

Assessment following self-harm in adults

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Executive summary

Self-harm is a significant problem and requires the coordinated input of a number of agencies, including acute medical and psychiatric care. It is a common cause of admission to hospital. Services for patients who have deliberately harmed themselves have changed in the past decade. Fewer people are admitted to hospital, and nurses increasingly have a primary role in assessment and management. It is logical that good services for the treatment of self-harm may play a part in suicide prevention. However, there are gaps between existing services and recommendations, despite a plethora of policy initiatives.

This report identifies consensus standards for assessment following self-harm. Competencies expected of both generalist and specialist staff are identified. Standards are described for the organisation and planning of self-harm services, for procedures and facilities, and for training and supervision. These are specifically described for the accident and emergency department, the general hospital, the community setting and the psychiatric in-patient unit. More detailed advice is given regarding particular patient groups: the intoxicated patient, the 'repeater' and the patient who is reluctant or appearing to refuse intervention. The specific risks associated with older adults are highlighted.

Managerial standards are suggested for a self-harm services planning group or coordinator. It is recommended that these standards, like the clinical standards, can be used as a basis for audit and quality monitoring. A suggested standard assessment tool and an algorithm describing consent and capacity issues are included in this report.

Introduction

The phenomenon of deliberate self-harm is the subject of extensive sociological, epidemiological, psychological, biological and clinical study, research and speculation. Any consideration of its assessment should aim to draw, as far as is possible, on the available evidence. The difficulty in addressing a topic such as this becomes immediately obvious when we consider the terminology itself. There is clearly a wide spectrum of behaviours which may be more or less deliberate and more or less harmful and which reflect a multiplicity of intentions. The use of the adjective 'deliberate' has not been acceptable to all and some service users fear it might be of itself stigmatising. For this reason we have dropped the term 'deliberate' from the title of this report.

Mental illness is an important contributing factor to suicide and self-harm. Age and substance misuse also influence the prevalence and significance of self-harm. Social, cultural and economic factors moderate the expression of suicidal behaviours (Department of Health, 1999a). Clinicians who assess and try to treat or help people who have harmed themselves are thus doing so in a context that makes evaluation of their strategies and interventions complicated. Furthermore, these assessments are done by different people, from different professions, working in different clinical and local service contexts.

Council Report CR32, *The General Hospital Management of Adult Deliberate Self-Harm* (Royal College of Psychiatrists, 1994) was a consensus statement arising from a conference held in Leeds in 1992. It set standards in terms of planning, organisation, clinical procedures and clinical facilities for the assessment of patients in general hospitals, across accident and emergency departments and in-patient wards. In the decade since that guidance was published, there have been developments in national policies, further information has been collected and there has been further evaluation of intervention strategies.

In revising that report, we wished to modify the recommendations where necessary in the light of these developments, and also to extend them to settings beyond that of the general hospital. However, we wished to retain the model of agreed standards that can be used as the basis for audit and help inform clinical governance strategies. We also aimed to identify standards that were high but also realistic and achievable, and simple enough to be widely adopted. As in the earlier report, we have focused on the assessment of self-harm as opposed to its treatment. There is no clear consensus regarding the treatment of self-harm. Psychological interventions have shown promising results for the treatment of people who present to accident and emergency departments following self-harm, and the results of a small number of studies have suggested that patients who repeatedly harm themselves may benefit from intensive psychological treatment. We feel, however, it is premature to lay down standards for the treatment of self-harm and that further evidence is required.

This report refers to the assessment of self-harm in adults. A related report (Royal College of Psychiatrists, 1998) refers to the management of self-harm in children and adolescents, but much of the information in this report will be relevant to younger people as well.

The context

Deliberate self-harm is a major public health problem. It is estimated that about 150 000 cases present to accident and emergency departments in the UK annually (Hawton & Fagg, 1992; Hawton *et al*, 1998). It is one of the five most frequent causes of acute medical admission for both men and women in the UK (University of York NHS Centre for Reviews and Dissemination, 1998). In the decade since the publication of Council Report CR32, *The General Hospital Management of Adult Deliberate Self-Harm* (Royal College of Psychiatrists, 1994), there have been a number of significant changes in the delivery of services for people who harm themselves. The proportion of male to female patients, however, is changing, and some centres in the North of England now see similar numbers of men and women with this problem (Kapur *et al*, 1998).

Overall figures for self-harm or suicide may conceal wide variations in rates between ethnic groups within a country. Although there is little evidence to suggest that the incidence of self-harm is significantly different across different ethnic groups, there may be a particularly high incidence in young Asian women (Bhugra *et al*, 1999). Furthermore, the relationship between ethnic background and self-harm is complicated by the fact that ethnic density may not have a linear relationship with rates of self-harm: there is some evidence that rates may relate to whether the numbers of the particular minority are relatively large or small within a given area (Neeleman *et al*, 2001).

Another important development has been the growth in the number of specialist mental health nurses who are attached to accident and emergency departments. This development has been going on for over 20 years, driven partly by need and partly by the early research in this area (Catalan *et al*, 1980). It has increased following the recommendation of the National Service Framework for Mental Health (Department of Health, 1999b). In many places specialist nurses now carry out a large proportion of the self-harm assessment work.

The average annual suicide rate for England and Wales is 10 per 100 000, with less than a quarter of those dying having been in contact with mental health services in the year prior to their death. Self-harm is a high risk factor for future suicide. Individuals who have deliberately harmed themselves have a 100-fold greater risk of suicide than the general population (Hawton & Fagg, 1992). It has been found that 1% will die within 1 year of an attempt and 3–5% do so within 5–10 years. A history of multiple episodes of self-harm is a particular risk factor. An act of self-harm is probably the most powerful single predictor of completed suicide. It has been calculated that reducing the suicide rate by 25% in this high-risk group would reduce the total suicide rate by 5.8% (Lewis *et al*, 1997). Services for self-harm potentially have an important role in suicide prevention, and this is highlighted in the Department of Health's recent document on suicide prevention (Department of Health, 2002).

Guidelines on the provision of services for those who have harmed themselves were issued by the Department of Health and Social Security in 1984. A national survey in the late 1980s indicated that these guidelines had generally not been implemented (Butterworth & O'Grady, 1989). In 1994 the Royal College of Psychiatrists published the first report on standards of service provision for the general hospital management of self-harm (Royal College of Psychiatrists, 1994). A more recent national survey (Slinn *et al*, 2001) found that standards of care for such individuals fell below these existing national guidelines, particularly in areas of planning and training. There is a significant gap between national recommendations and current service provision for self-harm.

Government policies

Since the early 1990s there have been many government policies and initiatives focusing on issues concerning the quality of health care, with a particular emphasis on risk and its reduction. Clinical governance has placed these issues at the cornerstone of health care delivery. During the 1990s the government promulgated its mental health policy in a number of documents, which have been pivotal in influencing the way mental health services are being shaped and delivered. *Modernising Mental Health Services* (Department of Health, 1998) set out the vision of creating safe, sound and supportive mental health services through a variety of measures. Further initiatives and publications that focused on issues of quality, safety and risk reduction followed this. Given the significance of a history of suicide attempt in the prediction of completed suicide, the importance of making comprehensive services available for suicidal patients in the emergency areas of general hospitals is a recurring theme in many Department of Health documents.

In 1992 *The Health of the Nation* (Department of Health, 1992) identified mental illness as one of five key areas in its health strategy, and set targets for a reduction in morbidity and mortality among those presenting to mental health services. A primary target was a reduction in the overall suicide rate by 15% by the year 2000 and a reduction in the suicide rate of people with severe mental illness by at least a third. The document emphasised the need for improved assessment and management of suicide risk in the accident and emergency department. It recommended that training in assessing suicide risk should be made widely available to staff working in areas where contact with suicidal patients regularly occurs, including accident and emergency departments and general medical wards. The survey by Slinn *et al* (2001) showed that training is sub-optimal.

In 1996, the Department of Health established the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness for the purpose of eliciting avoidable causes of death and determining best practice by detailed examination of the circumstances surrounding such events. The Inquiry published its findings in the document *Safer Services* (Department of Health, 1999a) and then *Safety First* (Department of Health, 2001a), and made several recommendations. A key finding was that a history of self-harm was

the most significant risk factor for suicide, with 63% of people who had been in contact with mental health services in the 12 months before death by suicide having a history of such self-harm. The Inquiry recommended that all staff in contact with patients at risk of suicide should receive training in the recognition, assessment and management of risk of suicide, at intervals of no more than 3 years (Department of Health, 1999a). Training should include risk indicators, high-risk periods, managing non-compliance and loss of contact, communication and the Mental Health Act.

The National Service Framework for Mental Health was published in 1999 (Department of Health, 1999b) and set national standards for mental health provision. It made several recommendations relating to the services that should be available for those who have harmed themselves, including the importance of safety and privacy of assessment facilities within the accident and emergency department. It emphasised the need for specialist psychosocial assessment of these people before they are discharged, preferably by a mental health nurse or other professional who knows local services and can arrange speedy follow-up and appropriate support. Other recommendations were that all staff involved in performing assessments should receive training in risk assessment and risk management, updated regularly. It was suggested that the presence of psychiatric liaison nurses based in the accident and emergency department would allow psychosocial assessments to be done in the department, and that these nurses would provide knowledge of local services and offer training to other accident and emergency staff. It was also suggested that the availability of social workers within the accident and emergency department could provide gains in terms of the links with local authority services. A further recommendation was that accident and emergency departments should develop and implement protocols for those who present with self-harm.

Background to recommendations about assessment

Despite the weak evidence base for the management of patients with self-harm (Isacsson & Rich, 2001), there is agreement that all hospital attendance following self-harm should lead to a specialist psychosocial assessment. This should aim to identify motives for the act and associated problems that might be amenable to intervention, such as psychological or social problems, mental disorder and alcohol or substance misuse (University of York NHS Centre for Reviews and Dissemination, 1998). Discharge from the accident and emergency department should be contemplated only if a psychosocial assessment and after-care plan can be arranged prior to discharge. The after-care plan should be recorded in accordance with the care programme approach and the patient's general practitioner should be involved and informed. The development of guidelines for staff involved in the immediate assessment and management of self-harm is the subject of one of the guideline developments being examined by the National Institute for Clinical Excellence.

Prevention of suicide

The Confidential Inquiry found that self-poisoning was one of the most common methods of suicide (Department of Health, 2001a), most often involving psychotropic drugs and analgesics. The prescribing of safer psychotropic medications, especially the use of modern, less-toxic drugs as an alternative to the tricyclic antidepressants, may be important in the prevention of suicide. Restrictions on the sale of analgesics led to a reduction in suicide from paracetamol poisoning by 21% and salicylate poisoning by 48% (Hawton *et al*, 2001). A Department of Health working group on strategy in suicide prevention is addressing the issue of prevention of suicide in detail.

Standards for specific settings

In this section of the report we set out standards for assessment following self-harm. We identified two levels of competence – standard and specialist – which should inform training standards. Standard competencies are those expected of non-specialist staff (primary care, non-specialist accident and emergency department and general hospital staff); specialist level competencies are expected of psychiatrists and specialist clinicians working in self-harm services (usually nurses). The standards have been expanded in each context to fit the special requirement of that context and are considered under the following headings:

- organisational and planning standards
- standards for clinical procedures and facilities
- training standards
- supervision standards.

General clinical competencies at standard level include:

- prompt assessment of the patient's physical condition, including level of consciousness
- effective treatment of the patient's physical condition to minimise risk of death or disability
- simple psychosocial and mental state assessment to detect mental illness, alcohol and drug problems or social crisis
- detection of immediate suicide risk
- judgement when further specialist assessment is appropriate
- making a culturally relevant assessment, using interpreters if necessary
- basic understanding of medico-legal issues in emergency situations, especially establishing consent to treatment, and in situations of non-consent making an assessment of capacity sufficient to manage an emergency.

Additional competencies at specialist level include:

- giving a diagnostic formulation
- assessment of risk of further self-harm in patients for whom concern has been raised
- drawing up an agreed management plan
- liaison with appropriate services in implementing the agreed plan
- assessing hostile or guarded patients
- implementation of treatment plans including psychological and social interventions.

The accident and emergency department and the general hospital

Non-specialist staff (accident and emergency department officers or pre-registration house officers) can be trained to perform assessments following self-harm. Two studies have demonstrated that certain key skills in both assessment and management of people at risk of suicide can be taught to non-mental health professionals including accident and emergency department staff, with improvements in skills, attitudes and confidence (Morriss *et al*, 1999; Appleby *et al*, 2000). In most centres, however, junior medical staff do not receive sufficient training in – or have the time to conduct – detailed psychosocial assessments of self-harm, so the standards we have set for this group relate to basic minimum requirements prior to a more detailed assessment by a specialist worker.

The standards that we have set relate primarily to the assessment of patients following self-harm, as opposed to specific recommendations for treatment. Psychiatric services are being urged by the Department of Health to incorporate some form of risk assessment in contacts with all patients. In relation to self-harm, we are aware of the limitations of risk assessment, and the difficulties in accurately predicting which particular individuals will go on to complete suicide. In the assessment of such patients, the detection of psychiatric disorder (including depressive and anxiety disorders, alcohol misuse and Axis II disorders) is important. It is hoped that future studies will provide evidence as to whether the detection of these disorders leads to interventions that can reduce the risk of suicide.

Standards for planning and organisation

All major trauma centres should have in place a self-harm services planning group. For large accident and emergency departments this might be for that department alone, but for smaller departments a regional planning group might be more practicable. Most patients will be under the care of an acute trust, and it is that trust's responsibility, in liaison with the mental health trust, to set the standards of assessment and care for these patients. The successful implementation of standards for self-harm services can only be achieved by a combination of staff, from accident and emergency, medicine, psychiatry and primary care. In smaller hospitals, a single person, in consultation with all the relevant stakeholders in the service, could undertake the remit and function of such a group. The standards for the planning group or self-harm coordinator are set out on pp. 34–35.

Specialist staff should work (in ideal circumstances) as part of a designated self-harm team. However, in small districts, particularly in rural areas, such a team might not be feasible. The training and mechanisms for supervision of the self-harm team, or those individuals carrying out self-harm assessments, should be regularly reviewed by the self-harm services planning group or the self-harm services coordinator.

Whether carried out by designated staff or on a rota system, assessment of people presenting with self-harm should be scheduled, not fitted in *ad hoc* at the end of a busy day.

Standards for clinical procedures and facilities

Assessment of immediate risk on arrival in the accident and emergency department Patients presenting with self-harm include some who are in urgent physical danger and some who may leave the hospital precipitately owing to an abnormal mental state. Therefore, when the presenting complaint is self-harm, prior to any consultation a member of the accident and emergency department (usually the triage nurse) should answer four questions immediately after the patient's arrival at the department:

- Is the person physically fit to wait?
- Is there obvious severe distress?
- Is the person actively suicidal?
- Is the person likely to wait until seen by the accident and emergency doctor?

Evidence of this triage process should be documented.

Assessment facilities Each patient should be interviewed in a setting that accords with privacy, confidentiality and respect. There should be a designated room to which patients can be directed for the necessary interview. In the accident and emergency department, the room should be close to or part of the main department's receiving area and should have a suitable security system. The door must open both ways and must not be lockable from the inside. All psychosocial self-harm assessments should take place 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). Some patients will need time to recover their equanimity in order for a management decision to be made. Further information may be required from a relative or care worker. It is therefore important that there are facilities to allow patients time in the accident and emergency department for a degree of recovery. Interpreter facilities should be available.

A specialist asked to assess a patient on a general hospital ward must also have access to adequate assessment facilities. Essentially this means a quiet, private interview room with security.

Clinical assessment and management in the accident and emergency department The self-harm services planning group or coordinator should stipulate that certain clinical management options be available to accident and emergency department staff.

It is essential that accident and emergency staff have access to a psychiatrist whose duties include advice to and attendance at the department, or another

designated self-harm mental health specialist who is equipped to undertake psychosocial assessment and management. Social services assistance should also be available for self-harm patients who have significant social difficulties. Adequate provision must be made for approved psychiatric and social work cover for Mental Health Act assessments (section 12 doctors and approved social workers). This must be explicitly provided for, and not left to a default on-call adult psychiatry service.

When the patient is neither admitted under the care of another doctor nor assessed by a specialist in the accident and emergency department, the accident and emergency staff should record in the case records the items listed in Box 1. Within 24 hours a member of the accident and emergency department's staff should pass on this information to the patient's general practitioner (usually by fax). Written communication should be forwarded to the general practitioner within 3 working days. Patients who leave the accident and emergency department before an assessment can be undertaken are known to be at high risk of repetition of self-harm (Hickey *et al*, 2001).

Specialist staff should be able to arrange for some patients to wait in the accident and emergency department for a degree of recovery, or for further information to be obtained. However, patients should not be required to wait in the department for more than 3 hours, if they are physically well and have recovered from the effects of drugs and alcohol.

A request for emergency attendance at the accident and emergency department should normally result in the arrival of a member of the self-harm specialist team within an agreed time. Each locality should work towards an ideal response time of 30 min in urban areas and 90 min in rural areas. A senior psychiatrist

Box 1 Patient information to be obtained before discharge

- Demographic data including ethnicity
- Consciousness level
- Psychiatric history
- Mood
- Presence or absence of thoughts and plans of suicide
- Alcohol and drug misuse
- Previous history of self-harm
- Social situation and events
- Assessment of risk of further self-harm or suicide
- Assessment of capacity to give informed consent
- Decisions taken
- Specific arrangements for any follow-up if not referred on for specialist opinion

should be available within 60 min in urban areas and 90 min in rural areas (Royal College of Psychiatrists, 2003). However, local standards for attendance will have to be agreed to reflect service configuration in any given locality. Exceptions to this should be subject to audit. Standards for out-of-hours assessments or assessments when the specialist team is not on duty should be the same as those for other patients requiring emergency psychiatric assessment; normally this is within 2 hours. Staff should have knowledge of how to contact an approved social worker or a section 12 approved doctor.

Clinical assessment and management in the in-patient unit On occasions it may be appropriate for the medical staff team to undertake psychosocial assessment without calling in the specialist self-harm team or the psychiatrist. In such circumstances, the individual making the assessment must have received appropriate training (see section on training below). Even if it is the policy of the medical team to refer all cases of self-harm to the self-harm specialist team, in each case the immediate risk and the disturbance of mental state should be observed, documented and acted upon.

Decisions about after-care should only be made by a member of the medical team who has been trained in the psychosocial assessment of self-harm. In-patients admitted for treatment of self-harm must be able to stay in hospital until fully assessed, even if the assessment needs to be delayed for physical, psychiatric or social reasons.

When members of the medical team make a decision to discharge a patient without specialist assessment, they should record their reasons for this in the medical notes, and ensure that the information in Box 1 is recorded. A member of the medical team should contact the patient's general practitioner within 24 hours of that decision. A discharge letter, including all this information, should be sent out within 3 working days.

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 of the person to contact if in doubt about the arrangements.

There should be a clear policy for referral to specialist assessment of patients admitted to general medical wards. Medical staff should be clear to whom referrals should be made, and referral details should be faxed or telephoned through before an agreed time, if patients are to be assessed that day. If referrals are made after the agreed time, the patient should be seen within 24 hours. A referral for self-harm assessment should be made when the patient is fully conscious and able to complete a psychosocial assessment. The patient does not have to be medically fit before a psychiatric assessment is done.

It is good practice for a relative or other informant to be seen by the specialist assessor and this contact documented. In cases where this cannot be arranged, the specialist assessor should document the reasons for this (e.g. patient refused permission for relatives to be contacted, patient has no relative or suitable informant). Interpreters must be available as appropriate.

The general practitioner should be notified of the assessment within 24 hours of the assessment and written information should be forwarded to the general practitioner within 3 working days. The written case record and the information sent to the general practitioner should contain the information set out in Box 1.

It is good practice for self-harm patients seen by a specialist to leave the hospital with written material about available local services and how to obtain access to them (see also 'The intoxicated patient', pp. 25–27).

It should be usual to refer patients aged over 65 years and under 16 years to the old age and child and adolescent specialist services respectively, as a matter of routine.

Training and supervision standards

Suitability of accident and emergency medical staff to undertake psychosocial assessment If accident and emergency medical staff are to undertake psychosocial assessments, they should undergo training in self-harm assessment. In each hospital the self-harm services planning group or the self-harm services coordinator should:

- set up training for newly appointed accident and emergency departments staff within the first week in post
- specify the duration and content of the training
- specify the degree of competence required before independent assessment is allowed.

Psychosocial assessments undertaken by accident and emergency medical staff should be done in a systematic way (preferably using a standardised form, such as that shown in Fig. 1). The practical management plan should show an awareness of local facilities (psychiatric services, self-harm support agencies in the voluntary sector, social work services, culturally specific services and crisis intervention services). In psychosocial assessment of self-harm the information in Box 1 (p. 16) should always be collected and documented in the case notes.

It is difficult to make an assessment if the patient's level of consciousness has been impaired by drugs or alcohol. The person should be asked to wait in the accident and emergency department (if the person's medical condition does not warrant admission to a medical in-patient bed) and reviewed on a regular basis until a psychosocial assessment can be made. When an intoxicated person attending for treatment of self-harm wants to leave the accident and emergency department without assessment, staff have an obligation to carry out as much assessment as is possible and to take appropriate action, especially if the person continues to express suicidal intent (see also 'The patient refusing physical intervention', pp. 28–30).

In some cases, patients may refuse potentially life-saving medical treatment. In these situations a careful assessment of capacity is required. Most doctors should be trained to determine whether the patient's level of consciousness is impaired and, if so, whether this is affecting capacity. If the patient lacks capacity,

SELF-HARM ASSESSMENT FORM

ID no.

PATIENT DETAILS	Surname	Date today																														
	Forename	GP name																														
	Address	GP address																														
	Postcode	GP telephone																														
	Telephone	Hospital																														
	Date of birth	Hospital number																														
	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	A&E number																														
DEMO- GRAPHIC RISK FACTORS	Marital status (tick box that applies) Single <input type="checkbox"/> Separated/divorced <input type="checkbox"/> Married/partnered <input type="checkbox"/> Widowed <input type="checkbox"/>																															
	Ethnic origin (tick most appropriate box) White <input type="checkbox"/> Black African <input type="checkbox"/> Black Caribbean <input type="checkbox"/> Chinese <input type="checkbox"/> Indian/Pakistani/ Bangladeshi <input type="checkbox"/> Other (please specify) <input type="checkbox"/> _____																															
	Usually living with (tick most appropriate box) Street homeless <input type="checkbox"/> Alone <input type="checkbox"/> Spouse/partner <input type="checkbox"/> Parent/sibling <input type="checkbox"/> Friends/other relatives <input type="checkbox"/> Child(ren) only <input type="checkbox"/> Hostel residents/lodgings <input type="checkbox"/> Other (please specify) <input type="checkbox"/> _____																															
	Employment (tick most appropriate box) Full/part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Registered sick <input type="checkbox"/> Retired <input type="checkbox"/> Homemaker/carer <input type="checkbox"/> Student/schoolchild <input type="checkbox"/> Other <input type="checkbox"/>																															
	If unemployed (tick box that applies) Under 26 weeks <input type="checkbox"/> Over 26 weeks <input type="checkbox"/> Not known <input type="checkbox"/>																															
SELF-HARM DETAILS	Method (tick all methods used) Self-poisoning, drugs (see below) <input type="checkbox"/> Self-poisoning, other <input type="checkbox"/> Self-injury (cutting or piercing) <input type="checkbox"/> Other (please specify) <input type="checkbox"/> _____																															
	If self-poisoning: tick all drugs that apply and complete boxes as appropriate																															
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Alcohol taken within 6 h of harm? Yes <input type="checkbox"/> No <input type="checkbox"/> How many units? _____																																

Fig. 1 Self-harm assessment form (reproduced with permission; see p. 4).

doctors have a duty of care to act in the best interests of the patient and proceed with emergency interventions. Specialist advice from a senior psychiatrist should be sought, if the patient's psychiatric status is thought to be affecting capacity, or if there is the possibility of compulsory admission under the Mental Health Act 1983. For further details and guidance about this complex area, see pp. 29–33.

Specialist staff Specialist staff should be suitably trained and supervised, and have a professional background in mental health (e.g. nurse, social worker, psychologist, occupational therapist or psychiatrist). The minimum standards for training are described below.

People new to the task, whatever their professional background, should receive specific training in self-harm assessment and risk assessment. They should carry out joint assessments under supervision, until deemed competent. In at least three cases involving self-harm the supervisor should make face-to-face contact with the patient during the course of the trainee's assessment.

Relevant literature should be pointed out to new staff (or copies provided), for example concerning well-established facts about risk of suicide and repetition. After reaching competency, the person being trained should receive supervision on their next six cases. The management should be discussed in detail with a designated supervisor, although after the initial training period the assessments need not be routinely carried out in the presence of the supervisor. The trainee should keep a logbook record of the three training cases and the six supervised post-training cases. The logbook should record the details of the case, the details of the risk assessment and the recommendations for management.

Once training has been completed, specialist staff should have access to regular supervision (on a weekly basis) and access at all times to a senior member of staff, such as a specialist registrar or duty consultant, to discuss emergency cases.

Senior house officers The self-harm services planning group or the self-harm services coordinator will need to devise a suitable training strategy and supervision policy for psychiatry level I and level II senior house officers. Liaison with the clinical tutor will be important. The amount of training and supervision required will depend upon the trainee's previous experience. We recommend that senior house officers new to psychiatry receive the same training as that stipulated for specialists in self harm (see above).

The psychiatric in-patient unit

The standards for general hospitals are developed from those originally set in 1992 by the consensus conference in Leeds (Royal College of Psychiatrists, 1994). People presenting to the in-patient psychiatric unit with episodes of self-harm are likely to differ from the general hospital attenders in a number of respects. First, they are more likely to have a previous diagnosis of mental illness, particularly severe mental illness. Second, they are more likely to be already known to, and aware of, local services. Third, they are likely to be at greater risk of

suicide. These patients should usually also have had a risk assessment. *Safety First* (Department of Health, 2001a) reported that for England and Wales, in 16% of the Inquiry cases (the Inquiry cases being almost a quarter of all suicides) the person was an in-patient at the time of death. The corresponding figures for Scotland and Northern Ireland are 12% and 10%, respectively. In-patient suicides were most likely to be by hanging. A quarter occurred during the first week of admission and a fifth of patients were under non-routine observation. Many patients (a third of those in England and Wales and half of those in Northern Ireland) were on agreed leave at the time of their death. In addition, the peak in post-discharge suicide has been highlighted in the National Confidential Inquiry (Department of Health, 2001a) and the National Service Framework (Department of Health, 1999b).

Reduction in suicidal behaviour is an important component of the in-patient treatment of mental illness and a common purpose of emergency admission to psychiatric hospital. There is a suggestion in the literature that there has been an increase in suicide among psychiatric in-patients worldwide (Wolfersdorf, 2000), but the National Confidential Inquiry reported a steady decline since 1997 in the UK (Department of Health, 2001a). Major mental illness requiring in-patient treatment is of itself a risk factor for suicide (Mortensen *et al*, 2000). Targeting resources to optimise the quality of in-patient psychiatric care may thus be reasonable. It is unclear, however, what the effect is of hospital admission itself as an intervention. It seems reasonable to assume that the emergency admission to hospital of patients requiring treatment for affective disorders or schizophrenia should reduce the risk of self-harm in these patients. There is also the commonly held clinical view that self-harm may precipitate inappropriate and non-therapeutic hospital admission of people with primary substance misuse problems or personality disorder. Well-controlled research in this area is difficult. We hope that the setting of standards for the assessment and management of acts of self-harm in the in-patient population may go some way towards helping different groups of patients receive the most appropriate help for their particular difficulties.

The general aims of the immediate assessment and management following an episode of self-harm are those listed in Box 1 (p. 16).

Standards for organisation and planning

Each in-patient psychiatric unit should have a written policy for the management of episodes of self-harm. This policy should be reviewed within local clinical governance strategies.

All episodes of self-harm should be documented and collated, and reviewed as untoward incidents, again within clinical governance structures.

Local policy should have input from specialist substance misuse services (where available) to set standards for access to specialist services.

The local procedures should include an audit of emergency holding powers (section 5(2) and (4) of the Mental Health Act 1983).

Standards for clinical procedures and facilities

There should be no obviously accessible ligature points in in-patient units.

All patients should have a comprehensive psychosocial assessment on admission. This should include an account of cultural factors. This will usually not need repeating following an episode of self-harm.

Following an episode of self-harm there should be an immediate review by the responsible clinicians (usually nurse and doctor) and an early review by the multidisciplinary team. Review should include assessment of:

- physical and medical well-being and risks
- assessment of mental state
- assessment of risk of repetition.

The immediate management plan should include:

- physical intervention
- psychological intervention
- pharmacological intervention
- nursing (especially observations) intervention
- legal intervention

and include an account of the reasons.

As with all hospital in-patients, those with a history of self-harm should have clearly documented follow-up arrangements on discharge.

Training standards

All new trainees in psychiatry should receive training in risk assessment including managing suicide risk. This should occur in the first week of training. Educational supervisors should establish that senior house officers at all levels are competent in risk assessment and the management of self-harm. Standards should be set for knowledge and skills for in-patient nursing staff. Training should include:

- knowledge of the Mental Health Act and relevant common law
- liaison with other relevant services, including knowledge of local addiction services
- understanding of issues of diversity and culture
- assessment of hostile or guarded patients
- pharmacological, psychological and environmental strategies.

Supervision standards

All episodes of self-harm should be reviewed and the management supervised by the multidisciplinary team.

Junior staff should always have access to senior staff for advice and, if necessary, assessment of a patient.

Staff should not be required to make treatment decisions beyond their level of expertise.

The community mental health team

The past decade has seen further development of community mental health teams, which remain the cornerstone of secondary psychiatric services for adults of working age. More recently, policy initiatives have resulted in the development of assertive outreach teams and crisis resolution teams. The reorganisation of community services will influence how self-harm is managed in the community.

The role of the community mental health team may be very different in different areas depending on local circumstances. The availability, for example, of local services for liaison psychiatry and substance misuse, and the range of non-statutory agencies available to help people who harm themselves, may affect the details of any local protocols for the community mental health team. In general, however, the purposes of the assessment and management of self-harm by the community mental health team will be those set out at the beginning of the chapter; that is:

- prompt assessment of the patient's physical condition, including level of consciousness
- effective treatment of the patient's physical condition to minimise risk of death or disability
- simple psychosocial and mental state assessment to detect mental illness, alcohol and drug problems or social crisis
- detection of immediate suicide risk
- judgement when further specialist assessment is appropriate.

Subsequent objectives are:

- giving a diagnostic formulation
- assessing risk of further self-harm in patients for whom concern has been raised
- drawing up an agreed management plan
- liaison with appropriate services in implementing the agreed plan (this may include working with local voluntary organisations, link workers or support workers)
- assessing hostile or guarded patients
- implementing treatment plans including psychological and social interventions.

The community mental health team may also be faced with a patient in the community who refuses to go to hospital for physical management of self-poisoning. The same principles covering consent and capacity apply in this situation as in the accident and emergency department (see pp. 29–33).

Administration and organisational standards

The operational policy of the community mental health team should allow for the immediate assessment of patients following an episode of self-harm. This may be by the community mental health team itself, the local in-patient unit, specialist self-harm services or crisis resolution team, depending on local circumstances.

All episodes of self-harm in patients under the care of the community mental health team should be recorded and fed into local clinical governance structures, as with the in-patient unit (see above).

If the community mental health team is responsible for the immediate assessment of a patient following an episode of self-harm, the standards for the specialist staff in general hospital settings should pertain (see p. 20).

The community mental health team should always consider the management of an episode of non-compliance with treatment, within a week of that non-compliance being known.

Patients becoming non-compliant or missing an appointment who are on the enhanced care programme approach should have assertive follow-up within 1 week of that occurring.

Training standards

All community mental health team staff should be trained in risk assessment and the management of self-harm. Responsibility for this may lie with the immediate supervisor. Ultimate responsibility to ensure that this is in place rests with the team manager. Training should include:

- psychological strategies
- engaging strategies
- access to medical support
- access to specialist services (substance misuse and specialist self-harm)
- cultural competence and issues of diversity
- advantages and disadvantages of hospital admission
- medico-legal issues.

Supervision standards

All community mental health team staff should have regular supervision.

There should be clear opportunity for individual or group supervision of clinical decisions.

Feedback to staff for consideration of local serious and untoward incidents should be in place.

Junior staff should not be required to make decisions beyond their level of expertise.

Special patient populations

The intoxicated patient

It is often difficult to assess the intoxicated patient, who may be uncooperative, belligerent or frankly assaultative. These patients test the patience of the most dedicated staff teams, especially in busy accident and emergency departments where staff may not perceive them to be 'real emergencies'. However, substance-misusing patients are at particular risk of completed suicide (Department of Health, 2001a). There is also evidence that advice given in medical settings (about alcohol misuse) results in a reduction in drinking behaviour (Chick, 1987).

It is difficult to assess accurately the mental state of an intoxicated patient and it is preferable to allow the patient to sober up before attempting this task. Patients will often be irritable and need tactful handling in order to persuade them to stay in the accident and emergency department. Information from friends and relatives will often be helpful in assessing risk. Consideration should routinely be given to issues such as child protection and domestic violence.

An assessment of the levels of physical and psychological dependency on any substance used should be made: this should include a thorough assessment of timing of use, presence of physical withdrawal symptoms, and use of the substance to relieve withdrawal symptoms.

The routine availability of breathalysers is recommended, as this may assist staff in both their general approach to the patient and in devising an overall appropriate management plan. Very high blood alcohol levels (over 120 mg per 100 ml) will usually indicate a degree of tolerance to alcohol, reflecting physical dependency requiring a referral for specialist treatment. Patients with a substantial degree of dependence will tolerate very high blood alcohol levels and may exhibit withdrawal symptoms at, for example, blood alcohol levels in excess of 200 mg per 100 ml. A blanket refusal to assess the mental state of patients who have 'high' blood alcohol levels is not therefore appropriate. Accident and emergency staff will need to exercise their judgement on this when they make referrals for psychosocial assessment.

Recommended routine screening instruments are the Fast Alcohol Screening Test (FAST; Hodgson *et al*, 2002), the Alcohol Use Disorders Identification Test (AUDIT; Babor *et al*, 1992), the Severity of Alcohol Dependence Questionnaire (Stockwell *et al*, 1979) and the CAGE questionnaire (Mayfield *et al*, 1974). The FAST instrument has the advantage of living up to its name – it is a screening test that picks up misuse as well as dependency, and is short enough to be routinely completed by the triage nurse in all cases of self-harm.

Patients with a history of haematemesis, seizures or symptoms suggestive of Wernicke's encephalopathy should always be referred for further medical assessment.

Tertiary referral

The following patients should usually be referred to an addictions team or service:

- patients with evidence of physical dependency
- patients with psychiatric comorbidity
- patients drinking more than 25 units of alcohol daily
- patients who require specialist interventions such as relapse prevention programmes, counselling, family therapy or group support
- patients who request referral.

Initiating detoxification in accident and emergency departments

It is recommended that acute trusts, in consultation with specialist substance misuse services, have in place a protocol covering the prescription and management of detoxification in the accident and emergency department. The following guidelines should be followed.

Detoxification should only be offered after a thorough physical and psychosocial assessment. There should be clear evidence of physical dependency requiring medication with benzodiazepines in order to prevent withdrawal symptoms *and* the patient wishes to stop drinking.

If possible, it is preferable to refer the patient to a local addiction team as an emergency.

Where there is a history of fits, delirium tremens, coexisting severe mental health problems, polysubstance dependency, cognitive impairment or poor social support, detoxification should probably be undertaken as an in-patient procedure.

Community detoxification should be completed within 5–10 days.

If medication is dispensed, patients should be given chlordiazepoxide or diazepam in sufficient dosage to cover only the period before they can be seen by either the addiction team or their general practitioner.

Written prescriptions for chlordiazepoxide should not be given.

Give parenteral thiamin if food intake has been reduced over the preceding 2 weeks and there is evidence of memory impairment, peripheral neuropathy or symptoms suggestive of Wernicke's encephalopathy (confusion, ataxia or nystagmus). Patients should be referred for immediate reassessment by physicians if these symptoms are present.

Make arrangements for further parenteral thiamin to be dispensed either by the general practitioner or the addiction team.

Information for patients

The following information is useful for patients and their families:

- safe limits for drinking
- local contact numbers for self-help groups such as Alcoholics Anonymous, Narcotics Anonymous, Drinkwise and local culturally appropriate groups

- telephone numbers of local support services for families and friends, such as Al-Anon
- contact numbers and information on local statutory and voluntary services.

It is useful to have all the above information on one standard card.

The ‘repeater’: the patient who presents with repetitive self-harm

One per cent of patients presenting to general hospitals in the UK kill themselves within a year; 3–5% do so within 5–10 years, and a history of multiple episodes of self-harm is a particular risk factor, suggesting that this sub-group of patients needs special consideration. However, there is considerable lack of clarity about which strategies of preventive treatment are likely to be effective in reducing persistent self-harm and subsequent suicide (Hawton *et al*, 1998).

Early studies in the UK (Newson-Smith & Hirsch, 1979) reported that psychiatric morbidity in self-poisoning was low, although data from other countries suggested the reverse. More recent studies in the UK have found higher rates of psychiatric disorder and personality disorder, particularly in people who repeat the act, indicating that recommendations about the assessment and treatment of these individuals may require more than a routine assessment (Haw *et al*, 2001).

Haw *et al* (2001) found the prevalence rates of psychiatric disorders and personality disorders in patients who repetitively harm themselves to be as high as 90% and 46%, respectively, and others have found rates that were equally high (e.g. Ferreira de Castro *et al*, 1998). Depression, substance misuse, stress-related disorders, eating disorders and psychotic disorders all occur. Depression is the most common disorder, with little apparent gender bias, and schizophrenia is the least common. Significantly higher rates of morbidity are detected through research-based interviews than by routine clinical interview (Suominen *et al*, 1999).

Personality disorders complicate the assessment and treatment of people who harm themselves, especially when associated with a psychiatric disorder. Comorbidity of psychiatric and personality disorders is around 40%. Most importantly, comorbidity of personality disorder and psychiatric disorder increases the risk of suicide 6 times compared with the risk in those with psychiatric disorder alone (Foster *et al*, 1999). Borderline personality disorder is the most common personality disorder reported in a number of studies (e.g. Gupta & Trzepacz, 1997), although others have found that paranoid, anankastic and anxious personalities are equally, if not more, common (Dirks, 1998). Engagement in treatment of patients with personality disorder is particularly problematic and may be especially so after an episode of self-harm, with high withdrawal rates being reported in follow-up (Hawton *et al*, 1998).

Clinical recommendations

In the context of the high prevalence rates of psychiatric disorder and personality disorder:

- people who repetitively harm themselves should have a specialist psychiatric and social assessment
- affective disorders may be underdiagnosed, and careful attention needs to be given to use of safe medication
- comorbidity suggests that an integrated care package should be considered, including biological, psychological and social interventions.

There remains considerable uncertainty about which care package may be effective in persistent self-harm, but any treatment plan needs:

- to be well structured
- to devote considerable effort to enhancing compliance
- to have a clear focus (whether that focus is a problem behaviour such as self-harm or an aspect of interpersonal relationship patterns)
- to be relatively long-term
- to be integrated with other services available to the patient
- to take cultural factors into account
- to have a clear pathway to care in an emergency
- to be implemented within the terms of the care programme approach.

The patient refusing physical intervention

There are a number of reasons why patients attending an accident and emergency department might actively refuse consent for an intervention that a doctor thinks advisable. They might be disoriented, intoxicated, too angry to think straight, in a state of panic or despair, or numb with shock or pain; they might have limited insight into their illness or not have fully grasped what it is the doctor has advised; they might be in their right mind but disagree with the doctor, or have religious or cultural values that preclude the treatment advised. Psychiatrists may be able to assist where mental disorder or possible mental disorder, however transient, interferes with an individual's decision-making ability to give meaningful consent or – as is more often the problem – make a valid refusal.

The concept of capacity

The case law and legislation discussed in this section applies to the jurisdiction of England and Wales. In Scotland, reference should be made to the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000. In Scotland, medical treatment for people who lack capacity, whether temporarily or permanently, is covered by the Adults with Incapacity (Scotland) Act 2000. Under this Act, an adult patient (age 16 years or over) is incapable if he or she is incapable of acting or making decisions or communicating decisions or understanding decisions or retaining the memory of decisions. This must be because of mental disorder or inability to communicate. Assessment of capacity relates to the particular decision being made and is not a blanket

judgement. Section 47 of this Act authorises medical treatment under a certificate of incapacity and adhering to key principles (benefit, minimum restriction, views of the adult and consultation with others where practical). However, treatment in emergency situations is outwith the scope of the Act and falls within the doctrine of necessity and common law duty of care. Treatment in accident and emergency departments in cases of self-harm are therefore unlikely to fall within the scope of the Act, but any ongoing physical intervention may proceed under a certificate of incapacity if the person lacks capacity. The certificate will not authorise the use of force or detention unless immediately necessary for the health and safety of the person (Lyons, 2002). In other jurisdictions, clinicians should familiarise themselves with local law.

Before involving a psychiatrist about an issue of consent or refusal, it is important to check first that the patient has been given all necessary information to make an informed choice about the risks and benefits of the intervention, and that you have assessed whether or not the patient has correctly understood this information, and held it in their mind for long enough to make their own decision, free from the pressure of others (including you). If you have done this, then you will have made an assessment of capacity (Box 2). Capacity involves being able to first, comprehend and retain treatment information; second, believe it; and third, weigh it in the balance to arrive at a choice (*Re C (adult: refusal of treatment)* [1994]). If patients have full capacity, it is of no consequence whether or not you agree with their decisions, and whatever their reasons, you must respect their wishes, unless they are detained under the Mental Health Act (Department of Health, 2001b).

Capacity to give meaningful consent or make a valid refusal is a legal concept and not a medical one. It is independent of diagnosis. In most situations where a judgement of capacity has to be made, a doctor's opinion will be obtained. The doctor could be a general practitioner, consultant, other hospital doctor or a

Box 2 Capacity

To demonstrate capacity to consent to or refuse medical treatment individuals should be able to:

- understand in simple language what the medical treatment is, its purpose and nature and why it is being proposed
- understand its principal benefits, risks and alternatives
- understand in broad terms what will be the consequences of not receiving the proposed treatment
- believe it
- retain the information for long enough to make an effective decision; and make a free choice (i.e. free from pressure)

prison or police doctor (British Medical Association & The Law Society, 1995). In England and Wales, there is a prior assumption in law that adults have capacity to consent or refuse unless proved otherwise, whereas people under the age of majority (18 years) do not have the same rights at law as adults. It is capacity, rather than chronological age, that determines whether a child or young person can legally give valid consent to medical interventions. In England and Wales, mentally competent young people aged 16 or 17 years can give consent in their own right without reference to their parents or legal guardian, but their refusal can be overridden in law by parents, legal guardians or the High Court.

Non-consenting patients

Very commonly, accident and emergency departments are faced with patients who have intentionally harmed themselves and then refuse consent to either stay in hospital or have essential treatment. All such patients will warrant assessment for possible mental disorder which might be interfering with their capacity as described above, and a psychiatrist may be called to assist in an emergency assessment of capacity (Box 2). The only exceptions to this rule might be patients who are so well known to the unit that there is a unit policy agreed with the psychiatric service on how to manage them when they present in a characteristic way.

Accident and emergency staff have a duty of care to detain (and, if necessary, restrain) the patient in order to allow a psychiatric assessment to take place. Unless the patient has been transferred under statutory Mental Health Act powers, the only immediate legal authority to detain will be from common law (as derived from legal precedent).

In an emergency, where time does not allow for the attendance of a psychiatrist to assist in this task, the accident and emergency doctor's own assessment of capacity would have to suffice. Treatment may proceed when there are reasonable grounds to doubt capacity, if it is an urgent necessity, the treatment is in the patient's best interests and the staff are acting in good faith, in line with a responsible body of medical opinion. Hospital staff have a duty of care to assist an incapacitous patient in the patient's own best interests, and could be found negligent for failing to do so. A careful written record should be made of all decisions and the reasons underpinning them.

When considering a person's capacity to refuse essential medical intervention, the doctor needs to consider whether the person has temporarily impaired judgement with respect to a grave irreversible decision. Case law has recognised that temporary factors such as confusion, shock, fatigue, pain, drugs or panic may completely erode capacity; those concerned must be satisfied that such factors are operating to such a degree that the ability to decide is absent (*Re T (adult: refusal of medical treatment)* [1992]; *Re MB (medical treatment)* [1997]). In patients who have deliberately harmed themselves, there is often impairment of judgement due to extreme emotional arousal, commonly compounded by intoxication. Thus,

where the consequences of a refusal of treatment are grave, the clinician should be clear that there is no impairment of capacity if the patient's refusal of treatment is to be respected despite those consequences. An algorithm summarising the approach to assessing capacity when patients refuse treatment is given in Fig. 2.

Case vignette 1: Intoxicated patient refusing to cooperate with assessment following self-harm

A young adult male is brought to the accident and emergency department by paramedics who found him lying in a doorway with a suicide note and an empty bottle of paracetamol. He is intoxicated with alcohol, belligerent, refuses to talk to any staff and is making moves to leave. You have no other information and have to make a decision as to whether or not to let him go.

This case typifies a common clinical problem faced by accident and emergency staff and psychiatrists covering the accident and emergency department. If there is sufficient concern to warrant detaining this patient for further assessment of a possible underlying mental disorder, then use of the Mental Health Act is justified. The fact that the patient is intoxicated is not an obstacle to the use of the Mental Health Act, as the Act is not being used to detain or treat someone because of alcohol misuse or dependence alone – a use of the Mental Health Act excluded under section 1(3) – but because of the concern that there might be an underlying mental disorder that is temporarily obscured by intoxication and lack of cooperation.

Case vignette 2: Patient refusing medical intervention after self-harm

A 30-year-old man is brought to the accident and emergency department following an overdose of 70 paracetamol tablets taken 4 hours prior to arrival at hospital. There is no history available and the patient refuses to say anything about himself other than he wants to be left alone to die. He refuses to give blood for a paracetamol level and refuses any medical intervention. Can medical treatment be given without his consent?

This illustrates a fairly common scenario. The case presents the medical staff with the dilemma of whether they should assume the person has full capacity to refuse medical treatment, in which case they must leave him to suffer the consequences of liver failure, possibly death, or whether they should act out of necessity and as part of their duty of care to treat someone in whom capacity may reasonably be in doubt and who could be mentally ill. A psychiatrist would not be in a position to assess the patient for mental disorder before the harmful effects of the paracetamol became irreversible. Even where there is no formal mental illness, someone in the state of emotional crisis surrounding attempted suicide might not be said to be in a position to make a fully reasoned decision, and many who refuse treatment on admission are grateful for their rescue the morning after. There is reasonable doubt with respect to such a person's capacity to make a fully informed and reasoned choice, and the physician should proceed with whatever action is needed, as a matter of urgent necessity, to save the person's life. This is defensible under common law. At the end of the day, is it

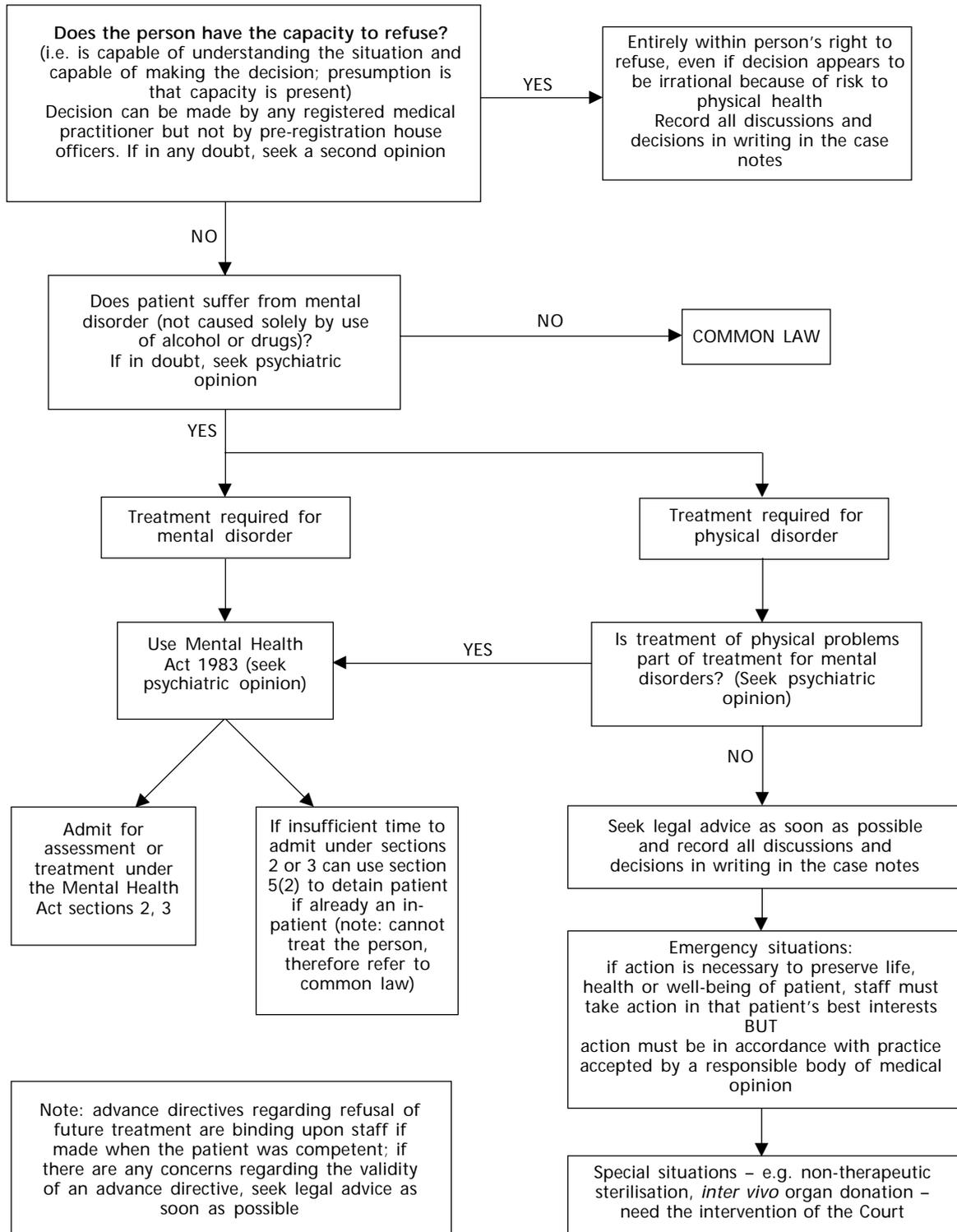


Fig. 2 Adult refusal of treatment (by kind permission of the Oxford Radcliffe Hospitals NHS Trust). Note: this is an example only; case law is subject to change; all hospitals and trusts should seek advice from their own legal advisors when developing policy guidance in this area.

better for a clinician to have a living patient who might sue for assault for saving the life he said he did not want when in a highly emotional state, or to have a dead patient with grieving relatives who might sue for negligence?

‘Although the consent of the patient is normally essential to the immunity of the doctor from criminal (and also from civil) process, there are occasions when the law permits doctors to proceed without it. Notably where urgent action is imperative in the interest of the patient, and because the patient is unconscious, or disoriented, or for some other reason the consent cannot be obtained until it is too late’ (*Airedale NHS Trust v. Bland* [1993]).

The older adult

Patients over the age of 65 years who have harmed themselves should always be referred for a specialist old age psychiatry assessment regardless of the medical seriousness of the event. In contrast to younger people, the characteristics of older patients who deliberately harm themselves are similar to those of older adults who die by suicide: half have a past psychiatric history and 30% have made previous suicide attempts (Draper, 1996; Hepple & Quinton, 1997). Among older people who harm themselves, 65–100% have a mental disorder and 47–93% have depression (50% major depression), and the vast majority will require psychiatric treatment (Draper, 1996). The completed suicide rate is at least 1.5% per year and repetition rate 5.4% per year. Those at continued risk are likely to be suffering from persistent depression (Hepple & Quinton, 1997).

The young patient

We have not addressed the particular problems of the assessment of acts of self-harm in this group. We do recommend that all such patients be referred for specialist assessment. For more detailed information, please see *Managing Deliberate Self-Harm in Young People* (Royal College of Psychiatrists, 1998).

The prisoner

The College is concerned about the high rates of self-harm and suicide in the prison population. This population is particularly vulnerable because of high rates of mental illness, substance misuse and personality disorder. Prisoners are further disadvantaged by the setting in which they live and the paucity of good health and psychological provision for them. Although many of the principles of assessment following self-harm will apply in prison, policy and practice will need to develop in line with general developments to improve mental health services for prisoners and suicide prevention programmes. Consideration of this is beyond the scope of this report, but is considered in the Council Report *Suicide in Prisons* (Royal College of Psychiatrists, 2002).

Standards for self-harm service planning groups and coordinators

Self-harm service planning groups should:

- consist of the following members: accident and emergency consultant, psychiatric consultant, consultant in addictions (where applicable), physician, general practitioner, accident and emergency nurse, psychiatric nurse, representative(s) of primary care trust(s), social services representative, senior manager, information officer, representative of users' groups and local voluntary agencies (e.g. the Samaritans)
- include representatives from diverse backgrounds
- meet regularly (at least every 6 months); record minutes of meetings and set out specifications for minimum quality in the general hospital
- ensure that the group's existence and activity are included in the contracts drawn up between providers and purchasers
- promote high standards for the assessment and management of self-harm
- set out a policy on whether non-psychiatric staff may undertake psychosocial assessment and management of patients presenting with self-harm
- consider whether certain groups should be subject to routine specialist referral, for example, patients under 18 years or over 65 years old, patients with a learning disability and patients under the care of a surgical or other non-medical team
- set up systems for the monitoring of ethnic demographics and analysis of any trends in relation to specific minority ethnic groups
- set up training (and specify its duration and content) for newly appointed staff within their first week in post if they are to undertake psychosocial assessments
- specify a policy for the supervision of any staff who have been trained to carry out self-harm assessments
- provide written guidance about clinical responsibility for discharge arrangements, specifying first the extent to which a specialist is providing advice to a medical or accident and emergency team or acting autonomously in making management decisions; and second, the lines of responsibility within a specialist service
- ensure there is a trust policy on medico-legal issues in situations of non-consent: there should be written guidance available on the assessment of capacity and consideration given to identifying a lead within the trust on training in the assessment of capacity; guidelines should be written in consultation with the trust's solicitors and risk managers

- specify patient management options to accident and emergency department staff – for example, time for recovery in the department, availability of self-harm specialists, and so on
- set out in writing a policy establishing which team has responsibility for contacting the general practitioner
- ensure that the out-of-hours and holiday cover for the assessment of patients in the accident and emergency department and on hospital wards in cases of self-harm are explicitly specified
- set out a written policy for referring patients to the self-harm services: the policy should be clearly understood and agreed by physicians, nurses and others on medical wards, psychiatric clerical staff and those who undertake the assessment
- stipulate that assessment of patients, whether done by designated staff or on a rota system, is scheduled and not fitted in as an *ad hoc* activity at the end of a busy day
- consider preparing a checklist or *pro forma* to help staff record important information about assessment and management
- set up a clerical system so that all contacts with specialist mental health services are filed in an appropriate location
- set up a data monitoring system so that relevant aspects of the self-harm service can be regularly audited (e.g. waiting times).

References

- Appleby, L., Morriss, R., Gask, L., *et al* (2000) An educational intervention for front-line health professionals in the assessment and management of suicidal patients (the STORM project). *Psychological Medicine*, **30**, 805–812.
- Babor, T. F., de la Fuente, J. R., Saunders, J., *et al* (1992) *AUDIT: The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Health Care* (2nd edn). Geneva: World Health Organization.
- Bhugra, D., Desai, M. & Baldwin, D. (1999) Attempted suicide in West London. Rates across ethnic communities. *Psychological Medicine*, **29**, 1125–1130.
- British Medical Association & The Law Society (1995) *Assessment of Mental Capacity: Guidance for Doctors and Lawyers*. London: British Medical Association.
- Butterworth, E. & O'Grady, T. (1989) Trends in the assessment of cases of deliberate self-harm. *Health Trends*, **21**, 61.
- Catalan, J., Marshack, P., Hawton, K. E., *et al* (1980) Comparison of doctors and nurses in the assessment of deliberate self-poisoning patients. *Psychological Medicine*, **10**, 483–491.
- Chick, J. (1987) Early intervention in general hospital. In *Helping the Problem Drinker* (eds T. Stockwell & S. Clement), p. 115. London: Croom Helm.
- Department of Health (1992). *The Health of the Nation: A Strategy for Health in England*. London: Department of Health.
- Department of Health (1998) *Modernising Mental Health Services: Safe, Sound and Supportive*. London: Department of Health.
- Department of Health (1999a) *Safer Services: Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. London: Department of Health.
- Department of Health (1999b) *National Service Framework for Mental Health*. London: Department of Health.
- Department of Health (2001a) *Safety First. Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. London: Department of Health.
- Department of Health (2001b) *Consent. Reference Guide to Consent for Examination and Treatment*. London: Department of Health.
- Department of Health (2002) *The National Suicide Prevention Strategy for England*. London: Department of Health.
- Department of Health and Social Security (1984) *The Management of Deliberate Self-Harm*. HN(84): 25. London: HMSO.
- Dirks, B. (1998) Repetition of parasuicide: ICD-10 personality disorders and adversity. *Acta Psychiatrica Scandinavica*, **98**, 208–213.
- Draper, B. (1996) Attempted suicide in old age. *International Journal of Geriatric Psychiatry*, **11**, 577–587.
- Ferreira de Castro, E., Cunha, M., Pimenta, F., *et al* (1998) Parasuicide and mental disorders. *Acta Psychiatrica Scandinavica*, **97**, 25–31.
- Foster, T., Gillespie, K., McClelland, R., *et al* (1999) Risk factors for suicide independent of DSM-III-R Axis I disorder. Case-control psychological autopsy study in Northern Ireland. *British Journal of Psychiatry*, **175**, 175–179.
- Gupta, B. & Trzepacz, P. (1997) Serious overdosers admitted to a general hospital: comparison with non-overdose self-injuries and medically ill patients with suicidal ideation. *General Hospital Psychiatry*, **19**, 209–215.
- Haw, C., Hawton, K., Houston, K., *et al* (2001) Psychiatric and personality disorders in deliberate self-harm patients. *British Journal of Psychiatry*, **178**, 48–54.

- Hawton, K. & Fagg, J. (1992) Trends in deliberate self-poisoning and self injury in Oxford 1976–90. *BMJ*, **304**, 1409–1411.
- Hawton, K., Arensman, E., Townsend, E., *et al* (1998) Deliberate self-harm: systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition. *BMJ*, **317**, 441–447.
- Hawton, K., Townsend, E., Deeks, J., *et al* (2001) Effects of legislation restricting pack sizes of paracetamol and salicylate on self poisoning in the United Kingdom: before and after study. *BMJ*, **322**, 1203–1207.
- Hepple, J. & Quinton, C. (1997) One hundred cases of attempted suicide in the elderly. *British Journal of Psychiatry*, **171**, 42–46.
- Hickey, L., Hawton, K., Fagg, J., *et al* (2001) Deliberate self-harm patients who leave the accident and emergency department without a psychiatric assessment: a neglected population at risk of suicide. *Journal of Psychosomatic Research*, **50**, 87–93.
- Hodgson, R. J., Alwyn, T., John, B., *et al* (2002) The Fast Alcohol Screening Test. *Alcohol and Alcoholism*, **37**, 61–66.
- Isacsson, G. & Rich, C. L. (2001) Management of patients who deliberately harm themselves. *BMJ*, **322**, 213–215.
- Kapur, N., House, A., Creed, F., *et al* (1988) Management of deliberate self poisoning in adults in four teaching hospitals: descriptive study. *BMJ*, **316**, 831–832.
- Lewis, G., Hawton, K. & Jones, P. (1997) Strategies for preventing suicide. *British Journal of Psychiatry*, **171**, 351–354.
- Lyons, D. (2002) Medical treatment using the Scottish Incapacity Act: will it work? *Journal of Mental Health Law*, **7**, 197–202.
- Mayfield, D., McLeod, G. & Hall, P. (1974) The CAGE questionnaire: validation of a new alcoholism screening instrument. *American Journal of Psychiatry*, **131**, 1121–1123.
- Morriss, R., Gask, L., Battersby, L., *et al* (1999) Teaching frontline health and voluntary workers to assess and manage suicidal patients. *Journal of Affective Disorders*, **52**, 77–83.
- Mortensen, P. B., Agerbo, E., Erikson, T., *et al* (2000) Psychiatric illness and risk factors for suicide in Denmark. *Lancet*, **355**, 9–12.
- Neeleman, J., Wilson-Jones, C. & Wessely, S. (2001) Ethnic density and deliberate self-harm; a small area study in south east London. *Journal of Epidemiology and Community Health*, **55**, 85–90.
- Newson-Smith, J. & Hirsch, S. (1979) Psychiatric symptoms in self-poisoning patients. *Psychological Medicine*, **9**, 493–500.
- Royal College of Psychiatrists (1994) *The General Hospital Management of Adult Deliberate Self-Harm: A Consensus Statement on Standards for Service Provision* (Council Report CR32). London: Royal College of Psychiatrists.
- Royal College of Psychiatrists (1998) *Managing Deliberate Self-Harm in Young People* (Council Report CR64). London: Royal College of Psychiatrists.
- Royal College of Psychiatrists (2002) *Suicide in Prisons* (Council Report CR99). London: Royal College of Psychiatrists.
- Royal College of Psychiatrists (2003) *Psychiatric Services to Accident and Emergency Departments* (Council Report CR118). London: Royal College of Psychiatrists.
- Slinn, R., King, A. & Evans, J. (2001) A national survey of the hospital services for the management of adult deliberate self-harm. *Psychiatric Bulletin*, **25**, 53–55.
- Stockwell, R. T., Hodgson, R. J., Edwards, G., *et al* (1979) The development of a questionnaire to measure severity of alcohol dependence. *British Journal of Addiction*, **74**, 79–87.
- Suominen, K., Isometsa, E. & Henriksson, M. (1999) Consultation versus research diagnoses of mental disorders among suicide attempters. *Nordic Journal of Psychiatry*, **53**, 253–256.
- University of York NHS Centre for Reviews and Dissemination (1998) Deliberate self-harm. *Effective Health Care*, **4**, 1–12.

Wolfersdorf, M. (2000) Patient suicide during in-patient psychiatric therapy. New developments [Patientensuizide während stationärer psychiatrischer Therapie. Neue Entwicklungen]. *Psychiatrische Praxis*, **27**, 277–281.

Legal references

Airedale NHS Trust v. Bland [1993] 1 All ER 821.

Re C (Adult: Refusal of Treatment) [1994] 1 All ER 819.

Re MB (Medical Treatment) [1997] 2 FLR 426, CA.

Re T (Adult: Refusal of Medical Treatment) [1992] 4 All ER 649, CA.