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Original articles

Assessment of deliberate self-harm on medical wards

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In 1984, the Department of Health and Social Security issued guidelines, based upon the recommendations of a working party of the Royal College of Psychiatrists, on the management of patients admitted to hospital following acts of deliberate self-harm (DSH). Unlike the 1968 Hill report (which recommended that all such patients should be assessed by a psychiatrist before discharge) the new guidelines placed the responsibility for psychosocial assessments on the admitting medical team.

One rationale for the change in policy was primarily an educational (and preventive) one since dependence upon routine assessment by a psychiatrist means that junior hospital medical staff do not learn to make their own assessments of suicide risk, psychosocial problems, and psychiatric disorder. Future general practitioners, in particular, need training in such skills since suicidal persons may consult their GPs shortly before harming themselves. Greater involvement in assessment might also encourage medical (and nursing) staff to be more considerate towards patients who harm themselves.

The new recommendations undoubtedly place greater responsibility on junior doctors, who will now have to select which patients to discharge (with various follow-up arrangements) and which to refer to psychiatrists for pre-discharge assessment. It has been shown that adequate psychosocial assessments can be made by junior medical staff (as well as nurses and social workers – references available) but the new guidelines suggest that junior doctors should receive additional training in the form of seminars. Having attempted this on several occasions, it is our experience that such seminars are poorly attended. As an alternative, we have devised a DSH assessment form (available on request) which contains explicit guidelines for assessment and referral of patients and lists essential points to be covered in an assessment interview.

Background

In 1984, psychiatrists at St Bartholomew's Hospital, as in the ten other teaching hospitals we contacted, were expected to assess all patients presenting to casualty or admitted to the wards with a diagnosis of deliberate self-harm. At that time, in a study of 50 consecutive admissions, we found that junior medical staff had failed to make social or mental state assessments in two-thirds of cases. In consultation with our Accident-and-Emergency department physician and nursing colleagues we began to collect prospective baseline data on a further 50 cases, analysis of which confirmed that there were three main types of self-harming patient – a large group of young patients with low suicidal intent; a smaller group of older patients with more serious suicidal intent (with or without formal psychiatric disorder); and a small group of self-harming recidivists with severe disturbances of personality. We regarded patients in the two latter groups as belonging to a 'high risk' category and therefore in need of ward-based assessment by a psychiatrist. Although patients in the first group may be suffering from social difficulties of one kind or another, most of the patients in this group were considered to be at low risk from the suicidal and/or psychiatric point of view and could therefore be discharged home with more appropriate follow-up by a social worker and/or GP. Suicidal intent was only one factor contributing to our notion of 'risk': other factors taken into consideration included the presence of psychiatric disorder, substance abuse, severe social and relationship difficulties, and a history of previous self-harming behaviour. Since junior doctors are expected to assess all these factors if the DHSS recommendations are implemented it was decided to include these aspects as well on the DSH assessment form.

Evaluation of the DSH assessment form

During the evaluative phase of the study, junior medical staff were asked to complete a DSH assessment form for each case of self-harm they attended. They were asked to rate patients into high or low risk on the basis of their overall clinical impressions and the urgency/necessity for specialist psychiatric

opinion. Routine psychiatrist assessments by senior registrar grade psychiatrists continued to be made as before, but only after the medical staff had completed the form. The assessing psychiatrist also completed an assessment form, and both copies, together with the medical notes, were subsequently examined by the authors. Fifty-six consecutive cases of DSH assessed in this way were compared with the 50 cases previously studied before the form was introduced.

The first finding of note was that the introduction of the form improved the rate of recorded psychosocial and mental state examinations in the medical notes from 24% to 89%, i.e. the availability of the form had prompted an encouraging increase in the frequency of mental state and social assessment by the junior medical staff.

Secondly, the junior medical staff had been able to complete all the items on the form in 89% of cases in which they had attempted to do so.

Two patients were reported to be too drowsy, one refused interview, and one was mentally retarded. No reason was given for the fifth and sixth failures. However, the real reason for these failures seems to have been that junior staff had attempted to assess the patient too soon after admission and at a time that the patient was unable to attend to the interview. This is shown by the fact that psychiatrists were later able to interview successfully all six patients. No single item on the form appeared to pose special difficulties for the medical staff, although some commented that certain patients seemed to fall between the high and low risk categories, thereby making allocation difficult. We rejected the introduction of a third, medium-risk, category for such patients on the grounds that it would be over-used, so blunting the educational impact of the forced choice between high or low risk – a choice that reproduces a dilemma often encountered in clinical practice. A patient whose immediate risk status is difficult to determine is best regarded as high risk until proven otherwise.

The third finding was that, using this form, the junior doctors were able to correctly identify and distinguish 89% of the high risk and 72% of the low risk patients (two cases were recorded as 'don't know'). No significant differences between the junior medical and psychiatrist assessments were found (Table I). Thus, for this small sample of 56 patients the DSH form appeared to help junior doctors in deciding which patients might have required psychiatrist referral before discharge.

TABLE I.
Frequency and 95% confidence intervals

	Physician assessment	Psychiatrist assessment	Diagnostic concordance
"High risk"	23 (16–30)	18 (11–25)	16 (89%)
"Low risk"	25 (18–32)	32 (25–39)	23 (72%)

χ^2 1 d.f. = 1.43 ($P > 0.1$).

Comment

Busy junior medical staff may find special training seminars difficult to attend (none of the medical staff in our study had attended the two training seminars provided for them) and individual bed-side psychiatric teaching is often impractical. The DSH assessment form, however, appears to be an effective way of teaching junior doctors (including future general practitioners) how to assess patients admitted to hospital after deliberate self-harm.

It is, of course, essential that self-harming patients receive proper assessment and follow-up, and we therefore believe that both routine and emergency psychiatric and social work back-up should continue to be available. It seems to us that the most important aspect of the new DHSS recommendations is the greater involvement of junior medical staff, not the withdrawal of psychiatric support.

Reference

DEPARTMENT OF HEALTH AND SOCIAL SECURITY (1984) *Guidance on the Management of Deliberate Self Harm.* London: DHSS. (Health notice HN(84)25).

A full list of references and copies of the DSH assessment are available from the authors.

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