Crisis card following self-harm: 12-month follow-up of a randomised controlled trial

JONATHAN EVANS, MARK EVANS, H. GETHIN MORGAN, ALAN HAYWARD and DAVID GUNNELL

Summary No intervention has been shown to be effective in preventing repetition of self-harm. In the 6-month follow-up of a large randomised controlled trial, we previously reported no effectiveness of the provision of a card offering 24-h crisis telephone consultation on repetition of self-harm. However, there was a possible benefit among those presenting following a first episode (OR=0.64, 95% CI 0.34–1.22). Here we report the 12-month follow-up of the trial. The results confirm no overall benefit of the intervention (OR=1.19, 95% CI 0.85–1.67). Among those with a first episode of self-harm, the possible benefit of the intervention had diminished (OR=0.89, 95% CI 0.52–1.52), although a modest effect cannot be excluded.

Declarations of interest None.

The trial is described in detail elsewhere (Evans (Evans 1996). We used logistic regression in Stata version 8.0 for Windows to calculate odds ratios for repetition comparing the intervention group with the single index episode and those with a previous history of self-harm (likelihood ratio χ²=2.37, P=0.12). Of the subjects in the intervention group with the single index episode, 30 (13.6%) had a repeat episode of self-harm within 1 year compared with 31 (15%) in the control group (OR=0.89, 95% CI 0.52–1.32). Of the individuals in the intervention group with a previous history of self-harm, 60 (30.9%) had repeat episodes of self-harm within 1 year compared with 45 (22.5%) in the control group (OR=1.54, 95% CI 0.98–2.42).

During the first 6 months following the provision of the card, 70 individuals made telephone contact; the majority only once; the maximum number of contacts was 16. We have no data on subjects trying to make contact but failing to get past the hospital switchboard. There was no report of such difficulties. Of patients in the intervention group, those making telephone contact were more likely to have repeat episodes of self-harm (OR=4.91, 95% CI 2.83–8.50).

RESULTS

We recruited 827 patients, representing 64% of those admitted to general hospital following self-harm during the study period; 417 were given a crisis card and 410 received standard treatment (Evans et al, 1999).

Main analysis

There were 167 individuals (20.2%) with repeat episodes of self-harm in the 12 months after the index episode. Of participants carrying a crisis card, 90 (21.6%) had a repeat episode of self-harm within 1 year compared with 77 (18.8%) in the control group (OR=1.19, 95% CI 0.85–1.67). Time to repetition did not differ between the control and intervention groups (log-rank test χ²=0.98, P=0.32). The Kaplan–Meier curve is shown in Fig. 1.

Subgroup analysis

There was no strong evidence that the effect of the crisis card differed between those with the single index episode and those with a past history of self-harm (likelihood ratio χ²=2.37, P=0.12). Of the subjects in the intervention group with the single index episode, 30 (13.6%) had a repeat episode of self-harm within 1 year compared with 31 (15%) in the control group (OR=0.89, 95% CI 0.52–1.32). Of the individuals in the intervention group with a previous history of self-harm, 60 (30.9%) had repeat episodes of self-harm within 1 year compared with 45 (22.5%) in the control group (OR=1.54, 95% CI 0.98–2.42).
These data confirm that there is no benefit in issuing a crisis card allowing telephone consultation to all those presenting to hospital after self-harm. There was no effect on the number of repeat episodes at 12 months and no difference between those with and without a previous history of self-harm. The possible benefit for those with a single past episode of self-harm (Evans et al, 1999) was not found at 12-month follow-up. It is important to note that while not significant, the 95% confidence interval for repetition among those with a previous history of self-harm includes a 142% increase. We can be confident that the crisis card is unlikely to be beneficial for this group.

A number of issues need consideration. We defined repetition by hospital attendance following self-harm. It is known that self-reported repetition rates are higher than those identified solely through hospital attendance (Guthrie et al, 2001). It is unlikely that this differed between intervention and control groups. Although this study was large, it was not large enough to exclude a clinically important effect in those presenting following a first episode. The 95% confidence intervals around the estimated effect of the intervention following a first episode included a 48% reduction and a 52% increase in repetition. As this intervention is likely to be much cheaper than manual-assisted cognitive therapy, a small beneficial effect may still be cost-effective.

This study was based on services running nearly 10 years ago. There have been major changes in mental health service provision in the UK in recent years (Department of Health, 1999). It is noteworthy that those who made contact were at greater risk of repetition, possibly because they had suicidal ideas. An alternative explanation is that the telephone contact evoked feelings of rejection thereby increasing risk. More skilled handling of those in crisis may be necessary. Crisis teams are now widely available and staffed 24 h a day. These teams include staff with specific training or experience in crisis management. It is possible that contact with crisis teams might prevent repeated self-harm more effectively than contact with on-call junior doctors as offered in this study. The context in which the card is provided is important. We did not have any information about how many subjects kept the card or whether they thought it might be useful. The card is more likely to be effective if the recipient is confident they can use it. Often specialist teams assess those presenting with an episode of self-harm; this includes crisis teams in some areas. Such teams might encourage greater confidence in the card as an alternative to self-harm.

Before conducting further trials of sufficient size, qualitative research should be undertaken to investigate whether this intervention might benefit those presenting following a first episode. This could help to refine the intervention to utilise some of the potentially beneficial changes in mental health service provision in the UK since the planning of this original trial.

ACKNOWLEDGEMENTS

We thank Gemma McCann for updating the self-harm register and Muriel Cole for preparing the manuscript.

REFERENCES


Crisis card following self-harm: 12-month follow-up of a randomised controlled trial
JONATHAN EVANS, MARK EVANS, H. GETHIN MORGAN, ALAN HAYWARD and DAVID GUNNELL
Access the most recent version at DOI: 10.1192/bjp.187.2.186

References
This article cites 6 articles, 5 of which you can access for free at: http://bjp.rcpsych.org/content/187/2/186#BIBL

Reprints/permissions
To obtain reprints or permission to reproduce material from this paper, please write to permissions@rcpsych.ac.uk

You can respond to this article at /letters/submit/bjprcpsych;187/2/186

Downloaded from http://bjp.rcpsych.org/ on June 26, 2017
Published by The Royal College of Psychiatrists