Assessing risk and managing patients who deliberately self harm

Introduction

Deliberate self-harm is one of the most frequent reasons for general hospital admission. It is estimated that about 150 000 cases present to accident and emergency departments in the UK annually (Hawton and Fagg, 1992; Hawton et al, 1998). Most cases are associated with a psychiatric disorder. A large proportion of cases involve an overdose of commonly available drugs such as aspirin, paracetamol, antidepressants and minor tranquillizers, often in conjunction with alcohol (Hawton et al, 2004). Self-harm is a high risk factor for future suicide. Individuals who have deliberately harmed themselves have a 100-fold greater risk of suicide than the general population (Hawton and Fagg, 1992). Hence it is essential that assessments are thorough and management is planned appropriately.

Definitions

Deliberate self-harm is a deliberate non-fatal act committed in the knowledge that it was potentially harmful and, in the case of drug overdosage, that the amount taken was excessive. Suicide is a wilful self-inflicted life-threatening act which has resulted in death (Goldberg, 1997).

Assessment

Before beginning an interview ensuring the safety of the patient is paramount. Barr et al (2004) suggest that people presenting with self-harm are considerably more likely to self-discharge or abscond. If medical treatment is necessary, begin the risk assessment by considering the prognosis had medical intervention not taken place, i.e. how lethal was the overdose? Prompt assessment of the patient's medical condition, level of consciousness and immediate suicide risk are the vital first steps.

Eliciting a patient's thoughts requires the use of an open-ended, non-judgmental interview style. This will encourage spontaneous elaboration of thoughts. The assessment should take place ideally when the patient is medically stable and in surroundings that will allow a private discussion where rapport can be developed.

While conducting the interview a problem list can be constructed to aid the management plan. Consider any areas where an intervention is possible. These include:

- Personal or social circumstances
- Medical illness
- Poorly managed psychiatric illness such as depression or anxiety disorder
- Alcohol or drug misuse.

As well as history of possible precipitating factors (*Table 1*) there are three main areas (*Figure 1*) that surround the actual deliberate event which will inform whether the patient is at high, medium or low risk of further deliberate self-harm or suicide should he or she be discharged home.

The following chronological framework can be used to gain an understanding of the deliberate self-harm event and the circumstances leading up to it. It will provide important referral information and help direct a further more detailed mental state examination where necessary. This framework for history taking can be applied to deliberate self-harm by any means.

These are nine key lead-in questions covering the thoughts and behaviour of the patient. Any 'positive' reply must lead to further inquiry. For example if the patient states 'yes', they did write goodbye letters, find out more, for example when the

Table 1. Precipitating factors for deliberate self-harm

Relationship problems
Financial or employment difficulties
Loss events
Physical illness
Isolation
Problems with the law
Physical or mental abuse

Figure 1. Areas which inform a patient's risk of further deliberate self-harm.

Leading up to deliberate self-harm

In this time period the key questions should aim to ascertain the level of planning and preparation involved before the attempt, including plans for obtaining the methods for the harm and also final acts, such as organizing finances:

- How long had you been planning this for?
- Did you plan a specific date or place to harm yourself?
- Have you written a will or goodbye letters?

At the time of deliberate self-harm

The thoughts of the patient in the moments leading up to the deliberate self-harm are important in giving an insight into the original intent. Often the level of an overdose does not closely reflect the degree of suicidal intent. Hence there should be an enquiry into the patient's beliefs about the effects of the deliberate self-harm:

- What was going through your mind when you self harmed?
- At the time did you believe that the overdose would be enough to end your life?
- Did you harm yourself at a time where you felt nobody would find you?

Following the deliberate self-harm act

The patient's thoughts and actions following deliberate self-harm will help determine the current state of mind and current intent:

- Did you avoid being brought into hospital?
- Do you regret what happened?
- Do you have current thoughts of attempting to end your life?

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recipient(s) would have discovered it or them. Could this have led the recipient to bring a halt to the deliberate self-harm act? High risk of suicidal intent is suggested by:

- Planning for several days
- Timing of the deliberate self-harm in order to avoid discovery
- A potentially lethal method of harm
- Not seeking help afterwards
- Pre-arranging finances and others acts in preparation of death, e.g. taking out insurance, writing a will or suicide letters
- Lack of regret following the attempt and ongoing suicidal thoughts.

One should aim to inquire sufficiently in order to encompass risk factors, the before, during and after deliberate self-harm time periods. The more information that is available, from the patient or an informant, the better. All information acquired helps one to decide whether the patient is at high, medium or low risk. This in turn greatly helps in determining subsequent management plans. Anyone presenting with an attempted suicide should have a psychiatric assessment.

Management

The management plan will depend on the findings of the assessment. The current level of risk and mental state will determine whether the patient will be admitted or discharged home with an after-care plan. If there are any concerns about patient safety, or if the patient responds with high risk answers on history taking, the patient should be referred for urgent mental health assessment. If the risks are high or available community resources are unable to adequately manage the patient, admission must be considered. If you are unsure seek advice from mental health specialists.

A Mental Health Act assessment may be necessary if the patient refuses admission and there is sufficient concern to warrant detaining the patient for further assessment of a possible underlying mental disorder. In this case it may be necessary to ensure that the patient does not leave the department while an assessment is arranged.

Discharge from the accident and emergency department should be considered only if a psychosocial assessment and after-care plan can be arranged before discharge. Available social support should be considered with discharge to relatives preferable. If psychiatric services follow up is required the mental health specialists will formulate a treatment plan and involve the patient's local community mental health team. Social services assistance should also be available for self-harm patients if appropriate.

Any contributing factors where intervention is possible, such as physical complaint, social problems, psychiatric disorder or substance misuse, should be addressed. For each intervention a supplier of the treatment should be identified and informed. This must be included in the agreed care plan. Liaison with these services is essential and as a matter of routine the patient's GP should be involved and informed.

On leaving hospital the patient should be given written information about how to seek further help, the treatment plan and the person to contact if in doubt about the arrangements.

Case study

An adult male is brought to the accident and emergency department by paramedics who were called by his partner. She saw him consuming several of his antidepressant tablets together with alcohol.

He is examined and does not need any life-saving treatment. Once sober and coherent he tells staff he impulsively took the overdose as he has been getting into difficulties paying rent and is out of work. At the time he wanted to end his life but admits to shouting for his partner who was nearby. He regrets what he did and the stress it has brought on his family. He has no current plans of self harm or suicide. He states that he wishes to get his life back in order.

This case typifies a common clinical problem faced by accident and emergency staff. Following a referral to the on-call psychiatrist a full psychiatric history was taken. The decision was made to discharge the patient. A care plan was agreed with the patient and his partner. The following interventions were arranged:

- Re-referral to the community mental health team, by fax and letter, for review of his ongoing depression
- The community psychiatric crisis team were contacted by telephone and informed of the situation. A home visit was arranged for the next day
- A letter was written to social services on the behalf of the patient requesting help with benefits and housing
- Details of the local alcohol team were given to the patient
- The patient's GP was informed by fax and letter about the deliberate self-harm and advised to prescribe repeat prescriptions for 7 days only until otherwise instructed
- The patient and his partner were given emergency contact details for their local community psychiatric crisis team and community mental health team.

Conclusions

Not all suicides are preventable and errors of judgment in assessing risk are likely to occur. However, errors in the methods of adequately assessing and managing risk following deliberate self-harm are preventable. Being aware of precipitating factors, key questions in assessing risk and after-care options is essential. BJHM

Conflict of interest: none.

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Further reading

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Royal College of Psychiatrists (2004) *Assessment following self-harm in adults.* Council Report CR122. Royal College of Psychiatrists, London

KEY POINTS

- Deliberate self-harm is a high risk factor for future suicide.
- A methodical history will uncover precipitating factors and level of suicide risk.
- All those presenting with attempted suicide should have a psychosocial assessment.
- An after-care plan must be arranged before discharge.