

Rapid access to brief psychological treatments for self-harm and suicidal crisis

SUICIDE AND SELF-HARM ARE PUBLIC HEALTH ISSUES

Suicide is an important public health issue. Over 800 000 people die by suicide each year worldwide,¹ and approximately 6000 people per year in the UK.² Self-harm is a public health priority.³ Self-harm is defined as any intentional act of self-injury or self-poisoning regardless of motivation or suicidal intent.⁴ Self-harm is associated with personal and social difficulties, as well as increased risk of suicide and premature death by other causes. The number of presentations for suicidal crisis without physical injury at emergency departments is unknown. In the UK, the increasing impact of those visits is evident through the increasing number of community crisis resolution/home treatment/first response schemes, and more recently the Core 24 response initiative.⁵ The Core 24 response initiative involves the provision of care for people experiencing a mental health crisis who attend in emergency departments, available 24 hours a day, 7 days a week.

For self-harm, there are over 200 000 presentations to emergency departments annually.^{4,6} This includes people who have physically harmed themselves without suicidal intent and those who have attempted to die by suicide. However, it is important to note that many people who self-harm do not present to hospital and may be managed within community settings. The true prevalence of self-harm or suicidal crisis is therefore estimated to be much higher.⁷ There are potential lifelong implications of non-suicidal self-harm and suicide attempts, such as an increased frequency of suicide, especially if the behaviours are adopted as a long-term coping strategy. Worryingly, adolescents and young adults are highly vulnerable to finding themselves in a crisis and rates in these groups is increasing for both self-harm and suicide.^{8,9}

WHAT IS A SUICIDAL CRISIS?

A suicidal crisis is a temporary state that occurs in response to overwhelming distress, characterised by unbearable emotional pain of such intensity and severity that death by

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suicide seems to be the only solution. For some people this is a time when they may have had suicidal thoughts or attempted to take their own lives. In terms of self-harm, often a point where self-harm risk is high or self-harm has already happened. In all these cases, a time when intervention seems important and vital. Previous research supports this as emergency department data on repetition rates and suicide rates following attendance for initial self-harm, suicide attempts, or suicidal ideation are high.¹⁰

INCREASING RAPID ACCESS TO TREATMENT

Challenges exist for increasing access to rapid interventions as many people may not present to hospital services when in crisis. Often physical health takes precedence over psychological factors in a crisis context, at least where self-harm has already taken place. While there is evidence that psychological therapies can help reduce the risk of self-harm,¹¹ waiting lists can be long, thus increasing the possible risk of deterioration. Effective suicide prevention and intervention is vital due to the prevalence of the problem.

Current initiatives addressing suicidal crisis or self-harm focus on mental health crisis in secondary care and are not acknowledging that most self-harm and suicidal crisis occurs in primary care or within community settings.⁸ Psychosocial assessment by trained mental health professionals is recommended in the National Institute for Health and Care Excellence (NICE) guidelines¹² for self-harm and suicidal ideation, and includes the assessment of patients' needs and risks with the aim of determining appropriate aftercare. The psychosocial assessment includes an evaluation of mental, physical, and emotional

health. The Department of Health³ reports that further action and strengthening of ongoing efforts in the implementation of key effective suicide prevention interventions is vital. Rapid access to interventions provides an opportunity to quickly bring together early help and support, which suggests positive outcomes. However, further research is needed to provide robust findings.

EVERYONE'S BUSINESS

Over recent years, there has been increased reporting of self-harm and suicidal ideation from teachers and charity based or third-sector organisations in frontline contact with children and adolescents.⁹ In the UK, the National Suicide Prevention Strategy¹³ has expanded its scope by aiming to reduce self-harm rates as a common precursor to suicide. One recommendation being adopted across the country is a single point of access for all service users in crisis, 24 hours a day, as part of the assessment and immediate care service — Core 24.⁵ This ensures rapid response to a crisis, short-term input (for example, by emergency department mental health liaison teams), and, whenever possible, other alternatives to admission. Most people in suicidal crisis or who may self-harm do not need admitting to hospital. A growing evidence base and service user feedback has highlighted the potential harmful consequences and more long-term negative outcomes of being admitted to hospital.⁵ However, effective alternative services are lacking, or there is little evidence known about services that have been implemented and are working well. Data on good practice models that can be replicated within other health and social care systems is needed. More research on the benefits of having accessible professionals, well developed community services, and specific policies for treating patients who present in suicidal crisis or following self-harm would be useful.

TREATMENT OPTIONS

There is some evidence that specifically structured psychological therapies can

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be effective in reducing repetition of self-harm or suicidality.^{11,14,15} Recommendations suggest that interventions should be tailored to individual needs and should include cognitive-behavioural, psychodynamic, or problem-solving elements. Therapists are required to be trained and supervised in the therapy being offered and able to work collaboratively with the person to identify the problems causing suicidal distress or leading to self-harm. A barrier, however, is that some psychological services will not see people in a suicidal crisis or those who have recently self-harmed.

IMPROVING ACCESS TO PSYCHOSOCIAL INTERVENTIONS

While patients may contact the NHS for suicidal crisis or self-harm, they may not be referred to a specialist service that treats people in a crisis, specifically for these issues. Crisis resolution teams and home treatment teams offer biopsychosocial intervention, but this may not be universal. Often the focus will be on risk monitoring, medication management, and the ongoing review of medication side effects and adherence. Training for staff may not be available universally on delivering psychosocial interventions to people in crisis. Thus, some patients may not receive the psychosocial aspect of care alongside crisis risk management. Patients may be referred for psychological therapy; however, waiting lists can be up to months. Furthermore, a person may not meet the criteria for psychological services if they disclose self-harm or suicidal thoughts, leaving limited options for people who may find themselves in a crisis. The voluntary sector can also play a key role in providing support to people in crisis. However, little is known about its contribution within mental health crisis care¹⁶ and if the suicide prevention interventions are regulated, evidence informed, or follow a governance structure.

IS RAPID ACCESS TO HELP IN THE MOMENT OF CRISIS EFFECTIVE?

Rapid access to interventions at point of crisis is important and could help in reducing suicides. Brief psychological interventions have been shown to be

effective in the prevention of suicide and self-harm.^{11,14,15} While some have reported promising findings, there remains a paucity of evaluative studies that considers the effectiveness of implementation of suicide prevention programmes. A recent pilot study reported reduced repetition of self-harm, reduced suicidality, and reduced readmission to hospital following rapid access to brief psychological therapy.¹⁵ However, to date, research has been focused on emergency department data. More research is needed on rapid response services delivered within community settings to fully understand how effective they are.

Pooja Saini

Senior Lecturer, Liverpool John Moores University, Liverpool, UK.

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ADDRESS FOR CORRESPONDENCE

Pooja Saini

Liverpool John Moores University, Tom Reilly Building, Byrom Street, Liverpool L3 3AF, UK.

Email: P.Saini@ljmu.ac.uk

Cecil Kullu

Consultant Psychiatrist, Mersey Care NHS Trust, Liverpool, UK.

Emma Mullin

HOPE Therapist, Mersey Care NHS Trust, Liverpool, UK.

Jane Boland

Clinical Lead, James' Place Therapeutic Centre for Men in Suicidal Crisis, Liverpool, UK.

Peter Taylor

Clinical Senior Lecturer, University of Manchester, Manchester, UK.

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