

## SELF HARM AND SUICIDALITY: AN AUDIT OF FOLLOW-UP IN PRIMARY CARE

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### SUMMARY

*Deliberate self harm is the strongest predictor of completed suicide. Primary care is often the entry point for those presenting with self harm and suicidality and so the primary care follow-up of such patients should include risk assessment for repeated self harm and completed suicide. This is of particular importance in patients at high risk for suicide, such as those with Bipolar Affective Disorder. This audit makes recommendations for the average UK GP Teaching Practice based on standards from the NICE guidelines relating to the prevalence, timing and content of follow-up in primary care of those patients who present with self harm or suicidality in the practice population.*

**Key words:** self harm - suicide attempt – depression - Bipolar Affective Disorder - primary care - risk assessment

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### BACKGROUND

Deliberate self harm is the strongest predictor of completed suicide (Karasouli 2015). Self harm encompasses 'any act of self-poisoning or self-injury carried out by an individual irrespective of motivation' and is commonly self-reported in the community setting (Allan 2012). Such behaviours are usually associated with depressive symptoms, however self harm can occur with any psychiatric illness, giving rise to a 10.5% lifetime risk (Allan 2012). There is a higher risk of repeated self-harm and suicidal behaviour in people with bipolar disorder who self harm when compared to those who self harm and have other diagnoses (Clements 2015). Since primary care can be considered the 'entry point' for those presenting with mental illness including self harm and suicidal ideation, it follows that risk assessment for repeated self harm and completed suicide would be a key component of the primary care consultation following an initial presentation of self harm or suicidality (Neves 2014).

### AUDIT AIMS

This audit is designed to analyse the prevalence, timing and content of follow-up in primary care for those patients who present with self harm or suicidality in the practice population. In reviewing current practices in an average UK GP teaching practice against standards generated from the NICE Guidelines, we aim to produce recommendations for the safe management of these patients in the primary care setting.

### METHODS

Medical records at an average GP Teaching Practice in the East of England were accessed by four medical

students at the University of Cambridge for the purposes of performing this audit. The entries for patients with read-codes indicating self-harm or suicidality between September 2013 and September 2018 were reviewed in October 2018. This timeframe was chosen so that data could be compared to the standards suggested by the NICE Guidelines published in June 2013 regarding managing self-harm in primary care. The authors reviewed the NICE guidelines for follow-up after acts of self-harm and/or suicidality and together developed an audit framework. Each case was assessed against the criteria displayed in table 1. This table also shows the percentage standards that each criterion should satisfy. Each case was audited independently by at least two of the authors. Data were tallied and any discrepancies were resolved by consensus. Events that were not documented were considered not to have taken place. Data were analysed, and key results were depicted graphically.

### FOLLOW-UP

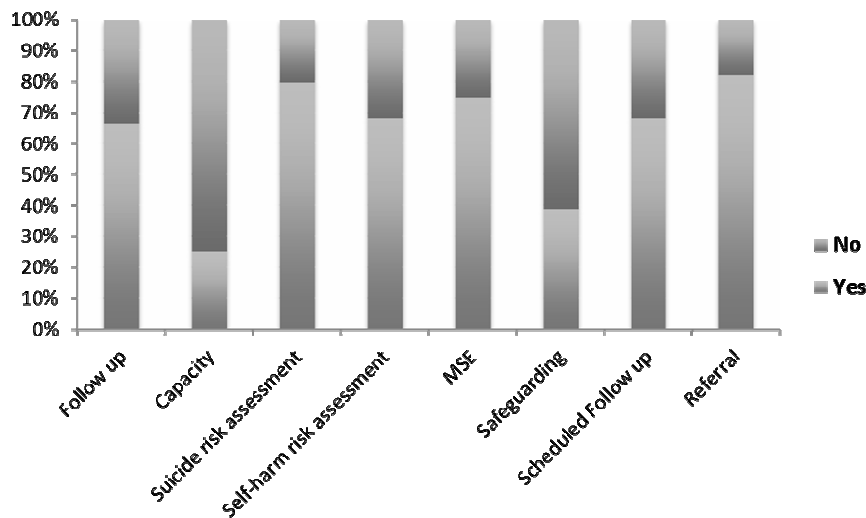
Of the 66 patients included in our study, two thirds (n=44) were followed up in the GP practice. The time interval between initial presentation and follow-up in primary care ranged from 0-27 days, with the mean time interval being 7 days. The fastest follow up was over the telephone, but the shortest face-to-face follow-up occurred after 1 day. Of the 44 patients who were followed up in primary care, 68.2% were later seen again in the GP practice (n=30). A higher proportion (81.8%, n=36) were referred to other services after initial follow-up.

### CAPACITY

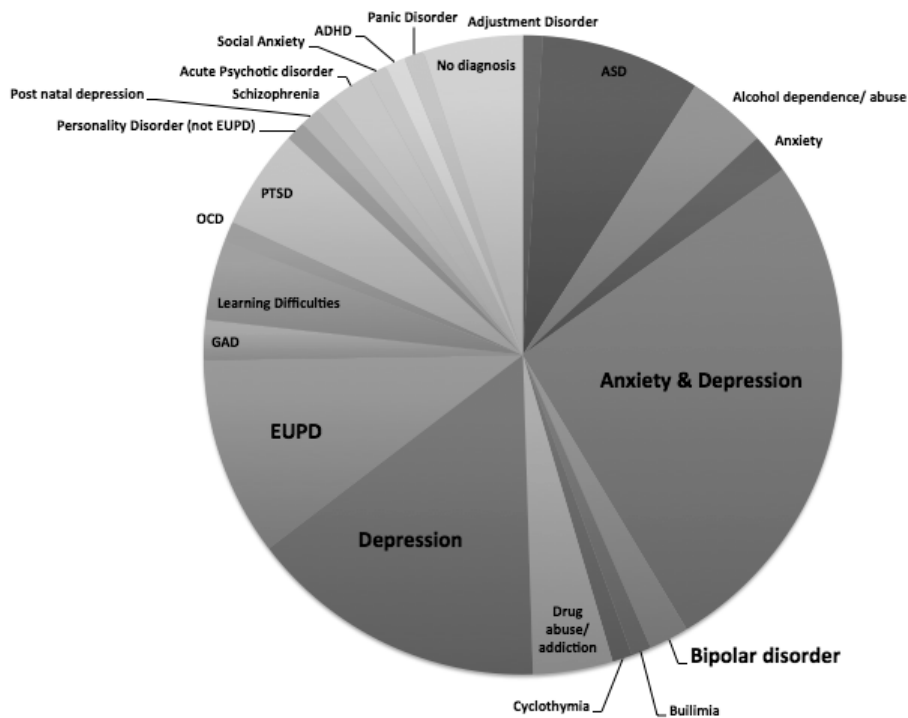
Capacity assessments are standard assessments based on the 'Capacity Act' in the UK in order to ascertain that patients are able to make their own decisions.

**Table 1.** Audit criteria and corresponding standards for primary care follow up of patients presenting with self harm or suicidality

Criteria	Standard
All patients should be followed up with a GP appointment	100%
All initial follow up appointments should occur within 7 days	100%
At first appointment all patients should be risk assessed for suicide	100%
At first appointment all patients should be risk assessed for self harm	100%
At first appointment all patients should receive a mental state examination	100%
At first appointment all patients should have their capacity assessed	100%
At first appointment all patients should have their safeguarding needs assessed	100%
All patients should receive a second follow up appointment at a later date for further assessment	100%



**Figure 1.** A 100% stacked column chart showing how often each audit criterion was assessed in the teaching practice follow up



**Figure 2.** Diagnoses recorded for 66 patients who presented with self harm and/or suicidality in a UK GP teaching practice population

Of the 44 patients who were followed up exclusively in primary care, there is evidence that capacity was assessed in 11 records. This corresponds to capacity assessments being recorded in only 25% of cases.

## FINDINGS

Be presented at figure 1.

### MENTAL STATE

There is evidence of assessment of the patient's mental state in 33 out of 44 records. This corresponds to 75% of follow-up appointments including some form of Mental State Examination. It is important to note that even in those where a Mental State examination was performed, the mental state was not assessed fully in the majority of patients. Whilst most records show evidence of the patient's mood, behaviour and appearance, there is limited evidence for the assessment of thought form and content, as well as perception.

### SELF HARM AND SUICIDALITY

Of the 44 patients who were reviewed in primary care only, 35 (80%) were documented to have been asked about continuing suicidal thoughts or intent. Fewer patients were asked about continuing thoughts of or active self harm behaviours, with this documented in 30 patients (68%). 5 patients were asked about suicide without also being asked about self harm, while 4 patients were asked about self harm but not suicide. 5 patients were not asked about suicide or self harm at all. Of these five, one was under the care of the local CAMHS (Community Mental Health) team but four patients who had not been asked about suicidality or self harm in primary care were not referred to secondary services. One of these patients was not subsequently followed up in primary care either.

### SAFEGUARDING

Safeguarding in the UK is the process whereby patients are assessed as to whether they are vulnerable to risks of violence and exploitation or are a risk to others. Seventeen out of 44 patient records show evidence of safeguarding assessments, meaning that only 38.6% of follow-up appointments were used to assess the risks of violence and exploitation to the patient, and the patient's risk to others.

### DIAGNOSIS

61 of the 66 patients had been diagnosed with at least one psychiatric condition, with a total of 94 diagnoses recorded for all patients regardless of follow-up location. The most common diagnosis was mixed anxiety and depressive disorder, with 26 cases.

Of these, 13 patients had additional psychiatric diagnoses. A further 15 patients received a diagnosis of depression without anxiety. 11 of the 15 patients had depression as their only mental health diagnosis, while 4 had co-morbid psychiatric conditions (other than anxiety). A third common diagnosis was emotionally unstable personality disorder, with 10 cases and 8 of the 10 patients also diagnosed with other psychiatric conditions including – most commonly – depression and anxiety. Only two patients had a diagnosis of Bipolar Affective Disorder and one patient had a tentative diagnosis of cyclothymia.

The full range of diagnosed conditions is displayed in figure 2.

### SCREENING FOR MANIA

Interestingly, of our sample of 66 patients, screening for bipolar symptoms of mania or hypomania was only carried out for two patients with an existing diagnosis of bipolar affective disorder. One further patient volunteered feelings of elevated mood and restlessness and was given a tentative diagnosis of cyclothymia. Mania and/or hypomania symptoms were otherwise not screened for or elicited during follow up of self harm in primary care.

## RECOMMENDATIONS

### Follow-up in general practice

Findings from a Multicentre Study show that the risk of completed suicide is highest during the first year after self harm, and especially in the initial period, with the risk of completed suicide being 49 times greater in those who have previously attempted self harm than in the general population (Hawton 2015). Early follow-up after self harm has been shown to decrease the risk of repetition (Bilén 2014), meaning that GPs should attempt to see patients as soon as reasonably practicable after initial presentation.

Currently, the NICE guidelines on self harm do not provide clear recommendations regarding follow-up of patients in primary care (NICE 2013). The evidence suggests that increased contact with practitioners is effective in preventing suicide, and so we strongly recommend that all patients are followed up by their general practitioner within 7 days of the initial incident.

Additionally, we recommend that GPs also invite patients who have been referred directly to Mental Health Services after first presentation for a consultation, as waiting lists can be long and may discourage patients from engaging with services. According to the CQC (Care Quality Commission – a commission in the UK which assesses the quality of services) in 2015/2016 only 52% of patients referred for assessment or brief interventions were seen within 4 weeks and maximum waiting times reached 26

weeks (CQC, 2017). It is essential that these patients are followed up in the interim and that their risk of suicide and self harm is assessed.

### **Assessment of Capacity in General Practice**

Only patients with capacity can make decisions regarding treatment. This is particularly important in the context of self-harm and suicide where patients may refuse treatment as a result of psychiatric illness and it is therefore essential to assess whether their capacity to make choices has been compromised. Whilst this is a more pressing issue in emergency settings, it also applies to primary care, particularly when considering engagement with long-term management. Currently, the practice is only recording patient capacity in 25% of cases, which we deem to be unacceptable and we would therefore like to strongly reinforce the recommendation in the NICE guidelines for self harm, which states that capacity should be assessed in all patients.

### **Mental State Examination in General Practice**

The 2013 NICE guidelines recommend that all patients have a full Mental State Examination when presenting after an incident of self harm. We recognize that a full mental state examination is not feasible in primary care due to time constraints, however we strongly encourage doctors to record examination of thoughts and perception, in addition to behavior, mood and appearance. This enables screening for psychosis and bipolar disorder. Not all the patients who were followed up after suicide attempts or self harm at this teaching practice had their mental state assessed, so we recommend that practitioners document the components of the MSE described above in all patients who attend for follow-up.

In addition, it is important to pay particular attention to screening for mania or hypomania since many patients with depressive disorder do in fact display a predisposition to 'convert' to bipolar affective disorder (Rogers 2013). For instance, patients presenting with agitated depression may in fact be presenting with an affective mixed state, associated with a high risk of suicide (Akiskal 2005, Chesin 2013). Since suicide prevention should remain a priority when assessing mental state, it is crucial that there is a comprehensive assessment of the patient to identify specific risks of self harm and suicide as well as high-risk conditions such as bipolar affective disorder and mixed affective states (Annear 2016). The recording of a family history of depression, anxiety, bipolar disorder and suicide or other mental health condition such as schizophrenia or indeed admission to mental hospital, and the recording of a past history of recurrent depression or manic or hypomanic episodes are important since these items should indicate the need for further assessment whether the patient has bipolar disorder (Agius 2015).

### **Risk assessment in General Practice**

Risk assessment is one of the most important tools to ensure patient safety. We recommend that every patient should undergo a risk assessment for suicidality and non-suicidal self harm, as both can have a devastating effect on the patient's health and safety. Additionally, there is an intimate relationship between suicidal and non-suicidal self injury (NSSI), with multiple studies showing that a history of NSSI, is the biggest risk factor for suicide (Cavanagh 2003). In fact, a 4-year cohort study which followed 7968 participants who self harmed showed that the risk of suicide was more strongly correlated to the practice of non-suicidal self harm than to the degree of suicidal intention (Cooper 2005). The recognition that a history of NSSI is a stronger predictor of successful suicide than intention to die strongly supports our recommendation to always assess both the risk of suicide and the risk of self harm.

Furthermore, we noted that when suicidal risk was assessed, patients were only asked about whether or not they had thoughts of hurting themselves, but other factors affecting risk of completed suicide were not considered. We encourage general practitioners to ask about factors that make suicide more likely, including access to lethal means, living in social isolation or in areas of high social fragmentation (Whitley 1999), or substance abuse (Yuodelis-Flores 2015). We also encourage GPs to enquire about protective factors, such as any dependent family members who would be upset should the patient commit suicide or beliefs that discourage suicide (Wu 2015).

### **Assessment of Safeguarding**

According to the NICE guidelines all records should contain evidence of whether any safeguarding concerns were raised, yet currently only 38.6% of the consultations showed any evidence of safeguarding assessments. It seems as though the current practice is to only record this if a concern is raised. We would encourage doctors to consider safeguarding issues in every consultation, particularly in the context of psychiatry where patients are themselves at an increased risk of exploitation and abuse, but may also be a risk to others, both actively and by neglect.

### **Recommendations for the Planning Stage of the Consultation**

Not every patient who self harms needs to be referred to secondary care, particularly if they have regular follow up with their GP. According to the NICE guidelines, referral is a priority if:

- levels of distress are rising, high or sustained;
- the risk of self-harm is increasing or unresponsive to attempts to help;
- the person requests further help from specialist services;

- levels of distress in parents or carers of children and young people are rising, high or sustained despite attempts to help.

Out of all 44 patients who were seen in primary care, 36 were referred to secondary mental health services. Of those remaining under the care of the GP, 4 were encouraged to schedule a further follow-up appointment, however 4 left without a care plan in place that included follow up. A study conducted across 5 culturally different countries, showed that increased contact time with practitioners significantly reduces the number of deaths by suicide (Fleischmann 2008). Therefore, we highly recommend that no patients are left without a plan to see a doctor, whether this be in primary or secondary care, so as to increase the contact time each patient has with professionals.

## FURTHER RECOMMENDATIONS

We would like to suggest the use of an electronic template when following-up a patient after self harm. The domains in table 2, encompass all recommendations made in this audit report, and are aimed at the average UK GP Teaching Practice.

**Table 2.** Suggested primary care follow-up template for patients presenting with self harm or suicidality

- Follow up all patients within 7 days of incident
- Does the patient have capacity?
- MSE
  - Thoughts
  - Perceptions
  - Behaviour
  - Mood
  - Appearance
- Does the patient have continuing suicidal thoughts?
  - Enabling factors
  - Protective factors
- Is the patient experiencing mania or hypomania?
- Are any safeguarding concerns raised?
  - Risks from others
  - Risks to others

## Contribution of individual authors:

Eduarda Ferreira Bruco is 'first author' and led the project she drafted the text;

Chloe Gamlin, Jack Bradbury, Simon Bill & Jack Bradbury collected the data and contributed to the text;

Charlotte Armour contributed the data and supervised the data collection;

Mark Agius mentored the project and added text.

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**Conflict of interest:** None to declare.

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