Management of patients presenting with self-harm

Self-harm is a growing problem, particularly in the UK where there has been a 24% increase in the number of hospital attendances since 2001. In young people the incidence of self-harm is among the highest in Europe (Royal College of Psychiatrists, 2013). General hospital staff play a vital role in managing a patient's physical and mental wellbeing and positive interactions can be beneficial for both patients and staff alike. This review discusses why a patient may present with self-harm and how general hospital staff can approach their psychosocial assessment and subsequent management.

Self-harm is a stigmatised and often private behaviour, where medical treatment is not always sought after each act. Rates are estimated at 400 per 100 000, although because this figure is based upon presentations to health care it under-represents the true extent of the problem. It is a commonly held belief that self-harm is more prevalent in females. This is true in adolescence, where self-harm is eight times commoner in 10–14-year-old girls than boys. However, this gender difference decreases across the age range. By age 20–24 years females are just 1.6 times as likely to present as males, whereas by 50 years of age this drops to 0.8 times as likely, meaning men are more likely to present (Hawton and Harriss, 2008).

Self-harm has been described using a variety of terms, including deliberate self-harm, non-suicidal self-injury and parasuicide. This article will refer simply to self-harm, which is defined by the National Institute for Health and Care Excellence (2004) as 'intentional self-poisoning or self-injury, irrespective of apparent purpose of the act'. This distinction is an important one, as suicidal intent is not always easy to ascertain, and may be best considered as on a spectrum rather than simply present or absent. Self-poisoning encompasses the intentional ingestion of medication or other toxic substances including recreational drugs, and accounts for the majority (75–80%) of hospital presentations with self-harm. Self-injury may include cutting, hitting, burning, biting and ingestion of foreign objects. Although the method of self-harm is useful clinically, for example in considering risk management or discharge planning, it is not helpful to classify a patient solely by the method he/she presents with. Individuals may switch methods of self-harm between episodes, and self-poisoning and injury can co-occur in 5% of hospital presentations.

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Reasons and motives

Those who care for people who self-harm, including friends, families and professionals, often struggle to understand why someone might harm themselves. It can be helpful to think of self-harm in two different ways; as a symptom of an underlying mental disorder or other personal difficulty, or as serving a function for the person harming him-/herself (*Table 1*).

Some of these functions are concerned with managing negative emotions and thoughts, but some reflect more positive to the act – these latter especially for those who repeatedly self-harm. *Figure 1* graphically represents the complexity of the presentation, with numerous proximal and distal factors accounting for an episode of self-harm (Hawton et al, 2012). The interactions between these factors vary not only between individuals, but also between different acts of self-harm for the same individual. The degree of suicidal intent with an act of self-harm can be thought of as lying on a spectrum, but is still not always clear. Patients may express ambivalence towards the act of self-harm and towards accepting further medical or psychiatric treatment.

Associations

Self-harm can be associated with mental disorders, adverse life events and psychological characteristics such as personality traits or patterns of thinking.

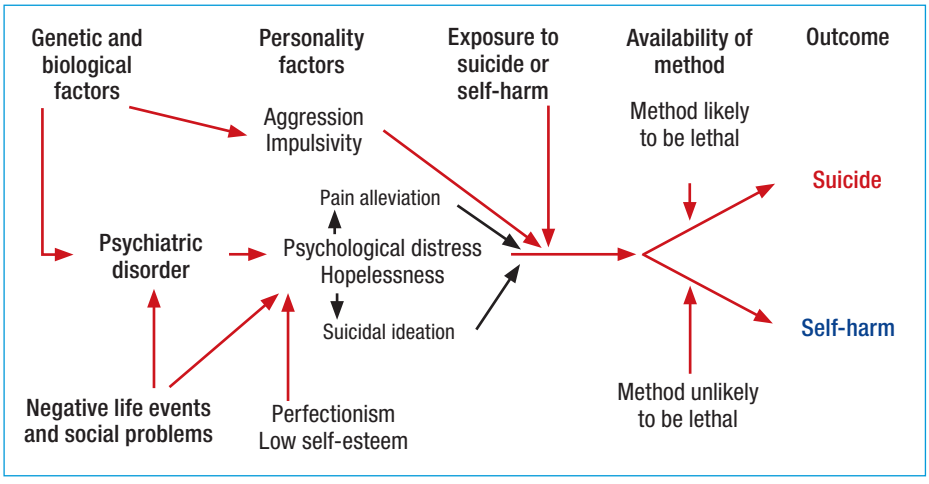
Psychiatric diagnosis

A psychiatric diagnosis can be made in most but by no means all individuals who present with self-harm. A large meta-analysis showed that psychiatric diagnoses were made in over 80% of adults and also of adolescents and young people who presented to hospital with self-harm (Hawton et al, 2013). However, it is important to bear in mind that the most frequent diagnoses are not those of mental illness like bipolar disorder or schizophrenia

Table 1. Reasons and motives for self-harm

Self-harm as a symptom	Mental disorder
	Other personal difficulties
Self-harm as function	Affect regulation
	Managing dissociation
	Releasing tension
	Preventing suicide
	Interpersonal influence
	To communicate pain
	Sensation seeking
	Experimentation
	Remembrance
	Cleansing
	Fitting in
	Finding the self
	Personal language
	Exerting control

Figure 1. Graphic representation of the complexity of presentation, with numerous proximal and distal factors accounting for an episode of self-harm. From Hawton et al (2012).



but are descriptions of states of distress (depression, anxiety) of alcohol misuse and of persistently antisocial or unusual behaviour – conduct disorder in young people and personality disorder in adults (*Table 2*). The role of substance use, including illicit drugs and alcohol, in self-harm is complex. Substance use lowers inhibitions and may contribute to precipitating an act of self-harm or be used as the method of self-harm itself. Some patients may use substances as a way of blocking out or managing difficult emotions, but in turn these substances lower mood and exacerbate underlying social stressors with work, finances or relationships, and so create a vicious circle.

Personal and social adversity

Self-harm is strongly associated with adverse life events. Approximately half of patients who present with self-harm cite relationship difficulties with partners or other family members, while one quarter complain of social isolation. Worries about finances or housing are expressed by a quarter of adults respectively, while one fifth cite unemployment as a difficulty. More recently concerns have been expressed about experiences like bullying (including cyber-bullying) for younger people and there is evidence that suggests portrayal of self-harm and suicide in the media has an influence on both of these acts.

Individual characteristics

The more recurrent self-harm is as a behaviour, the more important it is to recognize it as not just a response to external circumstances but also as associated with certain psychological characteristics. These include impulsivity, problem-solving deficits, dichotomous thinking, cognitive rigidity, autobiographical memory deficits and hopelessness.

Assessment at triage

National Institute for Health and Care Excellence (2004) guidance indicates that all adults who attend hospital following self-harm should be offered an initial psychosocial assessment at triage by emergency department staff. The importance of this initial assessment should not be overlooked. Patients express dissatisfaction with a purely medical approach that focuses on their physical health needs. This approach is at odds with the distress and painful emotions that underlie the act. A thorough psychosocial assessment at triage provides an opportunity to collect details about the act of self-harm and relevant background information that some patients may be reluctant to discuss at later assessment. It also plays a role in risk management if a patient wishes to leave the department. It is important first to assess mental capacity and the presence of mental illness that may be impairing judgement, so that if necessary appropriate steps can be taken to prevent a patient leaving if he/she is not mentally fit to make the decision safely (*Table 3*). Children and young people should be admitted to a paediatric ward overnight for a 'cooling off' period, before further specialist child and adolescent mental health services assessment the following day.

There are two main strands to the subsequent psychosocial assessment: assessing risk of suicide and a wider assessment of the patient's needs. It is important to be mindful of risks in other areas, such as self-neglect and exploitation, in dependent children and adults.

Table 2. Prevalence of psychiatric diagnoses in adults presenting to hospital following self-harm

Depression 49.4%
Bipolar disorders 6.4%
Anxiety 34.6%
Alcohol misuse 26.2%
Drug misuse 11.4%
Psychotic disorder 6%
Eating disorders 7%
Adjustment disorder 25.8%
Personality disorder 30%
From Hawton et al (2013)

One of the most important questions to ask in assessing risk is the simple: 'Can you tell me why you harmed yourself?' Even in patients who present multiple times, each episode of self-harm may represent different motivations or underlying difficulties that it is important to understand to inform further management. Obtaining a detailed, chronological account of events leading up to the act of self-harm, from the patient's perspective, can provide further insight. Asked sympathetically, it is more likely to lead on to an open discussion about suicidal intent. A history of past or present mental illness and an expression of current suicidal intent, especially in older people, should be treated as a sign of high risk unless specialist assessment disconfirms initial impressions.

In assessing risk of further self-harm or suicide it is important to take a holistic view of the patient and his/her circumstances, including the level of functioning and support networks at home. For children it is critical to ask about school and peer relationships. Older people in particular are at a greater risk following the recent loss of a loved one, and there is an increased risk of suicide in those with a significant physical illness or substance misuse.

Evidence of continued suicidal thoughts and feelings of hopelessness are also associated with increased risks.

Post-triage management

It is depressing how often patients who self-harm report that during hospital attendance they were not treated with care and respect

Table 3. Management of a patient who presents with self-harm and asks to leave the hospital

	Legislation involved	Clinical decisions	
Consider detention under Section 5(2) of the Mental Health Act	Section 5(2) confers holding powers to detain a patient to an inpatient ward (so it cannot be used in the emergency department) for 72 hours		
	During this time an assessment for detention under Section 2 or 3 of the Mental Health Act should be arranged		
	The grounds for detention under Section 5(2) are therefore the same as for Section 2 of the Mental Health Act	The patient suffers from a mental disorder of a nature or degree which warrants the detention of the patient in hospital for assessment, and	
		They ought to be detained in the interests of their own health or safety, or to protect others	
	The 5(2) can be used by any Approved Clinician or Nominated Deputy, i.e. a Registered Medical Practitioner who is looking after the patient (this does not include pre-registration FY1s)		
Consider assessment under the Mental Capacity Act	Where the Mental Health Act applies this will take precedence over the Mental Capacity Act. In other circumstances a capacity assessment may be appropriate. A patient is assumed to have capacity unless it is established that they do not	Does the patient have an impairment or disturbance in the function of the brain or mind?	
		With regard to a specific decision can they	Understand the information presented to them?
			Use the information to weigh up risks and benefits?
			Retain the information?
			Communicate their decision?
		If the patient lacks capacity can anything be done to maximize their ability to make a decision?	

and provided with a safe environment. Unfortunately, the attitudes of staff in the general hospital setting towards patients who self-harm are sometimes negative, with doctors tending to express more negative views than nursing colleagues. Patients may elicit feelings of irritation or anger in staff because of the perception of an unnecessary use of medical resources or sense of helplessness with managing this patient group. However, training and education about self-harm successfully produce improvements in attitudes in all staff groups (Saunders et al, 2012).

It is all too easy in the middle of our busy working day to forget about the distress preceding the act of self-harm, which is likely to persist in both the patient and his/her family. This should be taken into consideration when explaining medical procedures or treatment and in providing appropriate analgesia. Poor hospital care, sometimes worsened by negative attitudes towards those who self-harm, can result in patients leaving hospital early, missing follow-up appointments and ultimately not receiving a level of service to meet their needs. Patients' top self-reported needs from hospital care are for better communication, with greater involvement in treatment decisions and staff who are sympathetic and respectful.

Immediately following an episode of self-harm, the main focus of hospital treatment is often on short-term management of risks and discharge planning, although ultimately our intentions are to reduce the risks or frequency of further self-harm and improve quality of life and level of functioning for our patients. Much of this is best arranged following an interview with a member of the local self-harm team. Unfortunately not all hospitals offer this important service as accessibly as is desirable, and some patients are reluctant to wait or return to see a new professional, so this task can fall to front-line staff.

There is no treatment or therapy that is specific for reducing self-harm and so focus is placed on the management of underlying difficulties. On discharge from hospital patients will be offered follow up dependent on their needs, and there are three main options to consider when arranging post-discharge care. Those patients at highest risk, who may have active suicidal ideas or plans, or an underlying serious mental illness, can be referred urgently to mental health services. This high risk group can also include those with unusual presentations or particularly violent methods of self-harm. Patients requiring urgent mental health input will ideally be supported in the community, wherever possible by psychiatrists and the wider multidisciplinary team working as part of a crisis team or day hospital service. Patients whose level of risk cannot be safely managed in the community will be admitted to an inpatient ward. Low risk patients may include those with no further thoughts of self-harm, no underlying mental illness and robust support networks in the community. They may be supported by their GP in primary care and given advice and access to resources for self-management. Patients in between these two extremes can be referred to non-urgent community mental health services for outpatient care, or third sector organizations. Local provisions differ, but mental health charities often offer a varied range of services such as supportive counselling, peer support groups, activities and befriending.

A helpful starting point in planning aftercare is to ask if patients have already sought help, and where from. Patients may have either formal or informal resources in dealing with their problems. Informal resources include a supportive network of friends and family, and many young people seek support from social media. Formal sources are likely to be local mental health or social services, from whom some people will have a contact name.

Identifying a patient's individual triggering or protective factors can help to form a crisis plan, where information on how and where help can be sought is provided in a clear and easy to access way. Many departments use 'crisis cards' with several contacts, both for in and out of hours services. It is important to involve family in these discussions wherever possible, especially in young people as they provide a key resource in harm reduction

at home. Advice to family members should include the consideration of restricting access to means of self-harming. This may range from supporting and supervising patients in managing their own medication, to locking away all medication in the house, not just that belonging to the patient. It is helpful to have your own ideas for approved web-based or local resources.

Considerations for management of young people

National Institute for Health and Care Excellence (2004) guidance recommends that young people under the age of 16 years who present to the emergency department having self-harmed should be admitted overnight to a paediatric ward for a cooling-off period and receive specialist psychosocial assessment the following day.

The role of the family is especially important for young people, and psychosocial assessment will usually include both the young person and their parent or carer. Although it is important to respect confidentiality in a young person who is Gillick competent, where possible young people should be encouraged to involve their family. Family members can be helpful resources in monitoring the patient and reducing risk by providing a safe environment at home. However, fraught relationships with parents may be a source of distress or even a trigger for subsequent self-harm and so careful exploration of these relationships is needed, paying particular attention to any child protection concerns. Similarly, peer relationships at school, bullying and cyber-bullying should be explored as potential sources of distress. However, teachers and heads of year at school or college can also provide useful collateral information and sources of support through mentoring or counselling programmes.

Considerations for management of older people

The risk of completed suicide following an act of self-harm increases with age. National Institute for Health and Care Excellence (2004) guidance goes so far as to recommend that all acts of self-harm in people over 65 years of age should be regarded as evidence of suicidal intent until proven otherwise. Older people are therefore understandably more likely to be offered inpatient and outpatient after care with mental health services (Marriott et al, 2003). In managing risks and vulnerabilities in over 65-year-olds it is important to take a broad view of current social circumstances, including isolation and particularly bereavement, as well as the impact of physical illness, sensory impairment and subsequent loss of independence.

Outcomes

It is well known that self-harm is a strong, independent risk factor for predicting future suicide and this risk persists for years after the index episode. Prospective studies have shown that 1–2% die by suicide in the first year following presentation to hospital with self-harm, and 4–5% in the following 5 years. This means that at least 1 in every 25 patients who present to hospital following self-harm will die by suicide. The risks are even higher where alcohol was used at the time of self-harm, in older males and those who do not live with a close relative (Carroll et al, 2014). Appropriate management of self-harm in hospitals is therefore key in preventing suicide. All-cause mortality is higher after an episode of self-harm, as is emergency attendance for other reasons. It is not entirely clear why, but relevant factors are probably alcohol misuse and risk-taking of other sorts.

There is also the risk of non-fatal repetition of self-harm. The main risks focussed in the first year after the index episode, with an estimated 1-year rate of repetition of more than 20%. Those who go on to repeat multiple times are more likely to be male, working aged adults aged 25–54 years, who present with self-injury either alone or together with poisoning. Those who self-harm repeatedly are also more likely to leave before psychosocial assessment.

Other important outcomes following self-harm include general mental wellbeing and quality of life. A large birth cohort study has shown that young people who self-harm go on to have poorer outcomes in early adulthood compared to their peers, including lower levels of educational attainment and higher rates of depression, anxiety and substance misuse (Mars et al, 2014).

There are several areas within the management of self-harm which require more specialist knowledge and are unfortunately beyond the scope of this review. There is an interplay of socioeconomic risk factors, attitudes towards self-harm and stigma and within minority ethnic groups, those with learning disabilities, lesbian, gay, bisexual and transgender people and people with severe and enduring mental and physical illnesses, that influence presentation to and access to services (King et al, 2008; Cooper et al, 2010). **BJHM**

KEY POINTS

- Self-harm is the biggest independent predictor of future suicide. It is important that all patients receive a thorough psychosocial assessment at triage.
- Self-harm is a behaviour and not a diagnosis in itself. It can be a symptom of an underlying difficulty, or serve a function for the person harming him-/herself.
- Consider the distress that preceded the act of self-harm and approach patients with care and respect.

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