The College

Guidance on the Management of Deliberate Self-Harm

This paper was produced by a multiprofessional Working Party set up by the College at the request of the DHSS. It has been approved by the parent bodies concerned, including the College's Council, in June 1983.

The terms used to describe patients who injure themselves by poisoning or other means, and who may possibly die as a result, have varied over the years. 'Attempted suicide' does not always reflect their motivation. 'Parasuicide' is the term favoured by some authorities, but may not be widely understood.

When attempted suicide ceased to be an indictable offence, the then Ministry of Health[1] advised hospitals to see that these patients received psychiatric attention. Later, the Hill Report[2] recommended that in all cases of deliberate self-poisoning patients should be referred to designated treatment centres in district general hospitals and seen by psychiatrists. There has, however, been only patchy adherence to this recommendation. General practitioners do not refer all of their patients to hospital;[3] to date few special treatment centres for poisoning have been set up;[4] and many of our district general hospitals lack psychiatric units. Arrangements for assessment vary.[4,5,6,7,8] Since prolonged coma from poisoning is less common than formerly and there is often a shortage of acute medical beds, more patients are being discharged from accident departments. It is estimated that the increased incidence of deliberate self-harm, which has occurred particularly among the young,[9] results each year in 100,000 admissions to hospitals in England and Wales. Altogether about half of all such patients coming to hospital are offered further psychiatric treatment or after-care.

Whether it is necessary for a psychiatrist to assess every case of self-poisoning has been the subject of some research. Several studies[6,7,8,10,11] agree that in certain situations adequate psycho-social assessments can be carried out by suitably trained non-psychiatrists, junior medical staff, nurses or social workers.

Adverse attitudes among doctors, and to a lesser extent nurses, towards self-poisoning patients have been reported.[12,13] This finding makes it all the more important for staff to be trained to assess such patients and to gain a more sympathetic understanding of them. Indeed, their management in the general hospital is of particular educational value since it may help trainee doctors and nurses to realize the importance of their patients' psychological and social problems.[14] Training of all doctors in the assessment of suicidal risk is important, since most known suicides have recently seen a doctor before killing themselves and[15,16] most self-poisoned patients have taken prescribed drugs.

It was in relation to this background that the Department of Health asked the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee whether they agreed that it was time to review the existing guidance on the management of cases of attempted suicide. Both Committees endorsed this. In June 1981 the DHSS invited the Royal College of Psychiatrists to form a Working Group, composed of representatives from the relevant professional organizations, to 'consider whether any jointly agreed professional guidelines should be produced or whether it would be preferable to leave it to the discretion of those concerned locally to plan and jointly agree the arrangements they consider to be appropriate.'

Accordingly a Working Group was set up and has agreed the following recommendations.

Recommendations of the Working Group

While the first priority after deliberate self-harm is the management of the patient's physical condition, subsequent evaluation of the psychiatric and social state is essential in every case.

We agree that there is a need to amend the original recommendation of the Department of Health that all patients who have deliberately harmed themselves should necessarily be assessed by psychiatrists. This implies that other medical practitioners may carry out this assessment and decide the need for psychiatric referral. In some instances referral to another professional worker who has received special training such as a social worker, nurse or a clinical psychologist may be considered more appropriate.

If the general practitioner is called to such a patient he may, if he believes there is no risk to life, decide not to send the patient to hospital and to manage the case at home. In these circumstances he will also decide later whether or not to refer the patient for further advice to a psychiatrist, a social work department or in some cases a community psychiatric nurse.

Most patients who harm themselves in this way will be seen in a hospital Accident and Emergency Department, whether referred by their GP as an emergency, brought direct to the hospital by ambulance or presenting there independently. In hospital 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.

We consider it of crucial importance that each district or hospital should have a clearly laid down policy or code of practice agreed by clinical consultants, consultant

psychiatrists and other relevant staff with respect to the management of such patients. The District Health Authority should take the initiative for preparing this policy and for setting up a local multidisciplinary group which should include representatives of nursing, social work and general practice. The policy should specify: (a) who is to carry out assessments; (b) the procedure for referrals between professionals, including prompt communication with general practitioners; (c) arrangements for the immediate transfer of suicidal patients to psychiatric units; (d) out-patient and after-care arrangements; (e) a system for collecting appropriate statistical information for monitoring purposes; and (f) should specify which psychiatrist is to train staff.

We are aware of the very considerable variation in the resources available for these patients throughout the country. Nevertheless, the district policy should stipulate minimum acceptable standards of care. These must include complete physical and psychosocial assessments, treatment and after-care.

Local arrangements should pay particular attention to the needs of children and young people. We recommend that all children under 12 should be admitted, preferably to a paediatric ward. For children over 12 but under 16 admission is also desirable, as is the use of adolescent wards where these are available. Wherever possible a child and adolescent psychiatrist and other appropriate members of the team should help both to draw up local policy and take part in the assessment and management of young people under 16. Interviews with the parents or guardians are part of this assessment.[17]

Local arrangements should also take into account special problems associated with deliberate self-harm such as alcoholism or drug abuse, which may be more prevalent in some districts.

When patients arrive at hospital, all staff should recognize that the physical risk to patients who have deliberately harmed themselves does not necessarily indicate the severity of the mental disturbance or the likelihood of repetition and of suicide. It should be accepted by the medical staff with responsibility for beds that many such patients, whose physical condition is satisfactory, nevertheless need to be admitted, even briefly, for psychosocial reasons.

Patient management and staff training can be facilitated if arrangements are made for one or two medical wards to take the bulk of these cases. The nurse in charge of these beds, or another nurse appointed for this purpose, who should have some psychiatric nursing experience, can then act as a source of nursing and management advice to other wards which might occasionally take such patients. Alternatively, special beds may be designated in a short-stay ward or in a medical ward, or a poisoning treatment centre could be set up. Post-qualification and in-service training in the wards dealing with these patients should include a regular meeting at which doctors, nurses, social workers and others can develop greater understanding of the various professional contributions.

Arrangements should be made so that a psychiatrist is always available to give prompt advice, by telephone if necessary, to physicians and nursing staff and to the accident service. For less urgent cases, clinicians may prefer to consult a psychiatrist of their choice. This would help maintain continuity of patient care.

One or more specialist social workers in each District should devote a substantial part of their time to working with such cases and to developing liaison between the hospital and community services. In some districts they, community psychiatric nurses or other specially trained nurses, may undertake the assessment of some patients and their subsequent after-care in collaboration with the general practitioner.

One or more consultant psychiatrists should provide a regular liaison service to the medical beds or poison unit. It is important that they be responsible for the training of each new intake of junior medical staff including trainee psychiatrists. Psychiatrists should also play a major part in the training of other staff and the organization of services for cases of deliberate self-harm.

All medical students and nurses in training, social workers working in mental health, including 'Approved' social workers, and trainee clinical psychologists should receive instruction and examination on the subject of 'suicide and attempted suicide' and the management of patients who have deliberately harmed themselves. Newly qualified doctors require as much training during the pre-registration year to equip them to deal with these patients as they receive in the case of other acute medical and surgical emergencies, and should be expected to care for these cases with equal diligence.

We suggest that the Home Office should consider the provision of appropriate training for the police and for prison staff in the recognition and management of the problem of deliberate self-harm.

Finally, we would urge the Department of Health and the Medical Research Council to provide additional funds for research and training in this field. Much more needs to be known about the prevention of poisoning. Also, more research is needed to establish the most effective patterns of care for patients who have deliberately harmed themselves, while at the same time making better use of scarce resources.

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Spring Quarterly Meeting, 1983

The Spring Quarterly Meeting was held at the John Radcliffe Hospital, Oxford on 26 and 27 April 1983, under the Presidency of Professor Kenneth Rawnsley.

SCIENTIFIC MEETINGS

Tuesday 26 April: Morning Session A

Psychological Treatment of Depressive Disorders

A psychotherapist's view of depression—Dr Anthony Storr

Loss and internalization: A psychoanalyst's view—Dr Jonathan Pedder.

Interpersonal therapy and behavioural methods—Professor M. G. Gelder.

Cognitive therapy—Dr J. Teasdale.

Morning Session B

Catastrophes and Disasters

The toxic oil syndrome catastrophe: Psychiatric and psychological implications—Professor J. J. Lopez-Ibor Alino

Nuclear catastrophe versus traditional disaster—Where should psychiatry stand? Professor Robert Jay Lifton

The psychiatric sequelae of the Aberfan disaster—Dr J. M. Cuthill

Afternoon Session A

New Approaches to the Pharmacology of Depressive Disorders

How do antidepressant treatments work?—Professor D. Grahame Smith

The pharmacology of ECT—Dr D. Costain

Biochemistry and depression: How good is the relationship?—Dr P. J. Cowen

Which antidepressant?—Dr S. A. Montgomery