in the semi-structured interview study.

Inclusion criteria included: aged 18 and older; a history of five or more self-harm presentations to the ED; and being alive on admission to the hospital following the self-harm episode.

Overview of the study process



Results

Majority of the MRs were **female** (59.6%), single (56.1%), unemployed (57.4%).

Average age was 40 years (SD= 10.58)

Predominant self-harm method was **drug overdose** (61.3%), followed by cutting (27%) in the index presentation and recent presentations (overdose 67.3%; cutting (21.3%).

Alcohol consumed at the time of self-harm (55%)

Mental disorder, physical illness & treatment details of people with self-harm major repetition in file review (n=183)

Diagnosis	yes %	no %	Within any physical illness yes (%)	Within any physical illness no (%)
Any mental disorders	89.6	6.6	96.7	3.3
Any recent physical illness	56.8	43.2	----	----
Diagnosis				
BPD/EUPD	44.0	66.0	46.5	53.5
Major depressive disorders	37.8	62.1	35.8	64.2
BPAD	13.6	86	8.8	91.2
Psychosis/Schizophrenia	6.7	93.2	6.0	94.0
*Anxiety disorders	25.6	74.3	19.5	80.5
Alcohol use disorders	51.1	48.8	44.8	55.2
Drug use disorders	34.8	61.1	33.9	66.1
Treatment				
Previous mental health treatment (inpatient)	72.0	28.0		
Previous mental health treatment (outpatient)	92.4	7.5		
Previous treatment with addiction services Current	38.0	61.9		
psychiatric medications	83.7	16.2		

Note: Not recorded/missing values were ranged from 15-58 across the categories. BPD/EUPD=Borderline/Emotionally unstable personality disorder; BPAD=Bipolar affective disorder; *Includes GAD, phobia, social anxiety, panic, PTSD&OCD. **Includes epilepsy, appendix, asthma, stroke, COPD, gallstone, diabetics, encephalitis, parkinsonism, kidney infection, optic neuritis, malignant syndrome

Physical illness, traumatic life events and family history of mental disorders among MRs in semi-structured interviews (n=36)

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Investigating the relationship between childhood sexual abuse, self-harm repetition and suicidal intent: mixed-methods study

Maria Isabela Troya, Grace Cully, Dorothy Leahy, Eugene Cassidy, Anvar Sadath, Sarah Nicholson, Ana Paula Ramos Costa, Íñigo Alberdi-Páramo, Anne Jeffers, Frances Shiely and Ella Arensman

Background
Research into the association between childhood sexual abuse (CSA) and self-harm repetition is limited.

Aims
We aimed to examine the association between self-harm repetition, mental health conditions, suicidal intent and CSA experiences among people who frequently self-harm.

Method
A mixed-methods study was conducted including consecutive

self-harm repetition (odds ratio 6.26, 95% CI 3.94–9.94, $P = 0.00$). Three themes emerged when exploring participants' CSA experiences: CSA as a precipitating factor for self-harm, secrecy of CSA accentuating shame, and loss experiences linked to CSA and self-harm.

Conclusions
CSA was frequently reported among people who frequently self-harm, and associated with self-harm repetition. Identification of patients at risk of repetition is key for suicide prevention. This is an at-risk group with particular characteristics that must be

- Chronic physical pain (72.2%),
- Asthma (25%),
- Recent reduction in physical capabilities (55.6%)
- Medication for a physical illness (63.9%).

The participants experienced various traumatic life events including:

- Violent sexual assault (77.8%),
- Violent crime (27.8%),
- Directly witnessed a sudden death (22.2%),
- Family history of self-harm (47.2%),
- Family history of mental illness (63.9%), substance abuse (69.4%), and violent behaviour (55.6%).

Table 4. Association of sociodemographic and comorbidity variables with the use of violent or potentially violent methods in the index self-harm act and in the most recent self-harm act

	Violent methods in index self-harm act					Violent methods in most recent self-harm
	Yes (n=80)	No (n=101)	FET p-value	Unadjusted OR (CI)	Adjusted OR (CI)	Adjusted OR (CI)
Sociodemographic						
Age (35 years or above)	46.3%	52.5 %	.455	ns		
Gender (male)	51.2%	30.7%	.001	2.97 (1.69-4.36)	2.89 (1.41-5.91)	2.32 (1.08-4.95)
Marital status (single)	56.4%	56%	1.00ns			
Living arrangements (alone)	28.6%	21.1%	.287	ns		
Employment status (not working)	81.7%	65.3%	.023	2.97 (1.83-4.95)	ns	
Comorbidities						
Depressive disorder	41.7%	34.4%	.391ns			
Psychosis/schizophrenia	9.7%	4.6%	.320 ns			
Anxiety disorders	31.1%	20.7%	.176	ns		
Alcohol use disorders	63.8%	42.3%	.005	2.40 (1.27-4.53)	2.64 (1.30-5.34)	3.65 (1.69-7.87)
BPD/EUPD	50.8%	39.1%	.183	ns		
Physical illness (recently)	60.8%	54.8%	.581	ns		

Multivariable model for index act: Omnibus Tests of Model Coefficients== χ^2 = 17.63; df = 3; p = .001; Hosmer and Lemeshow test- p = .726; Cox & Snell R^2 =.108; Nagelkerke R^2 = .146. Dependent variable has 2 missing values. Multivariable model for most recent act: Omnibus Tests of Model Coefficients== χ^2 = 16.74; df = 2; p = .000; Hosmer and Lemeshow test p = .897; Cox & Snell R^2 = .114; Nagelkerke R^2 = .158. Dependent variable has 33 missing values; FET=Fisher's exact test; CI=Confidence interval

Qualitative findings

Uncontrollable self-harm urge

it's not really that I want to die. I just want problems and pain to stop…… It's like, you know, trying to tell myself not to do it, knowing a part of me wanted to do it. …. [Female, BPD]

I didn't want to die, I felt I just needed to punish myself for what the Council had done to me, I had no other way out, I couldn't harm anyone else, so I had to harm myself….. [Female, BPAD]

Self-harm comorbidity

I am an alcoholic, I use cannabis, cocaine, and prescribed medication as well. I started the drug use from the age of 15….I was under the influence of both alcohol and cannabis at the time of self-harm…. I don't remember how much I had (referring quantity of alcohol) [female, BPD&MDD]

I had a prolapsed disc which was operated on…I have back pain, it's a kind of chronic condition so that's going on more than 12 months… [Male, BPAD]

Qualitative findings

Familial predisposition

My mom, dad and my other brother are alcoholic. My Mom had depression, my dad had depression and anger management issues. My other brother and my sister had attention deficit hyperactivity disorder [Female, MDD&BPD]

I didn't want to die, I felt I just needed to punish myself for what the Council had done to me, I had no other way out, I couldn't harm anyone else, so I had to harm myself….. [Female, BPAD]

Contacts with mental health services

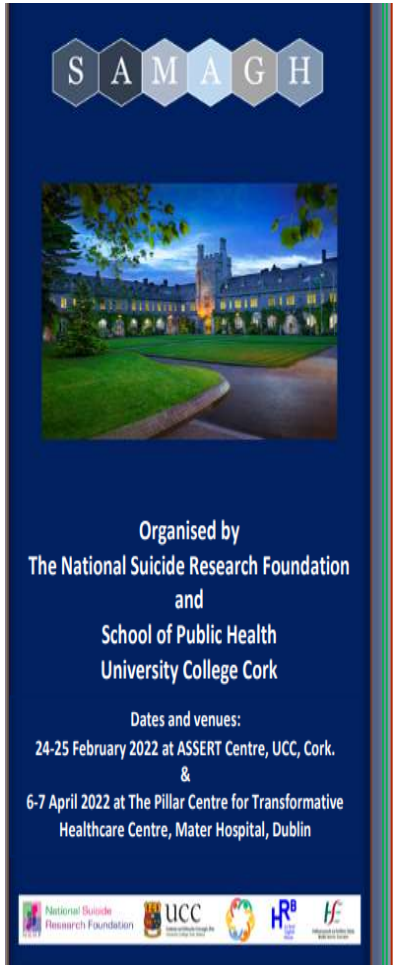
Appointment is in three months. If you need an appointment sooner, it's very hard. But it's hard enough to get an appointment (Female, MDD]

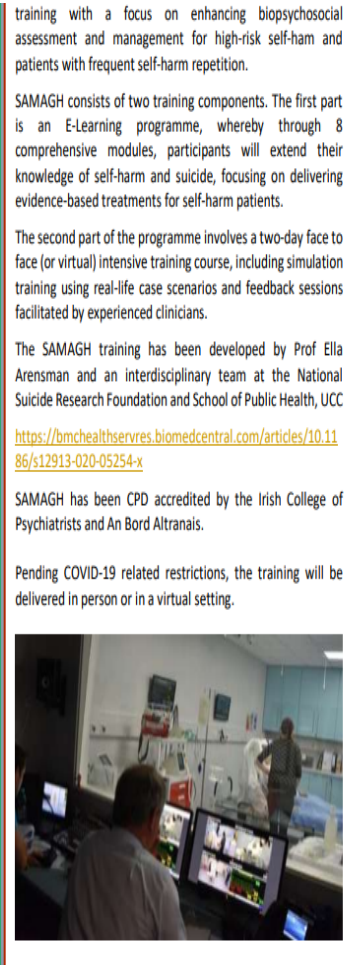
There is such a long waiting list (hospitals), I'm happy that I found someone (psychotherapist) but if there is someone not so confident to look for help themselves, then they might not even be here anymore at this stage [Female, BPD]

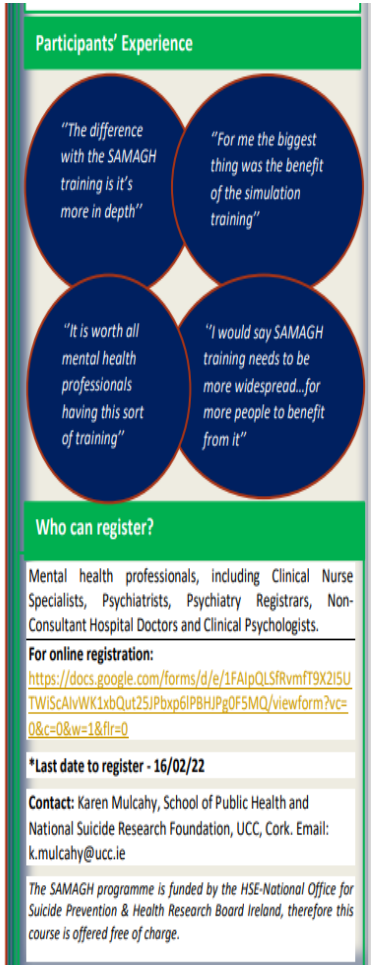
Implications for self-harm assessment and treatment

- Awareness and skills training related to self-harm and suicide risk among medical consultants
- Evidence-based guidance on prescribing of medication
- Communication between medical consultants and mental health professionals about safety plans
- Improve inter-/multi-disciplinary education and collaboration

Advanced training: The Self-Harm Assessment and MAnagement Programme for General Hospitals in Ireland (SAMAGH)







1. Conduct a systematic and comprehensive biopsychosocial assessment for self-harm patients;

2. Identify the different referral pathways and safety planning for self-harm patients;

3. Offer adequate support to all types of self-harm patients, with special emphasis on high-risk groups and comorbidities;

4. Provide additional information on evidence-based treatments for self-harm patients;

5. Emphasise the importance of self-care amongst healthcare professionals supporting self-harm patients.

Specific learning objectives

- To benefit from, experiential learning from simulation training sessions involving real-life scenarios.
- Modelling best-practice examples of interaction through participation in simulation training, detailed feedback and observation
- Improved preparation for various future scenarios involving interactions with self-harm patients
- Improved understanding of the needs of self-harm patients, in particular regarding clinical sub-groups.

Thank you!

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