The Practitioner®

CPD study pack

May 2012; 256 (1751)

The study pack contains this month's CPD exercise plus all the relevant articles:

- Identifying patients at risk of perinatal mood disorders
- Primary care management of patients who self-harm
- GPs have key role in helping patients to stop smoking
- Reducing deaths from smoking

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Practitioner CPD exercise

When you have answered the questions below and overleaf, based on articles in this issue, tear out the page and put it in your personal development plan

PERINATAL MOOD DISORDERS

1 Which of the following are confirmed risk factors for postnatal depression?
A First baby
B Multiple pregnancy
C Previous depression
D Family history of depression
E Gestational diabetes

2 Which of the statements are true?
A Routine screening with antenatal psychosocial assessment tools leads to better perinatal mental health
True ❑ False ❑

B Puerperal psychosis affects 1.5% of women
True ❑ False ❑

C Most women with puerperal psychosis already have a diagnosis of bipolar disorder or schizoaffective disorder
True ❑ False ❑

3 The midwife asks you to see a woman in the 30th week of pregnancy who is showing clear signs of antenatal depression.
A What might be your first therapeutic measure after assessment?

B If a drug is used what three principles should be considered?

C Which group of antidepressant drugs has the lowest risk in pregnancy?

4 Match the clinical association in pregnancy or lactation to the drug:
A Sodium valproate
B Clozapine
C Doxepin
D SSRI

1 Neural tube defects
2 High levels in milk
3 Persistent pulmonary hypertension in neonate
4 Agranulocytosis in infant

5 List any changes to your clinical practice that you may make having read this article.

SELF-HARM

6 Which of the following are red flags in patients who self-harm?
A Male gender
B Psychosis
C Increasing frequency of attempts

7 Which of the statements are true?
A Antidepressants may increase the risk of self-harm in some patients
True ❑ False ❑

B SSRIs are effective in reducing self-harm in the long term
True ❑ False ❑

C Psychological therapy is recommended by NICE for some patients
True ❑ False ❑

D Some patients should be advised how to harm more safely
True ❑ False ❑

E Patients with life-threatening self-harm can generally be treated against their wishes in an emergency
True ❑ False ❑

8 Complete the following statement:
Assessment of self-harm should include details of ..... and ....., the event itself, what happened afterwards, as well as broader ..... risk factors. Patients should be screened for ....., anxiety, ... and history of self-harm

9 The boyfriend of a 21-year-old patient telephones at 6pm on a Friday and reports that she is very upset and has taken an unknown quantity of paracetamol.
A What action should you take?

»

CME

B She does not require treatment as the blood levels of the drug were not dangerously high. She is brought to see you the next week asking for help. Should she be referred?

C If you would not refer at this point what additional factor(s) might need to be present to change this course of action?

10 List any changes to your clinical practice that you may make having read this article.

SMOKING CESSATION

11 Match the statistic to the statement:
A Percentage of people who stopped smoking a year ago who will relapse
B Percentage of deaths in people >35 attributable to smoking
C Percentage of regular smokers who quit before their mid-thirties

1 25
2 40
3 18

12 Which of the statements are true?
A Smokers without smoking-related diseases are just as likely to respond to advice from their GP as those with them
True ❑ False ❑

B Offering targetted advice to quit is seen as best practice
True ❑ False ❑

C Nicotine acts on nicotinic cholinergic receptors to release dopamine and other neurotransmitters
True ❑ False ❑

13 List three techniques of behavioural support found to enhance smokers' chances of remaining abstinent.

14 List the three pharmacotherapeutic options available to help smokers quit.

15 Which medication option(s) is (are) considered most effective?

16 List any changes to your clinical practice that you may make having read this article.

EDITORIAL (SMOKING)

17 Which of the statements are true?
A There are 15 million smokers in the UK
True ❑ False ❑

B Half of smokers will die prematurely unless they quit
True ❑ False ❑

C Poorer people are more likely to die prematurely because of smoking
True ❑ False ❑

Answers

PERINATAL MOOD DISORDERS
1 C,D
2 **A** False **B** False **C** True
3 **A** Cognitive behaviour and interpersonal therapy **B** Choose a drug with the lowest risk profile; start with the lowest possible dose; try to use monotherapy **C** Tricyclic antidepressants
4 **A** 1 **B** 4 **C** 2 **D** 3

SELF-HARM
6 B,C
7 **A** True **B** False **C** True **D** True **E** False
8 Pre-planning, final acts, psychosocial, depression, psychosis
9 **A** Advise him to call an ambulance or take her to A&E **B** No **C** Risk of repetition

SMOKING CESSATION
11 **A** 2 **B** 3 **C** 1
12 **A** True **B** False **C** True
13 Measurement of carbon monoxide in expired air; advice on best use of medication; 'not a puff' rule
14 Nicotine replacement therapy (NRT), varenicline and bupropion
15 Varenicline or combination NRT (i.e. the patch + gum or inhalator)

EDITORIAL (SMOKING)
17 **A** False (10M) **B** True **C** True

The Practitioner

Identifying patients at risk of perinatal mood disorders

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Dr Anya Topiwala
BA BM BCh MRCPsych
CT3 in Psychiatry, Oxford Deanery, Oxford, UK

Dr Gurjiven Hothi
MB BS
CT1 in Psychiatry, Oxford Deanery, Oxford, UK

Professor Klaus P. Ebmeier
MD
Professor of Old Age Psychiatry, University of Oxford, Oxford, UK

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www.thepractitioner.co.uk

Identifying patients at risk of perinatal mood disorders

AUTHORS
Dr Anya Topiwala
BA BM BCh MRCPsych
CT3 in Psychiatry, Oxford Deanery, Oxford, UK

Dr Gurjiven Hothi
MB BS
CT1 in Psychiatry, Oxford Deanery, Oxford, UK

Professor Klaus P. Ebmeier
MD
Professor of Old Age Psychiatry, University of Oxford, Oxford, UK



Which patients are at increased risk?

IN PERINATAL MENTAL ILLNESS NOT ONLY DOES THE PATIENT SUFFER,[1] BUT OBSTETRIC OUTCOMES, mother-baby interactions[2] and hence longer term emotional and cognitive development of the child are also affected.[3-6] Perinatal mental illness also has an impact on other family members.

The UK Confidential Enquiry into Maternal and Child Health has consistently found psychiatric disorders to be one of the leading causes of maternal death, often through suicide.[7] Postnatal depression and puerperal psychosis are two disorders most commonly associated with the perinatal period: the first, because of its high prevalence, 13% in the first few months following birth,[8] the second because of its potentially disastrous consequences, including suicide, neglect of the baby and infanticide.

When should patients be referred?

IDENTIFYING PATIENTS

The most efficient strategy to identify patients at risk relies on focussing on clinically vulnerable subgroups: enquiries about depressive symptoms should be made at the usual screening visits.[1,7,9,10] In particular, a personal and family history of postpartum psychosis (especially bipolar affective disorder and schizophrenia) and severe depression should be checked for, as well as previous psychiatric contact.[1,9]

What are the management options?

Although antenatal psychosocial assessment tools, such as the Whooley Questions, Edinburgh Postnatal Depression Scale or the Antenatal Psychosocial Health Assessment may increase awareness of psychosocial risk,[11,12] there is no good evidence that routine screening may lead to improved perinatal mental health.[13-18] Thus the extended Whooley questions, recommended by NICE,[11] (see box 1, p16) do not have sufficient sensitivity or positive predictive value to justify their routine use in the antenatal period.[18] Other screening instruments, such as the Patient Health Questionnaire »

Box 1

The extended Whooley questions

1. During the past month, have you often been bothered by feeling down, depressed or hopeless?

2. During the past month have you often been bothered by having little interest or pleasure in doing things?

3. Is this something you feel you need or want help with?

Table 2

Confirmed risk factors for postnatal depression

- Depressed/anxious during pregnancy
- Past history of depression
- Baby blues*
- Family history of perinatal depression
- Adverse life events
- Poor social support
- Dissatisfaction with relationship with partner[29]

*Intermittent mild affective symptoms that may affect more than 50% of women following childbirth and remit spontaneously after a few days

and the Hospital Anxiety and Depression Scale have not been validated in postnatal populations.[19]

Symptoms of perinatal depression are no different from symptoms of depression at other times of life: depressed mood; anhedonia; change of appetite or sleep patterns; fatigue; decreased libido; feelings of guilt and hopelessness. Attention should be paid to any signs of poor self-care, avoidance of eye contact, overactivity or underactivity or abnormalities in the rate of speech.

Particular care should be taken to ask about suicidal ideation and thoughts of harming others, including the baby. Patients with severe depression with psychotic features, or with puerperal psychosis, may hold delusional beliefs and be hallucinating. They may or may not have insight into their illness. As in postnatal depression, there are no validated screening tools for use in puerperal psychosis.[1]

RISK FACTORS

Antenatal depression

Awareness is increasing that pregnancy is not protective against depression as previously thought.[20] There are data from meta-analyses to support several risk factors for antenatal depression,[21] see table 1, above.

Postnatal depression

Several systematic reviews[8, 22-24] have identified a number of robust risk factors. One of the most important is a previous history of depression, see table 2, left. The degree of risk is directly correlated with severity of past episodes. Prior contact with specialist psychiatric services or psychiatric hospital admission may be useful information to elicit.

Several other associations have been reported, but not corroborated,[25, 26] and include: multiple births; assisted reproduction; stillbirth;[27] low birthweight baby;[28] history of abuse; obstetric complications; lower family income; lower occupational status/employment; unplanned pregnancy;[30] not breastfeeding; antenatal thyroid dysfunction; antenatal stress; and two or more children.

Both antenatal and postnatal depression are increasingly being recognised in men. Postnatal depression may occur in up to 26% of men three to six months postpartum.[31] Potential risk factors include maternal depression and poor relationship.[32]

'Both antenatal and postnatal depression are increasingly being recognised in men'

Puerperal psychosis

Puerperal psychosis is rare (around 1 to 2 per 1,000). Sixty per cent of women with puerperal psychosis already have a diagnosis of bipolar disorder or schizoaffective disorder.[33, 34] In untreated women with bipolar disorder, relapse rates may be up to 50% (antenatal), and 70% (postnatal).[35]

In women with bipolar disorder additional risk factors include:

- previous personal or family history of puerperal psychosis[36]
- discontinuation of mood stabiliser[35]
- primiparity[37]
- difficult labour[37]
- family history
- hormonal changes[38]

Table 1

Risk factors for antenatal depression

- Maternal anxiety
- Life stress
- Prior depression
- Lack of social support
- Domestic violence
- Unintended pregnancy
- Relationship factors

Risk factors in women without a psychiatric history are: being unmarried; having a first baby; perinatal death;[39] family history of puerperal illness;[36] older age at delivery[40] and not living with the infant's father. However, these factors have not been verified in a meta-analysis.

REFERRAL

Women with a personal history of postpartum psychosis or bipolar affective disorder should be considered as high risk for postpartum psychosis. Risk is further increased if there is additional family history of postpartum psychosis or bipolar affective disorder.

The Confidential Enquiry into Maternal Deaths and the Royal College of Obstetricians and Gynaecologists recommend that all pregnant women who are identified as being at high risk should have a shared care plan for their late pregnancy and early postnatal psychiatric management.[7, 16] With the woman's agreement, a copy of the plan should be kept in her records.

The plan should identify what support should be in place and who to contact if problems arise, together with their contact details (including out of hours), and address decisions on medication management in late pregnancy, the immediate postnatal period and breastfeeding.[1]

Women with current mood disorder of mild or moderate severity who have a first-degree relative with a history of bipolar disorder or postpartum psychosis should be referred for specialist psychiatric assessment.

A family history alone indicates a raised, but low, absolute risk of early postpartum serious mental illness.

Where family history only is identified, information should be shared between primary care and maternity services, and any evidence of mood disturbance during pregnancy or in the postnatal period should lead to referral to mental health services.[1] Patients should be referred to psychiatric services if indicated by increased risk and for specific psychiatric and psychological interventions.

key points

SELECTED BY

Dr Peter Saul
GP, Wrexham and Associate GP Dean for North Wales

Perinatal mental illness influences obstetric outcomes, mother-baby interactions and longer term emotional and cognitive development of the child. Psychiatric disorders have consistently been found to be one of the leading causes of maternal deaths, often through suicide. Postnatal depression and puerperal psychosis are two disorders most commonly associated with the perinatal period.

The most efficient strategy to identify patients at risk relies on focussing on clinically vulnerable subgroups: enquiries about depressive symptoms should be made at the usual screening visits. Antenatal psychosocial assessment tools may increase awareness of psychosocial risk but there is no good evidence that routine screening may lead to improved perinatal mental health. Attention should be paid to any sign of poor self-care, avoidance of eye contact, overactivity or underactivity, or abnormalities in the rate of speech. Particular care should be taken to ask about suicidal ideation and thoughts of harming others, including the baby.

One of the most important risk factors is a previous history of depression. The degree of risk is directly correlated with severity of past episodes. Both antenatal and postnatal depression are being increasingly recognised in men. Postnatal depression may occur in up to 26% of men three to six months postpartum. Potential risk factors include maternal depression and poor relationship.

Puerperal psychosis is rare (around 1 to 2 per 1,000). Sixty per cent of women with puerperal psychosis already have a diagnosis of bipolar disorder or schizoaffective disorder. Women with a personal history of postpartum psychosis or bipolar affective disorder should be considered as high risk for postpartum psychosis. All pregnant women who are identified as being at high risk should have a shared care plan for their late pregnancy and early postnatal psychiatric management. Women with current mood disorder of mild or moderate severity who have a first-degree relative with a history of bipolar disorder or postpartum psychosis should be referred for specialist psychiatric assessment.

Cognitive behaviour and interpersonal therapy are the most effective psychological treatments in the management of mild to moderate antenatal and postnatal depression. Tricyclic antidepressants have the lowest known risk in pregnancy and breastfeeding. All commonly used mood stabilisers are teratogenic when used in the first trimester. Use of antiepileptic medication in pregnancy is associated with increased congenital malformations (specifically neural tube defects). There is an increased risk of gestational diabetes with clozapine and olanzapine.

MANAGEMENT

Psychological treatments

Cognitive behaviour and interpersonal therapy are the most effective psychological treatments in the management of mild to moderate antenatal and postnatal depression.[41] They may help prevent postnatal depression in those at high risk. NICE recommends that women who require psychological treatment should be seen within one month of, and no longer than three months after, initial assessment.[9]

Pharmacotherapy

Women of childbearing potential should generally be made aware of the potential effects of medications in pregnancy. When prescribing during pregnancy and lactation good communication with the patient is essential. Discussion should centre on the following themes:

- What is the risk of relapse and deterioration during the perinatal and antenatal period?
- What is the patient's treatment preference?
- Discuss the potential risk-benefit balance
- What are the risks of suddenly stopping medications?
- Discuss increased harm to the fetus associated with overdose of medication
- Discuss which medications are safest when breastfeeding

During the perinatal and antenatal period prescribers should:

- Choose a drug with the lowest risk profile for both patient and fetus
- Always start with the lowest possible dose and increase slowly under review
- Try to use monotherapy when possible

Relevant up-to-date information should be taken from the most recent BNF, or can be requested from the UK Teratology Information Service (tel: 0844 892 0909; www.uktis.org).

Antidepressants

Antidepressants are effective in the antenatal and postpartum periods. As a group they are not thought to increase the risk of major malformations.

However, paroxetine has shown an association with cardiac malformations and should therefore be avoided in pregnancy and in those planning to become pregnant.[42]

Persistent pulmonary hypertension of the newborn has been linked with SSRI exposure after 20 weeks' gestation.[42]

Tricyclic antidepressants have the lowest known risk in pregnancy and breastfeeding; however they have a higher fatal toxicity when compared with SSRIs.

All antidepressants carry a risk of withdrawal and toxicity in neonates, so require careful monitoring.

Elevated drug concentrations of fluoxetine, citalopram and escitalopram have been found in breastfed infants. Doxepin has high milk to plasma ratios and should be avoided in breastfeeding. Sertraline, paroxetine, nortriptyline and imipramine have undetectable drug concentrations in the infant.[43,44]

Mood stabilisers

All commonly used mood stabilisers are teratogenic when used in the first trimester. When planning a pregnancy each case should be reviewed individually, and risk of relapse of mood disorder should be weighed against risk of harm to the fetus.

Lithium has been associated with an increased risk of: Ebstein's anomaly, floppy baby syndrome, non-toxic goitre, hypothyroidism, nephrogenic diabetes insipidus and cardiac arrhythmias.[45] Hence, if possible, lithium should be avoided in pregnancy.

However, if the benefits are deemed to outweigh the risks, a detailed ultrasound scan can be offered, looking specifically at the four chambers of the heart. If an abnormality is detected this is an indication for fetal cardioechogram to assess for Ebstein's anomaly. Serum monitoring is required monthly during pregnancy and more frequently during labour when the risk of toxicity to mother and neonate is high. Lithium is found in high concentrations in breast milk, and breastfeeding should therefore be avoided. If the baby is to be breastfed, careful serum monitoring of the infant should be implemented.[45, 46]

Use of antiepileptic medication in pregnancy is associated with increased congenital malformations, specifically neural tube defects. The use of reliable contraceptive methods should be discussed. Valproate, as a mood stabiliser, should be avoided.[1] It is considered the most teratogenic and has shown an association with long-term neurobehavioural changes. If no other alternative is available, and valproate has to be continued in pregnancy, NICE guidance suggests no more than 1g be given daily in divided doses with 5mg of folic acid.[9]

Excretion of antiepileptic medication in breast milk varies from sodium valproate, 1-2% of maternal serum levels, to carbamazepine, 6-65%, and lamotrigine, 18%.[47-49] Regular sodium valproate when breastfeeding has not shown short-term adverse effects in the baby.[48, 49] Decisions regarding the use of these medications »

during lactation should be made following a full discussion of the risks and benefits with the mother.

Antipsychotics

There is an increased risk of gestational diabetes with clozapine and olanzapine.[50] NICE guidance recommends switching from clozapine to another antipsychotic during pregnancy and lactation because of the theoretical risks of agranulocytosis in the infant.[9] Depot antipsychotics should be avoided in pregnancy.

FOLLOW-UP IN PRIMARY CARE

Women with mood disorders during pregnancy and lactation should be followed up at least as frequently as other patients with mental health disorders. Shared decision-making with this group of patients, including other healthcare professionals, such as health visitors, is vital.

Ideally psycho-education should be offered to women prior to conception, in addition to during and after pregnancy, to facilitate informed decision-making. Those with, or at high risk of, perinatal mood disorders should have a written care plan devised in conjunction with the patient and other healthcare professionals (see above), which will provide a useful resource for the GP.

Importantly, there should be good communication between specialist perinatal mental health services and primary care services.[9] During pregnancy and lactation certain medication, such as lithium, will require closer serum level monitoring.

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Useful information

Association for Post-Natal Illness
Has a network of volunteers who have experienced postnatal illness. Provides information leaflets and advice
www.apni.org
Helpline: 020 7386 0868
(Mon-Fri 10am-2pm)
Parentline (24 hours): 0808 800 2222

Family Action
Support and practical help for families affected by a range of problems including mental illness. Provides 'Newpin' services offering support to parents of children under 5 whose mental health is affecting their ability to provide safe parenting
Tel: 020 7254 6251
www.family-action.org.uk

Depression Alliance
Information and support for people who suffer with depression, and their families
Tel: 0845 123 23 20
www.depressionalliance.org

We welcome your feedback

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editor@thepractitioner.co.uk

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Primary care management of patients who self-harm

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Dr Charlotte L Allan
MBChB (Hons) MRCPsych
ST4 in Old Age Psychiatry,
Oxford Deanery,
Oxford, UK

Dr Sophie Behrman
BA BM BCh
CT1 in Psychiatry,
Oxford Deanery,
Oxford, UK

Professor Klaus P. Ebmeier
MD
Professor of Old Age Psychiatry, University
of Oxford, Oxford, UK

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Primary care management of patients who self-harm

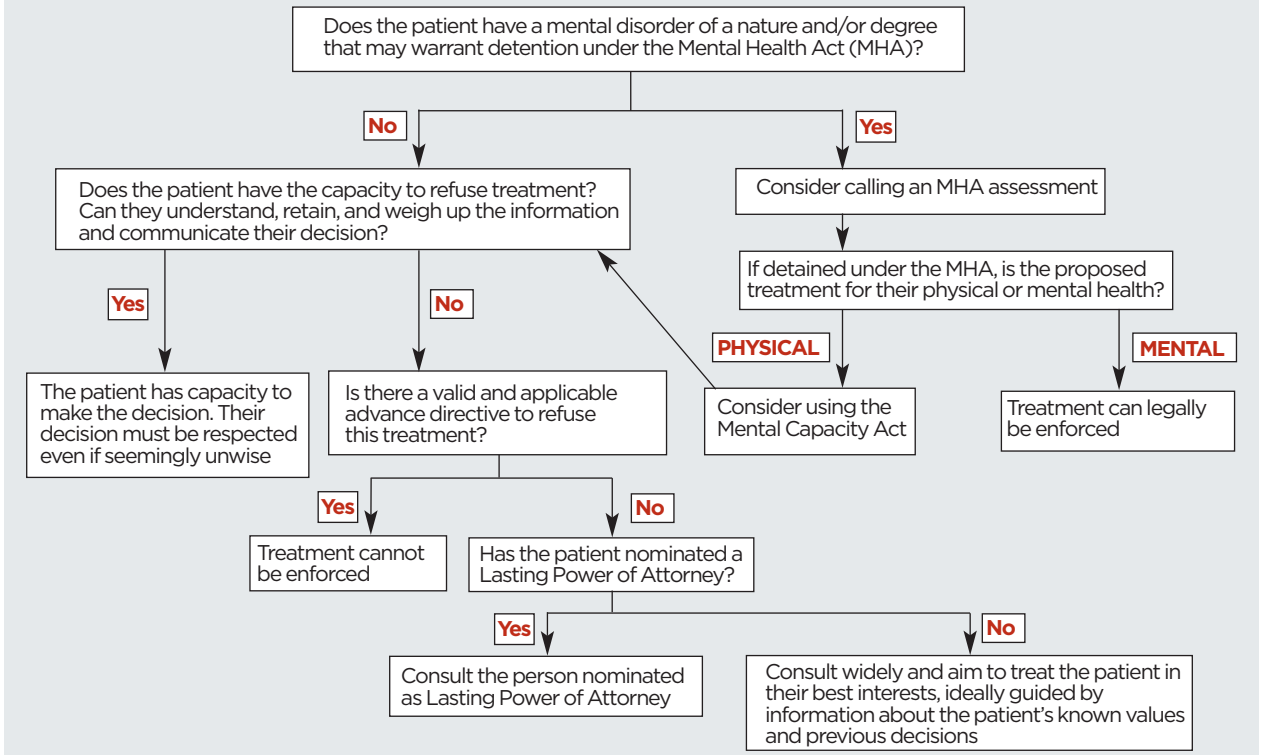
AUTHORS
Dr Charlotte L Allan
MBChB (Hons) MRCPsych ST4 in Old Age Psychiatry, Oxford Deanery, Oxford, UK

Dr Sophie Behrman
BA BM BCh CT1 in Psychiatry, Oxford Deanery, Oxford, UK

Professor Klaus P. Ebmeier
MD Professor of Old Age Psychiatry, University of Oxford, Oxford, UK

Figure 1

Pathway for managing an adult patient who refuses treatment after self-harm



How should patients be assessed?

SELF-HARM IS BEST DEFINED AS 'ANY ACT OF SELF-POISONING OR SELF-INJURY CARRIED OUT by an individual irrespective of motivation'.[1,2] With a 10.5% lifetime risk, self-reported self-harm is common in the community: 5.6% have made a suicide attempt. Self-harm without lethal intent is slightly less common at 4.9%.[3]

A significant proportion of self-harm episodes are without suicidal intent. Although these episodes may signal the wish to die, they primarily communicate distress and the need for help, or they may generate immediate relief from an unpleasant emotional state or an overwhelming situation.[1]

The most obvious path to identifying patients who self-harm in general practice is by asking the relevant questions if they appear depressed or have the risk factors mentioned below.

- Have you ever made an attempt to take your life, by taking an overdose of tablets or in some other way?
- Have you ever deliberately harmed yourself in any way but not with the intention of killing yourself?

In particular, it is important to consider the risk of self-harm in patients with past psychiatric illness, such as alcohol misuse, depression, schizophrenia, bipolar disorder or personality disorder.[1]

What are the red flags?

RISK FACTORS

Self-harm can occur at any age but is most common in young people. A school-based survey of 6,000 pupils aged 15-16 years in England suggested a rate of 13.2% of self-harm overall.[4]

Being female may be a generic risk factor for self-harm. If asked in a household survey,[3] women are more likely than men to have thought about suicide (19.2% of women vs 14.0% of men). As with suicidal thoughts, suicide attempts are more common in women than in men (6.9% compared with 4.3%). However, there is no significant difference in the overall prevalence of reported self-harm between men and women. »

What are the management strategies?

Box 1

Suicide risk with antidepressants

Antidepressant treatment tends to reduce the risk of suicidal ideation in people aged 25 years and over.

In the under-25s there is a non-significant increase in suicidal thoughts or behaviour (preparatory actions for suicide or attempted or completed suicide). When limited to suicidal behaviour alone this risk became significant.[5]

The particular risk in the younger age group is further characterised by an increased risk of non-fatal self-harm in those younger than 19 years who take SSRIs compared with older antidepressants.[6]

Box 2

Key questions in assessment of self-harm

- What happened before the episode?
- What happened during the episode?
- What happened after the episode?
- What are the patient's future plans?
- Explore risk factors (e.g. previous self-harm, mental illness, social circumstances)

Box 3

Red flags[1]

- Increasing frequency of self-harm
- Increasing severity of self-harm
- Dangerous methods e.g. jumping, hanging, drowning
- High levels of distress
- Hopelessness
- Continuing suicidal intent
- Mental illness e.g. depression, psychosis

Box 4

The SAD PERSONS scale[8]

Factor	Score
S Male sex	1 point
A Age < 19 or > 45 years	1 point
D Depression or hopelessness	2 points
P Previous suicide attempts or psychiatric care	1 point
E Excessive alcohol or drug use	1 point
R Rational thinking loss (psychotic or organic illness)	2 points
S Single, widowed or divorced	1 point
O Organised or serious attempt	2 points
N No social support	1 point
S Stated future intent (determined to repeat or ambivalent)	2 points

This score is then mapped onto a risk assessment scale as follows:
0–5: May be safe to discharge (depending upon circumstances)
6-8: Probably requires psychiatric consultation
>8: Probably requires hospital admission

Young women were more likely than young men to report having ever deliberately self-harmed: 17.0% of women aged 16-24 reported this behaviour, compared with 7.9% of men in the same age group.[3]

Prior self-harm is the key risk factor both for repeated self-harm and also for subsequent suicide. The presence of depressive symptoms predicts repeated self-harm, as does any history of psychiatric illness. There is evidence to suggest that being unemployed and registered sick are also associated with higher risk of repetition.[1]

Increased risk of completed suicide is associated with previous self-harm, with high suicidal intent, i.e. the expressed intent to die and not be discovered.[1] Men are at a higher risk of suicide following self-harm. Although antidepressants are a first-line treatment for patients with suicidal ideation as part of depression, there is some evidence that for certain subgroups of patients they raise the frequency of suicidal ideation and self-harm[5,6] (see box 1, above).

ASSESSMENT

Assessment of self-harm (actual or planned) should include details of pre-planning (e.g. stockpiling medication, preventing discovery) and final acts (e.g. leaving a note), the event itself, what happened afterwards (e.g. help-seeking behaviour), as well as broader psychosocial risk factors (see box 2, left).[1]

Careful assessment will not only inform the risk assessment and management plan, but also provides an opportunity to develop a rapport and empathy with the distressed patient. Objective evidence about the severity of the incident (what happened, how did it happen) in addition to the patient's own perception of whether it was intended as a lethal act helps to inform the risk assessment.

Patients should be asked to reflect on the episode of self-harm to consider whether they regret it, or whether it is something they are likely to repeat. Those with continuing feelings of hopelessness and suicidal intent are at greater risk. Social circumstances may aggravate or alleviate risk of suicide.[1]

Patients should be screened for depression, anxiety, psychosis and history of self-harm. Past medical history is relevant since physical illness and substance misuse raise the risk, and those on certain medications including opioid analgesia and insulin may have practical means for suicide at their disposal.

REFERRAL

Patients with low-risk self-harm behaviour can be managed within primary care if they can give an assurance that they are able to keep themselves safe and an appropriate, supportive management plan can be implemented.

Psychological support available within primary care may provide patients with the chance to explore triggers for self-harm, and to develop harm-reduction strategies. Problem-solving therapy and interpersonal therapy, if available, may be particularly useful.[7]

Referral to secondary care community mental health teams should be considered for patients who present in primary care with a history of self-harm and a risk of repetition.[1]

Red flags that should prompt referral are listed in box 3, above. Patients with continuing thoughts or serious intent of self-harm, where supportive or protective factors cannot be identified, may need urgent referral to secondary care. The same applies to those who have used, or plan to use, dangerous methods of self-harm. Patients who present following an overdose should be

key points

SELECTED BY

Dr Peter Saul

GP, Wrexham and Associate GP Dean for North Wales

Self-harm is best defined as 'any act of self-poisoning or self-injury carried out by an individual irrespective of motivation'. With a 10.5% lifetime risk, self-reported self-harm is common in the community and 5.6% have made a suicide attempt. A significant proportion of self-harm episodes are without suicidal intent.

Self-harm can occur at any age but is most common in young people. Prior self-harm is the key risk factor both for repeated self-harm and also for subsequent suicide. The presence of depressive symptoms predicts repeated self-harm, as does any history of psychiatric illness. Men are at a higher risk of suicide following self-harm.

Assessment of self-harm (actual or planned) should include: details of pre-planning; final acts; the event itself; what happened afterwards; as well as broader psychosocial risk factors. Patients should be asked to reflect on the episode to consider whether they regret it, or whether they are likely to repeat it. Patients should be screened for depression, anxiety, psychosis and history of self-harm. Physical illness and substance misuse increase risk.

Referral to secondary care community mental health teams should be considered for patients who present in primary care with a history of self-harm and a risk of repetition. Patients with continuing thoughts or serious intent of self-harm, where supportive or protective factors cannot be identified, may need urgent referral to secondary care. Prediction of further episodes of self-harm is notoriously difficult. Some clinicians may find the use of standardised rating scales, such as the SAD PERSONS scale, a useful way to identify patients who warrant referral and further assessment.

There is currently insufficient evidence to recommend any pharmacological prevention of self-harming. Problem-solving therapy showed promising results when compared with placebo but larger studies are required to corroborate findings. Dialectical behaviour therapy combines a psycho-education programme, aspects of cognitive behaviour therapy and mindfulness and has been effective in reducing self-injury behaviour in adolescents and adults with borderline personality.

Many self-harm episodes are triggered by life events and psychosocial stressors, such as housing, relationship, employment or financial problems. Documenting these in a care plan or letter can improve communication between healthcare professionals and ensure the patient feels their problems have been acknowledged. Any underlying mental disorder should be followed up and treated, in particular, efforts should be made to encourage patients to address alcohol and substance misuse behaviour.

The GP should provide long-term continuity of care, and maintain a holistic awareness of a patient's life events enabling discussion of the patient's emotional problems at an early stage with the aim of intervening before a crisis.

advised to attend A&E for physical investigations and toxicology screens, in addition to psychiatric assessment.

Prediction of further episodes of self-harm is notoriously difficult. In conjunction with a psychosocial assessment, some clinicians may find the use of standardised rating scales, such as the SAD PERSONS scale[8] a useful way to identify patients who warrant referral and further assessment (see box 4, opposite). If in doubt, clinicians should involve the local community mental health team or refer to the emergency department for advice, or to arrange urgent psychiatric assessment (depending on local referral pathways).[9]

MANAGEMENT

Developing a rapport with the patient through the assessment, listening to their concerns and making attempts to offer a mutually acceptable plan is more likely to lead to favourable outcomes and the patient engaging with services.[9]

Research into therapies has been limited to small trials recruiting subpopulations of patients.[7] In 2000 a Cochrane review[10] found insufficient evidence to draw robust conclusions and recommended larger trials of promising interventions. Other authors recommend considering endpoints other than a reduction in self-harm behaviour and widening the methodological approach to research, including qualitative or cohort study designs.[7]

Patients who frequently self-harm often feel mistreated by healthcare professionals.[11] The latter may harbour negative attitudes[12] and feel uncomfortable and inadequately trained.[13]

Recommendations for changes to clinical practice have largely been instigated by patient groups. These include:

- attempts to understand the individual's self-harming behaviour
- adopting a non-judgmental approach
- accepting the patient and their distress.

Contracts with patients requiring them early on not to attempt to self-harm again are sometimes unhelpful and may actually lead to further self-harm.[14]

The immediate risk to the patient's physical health and the potential need for monitoring or medical treatment of self-poisoning or surgical intervention require attention. The clinician should err on the side of caution if the extent of self-poisoning is not known, and consult with an emergency department consultant, or access information via the TOXBASE online resource for poisons information and initiation of treatment, if working in a more remote setting.[9]

There is currently insufficient evidence to recommend any pharmacological prevention of self-harming in the short-[10] and long-term.[1] Problem-solving therapy (a short psychological therapy designed to equip patients to deal with day-to-day problems better) showed promising results when compared with placebo[10] but larger studies are required to corroborate findings.

Dialectical behaviour therapy (DBT) is a relatively new therapy designed to treat patients with borderline personality disorder; this therapy combines a psycho-education programme, aspects of cognitive behaviour therapy and mindfulness. DBT has been effective in reducing self-injury behaviour in adolescents[15] and adults with borderline personality disorder[16] but further large-scale studies are required to confirm this finding.

NICE recommends a short course (3-12 sessions) of a psychological intervention structured for people who self-harm.[1] This recommendation is based on limited clinical evidence suggesting a reduction of repetition of self-harm episodes following psychological interventions, but the studies are too heterogeneous to calculate any meaningful risk reduction ratio. The recommendation is further substantiated by health economic evidence, but again the data are of doubtful significance.

Many self-harm episodes are triggered by life events and psychosocial stressors,[17] such as housing, relationship, employment or financial problems. Although, an initial treatment plan is unlikely to resolve these issues, acknowledging the patient's stressors and documenting them in a care plan or letter as issues to be dealt with in the future can improve communication between healthcare professionals[18] and ensure the patient feels their problems have been acknowledged.

Efforts to improve engagement with services following an episode of self-harm are important and emergency contact cards are a potentially beneficial intervention.[10]

REFUSING TREATMENT

The fine details of the Mental Health Act[19] and the Mental Capacity Act[20] are beyond the scope of this article, but a basic pathway of how to use English legislation to manage an adult patient who refuses treatment is outlined in figure 1, p19.

The case of Kerrie Wooltorton[21] made headlines in 2007, after she was deemed to have capacity to refuse »

treatment following ingestion of antifreeze 'in full knowledge of the consequences,' and died as a result. Such cases are ethically and legally challenging for all concerned, but fortunately are rare.[1]

FOLLOW-UP

It is important that any underlying mental disorder is adequately followed up and treated;[1] particular efforts should be made to encourage patients to address alcohol and substance misuse behaviour, as intoxication is associated with impulsivity and therefore increased risk of further self-harming behaviour.

NICE recommends that a care plan for longer-term treatment be drawn up with the patient and reviewed at least annually.[1] For some patients it is unrealistic to stop self-harming when it may be the only coping mechanism they can effectively use; in such situations, harm minimisation,[1] distraction techniques or safer methods of self-harming can be taught.[22] There is no evidence to support such techniques, so NICE labels them as tentative recommendations.

The role of the GP in caring for patients who self-harm depends very much on the extent of the self-harm and underlying mental disorder. Houston sees the role of the GP in particular as providing long-term continuity of care, and having a holistic awareness of a patient's life events enabling discussion of the patient's emotional problems at an early stage with the aim of intervening before a crisis.[23]

Following an episode of self-harm the GP can offer assessment and practical support, for example, monitoring type and quantity of medication prescribed,[1] and signposting or referral where relevant. Equally important, GPs are ideally placed to support patients and their families following self-harm through an understanding and nonjudgmental approach which aims to alleviate distress.

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Useful information

For healthcare professionals
NICE guidelines on self-harm (CG16 and CG133)
www.nice.org.uk

NHS evidence
www.evidence.nhs.uk

For patients
Royal College of Psychiatrists
www.rcpsych.ac.uk/mentalhealthinfo/problems/depression/self-harm.aspx

National Self Harm Network
www.nshn.co.uk/index.html

thesite.org
www.thesite.org/healthandwellbeing/mentalhealth/selfharm

Recover your life
www.recoveryourlife.com

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editor@thepractitioner.co.uk

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GPs have key role in helping patients to stop smoking

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Dr Jamie Brown
PhD
Research Associate, Cancer Research UK Health Behaviour Research Centre, Department of Epidemiology and Public Health, UCL, London, UK

Dr Tobias Raupach
MD
Cardiologist and Research Associate,
Department of Cardiology and Pneumology, University Hospital Göttingen, Göttingen, Germany

Professor Robert West
PhD
Professor of Health Psychology and Director of Tobacco Studies,
National Centre for Smoking Cessation and Training, London.
Cancer Research UK Health Behaviour Research Centre, Department of Epidemiology and Public Health, UCL, London, UK

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AUTHORS
Dr Jamie Brown
PhD
Research Associate, Cancer Research UK Health Behaviour Research Centre, Department of Epidemiology and Public Health, UCL, London, UK

Dr Tobias Raupach
MD
Cardiologist and Research Associate, Department of Cardiology and Pneumology, University Hospital Göttingen, Göttingen, Germany

Professor Robert West
PhD
Professor of Health Psychology and Director of Tobacco Studies, National Centre for Smoking Cessation and Training, London.
Cancer Research UK Health Behaviour Research Centre, Department of Epidemiology and Public Health, UCL, London, UK



www.ncsct.co.uk/vba

How can GPs support smokers?

Which patients should be referred?

What are the treatment options?

FIFTY YEARS AGO THE ROYAL COLLEGE OF PHYSICIANS PUBLISHED ITS REPORT *Smoking and Health*[1] that firmly established the impact of smoking on health in the public consciousness. This was the trigger for a sustained decline in smoking prevalence in the UK and a catalyst for many subsequent activities that have successfully reduced morbidity and mortality from smoking.[2]

However, 18% of all deaths in adults aged 35 or over in England are still attributable to smoking.[3] Almost all these premature deaths could be avoided if smokers stopped before their mid-thirties but only a quarter of people who have ever smoked regularly manage to quit by this age.

The pivotal role of GPs in smoking cessation is reflected by the inclusion of smoking indicators in the QOF, see box 1, p24. It has long been known that advice from the patient's GP is one of the most important triggers to a smoker making an attempt to quit.[4,5] Recent research has shown that this can be done more easily, quicker and more effectively than previously thought.[6,7]

SMOKING CESSATION ADVICE

All patients attending a surgery for any reason who have smoked within the past three years should be offered advice on stopping smoking.

Studies have shown that many GPs prefer to limit advice to current smokers with smoking-related conditions,[8,9] and feel that quite a large proportion of consultations are inappropriate for raising the topic of smoking.[10]

However, the evidence is clear: smokers without smoking-related diseases are just as likely to respond to advice as those with them.[11]

Every opportunity to raise the topic of smoking is a potential opportunity to save a patient's life. Every day that a person aged 35 or older continues to smoke costs him or her six hours of life expectancy.[12]

It is also important to re-assess the status of former smokers who were recorded as having stopped within the past three years. They may well have relapsed. Half of those who stopped six months ago will relapse at some point as will 40% of those who stopped a year ago.[13]

New evidence points to a change in the way smoking advice should be given. Rather than going through a litany of advising smokers to stop, asking whether smokers are interested in stopping and only if they »

Box 1

Quality and Outcomes Framework 2012/13: Smoking indicators

Ongoing management

Smoking 5: The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months. **25 points**

Smoking 6: The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record of an offer of support and treatment within the preceding 15 months. **25 points**

Smoking 7: The percentage of patients aged 15 years and over whose notes record smoking status in the preceding 27 months. **11 points**

Smoking 8: The percentage of patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months. **12 points**

Box 2

The three steps involved in delivering Very Brief Advice

Step 1 - Ask about the patient's smoking status.

Step 2 - Advise that the best way to stop is a combination of specialist support and medication. This avoids asking smokers whether they are interested in quitting, which may put them on the defensive and lead to a difficult and time-consuming conversation about the specifics of their situation, which should be saved for a dedicated consultation. This leads very rapidly to the 'act' phase.

Step 3 – Act, offer medication and support wherever it is locally available. The ideal support would be from a specialist stop smoking advisor who is either available within a practice or at a local stop smoking service.

If a patient does not want specialist support and would prefer only medication, it may be best to ask the patient to come back for a dedicated consultation to discuss all their options. In the meantime, patients could be directed to the NHS Smokefree website or free NHS helpline for more information. The most important thing is that help has been offered and then it is up to the patient to decide whether he or she wants to take it up.

Box 3

Summary points

- 18% of all deaths in adults aged 35 or over in England are attributable to smoking
- advice from a patient's GP to stop smoking is one of the most important triggers to a smoker making an attempt to quit
- GPs can make every contact count by simply offering support to all smokers. This is easier, quicker and likely to be more effective than advising smokers to stop or asking whether they are interested in quitting
- The National Centre for Smoking Cessation and Training has launched a new online training module for GPs on how best to deliver smoking cessation support to their patients (www.ncsct.co.uk/vba)
- The most effective smoking cessation treatment is a combination of behavioural support and pharmacotherapy
- The most effective pharmacotherapy is either varenicline or combination NRT (e.g. the patch and a faster acting product such as gum)

are interested offering support, a better approach is simply to offer help with stopping to all smokers.[6,7] This puts the interaction on a positive supportive footing with minimal risk of causing upset.[14]

ONLINE TRAINING MODULE

In response to this new evidence, the National Centre for Smoking Cessation and Training (NCSCT) has launched a new online training module on how GPs can best deliver smoking cessation support to their patients (www.ncsct.co.uk/vba).

The module is called Very Brief Advice and is designed to be used opportunistically in less than 30 seconds in almost any consultation with a smoker, see box 2, left.

'Advice from the patient's GP is one of the most important triggers to a smoker making an attempt to quit'

SMOKING CESSATION THERAPY

Smokers who attend stop smoking services should receive treatment for what is an addiction and not simply a lifestyle choice.[15-17] Smoking cigarettes leads to a rapid increase in nicotine concentration in the brain.[18] Nicotine then acts on nicotinic cholinergic receptors to release dopamine and other neurotransmitters.[19,20] This action results in several mechanisms that sustain addiction. These include powerful urges to smoke in the presence of particular cues and a nicotine hunger – a drive to smoke when CNS nicotine levels become depleted.[21-24]

Optimum treatment involves behavioural support plus one of the smoking cessation medications now available.[25,26] Behavioural support includes a number of specific behaviour change techniques that have been found to enhance the smoker's chances of remaining abstinent.[27,28] These techniques include:

- measurement of carbon monoxide in expired air to bring home the risks of smoking and show the immediate benefit of stopping
- advice on best use of medication
- helping smokers to put in place a very clear 'not a puff' rule to counter the

key points

SELECTED BY

Dr Peter Saul
GP, Wrexham and Associate GP Dean for North Wales

Eighteen per cent of all deaths in adults aged 35 or over in England are still attributable to smoking. Almost all these premature deaths could be avoided if smokers stopped before their mid-thirties but only a quarter of people who have ever smoked regularly manage to quit by this age. Advice from the patient's GP is one of the most important triggers to a smoker making an attempt to quit. Research has shown that this can be done more easily, quicker and more effectively than previously thought.

All patients attending a surgery for any reason who have smoked within the past three years should be offered advice on stopping smoking. Smokers without smoking-related diseases are just as likely to respond to advice as those with them. It is also important to re-assess the status of former smokers who were recorded as having stopped within the past three years. They may well have relapsed. Half of those who stopped six months ago will relapse at some point as will 40% of those who stopped a year ago.

Offer help with stopping to all smokers. The National Centre for Smoking Cessation and Training has launched a new online training module on how GPs can best deliver smoking cessation support to their patients. The module is called Very Brief Advice and is designed to be used opportunistically in less than 30 seconds in almost any consultation. There are three steps involved in delivering Very Brief Advice: ask, advise, act. Ask about the patient's smoking status. Advise that the best way to stop is a combination of specialist support and medication. Act, offer medication and support wherever it is locally available.

Smokers who attend stop smoking services should receive treatment for what is an addiction and not simply a lifestyle choice. Smoking cigarettes leads to a rapid increase in nicotine concentration in the brain. Several mechanisms sustain addiction, these include powerful urges to smoke in the presence of particular cues and a nicotine hunger — a drive to smoke when CNS nicotine levels become depleted.

Optimum treatment involves behavioural support plus one of the smoking cessation medications now available. Behavioural support includes a number of specific behaviour change techniques that have been found to enhance the smoker's chances of remaining abstinent. These include: measurement of carbon monoxide in expired air to bring home the risks of smoking and show the immediate benefit of stopping; advice on best use of medication and helping smokers to put in place a very clear 'not a puff' rule to counter the tendency to think they can 'just have one'.

The three pharmacotherapies currently licensed, and widely used, in the UK are nicotine replacement therapy (NRT), varenicline and bupropion. The most effective medication option is either varenicline or combination NRT (i.e. the patch and one of the faster acting products such as gum or an inhalator).

tendency to think they can 'just have one'.

The three pharmacotherapies currently licensed and widely used in the UK are nicotine replacement therapy (NRT), varenicline and bupropion.

The most effective medication option is either varenicline or combination NRT (i.e. the patch and one of the faster acting products such as gum or an inhalator).[26, 29, 30]

A large RCT has recently found that cytisine, a very low cost drug that acts in a similar way to varenicline, is effective but this is unlikely to be available on the NHS until the finding has been confirmed by further trial evidence.[31]

Although the popular press occasionally carries reports and opinion pieces arguing that treatment to aid smoking cessation is not effective in the real world[32] there is a wealth of evidence to refute this.[25, 26, 29, 30]

GP advice is one of the most important triggers to a smoker making an attempt to quit. This offers GPs the opportunity to play a critical role in reducing the huge number of premature deaths attributable to smoking. Evidence shows that offering help to all smokers is easier, quicker and likely to be more effective than just advising smokers to stop or asking whether they are interested in quitting.

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Useful information

NCSCT
www.ncsct.co.uk

Smokefree
smokefree.nhs.uk

QUIT
www.quit.org.uk

ASH
www.ash.org.uk

Smoking in England
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EDITORIAL

Reducing deaths from smoking

AUTHOR
Professor John Britton
MD MSc MRCS FRCP FFPH

Professor of Epidemiology and Director, UK Centre for Tobacco Control Studies, University of Nottingham, Nottingham, UK

IN 1962, WHEN THE RCP PUBLISHED *SMOKING AND HEALTH*,[1] MORE THAN 70% OF MEN AND 40% OF women smoked. Polite hosts would offer a cigarette. Smoking was an established component of the fabric of society. A behavioural epidemic that would claim more than 100,000 lives a year in the UK, for decades, was entrenched.

Fifty years on, the prevalence of smoking in the UK has halved, and the epidemic of deaths caused by smoking, which lags about 20 years behind smoking prevalence, is now also in decline. Since the publication of the White Paper *Smoking Kills* in 1998,[2] the UK has emerged as a world leader in smoking prevention.[3] Smoking, however, remains the largest avoidable cause of premature death and disability in the UK.

'Smoking remains the largest avoidable cause of premature death and disability in the UK'

After five decades of awareness of the health risks of smoking, and awareness of effective policies to prevent smoking, there are still around 10 million smokers in the UK, half of whom will die prematurely, losing many years of life, unless they quit. Smoking costs the NHS around £5 billion[4] and wider society an estimated £14 billion annually.[5]

Smoking is increasingly concentrated in the most disadvantaged sectors of society, and is now the biggest avoidable cause of social inequality in life expectancy in the UK.

Preventing smoking now, as in 1962, depends on reducing the affordability of cigarettes, using the media to educate and promote health, making non-smoking the norm in public and workplaces, preventing advertising and promotion, preventing supply to children, and providing effective support to individuals who want to quit.

Yet in the UK today, although heavily taxed, cigarettes are more affordable than they were in 1965. The Tobacco Advertising and Promotion Act of 2002 has prohibited most advertising and marketing of tobacco, but the industry continues to benefit from smoking behaviour and brand imagery in the media, which could easily be prevented. The use of point-of-sale displays to communicate with existing and potential new customers is now being prevented by new legislation, but the use of tobacco packaging to promote brands and mislead on health risks remains unchecked. Smoke-free policies could be extended substantially into more areas of everyday life. Sustained media campaigns are credited with major impacts on smoking prevalence in other countries, and could be applied to much greater effect in the UK.

Tighter restrictions on the retail availability of cigarettes would help smokers who want to quit, while children need protection from all sources of supply. Children also need more effective protection against exposure to smoke in the home and other private areas, and to the role model of adult smoking behaviour.

Stop Smoking Services could improve by assimilating the practices and approaches of the most successful, while adapting to the needs of different sectors of the population, including those who do not routinely access conventional health services.

Health professionals could do a lot more to integrate and deliver cessation services as a routine and systematic component of the services they provide.

Smokers who don't want to, or have been unable to, quit could also benefit substantially from access to alternative sources of nicotine through the same retailers that currently supply their cigarettes.[6,7]

These are the policies that need to be driven forward if the UK is to maintain the downward trends in smoking prevalence. The recent commitment by the Secretary of State for Health to enact some of these policies, and particularly to consult on plain packaging for tobacco products, is a welcome signal of intent to address the problem.

Smoking kills, and saving the lives of today's smokers, and preventing our children from becoming the smokers of tomorrow demands comprehensive action on all fronts. With that, perhaps, we could see an end to tobacco smoking in Britain in rather less than 50 years.

See also 'GPs have key role in helping patients to stop smoking', p23

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