The use of emergency department-based psychological interventions to reduce repetition of self-harm behaviour

Suicide is a public health emergency; over 800 000 people take their life each year, and by 2020, this figure is projected to rise to 1·53 million. Yet, for each suicide, an estimated 26·2 additional people present to hospital with self-harm. The prevention of self-harm is therefore highlighted within most countries’ national suicide prevention strategy.

There is good evidence to suggest that certain outpatient psychological treatments, and particularly cognitive behavioural therapy (CBT), are effective in reducing repetition of self-harm and, to a lesser extent, suicide. Because of resourcing limitations, however, patients often face delays of up to several weeks before their first appointment; even in countries with well-resourced psychiatric services. Yet almost half of all patients who repeat self-harm will do so in this period.

There is therefore substantial interest in the development of brief interventions that can be delivered while patients are receiving medical treatment in the emergency department. Rory O’Connor and colleagues’ randomised controlled trial of a volitional help-sheet (VHS), reported in The Lancet Psychiatry, represents a timely addition to this literature. Importantly, the VHS signals a departure from other emergency department-based interventions which, to date, have focused on the effectiveness of safety-planning and psychosocial risk or needs assessments alone.

Intention-to-treat analyses including all 518 randomised participants revealed that the VHS was not associated with a reduction in either the proportion of participants repeating self-harm, the number of repeated self-harm episodes, or the time to self-harm repetition in this trial. Post-hoc subgroup analyses including 507 participants who completed the trial, however, were suggestive of some, albeit non-significant, evidence of benefit in reducing the proportion of participants repeating self-harm as well as a significant reduction in the number of self-harm episodes in those with a history of self-harm. By contrast, in patients without a history of multiple episodes of self-harm, there was evidence the VHS might be harmful, suggesting that careful targeting of this intervention is required. These subgroup findings, although consistent with accumulating research evidence, require replication.

The VHS is grounded in an empirical theoretical rationale in which the authors hypothesise that behavioural intentions represent the key conduit between suicidal ideation and enaction. Although the VHS was effective in reducing self-reported self-harm intentions in a previous trial, the intervention was not effective in reducing the proportion of participants engaging in self-harming behaviour in this trial. This would suggest that further articulation of the mechanisms underpinning the VHS is warranted. Without delineation of the potential mechanisms of action of this intervention, alongside greater use of mediational analyses to investigate the extent to which the VHS results in actual change to these hypothesised mechanisms, it is difficult to know whether the intervention can, in fact, lead to lasting changes to the putative psychological processes that lead from suicidal ideation to action.

Brief psychological interventions that require minimal expertise to deliver hold promise for improving the reach and scalability of evidence-based treatments for self-harm; particularly for low-income to middle-income countries with constrained resources. However, these interventions also have the potential to increase rumination and negative affect, and potentially self-harm repetition, by serving as unhelpful reminders of negative experiences in the lead-up to the index self-harm event or during hospital treatment. Despite this observation, few trials have assessed the effect of interventions such as the VHS on these processes. A consensus standard of definitions of outcomes for benefit, harm, and cost-effectiveness is needed to enhance this evidence base. Outcome standardisation would also help to improve comparability between trials in this field in the future.

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Elucidating both the non-existent and extensive violent criminal career

Although most individuals with severe mental illness such as schizophrenia are neither antisocial nor violent, the risk of committing a homicide for people with schizophrenia is higher than that for those in the general population. Thus, a paradox typifies many psychiatric conditions for which a specific disorder is associated with increased risk of violence, despite a low prevalence of violence among those with the disorder. Seena Fazel and colleagues’ new study in The Lancet Psychiatry seeks to clarify this paradox by identifying low risk of committing violent crime among a national cohort of 75,158 Swedish individuals between the ages of 15 years and 65 years with a diagnosis of schizophrenia spectrum or bipolar disorders. A 16 item derivation model was developed and tested in external validation, and similar to their previous research, the authors also generated a web-based risk calculator (Oxford Mental Illness and Violence tool) to facilitate practical application. The risk of committing a violent offence at 1 year after hospital discharge with use of a 5% cutoff had a sensitivity of 62% (95% CI 55–68) and specificity of 94% (93–94). The positive predictive value was 11% and the negative predictive value was 99%. This risk calculator tool cannot be used in isolation from clinical assessment in predicting violence risk, and the low positive predictive value especially means that additional thorough clinical input is essential in determining need for extra risk management in high-risk individuals. Fazel and colleagues’ findings show that previous violent crime was the strongest predictor of violent offence, with an odds ratio of 5·03 (95% CI 4·23–5·98), although male sex, previous substance abuse, and previous self-harm were also associated with an elevated risk of committing violent crime. These findings are consistent with criminal career research, which has consistently shown the continuity between antisocial conduct and violence, particularly among those with previous evidence of these factors. Aside from not specifying psychopathy—a powerful predictor of antisociality—in their models, the study by Fazel and colleagues is strong. They also found that more than 80% of the sample had little-to-no risk of violent crime, despite their mental illness. Unlike their violent peers, these individuals lacked previous criminal offences and additional behavioural evidence of violence.

However, the real contribution of the study is the contemplation of those with non-existent criminal careers. Those who abstain from crime and violence have long been largely overlooked by clinicians and criminal justice practitioners who focus their energies on understanding those who do commit crime. Yet non-offenders serve as important exemplars, whose traits, attitudes, behaviours, and social circumstances serve to buffer them from antisocial conduct, even among those with serious mental illness. OxFMV has made an important step forward in helping to identify this group at low risk of committing violent crime. The prediction tool still needs to be combined with clinical judgement before decisions on violence risk are made, and there are ethical issues to...