

# ASSESSMENT OF SELF HARM IN AN ACCIDENT AND EMERGENCY SERVICE - THE DEVELOPMENT OF A PROFORMA TO ASSESS SUICIDE INTENT AND MENTAL STATE IN THOSE PRESENTING TO THE EMERGENCY DEPARTMENT WITH SELF HARM

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## SUMMARY

**Introduction:** The UK has one of the highest rates of self harm in Europe, around 400 per 100,000 people (Horrocks et al. 2002). It accounts for 150,000 attendances to the Emergency department each year and is one of the top five causes of acute medical admissions in the UK (NICE 2002).

**Aims:** Objectives included to explore the method of self harm and the demographic factors of those presenting the Emergency department with self harm. In addition we wanted to review the exploration of suicide risk factors and suicide intent by the Emergency department doctor and ascertain whether a psychiatric assessment with full mental state examination had been conducted with referral to psychiatric services if deemed necessary. We wanted to explore the current practice around self harm presentations in the Emergency department accordance with NICE guidelines.

**Methods:** Data was collected retrospectively from February to August 2009. Twenty-five sets of medical notes were collated at random for patients who had presented with self harm to the Emergency department. Notes were reviewed for evidence of exploration of the event, psychiatric assessment, risk factors for suicide and further referral.

**Results:** 14 of the 25 patients presented having taken an overdose. 9 had inflicted some other form of self injury, namely lacerations to self. In 2 cases a mixed presentation was found.

Previous psychiatric history was documented in 16 cases. 11 had a previous history of depression or anxiety disorder; 1 was known to have bipolar affective disorder; 1 was diagnosed in the past with borderline personality disorder; and 3 patients had no previous history. In 9 cases previous history was not documented.

**Discussion:** Twenty-five sets of medical notes were reviewed from February to August 2009 for individuals presenting to the Emergency department with self harm. Of those, 12 fell into the over 25 age group. 17 were female and 8 were male. The majority of patients were of white British ethnicity. 14 had taken an overdose; 9 had inflicted some other form of self injury; and 2 had a mixed presentation. Suicide risk factors and suicidal intent was poorly documented with mental state examination found not to be documented in all 25 cases reviewed. 18 were deemed medically fit in the Emergency department and were referred for psychiatric review. These unfortunate findings may be a reflection on the time pressures faced by Emergency department doctors, namely the four hour targets, and perhaps lack of adequate training in psychosocial risk assessment. With such poor documentation made by the Emergency department doctors, a proforma was produced which incorporates suicide risk factors and assessment of suicide intent in addition to a brief version of the mental state examination.

**Conclusion:** Concerns have been raised by the recent Royal College of Psychiatrists report on self harm, that current level of care provided to service users fall short of the standards set out in policies and guidelines, with poor assessments, unskilled staff and insufficient care pathways (Royal College of Psychiatrists. Report CR 158. 2010). Indeed evidence suggest that appropriate training and intervention given to A&E staff can lead to improvements in the quality of psychosocial assessment of patients with deliberate self harm (Crawford et al. 1998).

**Key words:** accident and emergency service - self harm - suicide - psychiatric assessment - psychosocial assessment.

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## Introduction

The UK has one of the highest rates of self harm in Europe, around 400 per 100,000 people (Horrocks et al. 2002). It accounts for 150,000 attendances to the Emergency department each year and is one of the top five causes of acute medical admissions in the UK (NICE 2002). Self harm may be defined as any intentional act done in the knowledge that it was potentially harmful. It can take various forms including self poisoning or self injury such as cutting or burning. Suicide is the act of intentionally and successfully

ending one's own life and parasuicide denotes an unsuccessful suicide attempt.

Individuals may self harm for many reasons and may not in itself be an attempt or indicator of suicidal intent. Indeed it can be viewed as a manifestation of distress, however some individuals use self harm as a coping mechanism or a way to escape unwanted emotional experiences (Chapman et al. 2006).

Self harm behavior may be a persistent pattern of behavior for some individuals, with studies suggesting non-fatal repetition rates at 1 year are around 15%. Following an act of self-harm, individuals are at a high

risk of suicide. Studies show the suicide risk among self-harm patients is 66 to hundred times higher than in the general population (Owens et al. 2002, Hawton et al. 2003).

Hence there is a strong association between self-harm and later suicide. Evidence suggests that between 0.5% and 2% of individuals who self harm commit suicide after 1 year and this rises above 5% after 9 years (Owens et al. 2002). 43% of individuals who commit suicide have attended the Emergency department at least once in the previous year. Of these, 28% would have attended on more than 3 occasions (Da Cruz et al. 2010).

Suicide is one of the leading causes of mortality in 10-24 year olds worldwide (WHO News release 2009) and is one of the three leading causes of death in young people in West. In the UK suicide accounts for 5 700 deaths per year, 1% of total mortality (Office for National Statistics 2010).

The assessment and treatment of people who self-harm uses a substantial amount of NHS resources. Inevitably there are economic costs incurred by those who self harm. Most of this direct cost is accounted for by the estimated 150,000 attendances at an emergency department each year and the subsequent medical and psychiatric care. The direct cost to the National Health Service has been estimated at £5.1 million per year from tricyclic antidepressant self poisoning alone (Royal College of Psychiatrists.2010). On average, each attendance costs at least £425.24, from attendance to A&E to hospital discharge (Yeo 1993). The indirect costs of self-harm are unknown but, given its prevalence, are likely to be substantial, particularly in terms of days lost from work.

Self harm and suicide are therefore important public health issues. The reduction of suicides has been a national priority for the health service by detection and treatment of those most at risk. NICE guidelines (2004) suggest that following triage, patients who have self-harmed should receive the requisite treatment for their physical condition, undergo risk and full psychosocial needs assessment and mental state examination, and referral for further treatment and care as necessary (NICE 2002).

The psychosocial and risk assessment of people attending the ED in UK has been described as inadequate, characterised by low assessment rates and poor recordings of mental health findings (Merrill et al. 1992). Some studies suggest that specialist psychosocial assessment is only conducted in 56% of episodes with subsequent psychiatric admission in 10% (Gunnel et al. 2005).

The attitudes of medical professionals toward self harm patients may be implicated. There is some evidence that Accident and Emergency doctors may hold particular views regarding treating the body and mirroring cultural and societal responses to self harm behavior which may prove unhelpful to the doctor patient relationship (Hadfield et al. 2009).

## Aims

Objectives included to explore the method of self harm and the demographic factors of those presenting the Emergency department with self harm. In addition we wanted to review the exploration of suicide risk factors and suicide intent by the Emergency department doctor and ascertain whether a psychiatric assessment with full mental state examination had been conducted with referral to psychiatric services if deemed necessary. We wanted to explore the current practice around self harm presentations in the Emergency department accordance with NICE guidelines.

## Methods

Data was collected retrospectively from February to August 2009. Twenty-five sets of medical notes were collated at random for patients who had presented with self harm to the Emergency department. Notes were reviewed for evidence of exploration of the event, psychiatric assessment, risk factors for suicide and further referral.

## Results

### Demographics:

Of the twenty-five cases, seventeen were female and eight male. Ages ranged from 13 years to 55 years but a large proportion of patients were over 25.

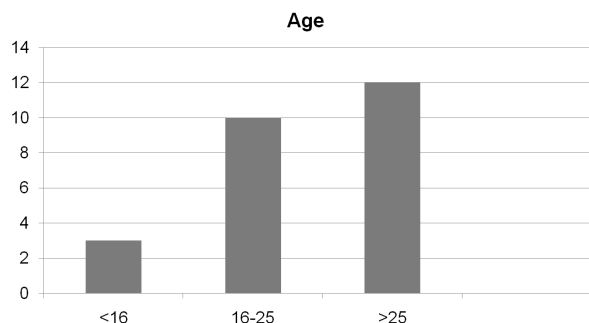


Figure 1. Age of Patients

The majority of patients were of white British ethnicity, that is 22 of the 25 patients. One was Afro-Caribbean, one of mixed ethnicity and in one case ethnicity was not documented in the notes.

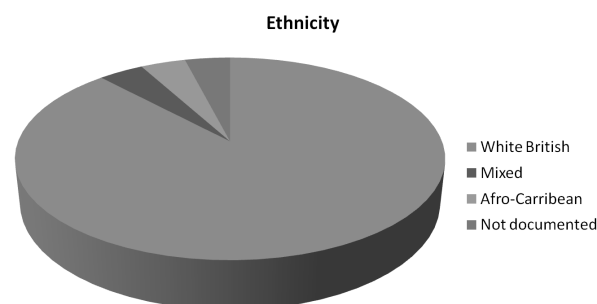
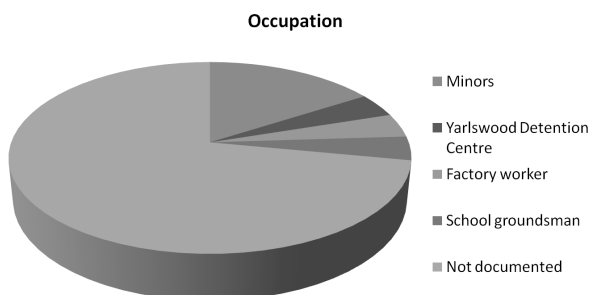


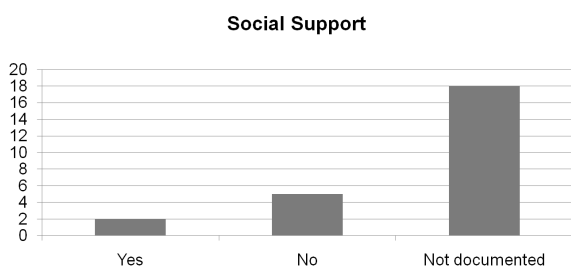
Figure 2. Ethnicity of Patients

The occupation of the patient was not documented in the medical notes in the majority of cases, 18 of the 25 cases reviewed. 4 patients were school pupils, 1 was a factory worker; 1 a school groundsman and 1 patient was from Yarlswood detention centre.



**Figure 3.** Occupation of Patients

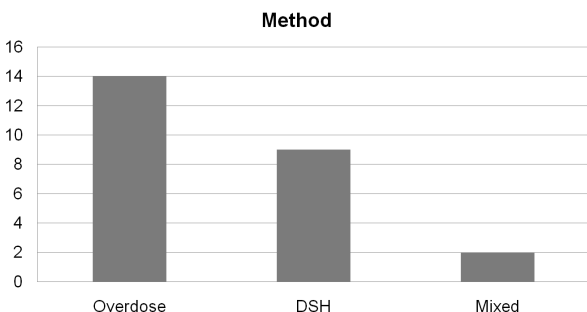
Social support was not documented in 18 of the 25 cases. 5 patients felt they had no social support and 2 patients felt they did have adequate social support.



**Figure 4.** Social Support

**Method of self harm:**

14 of the 25 patients presented having taken an overdose. 9 had inflicted some other form of self injury, namely lacerations to self. In 2 cases a mixed presentation was found.

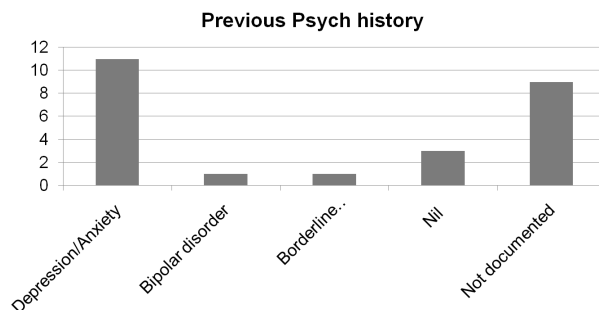


**Figure 5.** Method of self harm

**Previous psychiatric history:**

Previous psychiatric history was documented in 16 cases. 11 had a previous history of depression or anxiety

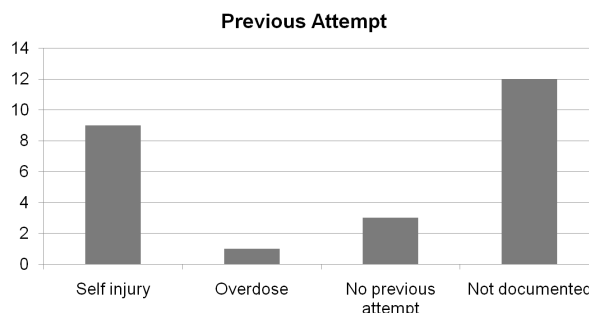
disorder; 1 was known to have bipolar affective disorder; 1 was diagnosed in the past with borderline personality disorder; and 3 patients had no previous history. In 9 cases previous history was not documented.



**Figure 6.** Previous Psychiatric History

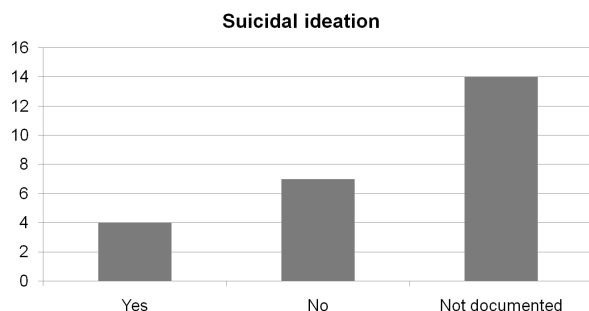
**Suicide risk factors and assessment of suicide intent:**

Whether the patient had made a previous attempt of self harm was explored. 9 patients had made a previous self harm attempt; 1 had taken a previous overdose; 3 patients had no previous attempt. Previous attempt was not documented in 12 cases.



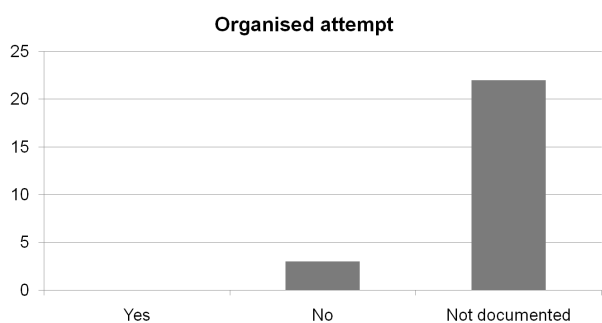
**Figure 7.** Previous Suicide Attempts

Persistent suicidal ideation was documented in 4 cases. 7 cases reported no further suicidal ideation. However, present suicidal ideation was not documented in 14 cases.



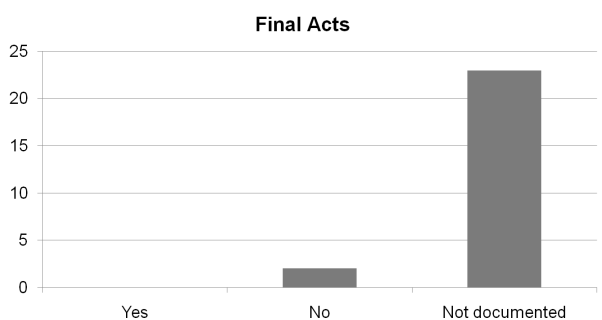
**Figure 8.** Suicidal Ideation

Exploration of whether the event was planned was not documented in 21 cases. In 4 cases, there was documented evidence that the event was impulsive.



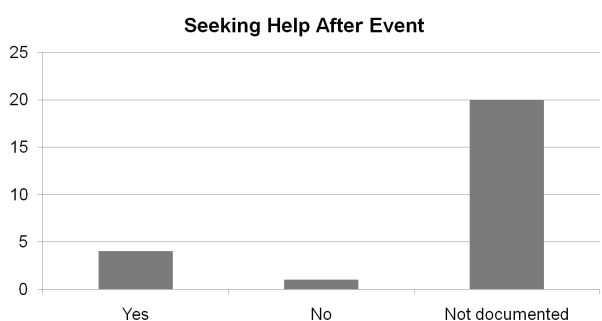
**Figure 9.** Organised Attempts

2 patients denied conducting any final acts prior to the self harm. In the remaining 23 cases exploration of final acts was not documented.



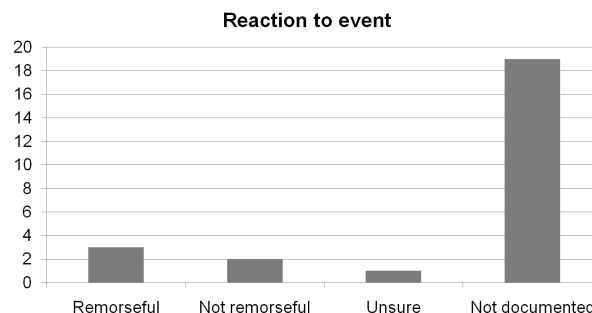
**Figure 10.** Final Acts

4 patients had sought help after the event. 1 patient had not sought for help after the event. In 20 cases there was no documentation at all regarding the patient seeking help after the event.



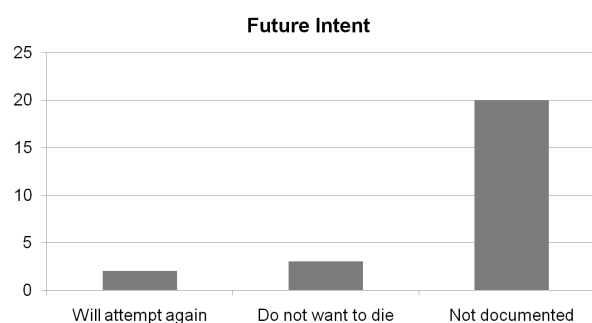
**Figure 11.** Help Seeking after the Event

In 3 cases there was documentation that the patient felt remorseful about the self harm event. 2 were not remorseful and 1 was unsure of their feelings towards the event. Patient reaction to the event was not documented in 19 cases.



**Figure 12.** Reaction to Event

3 patients denied any thoughts of wanting to end their life or harm themselves in the near future. 2 patients reported they would attempt to harm themselves again. Future intent was not documented in 20 cases.



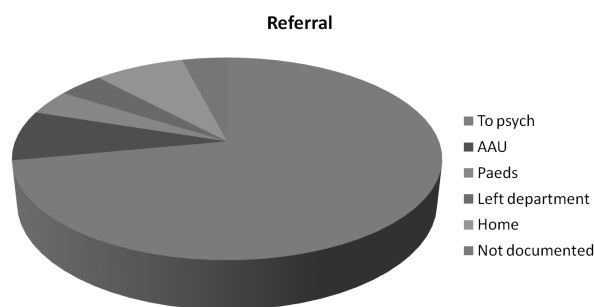
**Figure 13.** Future Intent

**Mental state examination:**

The mental state examination was not documented in all 25 cases.

**Further psychiatric referral:**

18 patients were deemed medically fit and were referred to the psychiatric team. 2 were referred to the acute assessment unit and 1 was referred to the paediatric ward for further medical input. 2 were discharged home with no psychiatric review or follow up. 1 patient had left the department during assessment in the Emergency department and in 1 case further psychiatric referral was not documented.



**Figure 14.** Psychiatric Referrals

## Discussion

Twenty-five sets of medical notes were reviewed from February to August 2009 for individuals presenting to the Emergency department with self harm. Of those, 12 fell into the over 25 age group. 17 were female and 8 were male. The majority of patients were of white British ethnicity. 14 had taken an overdose; 9 had inflicted some other form of self injury; and 2 had a mixed presentation.

Suicide risk factors and suicidal intent was poorly documented with mental state examination found not to be documented in all 25 cases reviewed. 18 were deemed medically fit in the Emergency department and were referred for psychiatric review. These unfortunate findings may be a reflection on the time pressures faced by Emergency department doctors, namely the four hour targets, and perhaps lack of adequate training in psychosocial risk assessment.

With such poor documentation made by the Emergency department doctors, a proforma was produced which incorporates suicide risk factors and assessment of suicide intent in addition to a brief version of the mental state examination.

This has been introduced to the Emergency department and a follow up audit is planned to assess the effectiveness of the proforma. We make further recommendation to explore the attitudes of Emergency department staff towards patients who self-harm and further study into the persistent pattern of repeat presentation to the Emergency department with self harming behaviour.

## Conclusion

Concerns have been raised by the recent Royal College of Psychiatrists report on self harm, that current level of care provided to service users fall short of the standards set out in policies and guidelines, with poor assessments, unskilled staff and insufficient care pathways (Royal College of Psychiatrists. Report CR 158. 2010). Indeed evidence suggest that appropriate training and intervention given to A&E staff can lead to improvements in the quality of psychosocial assessment of patients with deliberate self harm (Crawford et al. 1998).

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## APPENDIX

### Emergency Department Self Harm Proforma

<b>Name:</b> <b>Hospital number:</b> <b>Date of birth:</b> <b>Marital status:</b> <b>Occupation:</b>
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<b>1. Alone during the act</b>	
No	0
Yes	1
<b>2. Timing</b>	
Intervention to prevent self harm: likely	0
Intervention to prevent self harm: unlikely	1
<b>3. Precautions to avoid discovery</b>	
No	0
Yes	1
<b>4. Seeking help after the attempt</b>	
Yes	0
No	1
<b>5. Final acts</b>	
No	0
Yes	1
<b>6. Suicide note</b>	
No	0
Yes	1
<b>7. Patient's belief in lethality of method</b>	
Believed method would not be fatal	0
Believed method would be fatal	1
<b>8. Actual risk of lethality</b>	
Survival certain	0
Death unlikely	1
Death likely or certain	2
<b>9. Risk of fatality without medical intervention</b>	
No	0
Uncertain	1
Yes	2
<b>10. Stated intent</b>	
Did not want to die	0
Unsure	1
Wanted to die	2
<b>11. Length of planning</b>	
Impulsive	0
Planned for <1 hour	1
Planned for <1 day	2
Planned for >1 day	3
<b>12. Reaction to the act</b>	
Remorseful	0
Unsure	1
Not remorseful	2
<b>Score</b>	
0-6 Low intent	
7-12- Medium intent	
13+ High intent	

<b>Mental State Examination</b>			
<b>Appearance:</b>			
<b>Well dressed</b> <input type="checkbox"/>	<b>Good eye contact</b> <input type="checkbox"/>	<b>Unkempt</b> <input type="checkbox"/>	<b>Poor eye contact</b> <input type="checkbox"/>
<b>Behaviour:</b>			
<b>Appropriate</b> <input type="checkbox"/>	<b>Inappropriate</b> <input type="checkbox"/>		
<b>Speech:</b>			
<b>Normal</b> <input type="checkbox"/>	<b>Rapid and incoherent</b> <input type="checkbox"/>	<b>Poor</b> <input type="checkbox"/>	
<b>Mood:</b>			
<b>Normal</b> <input type="checkbox"/>	<b>Depressed or anxious</b> <input type="checkbox"/>	<b>Manic</b> <input type="checkbox"/>	
<b>Affect/ Emotional state:</b>			
<b>Normal</b> <input type="checkbox"/>	<b>Blunted or Flattened</b> <input type="checkbox"/>	<b>Very emotional</b> <input type="checkbox"/>	
<b>Thought:</b>			
<b>Normal</b> <input type="checkbox"/>	<b>Abnormal</b> <input type="checkbox"/>		
<b>Perception:</b>			
<b>Normal</b> <input type="checkbox"/>	<b>Visual hallucinations</b> <input type="checkbox"/>	<b>Auditory Hallucinations</b> <input type="checkbox"/>	
<b>Cognition:</b>			
<b>Oriented to time</b> <input type="checkbox"/>	<b>Oriented to place</b> <input type="checkbox"/>	<b>Oriented to person</b> <input type="checkbox"/>	
<b>Insight to disease:</b>			
<b>Aware</b> <input type="checkbox"/>	<b>Limited</b> <input type="checkbox"/>	<b>Thinks nothing is wrong</b> <input type="checkbox"/>	

Notes: completed forms should be kept in patient's cascard.

Date: \_\_\_\_\_ Name of person completing the form: \_\_\_\_\_

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