

# Assessment of deliberate self-harm in adults

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Deliberate self-harm remains a common problem in the United Kingdom, with rates in the order of 250–300 per 100 000 per year (Hawton & Fagg, 1992). Since the suicide rate in the 12 months after hospital attendance for deliberate self-harm is around 1% (Hawton & Fagg, 1988), each year approximately 2–3 per 100 000 of the population die by suicide within a year of attending hospital with a non-fatal episode of deliberate self-harm. This is about a quarter of the overall suicide rate of 11 per 100 000. There is therefore an easily definable group at risk of suicide who should be the focus of a suicide prevention strategy.

Conscious of a need to improve services for self-harm patients, the Royal College of Psychiatrists recently examined standards of care. The then Audit Working Group of the College and its Liaison Psychiatry Special Interest Group arranged a consensus conference of mental health and public health professionals to consider and set standards for the hospital management of adult deliberate self-harm patients. Many of the steps towards better care and the standards suggested below are drawn from the agreed statement which resulted from that meeting (Royal College of Psychiatrists, 1994). All those who are involved with services for deliberate self-harm should examine the recommendations of the College closely.

## Organisation of services

Despite the scale of deliberate self-harm, planning and delivery of services are in disarray locally and nationally. The situation in most places is much as described in an audit carried out in one hospital in the 1970s. Blake & Mitchell (1978) found wide variations in the aftercare arrangements made by the ten separate consultant teams responsible for

the deliberate self-harm assessment service. For example, further follow-up was arranged for almost all patients by one team but for less than half by another. More contemporary figures from around the country vary just as much: referrals for psychiatric care range between 21% (Hawton & Catalan, 1987) and 76% (Hamer *et al.*, 1991).

Variations in the actions of clinicians are paralleled by inconsistencies in organisation of services. A survey around Yorkshire Region revealed that less than half of districts had written guidelines on management of deliberate self-harm, or had a named consultant psychiatrist with responsibility for the service (Renvoize & Storer, 1991, unpublished). A national survey of practice in the late 1980s suggested that there had been little movement towards the use of specific self-harm teams and only a quarter of health districts reported use of multi-disciplinary assessment as suggested in the 1984 Department of Health and Social Security guidelines (Butterworth & O'Grady, 1989).

This is unfortunate because there is evidence that staff other than psychiatrists can make satisfactory psychosocial assessments of self-harm patients. These staff are most commonly social workers (Newson-Smith & Hirsch, 1979) and psychiatric nurses (Catalan *et al.*, 1980). Non-psychiatric medical staff have been shown to be competent in assessing in-patients (Gardner *et al.*, 1977) and attenders in the accident and emergency (A & E) department (Gardner *et al.*, 1982; Waterhouse & Platt, 1990; Owens *et al.*, 1991).

Whatever the style of assessment and aftercare, self-harm services need to be planned, and responsibilities defined. Because of the scale and importance of deliberate self-harm, those who commission and purchase hospital services are increasingly likely to want specifications for minimum quality. Each hospital or Trust should take a number of steps.

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### Self-harm services planning group

A deliberate self-harm services planning group should be set up. A consultant and a nurse from A & E, general medicine and psychiatry are the obvious clinical members of the planning group, together with a social worker. Also essential are a senior manager and a representative of purchasers. The involvement of several distinct parts of the hospital or Trust points to inclusion of an information officer to help with service monitoring.

### A designated clinical team

Two aspects of the work have led some hospitals to set up a designated, multi-disciplinary deliberate self-harm clinical team – staffed by a variety of psychiatrists, nurses, social workers and others. First, such teams can coordinate and deliver prompt services for the hundreds of patients to be assessed across the different settings in the hospital. Second, interventions following self-harm differ from those used in general psychiatric practice. Although identifying and instituting treatment for severe mental illness is among the most important tasks in the assessment of deliberate self-harm patients, in a majority of patients the precipitating events are psychosocial problems which are not amenable to routine treatments for mental illness. Self-harm clinical teams must offer psychosocial interventions, often based around helping patients to learn new ways to solve problems, through a mixture of cognitive-behavioural and counselling techniques.

Specialist multi-disciplinary teams can improve quality of care for deliberate self-harm patients and each planning group should consider setting one up. A specialist team may not be feasible in small districts, particularly in rural areas. In those circumstances sectorised multi-disciplinary mental health teams may more appropriately offer the assessment and aftercare. In larger hospitals it is difficult for multiple sector mental health teams to offer the full range of interventions swiftly and to communicate adequately with the relevant departments. In either case – special teams or regular mental health services – the planning group must ensure the support of psychiatric colleagues so that the general adult psychiatric service provides necessary backup (for example, out-of-hours and holiday cover) for the assessment of self-harm patients in A & E and on in-patient wards.

### Policy on direct discharge

Published reports from around the country reveal that in many hospitals between a quarter and a

half of all self-harm patients are discharged directly from the A & E department (Owens, 1990). A high proportion of these patients are not assessed by specialist mental health staff before their discharge. Often this practice is not openly acknowledged; discharge without specialist referral will occur from some A & E departments, but there should always be a written policy, and cases should be documented so that rates of discharge and referral can be monitored and audited.

### Recovery time

Some patients will need time to recover their equanimity before a decision can be made about what to do next. Sometimes a relative or other informant is awaited, or there may be social needs which must be organised. It is therefore important that there are facilities to allow some patients time either in A & E or a medical ward for a degree of recovery. Short-stay wards may be a useful setting for brief admissions; patients should not spend many hours in A & E.

## Training and supervision

Opinions vary on how best to carry out psychosocial assessment of patients who attend hospital as a result of deliberate self-harm (usually self-poisoning, less often self-injury). Although there has been a good deal of argument about who should carry out such assessments, these issues were largely resolved before the latest set of official guidelines were issued ten years ago (Department of Health and Social Security, 1984). In particular, evidence was accepted that in some circumstances adequate assessment could be carried out by non-psychiatrists (Black & Pond, 1980). As the current guidance stands, "the consultant who has charge of the patient whether in the Accident and Emergency department or in a ward will be responsible for ensuring that a full physical assessment is made and that before patients are discharged from hospital, a psychosocial assessment is carried out by staff *specifically trained for this task*" (Department of Health and Social Security, 1984).

In reality, patients are often not assessed by staff with adequate training and supervision in psychosocial assessment before their discharge. Even when patients are referred for specialist psychiatric assessment, whether in A & E or on an in-patient ward, they are frequently seen by junior psychiatrists with indifferent supervision.

## Non-specialist staff

Where A & E and other non-psychiatric medical staff undertake psychosocial assessment of self-harm patients they should undergo post-qualification training. The planning group for each hospital should arrange for newly appointed A & E and general medical staff to receive training before they are expected to carry out this task, probably within days of taking up a post.

As well as training, A & E medical staff who carry out assessments need supervision by senior staff who have themselves had designated training in psychiatry. It is now commonplace for those appointed as consultants in A & E to have spent a period of post-qualification training in psychiatry, but where they have not, appropriate supervision needs to be identified. If physicians opt to undertake psychosocial assessment of in-patients without calling in the specialist self-harm team or a psychiatrist, that assessment then becomes a major part of the patient's management and must be dealt with by the medical team as a whole (involving nurses, senior doctors and other staff) and not by an unsupervised house officer.

## Specialist staff

In many cases, however, a specialist mental health worker will be called to A & E or an in-patient ward in order to assess deliberate self-harm patients. This person should be suitably trained and supervised, but need not be a psychiatrist. There are numerous services in which nurses and social workers act as specialist assessors. Whatever the professional background of the specialist assessor, there are minimum standards for their training. Someone new to the task should undertake observed assessments, i.e. under direct supervision, until judged competent. New specialist staff should be provided with or directed to relevant literature.

During the first six months of carrying out specialist assessments, every case should be supervised, and the management should be discussed in detail with a designated supervisor. Out of hours, when cases can be particularly complex, self-harm assessments by new staff should routinely be discussed with the on-duty consultant or senior registrar. Rotational senior house officers who have previously undertaken work of this kind do not need to discuss every case in detail but they should routinely discuss, over the telephone or face-to-face, the management with a designated supervisor. Psychiatric registrars

should have the experience to decide when to discuss management with a more senior person.

The planning group should set a policy for supervision of non-medical staff once they are adequately trained for self-harm assessments. These arrangements will vary according to the experience of the specialist nurse or social worker, and the views of senior psychiatrists – both in the planning group and within adult psychiatry in the district.

Tricky areas of clinical responsibility arise when specialist staff are asked to make an assessment. First, is the specialist providing advice to the A & E or medical team, or acting autonomously and making management decisions? Second, is a training-grade doctor or a non-medical specialist acting independently or on behalf of a consultant psychiatrist? Local views on these issues will vary. The essential thing is written guidance, preferably agreed across the service; another job for the deliberate self-harm services planning group.

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## **Assessment of patients**

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The purpose of psychosocial assessment is to identify among self-harm patients those who have a psychiatric illness, high suicide risk, co-existing problems (for example alcohol or drug problems), and those in social crisis. Those with mental illness or a substance use problem may need prompt and effective psychiatric treatment, and where other psychosocial problems are identified patients should have access to various forms of social and psychological help.

The first task in A & E and on a medical or short-stay ward will usually be to provide prompt assessment and effective treatment of the patient's physical condition in order to minimise risk of death and disability. However, not far behind in importance and urgency are detection of suicide risk and of severe mental illness. Patients in A & E include some who may leave the hospital precipitately due to an abnormal mental state. Therefore, when the presenting complaint is deliberate self-harm, prior to any consultation a member of the A & E staff (probably a nurse) should answer three questions immediately after the patient's arrival :

- (a) Is the person physically fit to wait?
- (b) Is there obvious distress?
- (c) Is the person likely to wait until seen by the accident and emergency doctor?

This process should lead to rapid medical assessment for some patients and for some a request for psychosocial assessment in A & E.

Nurses on general medical and short-stay wards should be trained in the nursing of suicidal patients and be able to produce a nursing care-plan which assesses immediate risk and recognises that risk fluctuates.

When a psychosocial assessment is undertaken in A & E or on a ward, the physical environment needs to be adequate. Each patient should be interviewed in a setting which accords with privacy, confidentiality and respect. There should be a designated room to which patients can be directed for the necessary interview. In A & E the room should be close to, or part of, the main receiving area and should have a suitable security system. Psychosocial assessment should be carried out in such a room unless it is inappropriate (for example, when a patient is threatening and abusive and it is necessary for other staff to be present or immediately available).

#### Information to be documented

Whether psychosocial assessment is carried out by A & E medical staff, psychiatrists or specialist non-medical staff, it should be systematic. The information in Box 1 should always be collected and documented in either A & E or standard hospital casenotes. A pre-printed checklist prepared by the planning group may assist with this task.

The most important information is level of consciousness. If the drugs or alcohol taken have impaired the patient's consciousness then much of the assessment is rendered unreliable or may be impossible to carry out. Where an intoxicated deliberate self-poisoning patient wants to leave A & E or a ward without assessment, staff nevertheless have an obligation to carry out as much assessment as is possible – and to take appropriate action, especially if the patient continues to express suicidal intent.

It is particularly important for A & E and medical staff to recognise that deliberate self-harm patients with impaired consciousness must be able

- Box 1. Information to be collected and documented during assessment**
- Conscious level
  - Psychiatric history and mental state examination
  - Social situation and events
  - Risk
  - Alcohol and drug use
  - Decisions taken
  - Specific arrangements for any follow-up

to stay in hospital until fully assessed, even if assessment needs to be delayed for physical, psychiatric or social reasons. If monitoring reveals that discharge of in-patients who have not undergone specialist assessment is commonplace, regular meetings between general medical staff and the specialist self-harm team should be held.

Where the patient's condition and the physical surroundings permit adequate psychosocial assessment, assessing risk may be the most difficult task. In this article we have concentrated on the importance of proper procedures for self-harm assessment. Assessment of risk in individual patients is a topic which warrants a separate article; only a few remarks about it are included here, with useful references for further reading.

#### Risk assessment

There are available lists of risk factors which predict repetition of self-harm or subsequent suicide (Hawton & Catalán, 1987; Williams & Morgan, 1994). However, although factors such as psychiatric history, past episodes of self-harm, or advancing age may indicate increased risk among groups of patients, predictive values of all risk factors are poor, and consequently of limited clinical value (Owens *et al.*, 1994). In the assessment of the risk for an individual patient attention needs to be paid to three key areas: suicidal intent at the time of the self-harm, present psychiatric state, and social support.

Suicidal intent has been studied closely by Beck *et al.* (1974) and their intent scale is widely used in clinical practice; it is reproduced in the excellent book on self-harm by Hawton & Catalán (1987). Assessing the present psychiatric state requires a full history and mental state examination. Particular attention needs to be paid to indications of depressive features, especially hopelessness. Adverse social circumstances add to despair and it is essential to enquire into the extent of the patient's social support. Useful guides to interviewing self-harm patients, with specific questions about intent, present state and social support, are included in one of the Health of the Nation publications – a review on the theme of suicide prevention, carried out by the Health Advisory Service (Williams & Morgan, 1994). Table 1 sets out some examples of important questions about intent, psychiatric state and social support.

Certain groups of patients can be particularly difficult to assess. For patients aged over 65 years, and those with a learning disability, referral to the specialist service as a matter of routine is recommended. Some would advocate routine

**Table 1.** Estimating risk of further suicidal behaviour: examples of enquiry<sup>1</sup>

Risk factors	Past psychiatric contact or admission, previous self-harm, advancing age, living alone
Suicidal intent of self-harm episode	Premeditation, risk of discovery, calls for assistance, patient's stated intent, actual lethality of method and patient's perception
Present psychiatric state	Recent history of depressive features, guilt, hopelessness, desperation, suicidal thoughts or plans
Social support	Housing, employment, support from family or partner, isolation or solitude, professional helper (for example, social worker)

1. These are only examples – see text for references to more complete lists.

referral to specialists of all deliberate self-harm patients aged under 18 years.

In many hospitals a large proportion of self-harm patients are discharged directly from A & E. The evidence is that those who return home are, in general, a group whose risk of further suicidal behaviour is lower than those who are admitted to medical or short-stay wards; they are younger and have less history of self-harm or of psychiatric care (Owens *et al*, 1991). Where the patients discharged from A & E are being selected appropriately, there must be a corresponding concentration of morbidity and risk within the remainder who are admitted to medical or short-stay beds. This in turn will make the task of assessing these patients more difficult.

Accident and emergency staff must have immediate access to telephone advice, either from a psychiatrist whose designated duties include attendance at A & E, or from another designated self-harm health specialist (a nurse or social worker) who is equipped to undertake psychosocial assessment and management. A request for emergency attendance should result in the prompt arrival of a member of the self-harm specialist team or a duty psychiatrist. There should also be available social services assistance for those self-harm patients who have significant social difficulties (for example, homelessness).

If all in-patients are referred for specialist assessment, there will be no need for the general medical staff to do more than make the initial assessment of immediate risk and disturbance of mental state. The system for referring patients should be efficient and clearly understood by physicians, nurses and others on medical wards, psychiatric clerical staff, and those who undertake the assessment.

Patients should be seen for assessment on the same working day provided that the referral is made from the ward during the first part of the morning. At weekends and public holidays in small hospitals it may not be possible to arrange for a daily round of routine assessment. However, when a psychiatric emergency arises with a deliberate self-harm patient – as it does from time

to time – it should be agreed policy that a member of the self-harm specialist team or a duty psychiatrist will attend any hospital ward within one hour of an urgent request for consultation from the medical team in charge of the patient's care.

Where there is no designated self-harm team, the rota for routine assessments of self-harm patients should name the consultant team responsible for the assessment rather than the names of trainee psychiatrists. This step helps to emphasise that assessment of deliberate self-harm patients should be a scheduled team activity with adequate time and supervision set aside.

## Intervention

It is unfortunate that neither official guidelines nor research findings have led to uniformly high standards of service, because the research evidence strongly suggests that psychiatric intervention can improve psychiatric and social function after deliberate self-harm; whether it can reduce repetition rates or suicide rates is not yet clear. Six randomised controlled trials of psychosocial aftercare have been undertaken in the UK. Although they used widely differing interventions, each showed significant improvements among those receiving the psychosocial intervention, compared with the patients receiving routine care. The studies, their interventions, and findings are summarised in Table 2.

In the two earliest studies repetition rates were similar in those receiving new and established interventions. The four more recent studies found markedly less repetition among those receiving the new intervention. All six studies were however far too small to ensure a definite answer on lowering repetition (House *et al*, 1992); and intervention to reduce suicide following non-fatal self-harm cannot be demonstrated without a study of many thousands of patients. In the likelihood of a continued lack of such a study, demonstrable improvements in outcomes such as repetition

might be taken as a reasonable proxy measure of reduction in suicides. We badly need more research findings about the interventions best suited for deliberate self-harm patients.

In the meantime, what should be done? In a practical way Hawton & Catalan's book indicates how the specialist deliberate self-harm counsellors in Oxford approach the real problems encountered by their patients. The authors describe how to formulate problems and tackle them with brief psychotherapeutic and social interventions. Further description of problem-solving after self-harm is provided by Salkovskis *et al* (1990) in a report of a small but successful intervention study using cognitive-behavioural techniques. From a preliminary study (Morgan *et al*, 1993) it also seems possible that further self-harm may be reduced by giving the patient written guidance on how to gain access to psychiatric help at times of crisis. The card given to deliberate self-harm patients in Bristol is reproduced in the Health Advisory Service document referred to previously (Williams & Morgan, 1994).

## Aftercare

One of the established findings about aftercare for self-harm patients is the tendency of many to default from follow-up appointments. In a recent study in our hospital of almost 200 self-harm patients who repeated within one year of an index episode, their median time to repetition was 12 weeks; a quarter had repeated by only three weeks

from the index episode (Gilbody *et al*, submitted for publication). This means that where any kind of follow-up appointment is arranged, it must be very prompt to be effective, probably within seven working days of discharge from hospital.

On leaving hospital, the patient should be given written information about how to seek further help, together with written details of the treatment plan and who to contact if in doubt about the arrangements. Whoever makes the decision to discharge the patient should ensure that the patient's GP is contacted promptly, often telephoning during the next 24 hours. A discharge letter, including all the information in Box 1, should be sent out within a few days. To assist both GP and patient, the letter should record whether the GP agreed to see the patient, and what action the patient was told to take in order to see the GP.

It should be standard practice for a relative or other informant to be contacted, in order to obtain details about the circumstances of the self-harm event, and to discuss any aftercare or discharge. Where medical or A & E staff undertake psychosocial assessments, they need to be able to produce a practical management plan which shows awareness of local facilities (such as psychiatric clinics, social work services, and voluntary services).

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Table 2. Six randomised treatment trials in deliberate self-harm: Details of methods and outcome

Study	n	Nature of intervention	Repetition rate Treatment	Repetition rate Control	Other outcomes (benefits seen in treatment group)
Chowdhury <i>et al</i> (1973)	197	General psychiatry	24%	23%	More improvement in social circumstances
Gibbons <i>et al</i> (1978)	400	Task-centred social work	14%	15%	Less psychiatric contact; more satisfaction with services; more improvement in social problems
Hawton <i>et al</i> (1981)	96	Brief problem-oriented counselling (Domiciliary v. out-patient care)	10%	15%	More improvement in social adjustment
Hawton <i>et al</i> (1987)	80	Brief problem-oriented counselling (Out-patient v. general practitioner care)	7%	15%	More improvement in target problems (in women); more improvement in symptoms (General Health Questionnaire) and mood (Beck Depression) scores; more improve- ment in social adjustment
Salkovskis <i>et al</i> (1990)	20	Problem-solving therapy	0%	38%	More improvement in mood (Beck Dep- ression) scores; greater reduction in hopelessness
Morgan <i>et al</i> (1993)	212	Giving of a card setting out help available (if despairing or close to further self-harm)	5%	11%	Fewer patients who either threatened or carried out further self-harm

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## Multiple choice questions

- 1 Current Department of Health guidelines on management of deliberate self-harm
  - a are largely adhered to across the UK
  - b recommend multi-disciplinary assessment of patients
  - c have led extensively to the setting-up of self-harm assessment teams
  - d allow for psychosocial assessments by non-psychiatric medical staff
  - e allow for psychosocial assessments by non-medical health professionals
- 2 Discharge of deliberate self-harm patients directly from A & E departments
  - a accounts for between a quarter and a half of patients at some hospitals
  - b is a local policy which rests with the A & E consultant
  - c runs contrary to the current Department of Health guidelines
  - d is usually only undertaken after patients have received psychosocial assessment by staff specially trained for that task
  - e has not proved to be unsafe when examined in research studies
- 3 Research into psychosocial intervention following deliberate self-harm
  - a has shown psychosocial intervention to be ineffective
  - b has shown that psychosocial intervention can reduce subsequent suicide
  - c has shown that psychosocial intervention can reduce repetition of self-harm
  - d has shown demonstrable psychosocial benefits from psychosocial intervention in several clinical trials
  - e has led to improved services for self-harm patients

### MCQ answers

1	2	3
a F	a T	a F
b T	b F	b F
c F	c F	c F
d T	d F	d T
e T	e T	e F