Self-harm in the general hospital

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Self-harm is a major public health problem, accounting for over 170,000 hospital attendances per year in the UK. It is one of the commonest reasons for admission to a medical ward and its incidence is increasing. Patients who harm themselves are at greatly increased risk of subsequent suicide, and up to half of those who die by suicide have a history of self-harm. Suicide reduction is one of the cornerstones of current UK mental health policy – the latest Government target is a reduction of 20% by 2010.[1] The rigorous management of self-harm patients by psychiatrists working in the general hospital setting might help to achieve these targets as well as improving service provision for a neglected patient group.

A number of terms have been used to describe aspects of suicidal behaviour (e.g. parasuicide, attempted suicide, overdose, self-injurious behaviour). 'Deliberate self-harm' can be defined as an act of intentional self-poisoning or injury irrespective of the apparent purpose of the act.[2] Recently, the prefix 'deliberate' has been dropped from 'self-harm' in response to the heterogeneous nature of the phenomenon and the concerns of service users.[3,4] Self-harm is the term that will be used throughout this paper. The majority of cases (80%) involve self-poisoning.

What's new?

- Self-harm remains a major public health problem and its current incidence is between 300 and 500 cases per 100,000 per year
- The proportion of patients who self-harm and misuse alcohol has risen as has the proportion who repeat self-harm. Services for self-harm remain extremely variable
- Two important sets of guidelines have been published recently by the National Institute of Clinical Excellence and the Royal College of Psychiatrists but the evidence to guide clinical practice remains weak
- Recent work has confirmed that high-risk approaches to treatment are unlikely to have a major impact on rates of repeat self-harm

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Epidemiology

The epidemiology of self-harm is changing in the UK but it is difficult to obtain accurate data because few centres have a comprehensive monitoring system in place. This may change in the future – a multicentre monitoring project of self-harm has recently been proposed as part of the English Suicide Prevention Strategy.[1] It should be noted that rates of self-harm tend to be based on hospital-treated episodes and so may represent an underestimate. The current incidence of self-harm is between 300 and 500 cases per 100,000 per year.[5,6] There has been a steady decrease in the female:male ratio; whereas formerly twice as many women harmed themselves, currently the numbers are almost equal in many centres.[7] Peak ages are 15–24 years for women and 25–34 years for men. There are some suggestions of an increased incidence in certain ethnic groups; for example, young women of South Asian origin are 2.5 times more likely to harm themselves than white women. In most cases, individuals report that the episode was precipitated by interpersonal or social problems. Although early studies suggested that only a minority of self-harming patients had clinically important psychiatric illness, more recent work suggests that up to 90% may have psychiatric disorder according to ICD-10 criteria.[8] The most common diagnosis is affective disorder (70%). However, such disorders may be self-limiting. Between a quarter and a half of patients misuse alcohol.

Recent work examining trends in self-harm suggests overdoses of paracetamol have become less common (following legislation restricting pack sizes) but antidepressant overdoses (particularly SSRI overdoses) have become more common.[5,9] The proportion of patients misusing alcohol has risen as has the proportion who repeat self-harm (for example, in Oxford the proportion of individuals repeating within one year of an episode was 14.4% in 1990–1992 and 21.4% in 1997–1999).

Most epidemiological data comes from the UK and Europe, with very little from the US or developing countries. A study carried out in 13 European countries found a wide variation in annual rates of self-harm. The rates for the UK centre were among the highest in Europe.[10] Large surveys have suggested that 4.6% of the population in the US and 4.4% in the UK had previously self-harmed.[11,12]

Services for self-harm

Despite the scale of the problem, services for self-harm have been highly variable and poorly delivered. In 1978 an audit in Nottingham, UK, found wide variations in the management of self-poisoning by 10 psychiatric teams working in the same hospital. A study of four English teaching hospitals 20 years later suggested that the variations in service provision were even more pronounced.[13] For example, there was a four-fold difference in the proportion of patients discharged directly from the emergency department (18% versus 76%), and a two-fold difference in the proportion of patients leaving hospital without a psychosocial assessment (32% versus 64%). More recent work has suggested these differences are as wide as ever.[14] This striking variability in management is not due to differences in patient characteristics, so what might account for these findings? Poor resources and a lack of research evidence could be contributing factors, but there may also be a perception among hospital staff and managers that individuals who burden the health service with self-inflicted problems deserve less comprehensive services than those with 'serious' medical and psychiatric illnesses.

Outcome

Two main outcomes of particular importance are repetition of self-harm and suicide. The one-year repetition rate for self-harm is in the region of 15%.[15] Repetition tends to occur quickly – one-quarter of patients repeat within 3 weeks, and the median time to repetition is only 12 weeks. Follow-up studies have shown rates of suicide to be 1.8% in the year after a self-harm episode, 3% at 5 years and around 7% for periods longer than 9 years.[15] Much has been made of so-called risk factors for repetition and suicide (some of the most widely reported are listed in Figure 1). Such risk factors are of only limited usefulness in everyday practice because of their poor predictive value. There is some suggestion that people who cut themselves are at greater risk of eventual suicide than those who harm themselves using other methods.[16]

Management in the general hospital

There are a number of basic principles that can be applied to all patients after a self-harm episode.

- The initial priority is to ensure that the individual's physical condition is thoroughly assessed and appropriately managed. Thereafter a psychosocial assessment needs to be carried out in all patients in order to identify and manage those with significant mental health problems and those at high risk of suicide. Information collected during a psychosocial assessment might include conscious level, psychiatric history and mental state examination, social situation and recent life events, alcohol and drug use, and a risk assessment.
- Risk assessment – i.e. assessing the risk of future self-harm or suicide – is an important clinical skill. Risk is not easy to quantify and is difficult to assess because the tools for doing so are crude and the outcomes clinicians are interested in are rare. However,

Risk factors for repetition of self-harm and completed suicide

Risk factors for repetition of self-harm

- Previous history of self-harm
- Psychiatric history
- Unemployment
- Lower social class
- Alcohol or drug problems
- Criminal record
- Antisocial personality
- Lack of cooperation with treatment
- Hopelessness
- High suicidal intent

Risk factors for completed suicide

- Older age
- Male
- Previous history of self-harm
- Psychiatric history
- Unemployment
- Poor physical health
- Social isolation

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