Deliberate self harm and assessing suicidal risk

Introduction

Deliberate self harm (DSH) is one of the leading causes of acute medical admissions, with an estimated prevalence of 400 per 100 000 people (NHS Centre for Reviews and Dissemination, 1998). A large proportion of individuals who self harm do not present to accident and emergency and therefore the figure above is an underestimate of the true incidence. DSH has a strong association with completed suicide. The rate of suicide is highest in the year following an episode of DSH (Owens et al, 2002). Suicide accounts for 1% of all deaths every year, and the current rate is 10 per 100 000 people per year (Wright et al, 2003). Rates of suicide also increase following discharge from psychiatric hospital and release from prison. Patients who regularly present with DSH have a greater rate of eventual suicide.

Eighty to ninety per cent of all cases of DSH involve self poisoning. The substances used tend to reflect availability and trends in prescribing. Aspirin and paracetamol are the most widely used substances in the UK, whereas in developing countries, use of organophosphates and other pesticides is more common. Self injury accounts for 10–15% of cases, usually in the form of cutting the wrist and forearm. Violent methods such as hanging or jumping in front of vehicles are less common in those who survive DSH and are more likely to occur in men. Such methods suggest serious suicidal intent. Suicidal intent is the degree to which the person wished to die at the time of the act and is associated with an increased risk of subsequent suicide (see below).

DSH is now only slightly more common in females. The mean age for both sexes is in the early 30s, with the peak age for presentation being 15–24 years in women and 25–34 years in men. DSH in elderly patients is uncommon and is usually associated with suicidal intent. *Table 1* lists patient characteristics. Most people who self harm do so in response to social problems, such as housing or financial problems. Common reasons for DSH include the desire to escape from intolerable worries or thoughts, as a way of expressing anger or frustration, or to release tension, or as a way of communicating distress to others.

Following an episode of DSH, approximately 30–40% of cases are given a psychiatric diagnosis, with depression being the most common. Alcohol dependence is diagnosed in 10% of cases. Schizophrenia and bipolar affective disorder is diagnosed in less than 10% of cases.

Dr Afia Ali *is Senior House Officer in Psychiatry, Jules Thorn Day Hospital, St Pancras Hospital, London and* **Dr Angela Hassiotis** *is Consultant Psychiatrist for People with Learning Disabilities and Senior Lecturer, The Department of Mental Health Sciences, Royal Free and University College London Medical School, London W1W 7EY*

Correspondence to: Dr A Hassiotis

Assessment of the patient

All patients who present with DSH should have a specialist psychosocial assessment. The aim of the assessment is to identify factors associated with suicidal behaviour, to determine the motives for the act, to identify whether the patient suffers from a psychiatric illness and to evaluate the risk of further self harm or suicide. Ensure that the patient has received adequate medical attention and is not drowsy. A reliable assessment cannot be performed if the patient is confused or intoxicated. It is important to establish rapport and to be non-judgmental. Below is a brief outline of the assessment process. A collateral history should be obtained from the patient's family and from others who are involved in the patient's care.

Table 1. Patient characteristics associated with deliberate self harm

More common in females and those under 35 years of age
Single or divorced
Lower socioeconomic group
Unemployment
Alcohol or drug abuse
Mental illness: depression, personality disorders
Physical illness
Relationship difficulties
Physical and sexual abuse
History of loss of parent in early life

Patient history

History of presenting complaint

Enquire about the sequence of events that occurred in the days or weeks leading up to the act and attempt to identify any precipitating factors or changes in circumstances. These may include relationship difficulties, a recent bereavement, loss of a job, or housing and financial problems. Episodes often occur in the context of multiple social difficulties and interpersonal problems.

Evaluate the degree of suicidal intent (*Tables 2* and *3*):

- Degree of planning and preparation: was the act carefully planned or was it impulsive?
- Final acts: were financial affairs arranged (writing a will)? Was there a suicide note and did the individual say farewell to friends and family?

Table 2. Factors suggesting suicidal intent

High risk	Planned act
	Act performed in isolation
	Precautions taken to avoid discovery
	Violent method (gun shot, hanging)
	Preparations made in anticipation of death
	Patient admits act was intended to cause death
	Patient regrets being rescued
	Previous attempts
Low risk	First attempt
	Impulsive act
	Act performed in front of others
	Intervention actively sought
	Non-violent method (overdose)
	No preparations made
	Patient unsure of intention
	Patient relieved at being rescued

- Precautions: were any precautions taken to avoid discovery? Was the act performed in isolation?
- Dangerousness: was a dangerous method used (hanging, shooting)? How was the intended implement obtained and what did the individual think would happen or what did he/she intend to happen?
- Help seeking: was anyone alerted during or after the act? How was the individual found and how did he/she feel about being discovered?

Enquire about any current suicidal thoughts or plans: how does he or she feel about the act now? Are there any regrets? Are there any ongoing suicidal thoughts? If so, what does he or she intend to do? Have any plans been made? Is there anything preventing the individual from performing the act? Have any of the problems changed in any way?

It is important to assess for the presence of psychiatric disorders such as depression, anxiety and psychosis. Always enquire about the patient's mood and any feelings of hopelessness.

Previous psychiatric history

Ask about any previous attempts: the number of attempts, the methods used, and any treatments received. The more serious the attempt, the higher the risk of a future attempt. Were there any inpatient admissions or any admissions under the Mental Health Act? What contact does the individual currently have with psychiatric services?

Family history

Is there a family history of mental illness, substance abuse or suicide? A family history of suicide is associated with an increased risk of DSH and suicide.

Drug and/or alcohol history

Establish current intake of alcohol and use of any illicit substances. Alcohol abuse is associated with DSH and suicide.

Social history and coping strategies

How does he or she normally react to stress? What support is available from friends and family? What is the current housing and financial situation?

Mental state examination

Enquire about depressive symptoms and psychotic symptoms, in particular command auditory hallucinations asking the patient to commit suicide and delusions of passivity (believing that one's actions are being controlled by an external force). Assess the degree of insight regarding the attempt. What does the patient attribute as the cause of his or her problems and is he or she willing to engage in treatment?

Management

Patients who have a serious psychiatric disorder and/or are considered to be at high risk of suicide are likely to require an inpatient admission for treatment of the underlying disorder. Crisis resolution and home treatment teams may be able to provide treatment and support at home in some cases. Patients presenting with drug- and alcohol-related problems should receive appropriate treatment and should be referred to community drug and alcohol services if necessary. Patients presenting with low risk may be discharged home but it is essential to ensure that there is adequate support at home from friends or family, and a list of useful numbers (e.g. Samaritans) is helpful.

For patients presenting with moderate risk, a referral should be made to the local community mental health team and to the outpatient's clinic to maintain follow up of the patient. The GP should be informed in all cases. Treatment may involve drugs such as antidepressants, mood stabilizers or antipsychotics, or psychological therapies such as interpersonal therapy and problem-solving therapy, particularly where relationship difficulties exist.

Conclusions

It is vital that all patients presenting with DSH receive a comprehensive risk assessment and treatment of any underlying psychiatric disorder. Information regarding risk should be shared by all the agencies involved with the patient's care in order to ensure that a plan is carefully formulated regarding the management of any risks. BJHM

Conflict of interest: none.

NHS Centre for Reviews and Dissemination (1998) Effective health care bulletin: deliberate self harm. *Effective Health Care* **4**: 1–12

Owens D, Horrocks J, House A (2002) Fatal and non fatal repetition of self harm. Systematic review. *Br J Psychiatry* **181**: 193–9

Wright P, Stern J, Phelan M (2003) *Core Psychiatry.* 1st edn. WB Saunders, London

Further reading

Frierson RL, Melikian M, Wadman PC (2002) How to interview depressed patients and tailor treatment. *Postgrad Med* **112**(3): 65–71

National Institute of Clinical Excellence (2004) *Self harm, the short term physical and psychological management and secondary prevention of self harm in primary and secondary care.* Clinical Guideline 16. National Institute of Clinical Excellence, London (www.nice.org.uk)

Table 3. Factors associated with an increased risk of suicide after deliberate self harm

Male gender
Living alone
Increasing age
Divorced, separated or widowed
Unemployed or retired
Previous history of self harm
Self harm involved high suicidal intent and violent method
Psychiatric disorder (depression, schizophrenia, dissocial personality disorder)
Co-morbid psychiatric disorder with substance misuse or personality disorders
Physical problems

KEY POINTS

- All patients presenting with deliberate self harm (DSH) should have a full risk assessment that covers risk of further DSH and suicide.
- An assessment of the degree of suicidal intent and current suicidal ideation is essential.
- Management of patients depends on the degree of risk of suicide. Patients at high risk should be offered an inpatient psychiatric admission.