Self-harm patients not admitted to hospital

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ABSTRACT – In recent years a large proportion of self-harm patients attending hospital have not been admitted to medical or short-stay wards but have returned home directly from accident and emergency departments. A continued trend towards such a policy seems likely despite limited and conflicting evidence on its desirability. The clinical, training and epidemiological implications of changes in self-harm admission policy are outlined, together with recommendations concerning clinical audit.

Attempted suicide ceased to be illegal with the passage of the Suicide Act in August 1961. A few weeks later the Ministry of Health issued a recommendation that henceforth all cases of attempted suicide brought to hospital should receive psychiatric investigation before discharge [1]. There have been outspoken objections to the official guidelines, a common complaint being that they restrict clinical choice by non-psychiatric doctors [2]. This view has received support from a number of research studies which have suggested that junior medical staff [3], social workers [4] and nurses [5] are able to assess self-harm patients as effectively as psychiatrists.

Official guidance about hospital admission

While discussion over the years has centred around the question of which professional staff should assess patients at the hospital, a separate question has been relatively neglected: should all self-harm patients seen by doctors be admitted to hospital in the first place? There are some patients who do not consult a doctor after an episode of self-harm, and others who are seen by a general practitioner but not sent to hospital [6]. Moreover, there has been a tendency to overlook the fact that in many places substantial numbers of self-harm patients have, by tradition, been discharged directly from Accident and Emergency (A&E). For example, a number of studies in the early 1970s reported rates of discharge from A&E of around 20% or more [7–10]. There are indications that, over a few years, A&E discharge rates have increased in some hospitals from 10–15% of cases seen up to 30% or more [11, 12], with only a minority of those discharged being assessed by a psychiatrist. This practice can only have been encouraged by a study in 1982 which suggested that non-psychiatric doctors in A&E were able to select self-harm patients appropriately for admission to hospital or discharge home [13].

In new guidance from the Department of Health and Social Security (DHSS), circulated early in 1985 [14], it was acknowledged that general practitioners would manage some cases at home and that some patients would be assessed in A&E and discharged without being seen by a psychiatrist. However, A&E consultants were charged with responsibility for ensuring that 'before patients are discharged from hospital, a psycho-social assessment is carried out by staff specifically trained for this task' [14]. Such a change in official guidance is likely to have promoted further reduction in the proportion of self-harm patients admitted; one recent study noted discharge direct from A&E of more than half of the self-poisoning attenders [15]. This trend has not developed everywhere, there being reports of continued admission of most self-harm patients [16, 17]. Practice is not uniform and few districts have followed the DHSS recommendation to establish an active multi-disciplinary group of relevant clinical staff to form policies for practice, monitoring and training [18].

Implications of a rise in direct discharges from A&E

If there is a continued trend towards discharge of self-harm patients from A&E there will be important consequences.

First, there are clinical implications. Some studies report that patients not referred to hospital by their general practitioners [6] and those discharged directly from A&E [7] have a higher subsequent repeat rate for self-harm than those referred and admitted. Others, conversely, suggest that A&E departments screen patients effectively, resulting in less risk and lower morbidity amongst the discharged patients [12, 13]. None of these studies was a randomised clinical trial and the contradictory findings are reasons to counsel caution. Many may share Kreitman's opinion that assessment in a busy casualty department is a difficult task and that hospital admission offers patients valuable respite at a time of crisis [19].

Second, there are likely to be training implications. A shift in policy towards more discharges from A&E increases the need for education and supervision of casualty staff carrying out assessments. Furthermore, if those patients discharged from A&E are selected appropriately, there must be a corresponding concen-

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tration of morbidity and risk within the group admitted to medical or short-stay beds, and this in turn will make the task of assessing these patients more difficult. In such circumstances the assessors of hospitalised patients need a high level of psychiatric expertise or supervision. Junior medical staff or those from non-medical disciplines, acting without expert supervision or training, may not perform adequately in the face of an increasingly difficult task.

Third, following the revised guidelines, epidemiological studies of trends in self-harm must begin to pay closer attention to patients not admitted to hospital and seek more information about the activities of general practitioners and A&E departments. For example, the number of patients attending the general hospitals in Oxford between 1972 and 1980 following deliberate self-poisoning reached a peak in 1978, with a sharp decline over the following two years [20]. Subsequent monitoring of the number of patients admitted to hospitals in Oxford and Edinburgh between 1976 and 1984 indicates a further reduction [16]. Other authors have used national figures to show a similar peak for admissions over the whole country in 1978 with decline since then [21, 22]. In these studies hospital admission rates have been taken to reflect changing patterns of deliberate self-harm in the general population. However, an increase in the proportion of patients discharged home directly from A&E seems certain to have contributed to any national decline in admissions, and hospital discharges alone cannot be assumed to reflect the rate of deliberate self-poisoning. Trends based on inpatient statistics, with an assumption of stable patterns of general practitioner and A&E practice, need to be viewed with caution, particularly after 1985 when the changes in guidance from the DHSS became widely known.

Recommendations

Recognition that many A&E units operate a policy of direct discharge leads to corresponding recommendations.

1. In most hospitals it may not be possible to monitor repeat attempts and suicides. However, in each health district, audit undertaken jointly by physicians and psychiatrists might at least examine the process of A&E management of self-harm attenders—determining local discharge rates and trends, and encouraging attention to known correlates of suicidal risk (such as age, sex, past attempts, previous psychiatric care, living arrangements etc).
2. In districts where discharge of self-harm patients from A&E is commonplace, such an audit might demonstrate the need for additional training or support in psychiatric and social assessment, either in A&E or within the hospital wards.
3. Monitoring rates of deliberate self-harm in any health district must combine figures for admitted patients with those from A&E. Figures from general practice would be of additional benefit—there have been no substantial studies of the epidemiology of self-harm in primary care since 1970 [6].

It was estimated in the mid-1970s that there were more than 100,000 admissions yearly to UK hospitals [23]. Despite some subsequent reduction [16, 21, 22], the current figure is not likely to be much less. For the majority, the length of stay is only one day, but this amounts to an annual requirement for about 300 patient-years of acute hospital care. Inpatient accommodation is under increasing pressure; wards have recently been closed to make savings. Enactment of the part of the White Paper *Working for patients* that deals with competitive market contracts will add to financial pressures on the pattern of service provision [24] and seems likely to accelerate the trend towards non-admission of self-poisoning patients. One reason for the serious inadequacy of epidemiological data and clinical research findings for the planning and auditing of services is the lack of attention paid to those patients not admitted to hospital.

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