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Increasing psychosocial assessment by introducing a self-harm pathway

AIMS AND METHOD

To audit whether the introduction of a self-harm pathway and protocol increases the number of psychosocial assessments. All episodes of self-harm in a defined period during 2002 ($n=335$) and 2004 ($n=390$) were reviewed before and after the introduction of a self-harm pathway and protocol. Adherence to the protocol was also investigated.

RESULTS

After the introduction of the self-harm pathway and protocol, the proportion of psychosocial assessments requested had risen from 57% (2002) to 85% (2004). The proportion of psychosocial assessments completed had risen from 47% to 70%. Over the 2 years, the overall number of self-harm presentations was reduced by 27%.

CLINICAL IMPLICATIONS

The introduction of a self-harm pathway and protocol through a self-harm steering group is feasible, was well accepted and increased the number of psychosocial assessments after self-harm. It may also contribute to a reduction in the number of overall presentations with self-harm to the accident and emergency department.

Self-harm is one of the most common presentations to general hospitals. There are over 140 000 estimated attendances at the accident and emergency (A&E) department each year as a result of self-harm (Hawton *et al*, 1997). The rates and treatment vary significantly across the UK (Bennewith *et al*, 2004). One per cent of patients who self-harm will go on to kill themselves within a year (Hawton & Fagg, 1988). Repetition of self-harm is associated with an increased risk of suicide in both males and females (Zahl & Hawton, 2004), yet there are few large studies investigating the effectiveness of interventions. In a Cochrane Systematic Review, Hawton *et al* (2000) showed that there are trends towards reduced repetition rates with problem-solving therapy and emergency contact cards, in addition to standard after-care. Single small trials showed significantly reduced rates of further self-harm for depot flupenthixol *v.* placebo in those repeatedly self-harming and for dialectical behavioural therapy *v.* standard after-care.

The *National Standard Framework for Mental Health Service* (standard seven) states the aim of reducing suicide rates by 20% by the year 2010 (Department of Health, 1999). A functioning self-harm service planning group, and the provision of a psychosocial assessment after self-harm, are part of the recommended strategy to manage self-harm in the UK (Royal College of Psychiatrists, 1994, 2004; Lepping, 2004). The existing literature supports the idea that relatively minor service changes, especially checklists, can significantly improve delivery and the recorded standard of care (Dennis *et al*, 2001). Furthermore, it was recently shown that psychosocial assessment reduces the repetition rates of self-harm by up to 50% (Kapur *et al*, 2002) but the provision of psychosocial assessment in many hospitals remains poor (Kapur *et al*, 1998, 1999). These observations are supported by further studies showing those who leave the A&E department after self-harm without an assessment are at greater risk of repetition of self-harm (Hickey *et al*, 2001). It seems desirable, therefore, to ensure the optimal use of these assessments in A&E settings. To

address this issue, we examined whether a self-harm pathway, developed by a local self-harm service planning group, could increase the number of psychosocial assessments.

Method

In 2002, we examined all self-harm presentations to Arrows Park Hospital which serves urban as well as semi-urban areas around Liverpool, with large variation in levels of social deprivation. During an 8-week period, 335 adults over 16 years of age presented to the A&E department with self-harm. Of these 335, only 157 (47%) received a psychosocial assessment despite the existence of a local liaison psychiatry team consisting of medical and nursing staff. We therefore set up a local self-harm service planning group led by the specialist registrar in liaison psychiatry. This group met four times to discuss the difficulties faced by the A&E department and psychiatric services in responding to the assessment and management of self-harm in a coordinated way. These meetings allowed a mutual appreciation and understanding of the difficulties faced by both services. It was thus agreed to develop a common pathway to deal with self-harm based on the College recommendations and the Manchester triage system (Mackway-Jones, 1996). This included a self-harm protocol with clear allocation of responsibilities. More importantly, all participants in the planning group accepted ownership of the pathway and protocol feeling that their particular concerns had been addressed.

Accident and emergency triage nurses initially assessed patients to ascertain their willingness to wait for psychosocial assessment. This first appraisal was followed by an extended risk assessment using questions designed to measure immediate risk and whether the patient was known to mental health services. It was agreed that an A&E doctor would complete a medical examination and be responsible for completing an immediate risk assessment. Following any necessary physical treatment, the liaison psychiatry team would perform a specialist

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psychosocial assessment. A discharge summary page would be completed by A&E or ward staff and faxed to the general practitioner (GP) and community mental health team where appropriate. The format for the pathway was similar to that of other pathways currently in use in the hospital and it was hoped this familiarity would further increase acceptance among staff.

Once the format for the pathway was agreed, consideration was given to potential problems, such as patients absconding or refusing assessment. In such cases telephone helpline numbers would be provided to the patient and the GP would be informed by faxing a copy of the pathway to the surgery. Consideration was also given to patients who required time to recover from overdose as well as any co-ingestants such as alcohol. It was agreed that patients who were not admitted to a medical or surgical ward would be allowed to recover in the observation ward adjoining the A&E department.

In order to promote and facilitate the use of the pathway, training needs were identified and a programme of training formulated. Accident and emergency doctors received training as part of their teaching programme and it was agreed this would continue with the liaison psychiatry team providing training. To raise awareness of the policy and pathway, all hospital staff were invited to a high profile launch day. The pathway was introduced in June 2003. Over a 3-month period from June to August 2004 we again examined all self-harm presentations to Arrowe Park Hospital using the same procedures as in 2002. Collected data included age, gender, day of admission, time of admission, type of self-harm, evidence of psychosocial assessments being requested, whether undertaken, and by whom, as well as the outcome of the assessments, including admission to other hospital units. We asked for a previous history of self-harm, whether patients were currently in receipt of mental health services and who provided follow-up. In 2002, data from all age-groups were recorded but data for those under 16 were later removed from the analysis. In 2004, only data from patients who were 16 years or older on the day of presentation were examined.

Results

In June and July 2002, there were 335 presentations of self-harm at Arrowe Park Hospital A&E department; all episodes were traceable. The same months were examined in 2004 plus one additional month (August). In 2004, 390 episodes of self-harm were recorded over 3 months, 261 of these in the first 2 months. In 2004, two presentations were excluded because we were unable to find the relevant notes. The proportion of psychosocial assessments requested after the introduction of the self-harm pathway had risen from 57% (2002) to 85% (2004). The completed psychosocial assessments had risen from 47% to 70%.

Reasons why psychosocial assessments were not requested included patients leaving the department before seeing a doctor, refusing an assessment, self-discharging, or not being medically fit. All these reasons

were rare; only 17 patients in 2002 and 25 patients in 2004 left the department or self-discharged before being seen for a psychosocial assessment. Only eight patients in 2002 and nine patients in 2004 refused a psychosocial assessment; the vast majority were willing to stay for assessment. In 2 years, the overall number of self-harm presentations decreased from 355 to 261, with the months of June and July alone showing a reduction of 27% (Table 1). The reference group for 2002 excluded all episodes of pure alcohol or illegal drug self-harm.

The proportion of assessments performed within 24 h rose sharply, and most patients were seen by a mental health liaison nurse or a psychiatric senior house officer in 2004 (92% v. 59% in 2002). In 2002, 23 patients left or discharged themselves before they were seen for a psychosocial assessment but after it had been requested. Only one refused assessment after agreeing to a request. In 2004, 35 left before the assessment was performed, 3 refused and 6 were not medically fit even 24 h after they first presented. The remaining patients had other explanations for non-attendance. In 2004, 77% of patients who presented were admitted. Psychiatric admissions were rare. In 2004, the proportion of patients with a history of self-harm had decreased by 10% (Table 1).

In December 2003, we audited how well our self-harm pathways were being followed. We applied very strict criteria for completion of forms and found that at triage 81% of all forms were fully completed with 6% mostly completed; 71% of all forms for psychosocial assessment were fully completed and 10% mostly completed (Table 2). This suggests that the pathway was very well accepted overall.

Discussion

The introduction of a local self-harm pathway and protocol that started at the time of triage in the A&E department and ended when the patient was discharged, significantly increased the number of psychosocial assessments. This audit has shown it is feasible to develop a self-harm pathway through self-harm steering groups. There was a high acceptance of the pathway, which we believe was partly owing to the fact that it was developed jointly with all relevant parties. The significance of these data lies in the relative simplicity of the pathway, along with the significant increase in psychosocial assessments requested and completed. This formula will help solve one of the many problems UK hospitals are currently experiencing. Furthermore, these results emphasise the importance of placing liaison psychiatry teams within hospital A&E departments, as well as the establishment of self-harm steering groups to develop local pathways and protocols.

After the introduction of the pathway the number of people presenting to the A&E department with self-harm was considerably reduced (27%), coinciding with a 10% reduction of people presenting with a history of self-harm. This reduction cannot be explained by a national trend or by any other specific hospital intervention. It is

**Table 1. Comparison of self-harm audits in 2002 and 2004**

	2002 % ¹	2004 % ²	Change % ³	95% CI	P
Females	60	55	5	−3 to 13	0.10
PsA requested	57	85	−27	−34 to −21	<0.001
PsA completed	47	70	−23	−30 to −16	<0.001
Assessed within 24 h	58	93	−35	−42 to −27	<0.001
Patients refusing PsA	7	6	1	−3 to 5	0.35
PsA outcome					
Hospital admission, total	79	77	1	−5 to 8	0.34
Admission to A&E observation	67	51	16	8 to 24	<0.001
Ward data					
Admission to medical ward	6	22	−16	−22 to −10	<0.001
Admission to psychiatric ward	6	4	2	−2 to 5	0.19
History of self-harm	65	55	10	2 to 18	0.01

PsA, psychosocial assessment.

1. As a proportion of 235.

2. As a proportion of 388.

3. Negative number indicates proportion was higher in 2004 than in 2002.

Table 2. Adherence to the self-harm pathway at triage and overall

Completion of forms (Total n=79)	Triage		Overall	
	n	(%)	n	(%)
Fully complete	64	(81)	56	(71)
Mostly complete	5	(6)	8	(10)
Mostly incomplete	2	(3)	5	(6)
Fully incomplete	5	(6)	7	(9)
No self-harm pathway	2	(3)	2	(3)
Missing	1	(1)	1	(1)

unfortunate that this audit could not collect the necessary data that would show an association between reduced presentation with self-harm and the introduction of the pathway. More studies are needed to examine whether such a link exists.

Although we have robust data regarding the increase of psychosocial assessments there remain patients who do not receive such assessments despite local efforts. It is still unclear what intervention would most benefit this group. Furthermore, our data do not allow individuals to be followed up over 2 years and the overall reduction of self-harm presentations needs further research.

Declaration of interest

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RUDOLF UHER AND CLIVE TIMEHIN

Managing patients' information in a community mental health team

AIMS AND METHOD

To explore current practice in offering patients copies of correspondence, we audited the documentation of 422 patients of a community mental health team.

RESULTS

Discussion about copying letters was documented in 194 case notes (46%);

older patients and those with medically unexplained physical symptoms were less likely to be offered copies. There were 159 patients (82%) that wanted to receive copies of letters; male gender was associated with declining this option. In 167 (87%) instances the professional completing the form was a psychiatrist.

CLINICAL IMPLICATIONS

Older patients need to be offered the opportunity to receive correspondence. Clinicians should record and substantiate their decision not to offer copies of letters to some patients. Professionals other than psychiatrists should be encouraged to discuss copying letters with patients.

A number of studies have demonstrated the benefits of sharing medical information with patients: these include enhanced trust and a cooperative relationship between patients and health professionals, better informed patients, increased adherence, health promotion and improved accuracy and clarity of records (Ross & Lin, 2003).

Although the right to access one's own medical records is granted in the Data Protection Act 1998 and Health and Social Care Act 2001, only a small number of patients request to see their documentation. The NHS Plan for England (Department of Health, 2000) incorporated the requirement to actively offer patients copies of medical correspondence. The good practice guideline on copying letters to patients specifies that during a consultation, patients should be routinely asked whether they want a copy of any letter written as a result of that consultation, how they want to receive such letters and what is their preferred format for such communication; their wishes should be clearly recorded and respected (Department of Health, 2003). Exceptions to this rule are instances where sharing information would cause serious harm to the patient or would reveal information provided by a third person who has not consented to disclosure. This directive has been implemented in the NHS from 1 April 2004 but it is not accepted universally (Boaden & Harris, 2005) and, to date, there are no data available on how it is applied in practice.

Although patients attending mental health services welcome the opportunity of receiving copies of correspondence (Ash *et al*, 1991; Marzanski *et al*, 2005), there have been specific concerns regarding sharing information in psychiatry (Stein *et al*, 1979; Ross & Lin, 2003). These include stigmatisation and distress associated with a psychiatric diagnosis, and illness-related litigation. Some subgroups of patients, especially those with psychotic illness, personality disorders and medically unexplained physical symptoms may present particular difficulties and many mental health professionals have reservations about sharing information with them (Stein *et al*, 1979; Goddard *et al*, 1997; Page & Wessely, 2003; Nandhra *et al*, 2004).

To gauge the practice in the first year of the implementation of the NHS Plan, we have performed an audit of the documentation of patients' wishes regarding copies of correspondence in a multidisciplinary community mental health team. We have addressed these principal questions.

- How many patients have been asked whether they want a copy of their letters?
- Are patients in specific age, gender, ethnic or diagnostic groups less likely to be offered copies of letters?
- How many patients want a copy of their letters?