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BMJ Practice Pointer

Title. Assessment and management of self-harm and suicide risk in young people

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**What you need to know**

* Speak to young people with respect, compassion, and sympathy
* Do not solely use risk assessment scores, tools, or stratification to inform treatment
* Each young person requires a personalised assessment of unmet clinical needs and tailored treatment

A 16-year-old female visits her general practitioner (GP) with her mother describing how she is being bullied at school and how she has felt more anxious as a result. The GP notices a cut on her left wrist.

A 23-year-old male is brought into the emergency department by paramedics after taking a paracetamol overdose at home a few hours earlier.

In both cases, the doctor wants to know how to adequately assess the self-harm episode and how to best help the young person.

Self-harm and suicide in young people are growing and serious public health concerns. Young people can present with self-harm or suicidal thoughts in all clinical contexts. However, the frontline settings of primary care and emergency care allow for early identification and intervention. Managing young people after self-harm or with suicidal thoughts is a daily reality for many GPs and non-mental health clinicians, and so they should be comfortable in performing high-quality assessments.

**How common is self-harm and suicide in young people?**

The National Institute for Health and Care Excellence (NICE) definition of self-harm is intentional self-poisoning or injury irrespective of the apparent purpose.(1) This definition encompasses self-harm with or without suicidal intent and examples of self-harm include cutting, medication overdose, burning, or hair pulling.(2)

Self-harm is common among young people with a pooled 17% lifetime prevalence of self-harm in 12–18-year-olds.(3) Self-cutting is the most common (45%) type of self-harm, followed by head banging (31%), hitting (27%), and self-poisoning (20%) in 12-18 year old adolescents.(3)

The rates of primary care recorded self-harm in boys and girls aged 10-24 in the UK have been increasing since 2010, and in the early pandemic (2020-2022) the incidence of self-harm was higher than expected in 13-16 year old girls specifically.(4) In a UK case-control study of young people aged 10-19, 85% presented to a GP in the year preceding self-harm, and the risk of self-harm rose with the frequency of clinical consultations in the previous year (OR 3.3, 95% CI 3.2-3.5 for one contact vs no contact and OR 9.3, 95% CI 9.0-9.6, for five or more contacts vs no contact) which highlights the need for early identification and intervention in non-mental health settings.(5)

Self-harm is also strongly associated with suicide. According to the World Health Organisation, suicide was the fourth leading cause of death in 15–29-year-olds globally in 2019.(6) The rates of suicide in young people aged 15-24 years in Australia, Canada, the UK, and the USA have been rising over the last two decades and were found to be associated with income.(7, 8) Suicide can occur in clusters at any age but perhaps particularly in young people.(9) Potential mechanisms include clustering of underlying risk factors or social transmission (through in-person contact or from any types of media). Suicide rates in low and middle-income countries (LMICs) are highest among young people aged 10-29 years.(10) In a prospective observational cohort study of young people aged 10-18 who presented to five emergency departments in England between 2000 to 2013, there was a thirty-fold increased risk of suicide in the year after a self-harm episode (SMR 31.0, 95% CI 15.5-61.9).(11) Young people from an online discussion forum described feelings of shame, influenced by previous poor experiences, when seeking help for self-harm from emergency departments which highlights challenges in accessing urgent care.(12)

In this practice pointer, we outline how GPs and non-mental health clinicians can assess and manage young people aged 12-25 years after self-harm or suicidal thoughts. Our approach is informed by the 2022 NICE guideline for self-harm.(1)

**What is the general approach to assessment?**

GPs and non-mental health clinicians should enquire about self-harm and thoughts of suicide in young people in all instances where there is a clinical concern (for example, a presenting psychosocial problem, or when reviewing a chronic condition, or when the young person seeks help for mental health symptoms). Box 1 lists factors that increase the risk of suicide in young people. If self-harm or suicidal thoughts are identified, a full clinical assessment of needs should be conducted by the GP or non-mental health clinician. The assessment should be done with sympathy, respect, and compassion. Where possible and respecting confidentiality, collateral information from the young person’s family, friends, or other professionals should be sought to add to the patient’s account. If the young person refuses the sharing of information with others and holds mental capacity, the clinician can still ask for views from those close to the young person. Of course, such assessments may not be as comprehensive as full psychosocial assessments undertaken by mental health professionals.

The assessment of a young person after self-harm or suicidal thoughts is a dynamic, continuous, and iterative process, where new factors or circumstances may occur in the young person’s life which can elevate or reduce the risk of future self-harm or suicide.(13) Clear documentation in patient records outlining clinical reasoning and rationale for management is essential and can facilitate informational continuity if people re-present.(13) GPs and non-mental health clinicians should not be expected to have the skills and knowledge of mental health specialists, but they should feel competent and confident to speak to a young person after self-harm and know how to seek a specialist assessment when needed.

**What is the role of risk assessment tools and scales?**

The NICE guideline recommends that risk assessment tools or scales should not be used to predict future suicide or repeat self-harm or used for determining treatment decisions, particularly in isolation. This recommendation is based on a meta-analysis of clinical instruments aimed to predict future suicidal behaviour which found only a 6% combined positive predictive value of these tools for future suicide.(1, 14) NICE also recommends that risk should not be stratified into global categories of low, medium, or high.(1) A cohort study of patients presenting to emergency departments after self-harm across four centres in England found that the majority (67% and 83%) of deaths by suicide after six months of self-harm were categorised as ‘low risk’ based on two risk scales, thus highlighting the additional challenge of false negative risk ratings generated by some tools.(15)

We acknowledge that the use of these tools and scales by doctors is still common practice. There are several drivers for this: clinicians may find aspects of tools helpful as an aide memoire, the culture of using these tools is embedded in clinical practice, and tools may be regarded as an assessment shortcut or clinical shorthand in pressured services. However, these tools can provide clinicians false reassurance, detract from the personal assessment of a young person, and are potentially harmful when young people may not receive the care they need.(16)

**How to assess young people**

Clinicians should therefore undertake a clinical assessment of needs. In primary care this assessment might occur across appointments with a GP/family doctor, facilitating the building of therapeutic alliance, focusing on the young person’s circumstances, identifying modifiable risk factors (such as untreated mental illness or substance misuse, or exposure to self-harm images), and working together with the young person and their families to address unmet clinical needs.(1) Young people presenting to general hospital settings should be referred to age-appropriate mental health liaison teams for assessment.(1)

In LMICs such as India, there is guidance for clinicians outlining key areas to cover in a comprehensive assessment of suicidality in young people which includes risk factors; level of functioning; identifying strengths and supports; clarifying goals; and determining level of future caret.(17)

Enquire about clinical factors that may raise suicide risk. In emergency departments and primary care, screening instruments such as Patient Health Questionnaire-9 can help support the identification of concurrent low mood but they are not a substitute for a full clinical assessment of needs.(18) On examination, physical signs such as scars, skin lacerations, wounds, or burns may be evident. Self-poisoning can often present with no physical symptoms but a full physical examination, with a particular focus on the cardiovascular and gastrointestinal systems, is important. Practical tips and features to consider in a mental state examination are listed in Box 2. Request blood tests where appropriate.

Clinicians should consider referring a young person for specialist mental health assessment (including a full psychosocial assessment), when the:

* frequency or degree of self-harm or suicidal ideation is rising or persistent
* clinician undertaking assessment is concerned
* young person’s level of distress is rising, or high, or sustained
* young person asks for specific support from mental health services
* levels of distress or concern in family members or carers of young people are rising, high, or sustained despite help and support offered
* assessment suggests evidence of an underlying mental disorder

**Suicidal thoughts and plans**

Clinicians should enquire whether the young person is having or has experienced thoughts about ending their life and how transient, intrusive, and persistent these are. It should be noted that thoughts of not wanting to be alive, especially those that are short-lived, are common among the general population and are of uncertain prognostic significance. Inquiring about thoughts and behaviours does not make a young person more likely to experience them in the future: a recent meta-analysis, that included studies about young people, found that asking about suicide or self-harm had no impact on future harmful outcomes.(19) In young people who disclose suicidal thoughts, clinicians should sensitively ask whether they have made any plans about suicide. The usual single-item response of yes/no is insufficient, and clinicians will need to probe further where appropriate to facilitate gathering as complete a picture as possible.

Introducing these questions gently and incrementally (while perhaps also mentioning that these are common questions asked to all) may help make the young person feel more comfortable in replying openly. Example questions are ‘Have you ever had any thoughts about going to sleep and not waking up’ and ‘Have thoughts ever come into your head about life not being worth living’? Further sensitive inquiry might explore thoughts and behaviours in more detail, for example, ‘Have you done anything to prepare for ending your life such as giving away a prized possession or writing a letter for one’s family’?.(20)

There can be a difference of views between young people and clinicians about the degree of suicidal intent associated with a self-harm episode.(2) It is often difficult to identify the degree of suicidal intent before self-harm because of preceding distress before an episode, and because reported motivations and intent often change before, during, and after, an episode of self-harm.(2) In addition to asking about thoughts and plans of suicide, imagery can be an element of suicidal thinking for many people.(21) This will probably require a further prompt such as asking the young person if they imagine or picture any aspect of the thoughts they have expressed.

If active suicidal thoughts and/or plans are detected, explore, and identify any protective factors the young person has at the time: the young person can be encouraged to view these as strengths and areas of hope in the management plan.(20) Examples of protective factors include support from family and friends, religious faith, or education or employment commitments (see Box 2).

**Initial aftercare after self-harm**

People who have self-harmed are thought to most likely repeat self-harm within 48 to 72 hours after the episode of self-harm.(1) It is good practice for clinicians to obtain an account of the factors leading up to the self-harm episode, the type, method (including location), and severity of self-harm, reasons for self-harm, and what happened subsequently. The assessor should discuss with the young person, and family if appropriate, the format and frequency of initial aftercare and where there are safety concerns, the young person should be seen again within 48 hours and if possible with the same clinician who did the initial assessment.(1)

**Safety plans in management**

NICE suggest the development of safety plans should be considered for young people after self-harm: elements include *recognising warning signs*; *identifying coping strategies*; *distraction by connecting with others*; *supporting by using social contacts*; *accessing professional contacts*; and *ensuring a safe environment*.(1, 13)

While there is a lack of high-quality RCT evidence, they are in widespread use because they are acknowledged as good practice and may lead to reducing repetition of self-harm. Safety plans should be created collaboratively between young people and clinicians, with input from family members or carers where appropriate, and should be accessible to the person, healthcare professionals who may be named as a source of support such as the GP or mental health team, cover protective factors, and require regular review. Safety plans are dynamic documents and should be adapted as needs and circumstances change. Although non-specialists will not in general lead on developing a safety plan with a young person (this would occur more commonly in mental health services), they may be involved in reviewing it, amending it, and considering it in their management plans.

**Treatment**

There is a lack of evidence for the effectiveness of specific interventions for self-harm in young people.(1, 22) There is some evidence that CBT-type psychological interventions, dialectical behaviour therapy for adolescents, and mentalisation-based therapy, can lead to reductions in self-harm repetition and frequency, however, these interventions tend to be delivered in specialist care settings, and the strength of evidence is not high.(22, 23)

GPs and non-mental health clinicians in non-specialist settings should apply general principles of good care: treating underlying mental or physical illness, safe prescribing considering the toxicity and lethality of medications, addressing social or educational needs, fully involving patients and their families, referring for specialist input where appropriate, and personalising care. In young people in particular with past episodes of self-poisoning a medication review is prudent, and clinicians should consider limiting quantities of medication, and wider access to medicines at home.(1)

In LMIC settings the focus of treatment is likely to be different – social care and public health interventions are at least as important as mental health ones, multilevel interventions (at population, community, and individual levels) might be more effective than those that are exclusively clinical, and digital interventions which improve access may have more of a role.(24)

* a history of current mental illness and distress
* past history of self-harm
* use of alcohol or illicit drugs
* parental separation/death/mental illness
* history of abuse
* chronic physical health conditions
* difficulties in family relationships
* family history of suicide
* stress at home/work/or in place of education
* young people who identify as LGBTQ+

**Box 1**. Factors increasing risk of suicide among young people(25)

**Box 2:** Practical tips for clinical assessment in young people **(26, 27)**

General principles

* Listen attentively and be non-judgemental
* Pay attention to rapport
* Communicate sympathetically and compassionately
* Generate a trusting relationship
* Demonstrate acceptance of the patient
* Ask about sharing information with family and friends early on

Assess mental state including:

* Observe facial expression, eye contact, rate, volume, and tone of speech, abnormal movements, or emotional distress
* Mood and feelings of hopelessness
* Where suspected - delusions and hallucinations
* Self-harm and suicidal thoughts: ideas, intent, and plans

Associated factors to consider

* Academic pressures
* Bullying
* Bereavement
* Suicide or self-harm in family/friends
* Physical health problem
* Child abuse
* Family problems
* Relationship difficulties
* Eating problems
* Alcohol and substance misuse
* Hopelessness
* Mental health disorders
* Suicide-related internet and social media use
* Recent self-harm or suicidal thoughts

Protective factors

* Support from family and friends
* Religion
* Education
* Employment

Narrative summary

Write a summary, bringing components of the assessment together for a coherent narrative, and compose a concluding statement focussed on management. The treatment plan should target identified clinical needs and be developed with the young person. If uncertain, discuss with a specialist mental health professional.

Example concluding statement by a GP:

Recent self-harm by cutting following a disagreement with sister. Low mood for three weeks but no current suicidal thoughts, plans, or intent. Has support from friends. Plan: may have concurrent depression - encourage exercise, good diet, signpost to self-care information. Offered talking therapies referral but at present not keen. Discussed mitigation and help-seeking if thoughts of self-harm recur. For follow-up review in 10 days. Emergency contact details given if self-harm or suicidal intent.

**Conclusion**

Clinicians need to take self-harm seriously, be compassionate towards young people, involve their families, undertake holistic clinical assessments, prescribe safely, and know how to seek specialist input. Young people are a potentially vulnerable group of patients, and every episode of self-harm should be regarded as an opportunity to intervene.

**Education into practice?**

* How do you currently assess risk of repeat self-harm and suicide in young people?
* When you last assessed a young person after self-harm or suicidal thoughts, were you considerate and non-judgemental towards their circumstances?

**How were patients involved in the creation of this article?**

A young person with lived experience of seeking help from healthcare professionals for self-harm was involved in writing, reviewing, and editing this entire article and ensured the piece is appropriate and relevant to young people, and is a co-author.

**How was this article created?**

To write this article we used data presented in the 2022 NICE guideline for self-harm which was underpinned by systematic reviews, the 2021 Cochrane review of interventions for self-harm in children and adolescents, authors’ knowledge of the literature, and a Google Scholar search using search terms ‘suicide’, ‘self-harm’, ‘risk assessment’, and ‘young people’.

**Contributorship and the guarantor**

FM conceived the article idea and is the guarantor. All authors wrote and critically reviewed the article, and agreed to submit the article.

**Conflicts of interest**

FM and NK were members of the NICE self-harm guideline development committee 2022. NK was topic expert for the guideline. NK is a member of the National Suicide Prevention Strategy Advisory Group, DHSC.

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