Self-harm and suicide – treatment and prevention

Advanced Course in Liaison Psychiatry
Exeter
June 2018

Professor Nav Kapur
Centre for Suicide Prevention University of Manchester
Outline

Self-harm
1. Current epidemiology
2. Guidelines
3. Deciding what works

Suicide
Risk assessment
Outline

Self-harm
1. Current epidemiology
2. Guidelines
3. Deciding what works
Self-harm

Self-poisoning or self-injury irrespective of apparent motivation or medical seriousness

80%

20%
Terminology

Editorial

Non-suicidal self-injury v. attempted suicide: new diagnosis or false dichotomy?†

Navneet Kapur, Jayne Cooper, Rory C. O’Connor and Keith Hawton

Summary
Non-suicidal self-injury (NSSI) is a term that is becoming popular especially in North America and it has been proposed as a new diagnosis in DSM-5. In this paper we consider what self-harm research can tell us about the concept of NSSI and examine the potential pitfalls of introducing NSSI into clinical practice.

Declaration of Interest
N.K. was Chair of the National Institute for Health and Clinical Excellence (NICE) guideline development group for the longer-term management of self-harm, of which R.O.C. was also a member. N.K. currently chairs the NICE Topic Expert Group that is developing quality standards for self-harm services. N.K. and K.H. are members of the National Suicide Prevention Strategy Advisory Group and R.O.C. is a member of the Scottish Government’s National Suicide and Self-harm Monitoring and Implementation Group. K.H. is a National Institute for Health Research (NIHR) senior investigator.

Navneet Kapur (pictured) is Professor of Psychiatry and Population Health at the Centre for Suicide Prevention, in the Centre for Mental Health and Risk at the University of Manchester. Jayne Cooper is Senior Research Fellow at the Centre for Mental Health and Risk, University of Manchester. Rory C. O’Connor is Professor of Psychology at the Stirling Suicidal Behaviour Research Laboratory in the Centre for Health and Behaviour Change at the University of Stirling. Keith Hawton is Professor of Psychiatry and Director of the Centre for Suicide Research at the University of Oxford.
Every year, hospitals in England deal with around 220,000 self-harm episodes by 150,000 people.

Hawton et al 2007
Iceberg model of suicidal behaviour

**Boys**
- Suicide Rate*: 16.5
- Hospital-treated self-harm*: 256.2
- Self-harm in the community*: 2,400

**Girls**
- Suicide Rate*: 2.7
- Hospital-treated self-harm*: 438.1
- Self-harm in the community*: 8,900

Ratio of suicide rate to rate of hospital-treated self-harm and to rate of self-harm in the community

1:16:146

1:162:3,296
Self-harm in England

Claim that youth self-harm is at an 'epidemic' level

Interview by Chris Smith, words by Jimmy Blake
Newsbeat reporters

6 June 2013 | Health
Temporal trends in annual age specific self harm incidence stratified by sex.
Temporal trends in annual age specific self harm incidence stratified by sex.

- Inverse care law
- Risk of suicide
Self-harm in England

Suicide by children and young people in England

Over 50% of children and young people who died by suicide had a history of self-harm

30-50 times greater risk of suicide in the year after self-harm
Men
80+ years

Men who self-harm
40 years

Bergen et al 2012, Lancet
Variations in self-harm services

(Cooper et al BMJ Open 2013)
Service user experience

`They wouldn't touch me... they looked at me as if to say "I'm not touching you in case you flip on me"... they didn't actually say it, it was their attitude...`

`The last time I had a blood transfusion the consultant said that I was wasting blood that was meant for patients after they'd had operations or accident victims. He asked whether I was proud of what I'd done...`

(Taylor et al 2009, BJPsych)
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NICE self-harm guidelines 2012

SELF-HARM
THE NICE GUIDELINE ON LONGER-TERM MANAGEMENT
NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH
Key priorities for implementation

- Working with people who self-harm
- Psychosocial assessment
- Risk assessment
- Risk assessment tools and scales
- Care plans
- Risk management plans
- Interventions for self-harm
- Treating associated mental health conditions.
But do guidelines make a difference?

National clinical guidelines

Self-harm

The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care

Issued: July 2004

NICE clinical guideline 16
www.nice.org.uk/cg16
But do guidelines make a difference?

National Clinical Guidelines:

Change in self-harm service provision in 31 hospitals in England (2001/2 vs 2010/11)
But do guidelines make a difference?

National Clinical Guidelines:

Change in global quality scores for self-harm services in 31 hospitals in England 2001/2 vs 2010/11.

Median Quality Score (IQR):
11.5 (10-14) in 2001/2 vs 14.5 (11.5 -16) in 2010/11
The NICE self-harm pathway covers:

- planning of services
- general principles of care
- assessment, treatment and management
- longer-term treatment and management.

Click here to go to NICE Pathways website
Implementing guidance

NICE quality standards for self-harm June 28th 2013

1. People are treated with compassion, respect and dignity
2. They receive an initial assessment of physical health, mental state, social circumstances and risk of suicide.
3. They receive a comprehensive psychosocial assessment
4. They receive the monitoring they need to keep them safe
5. They are cared for in a safe physical environment
6. Collaborative risk management plan are in place.
7. They have access to psychological interventions.
8. There is a transition plan when moving between services.

http://publications.nice.org.uk/quality-standard-for-selfharm-qs34
Implementing guidance

Improving outcomes and supporting transparency

Part 2: Summary technical specifications of public health indicators

Updated November 2013

The indicator will have two elements:

2.10i Attendances at A&E for self-harm per 100,000 population

2.10ii Percentage of attendances at A&E for self-harm that received a psychosocial assessment
PITSTOP Trial

- Cluster RCT
- 45 departments of psychiatry
- 881 patients
- A structured training intervention - face to face and e-learning - to improve guideline adherence delivered to whole clinical teams (vs TAU)
- Looked at effects on clinicians and patients

(De Beurs et al 2015)
PITSTOP Trial - Findings

Clinicians
- Better guideline adherence
- Improved knowledge and confidence
- Around a 10% improvement

Patients
- Little effect overall on change in suicidal ideation, future attempts, satisfaction
- A possible effect on patients with depression?

(De Beurs et al 2015)
Outline

Self-harm
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Interventions for self-harm

Distribution of time to repeat self-harm after index
censored at 1 year

Bar width = 30 days

Days to repeat self-harm

(Kapur et al J Clin Psychiatry 2006)
Review: Psychosocial interventions for self-harm in adults
Comparison: 1 Cognitive behavioural therapy (CBT)-based psychotherapy vs. treatment as usual (TAU)
Outcome: 4 Repetition of S/H at final follow-up

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Total events: 238 (CBT-based therapy), 300 (TAU)
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Test for overall effect: χ² = 3.47 (P = 0.0005)
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(Hawton et al 2016)
Effective psychological and psychosocial approaches to reduce repetition of self-harm: a systematic review, meta-analysis and meta-regression

Sarah E Hetrick,1,2 Jo Robinson,1,2 Matthew J Spittal,3 Greg Carter4

ABSTRACT

Objective: To examine the efficacy of psychological and psychosocial interventions for reductions in repeated self-harm.

Design: We conducted a systematic review, meta-analysis and meta-regression to examine the efficacy of psychological and psychosocial interventions to reduce repeat self-harm in adults. We included a sensitivity analysis of studies with a low risk of bias for the meta-analysis. For the meta-regression, we examined whether the type, intensity (primary analyses) and other components of intervention or methodology (secondary analyses) were associated with variation in efficacy.

Strengths and limitations of this study

- We used robust systematic review methodology, including analysis of meaningful secondary outcomes, and sensitivity analyses to assess the impact of risk of bias on the results.
- Our search was thorough and has identified 45 relevant randomised controlled trials; this is the largest number of trials identified in a systematic review of this type.
- The risk of bias in various domains was rated as high, and sensitivity analyses were performed to...
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- Risk Ratio: 0.84 (0.74 to 0.96)
- NNT: 33
- No effect of type, intensity or site of therapy
Postcards from the EDge

Hunter Area
Toxicology Service

Dear «FirstName»

It has been a short time since you were here at the Newcastle Mater Hospital, and we hope things are going well for you.

If you wish to drop us a note we would be happy to hear from you.

Best wishes,

Dr Andrew Dawson

Dr Ian Whyte

Newcastle Mater Misericordiae Hospital
Bag 7, Hunter Regional Mail Centre NSW 2310
Phone: 49 211 283 Fax 49 211 870

Relative Risk Reduction 0.13 (NS)
Postcards from Persia

Relative Risk Reduction 0.42

(With thanks to Greg carter for the slide)
Postcards from Persia

Dear . . . . .

Life is similar to riding on a bicycle, you only fall if you do not pedal.

New Year, New Effort, New Hope

Regards
Dr Hossein Hassanian-Moghaddam, Dr Saeedeh Sarjami

Relative Risk Reduction 0.42

(With thanks to Greg carter for the slide)
Dear [Name],

It has been a short time since you attended the Accident & Emergency Department. We know that this can be a difficult time so we wanted to drop you a line. If you wish you can write back and let us know how you are.

Just to remind you that your GP is [name] and you can contact [him/her] on [number]. Your care coordinator is [name] and that if things get difficult you can contact [him/her] on [number]. You can talk to your care coordinator about any areas of your life that are causing you concern (e.g. money or housing problems), not just mental health issues.

Enclosed is another copy of the leaflet that we have put together to provide you with some information about other services that might be of interest to you. These include telephone support lines and support groups.

With best wishes,
Messages from Manchester: the CiSH study

Repeat self-harm within 12 months

- Group A: 35%
- Group B: 15%
Messages from Manchester: the CiSH study

Repeat self-harm within 12 months

(Kapur et al 2013, BJPsych)
What works?
What works?

Using the data we have: Psychosocial assessment

Observational data on 35,938 individuals presenting with self-harm to 3 centres in England, comparing repetition in those receiving vs not receiving specialist assessment (adjusted for baseline characteristics)

(Kapur et al 2013)
How does it work?

The assessment itself
The main thing was that [psychiatrist] did look as if he actually cared, that's it, and he wanted, he really wanted to help me, and so that was a very positive thing” (P4)

Access to aftercare
[I'm] hugely grateful that I've got the help, it's made a whole world of difference [yeah], I'm getting regular phonecalls, people are phoning me, keeping me informed, my care people are coming, I know that within the next couple of weeks, I will have the support I need” (P10).

(Hunter et al 2013)
Helping young people and parents

Self-harm: experiences of parents
Watch parents and carers share their experiences of having a child who self-harms, on the award-winning website healthtalk.org. Research by The University of Oxford.

“I’m just thinking ‘why is my little girl doing this? What did I do?’”

“Just remain hopeful and strong and realise that nothing stays the same”
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Suicide
Risk assessment
The wider context: suicide
Figure 1: Age-standardised suicide rates by sex, for the UK, registered between 1981 and 2016
Men and high suicide risk

- Dangerous methods
- Poor help-seeking
- More risk factors (drugs, alcohol, socioeconomic)
- Psychological characteristics
Policy Context

Preventing suicide in England
A cross-government outcomes strategy to save lives

Preventing suicide in England:
Third progress report of the cross-government outcomes strategy to save lives

House of Commons Health Committee
Suicide prevention: interim report
Fourth Report of Session 2016–17

THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH

A report from the independent Mental Health Taskforce to the NHS in England
February 2016

Local suicide prevention planning
A practice resource

October 2016

Supporting and improving the nation’s health
Policy Context

Press release

New funding for suicide prevention in England

Funding given to local communities that are worst affected by suicide to develop suicide prevention and reduction schemes.

Published 16 May 2018
From: Public Health England and Jackie Doyle-Price MP

The investment announced today by the Department for Health and Social Care, Public Health England (PHE) and NHS England marks the start of a 3-year programme worth £25 million that will reach the whole country by 2021.
The Suicide Prevention Strategy for England 2012

Preventing suicide in England

A cross-government outcomes strategy to save lives
The Suicide Prevention Strategy for England 2012

- Reduce risk in high risk groups
- Promote mental health
- Reduce availability of means
- Improve care for the bereaved
- Improve media reporting
- Promote research and monitoring
The Suicide Prevention Strategy for England 2012

• Reduce risk in high risk groups
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Can mental health services prevent suicide?
In-patient suicide

(Kapur et al Psychological Medicine 2012)
In-patient and post discharge suicide

(Kapur et al Psychological Medicine 2012)
In-patient suicide and suicide under crisis resolution/home treatment teams (CRHTs)

(Hunt et al Lancet Psychiatry 2014)
National Confidential Inquiry

National policies and recommendations

• Removal of ligature points
• Assertive outreach
• 24-hour crisis team
• 7-day follow-up
• Non-compliance
• Dual diagnosis
• Criminal justice information sharing
• Multi-disciplinary review
• Training in suicide risk management

Safety First, 2001
12 Steps to a Safer Service
Questions

- Do mental health services implement policies?
- Do they make a difference?
Do policies make a difference?

24-hour crisis team | Dual diagnosis policy | Multi-disciplinary review

Suicide rate per 10,000 patients in contact (exact Poisson 95% CI)

(Wile et al Lancet, 2012)
Suicide rate vs non-medical staff turnover (%)

- Correlation coefficient: 0.34
- P-value: 0.01
Policy on multi-disciplinary review information sharing with families

Suicide Rate per 10,000 patients per year in contact (exact Poisson 95% CI)

- high turnover
- low turnover

Non-medical staff turnover (%)

(Kapur et al Lancet, Psychiatry 2016)
The Suicide Prevention Strategy for England 2012

- Reduce risk in high risk groups
- Promote mental health
- Reduce availability of means
- Improve care for the bereaved
- Improve media reporting
- Promote research and monitoring
How can we prevent suicide?
Fig 2 Mortality in England and Wales from analgesic poisoning (suicide and open verdicts), 1998-2007, for people aged 10 years and over (substances taken alone, with or without alcohol)
How can we prevent suicide?

(Slide: Louis Appleby)
Improve media reporting
National study of suicide in young people

- Linked to suicide bereavement, isolation, exams
- Suicide-related internet use in 23%
- No service contact in 43%

Support for bereaved families

- Help is at Hand
- How to commission and deliver bereavement support
- Consensus statement on balance of confidentiality and disclosure of risk
The Suicide Prevention Strategy for England 2012

• Reduce risk in high risk groups
• Promote mental health
• Reduce availability of means
• Improve care for the bereaved
• Improve media reporting
• Promote research and monitoring
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