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Deliberate self harm (DSH) – assessment of patients admitted to hospitals

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1. Introduction

Suicide rate in Sri Lanka has been alarmingly high during the past few decades. Reasons such as social problems, psychiatric disorders, availability of poisonous agents, glamorization of such incidents by the media has been postulated as reasons for high suicide rate. For every completed suicide there are a number of attempted suicides.

Major proportions of deliberate self-harm patients are admitted directly to non-psychiatric units of hospitals. Many of these patients are discharged directly, soon after recovering from physical consequences and may not have been adequately assessed prior to discharge. 1% of them die by suicide within one year following discharge from hospital and 2% to 3% die within five years by the same means[1]. The proportions could be more in Sri Lanka.

To reduce the rate of suicide, a high quality service for patients who have harmed themselves is essential. But there is no assessment policy on the assessment of these patients[2]. Hospitals and consultants use variety of methods depending on the attitudes, experience and available resources[2]. Even when decided to refer to a psychiatric unit some face practical difficulties such as delay in referring or delay in assessing due to poor communication between the wards. Some hospitals lack psychiatric assessment or treatment facilities. Therefore it is essential that these patients be assessed adequately by the staff in the wards where they are admitted. Number of research studies have suggested that junior medical staff, social workers and nurses are able to assess deliberate self-harm patients as effectively as psychiatrists[3].

Further the general circular No. 01-13\98 of Ministry of Health, on the recommendations of National programme for prevention of suicide and the amended law, proposes that punishment be replaced with counselling and medical support, as well as referral to a psychiatric service if the suicide attempt was due to serious psychiatric illness[4]. This recommendation also highlights the need of proper assessment at the ward they were admitted to, to decide on further management.

Hence, it is essential that doctors who have contact with these patients in the hospital be trained in assessing deliberate self harm patients in order to achieve quality care for them. Since the hospitals and consultants use a variety of methods in care of these patients, it is beneficial to have guidelines for assessment and management practices at general hospitals.

This book is prepared to provide guidelines for management of deliberate self-harm patients admitted to the hospitals. It is primarily for the medical staff, but can be used by nurses, social workers who are involved in the management of deliberate self harm patients and medical students.

2. Few more facts on deliberate self harm

2.1 *Terminology*

A suicide attempt has been defined as any action resulting in self-injury, when this action is undertaken consciously for the purpose of self destruction, and death is prevented by intervention of factors beyond the persons control such as mechanical failure, detection or rescue by another party or medical intervention[5].

Morgan (1975) defined deliberate self harm (DSH) as an act of non fatal injury to self, by means of physical injury, drug overdose or poisoning, carried out in the knowledge that it was potentially harmful, and in the case of drug overdose the amount taken was excessive[6].

The above explanation shows that the person has deliberately initiated an act of self-damage and leaves open the often-intangible issue of his ultimate intention, as in the case of attempted suicide.

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Krietman, et al introduced the concept of para-suicide, to describe behaviour that, mostly without the intention to kill one self communicates the degree of suicidal intent[7].

For practical reasons, the term deliberate self harm (DSH) is used in this book.

2.2 Global situation of deliberate self harm in relation to Sri Lanka

Since no country in the world collects national statistics for attempted suicide, it is not possible to relate trends in suicide attempts to trends in suicide[8]. However it has been argued that current trends in suicides and suicide attempts are closely related.

Data from studies in several countries with well-defined catchment areas indicate that hospital discharge rates for attempted suicide rose sharply during 1965-1980, during which suicide rates were also rising, especially in the younger age groups[8].

There is a consistency of the global picture of suicide statistics both geographically and chronologically. Arabic countries have relatively low rates, whereas European countries and countries of European decent (e.g. Australia, USA) tend to have relatively high rates. Relatively large increases are observed in south East Asia (e.g. Sri Lanka, Thailand, Singapore)[8].

According to the World Health Organization, the highest rate of suicides which was 73.3 per 100,000 population, was reported in Lithuania[9]. According to the statistics of the Annual Health Bulletin, suicides in Sri Lanka per 100,000 population were recorded as 30.1 in 1999[10]. In 1982, Abeysinghe reported that the majority of suicides in Sri Lanka are youth who attempt suicide without intending to die, but use lethal agents[11]. Therefore, a big overlap in suicide and attempted suicides can be expected in Sri Lanka.

All patients admitted with deliberate self harm are not routinely referred to a psychiatrist, nor do general practitioners send all such patients to hospitals. In many hospitals majority of patients with deliberate self harm are discharged directly. There are few special treatment centres for poisoning, and some hospitals lack psychiatric units. Arrangements for assessing these patients vary. Even in general hospitals where psychiatrists provide a service, only 4% of these patients are seen by them[12]. Therefore it is apparent that despite the scale of deliberate self harm, planning and delivery of services are in a state of disarray[3].

2.3 Current approach of medical staff to patients with deliberate self harm

The importance of having a positive attitude towards suicide prevention cannot be over emphasized. However, a negative approach is all too common.

Deliberate self harm is a powerful form of communication. The hospital staff is among the first to react to this communication and their attitude to this behaviour is likely to be important in determining consequence[13]. Clinical experience with suicidal patients demonstrates the immense value of reaching out and listening and helping to resolve a suicidal crisis, no matter how complex and apparently insoluble the individual problems may seem[14].

Following recovery from the physical effects of deliberate self harm, the patients should be interviewed to determine the reasons for the episode and to identify any psychiatric illness or social precipitant, which can be corrected. Current stresses are often of such a kind that with relatively little help from suitably trained staff, a generally better psychosocial adjustment can be obtained, and further suicidal tendencies reduced.

The WHO (1982) has expressed great concern at the lack of training and coherent policies for managing the suicidal patient, reflected in an unsympathetic attitude to such people[15]. Improved interviewing skills, treatment of depressive illness, education, the alteration of attitude among general and hospital practitioners and community help for the socially isolated are some of its recommendations[15].

3. Assessment of the patient with deliberate self harm

The following scheme of assessment of the admitted patient is formulated after considering the special circumstances in Sri Lanka.

3.1 *Assessor*

3.1.1 Primary assessor

Junior doctor of the team will be the primary assessor. The junior doctors are house officers, senior house officers and registrars. The junior doctors after completing the assessment has to discuss the findings and formulation with the supervising consultant or senior registrar. In addition to the training received in the medical school, junior doctors of hospitals will be trained in obtaining a relevant history and assessing the mental state and also in the decision making process with regards to DSH patients.

3.1.2 The assessment setting

In addition to the history received on admission, the doctor should interview the patient after he recovers from the physical complications or discomfort. The doctor must use his judgement in deciding the time of assessment. The doctor must ensure privacy. Ideally a side room of the ward could be arranged to interview such patients, but if not available, the doctors station could be used at not so busy times (e.g. afternoon).

3.2 *Assessment*

The doctor should explain to the patient that the purpose of the interview is to help him in psychosocial adjustment and not to punish him. The doctor should emphasize on the confidentiality of the interview. The purpose of the interview is listed below:

a) Assess the suicidal intent of the patient.
b) Assess for presence and if so the severity of mental illness.
c) Assess the extent of current problems.
d) Assess the coping strategies of the person.
e) Assess the availability of support system to the patient.
f) Plan management, taking into consideration person's psychosocial issues.
g) Negotiate the plan with the patient.

a) Assessment of suicidal intent

A general idea will be obtained by assessing the circumstances of the act, motive and current thinking on escaping the situation.

Table 1 is a guide to understand the suicidal intent:

Table 1. A guide to assess high risk of suicide

High risk
Planning in advance
Precautions to avoid discovery
No attempts to obtain help afterwards
'Final acts' e.g. suicidal notes
Loneliness
Physical or mental disorders
Continuing wish to die (at present)

Some patients may conceal the fact of intentional harm and might try to convince the doctor that the incident was accidental. This is a common occurrence in clinical practice in Sri Lanka. The doctor should be aware of such distortions and should facilitate communication to help the patient to reveal the truth. Developing a good rapport, stressing on confidentiality and the purpose of interview will be of use in this regard.

In a more objective manner suicide intent score can be used. (Annex: 1)[16]

b) Assess for presence and severity of mental illness

The doctor should be knowledgeable on signs and symptoms of mental disorders (e.g. delusions, hallucinations) and should be able to assess the mental state accurately. Also he should have skills in obtaining a psychiatric history. The doctor will be trained in these during the training workshops. (Annex: 2)

A brief scheme of a psychiatric history and Mental State Examination (MSE) is given in Table 2 and 3 for easy reference. Important components are highlighted.

After completing the history and MSE, the doctor should be able to decide on the presence of mental illness, categorizing it and determining the severity.

This process is guided in the workshop, and doctors are advised to use ICD -10 for reference, if there is a doubt.

Schizophrenia, alcohol and other drug dependence, personality disorders and depression are associated with high suicidal risk.

c) Assessment of current problems.

Once the doctor develops rapport, patient will be at ease to discuss his problems with the doctor. The documented problems that increase the suicidal risk are listed below. (Presence or absence of mental illness is not discussed here since it was discussed in section (b))

1. Males have a higher frequency of completing suicide after an attempt of DSH.
2. Living in isolation.
3. Older age group
4. Unemployment
5. Previous acts of deliberate self harm
6. Having major physical illnesses e.g. epilepsy, chronic painful conditions

Table 2. The relevant history

History of present condition

- ***Patient's description of the problem***
- Details of the nature of the problem and present severity of the symptoms
- Systematic enquiry about other relevant problems and symptoms
- Onset and course of symptoms, and problems

Family history

- Parents: age (now or at death), occupation, personality and relationship with the patient
- Similar information about siblings
- ***Mental disorder in other members of the (extended) family and abuse of alcohol and drugs***

Personal history

- Mothers pregnancy and the birth
- Early development
- Childhood separations, emotional problems, illnesses
- Schooling and higher education
- ***Occupations***
- ***Sexual relationships***
- Menstrual history
- ***Marriage, Children***
- ***Social circumstances***
- ***Forensic history***

Past illness

- ***Past medical history***
- ***Past psychiatric history***

Personality

- ***Relationships***
- ***Leisure activities***
- ***Prevailing mood***
- ***Character***
- ***Attitudes and standards***
- ***Habits - Drugs, alcohol, tobacco***

Table 3. Mental state examination (MSE)

Appearance and behaviour
- ***General appearance***
- Facial expression
- Posture
- Movements
- Social behaviour

Speech
- Rate
- Amount
- Continuity

Mood
- ***Prevailing mood and associated symptoms***
- Variations of mood
- Appropriateness of mood

Thought content
- ***Preoccupations***
- Obsessional or compulsive symptoms
- ***Delusions***
- ***Suicidal ideation***

Depersonalization and derealization

Perception
- Illusions
- ***Hallucinations***

Cognitive function
- Estimate intelligence
- Orientation (time, place, person)
- Attention and concentration (digit span, serial 7s)
- Memory (name and address; remote personal events)

Insight

Often these are not identified by the patient as problems. It is very important to identify the problems and appropriate and immediate action to be taken to help the patient, if there are current, severe problems.

Many young patients are admitted with episodes of DSH due to impulsive acts, when they are faced with adverse circumstances. Here, mainly the coping strategies need to be focused on, in order to improve coping skills.

d) Assessment of coping strategies

DSH is a means of communicating distress to others. Often a person uses this strategy when he fails in other strategies to face problems.

At the time of the act, the person has a tunnel vision, and might see only one or two options to solve his problem/s. E.g. A young person who was not given permission to marry the person whom he loves, might see only two options – either to runaway with the desired person or to end his life.

This happens when the person has poor coping strategies, which might also have been maladaptive. Therefore, it is essential to look into a person's coping strategies in previous stressful conditions, and identify those which are maladaptive.

e.g. - Handling problems: by emotion focused coping

- Maladaptive behaviours (drugs & alcohol abuse, isolating self and crying)
- Excessive use of defence mechanisms - (excessive denial or projection)
- Cognitive distortions: e.g. thinking every bad thing happens to me.
- Poor attitudes to self: e.g. poor self image which might prevent seeking help due to fear of rejection

In addition, poor communication skills would also influence coping:

e) Assess the availability of support

It is very important to mobilize available support to the person. Often families could be rejecting or feeling guilty after the act of their family member. They may be worried about stigma and might reject any support that is offered.

E.g. A young primipara, who lost her baby in utero, developed schizophrenia. She attempted suicide twice but relatives were not willing to accept medical treatment for mental illness due to stigma attached to it.

It is very much essential to discuss with family members and / or spouse to find out their commitment and willingness to help the affected person in a proper manner. But this has to be done with the consent of the patient.

Also the doctor should have an idea of available support services of the region such as community rehabilitation centres, crisis intervention centres, and centres for drug and alcohol abuse if they are to help the patients.

This knowledge will be strengthened at the training workshop.

f) Planning of management

After completing the assessment, the doctor should carefully plan further management. This has to be done in collaboration with the patient and if necessary with the families.

The next chapter will help in decision making regarding further management. However, since this is the most important component, doctors will be trained during the training workshop.

During the interview the following checklist could be used as a guide, but maximum care should be exercised to carry out an informal interview.

Chart I – Summary of findings

DATE OF ADMISSION	*DATE OF ASSESSMENT*	*WARD*	*BHT NUMBER*
PROBLEM	*KNOWN TO THE PATIENT*	*SUSPECTED BY THE DOCTOR*	*OUTCOME*
FAMILY			
MARITAL			
OTHER RELATIONSHIPS			
PAST SUICIDAL ATTEMPTS			
FINANCES			
ADJUSTMENT TO SITUATIONS			
ALCOHOL DEPENDENCE			
OTHER DRUG DEPENDENCE			
DEPRESSION			
SCHIZOPHRENIA/ OTHER PSYCHOSES			
PERSONALITY DISORDERS			
EPILEPSY			
CHRONIC PAINFUL CONDITIONS			
OTHER			
SUICIDE INTENT SCORE	*(High/Moderate/Low)*		

4. Management

Depending on the information available after the assessment, the doctor should decide regarding further management.

Flow charts on management (depending on the predominant problem/s)

Chart II

4.1 Presence of mental illness

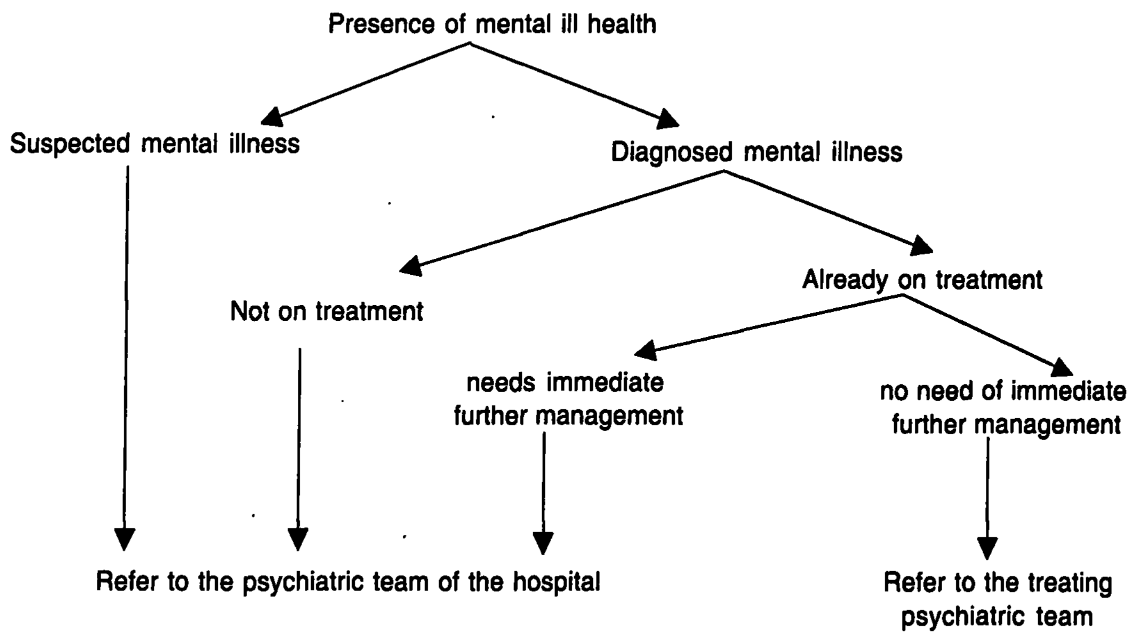


Chart III

4.2 Suicidal risk

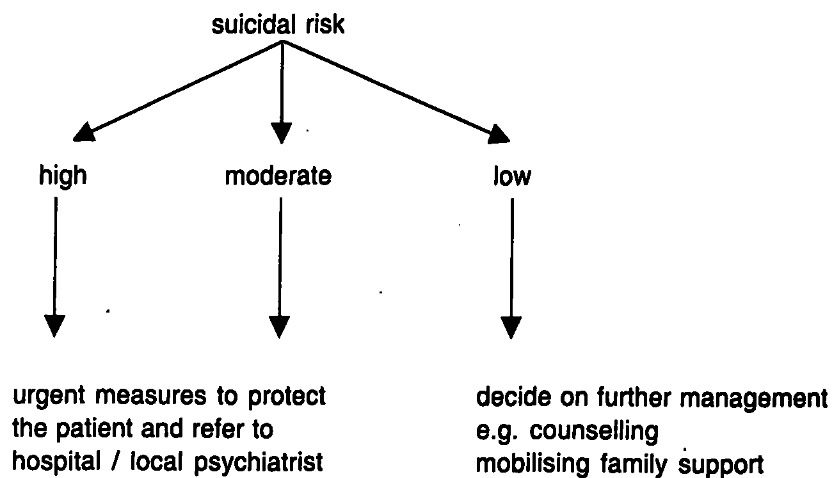
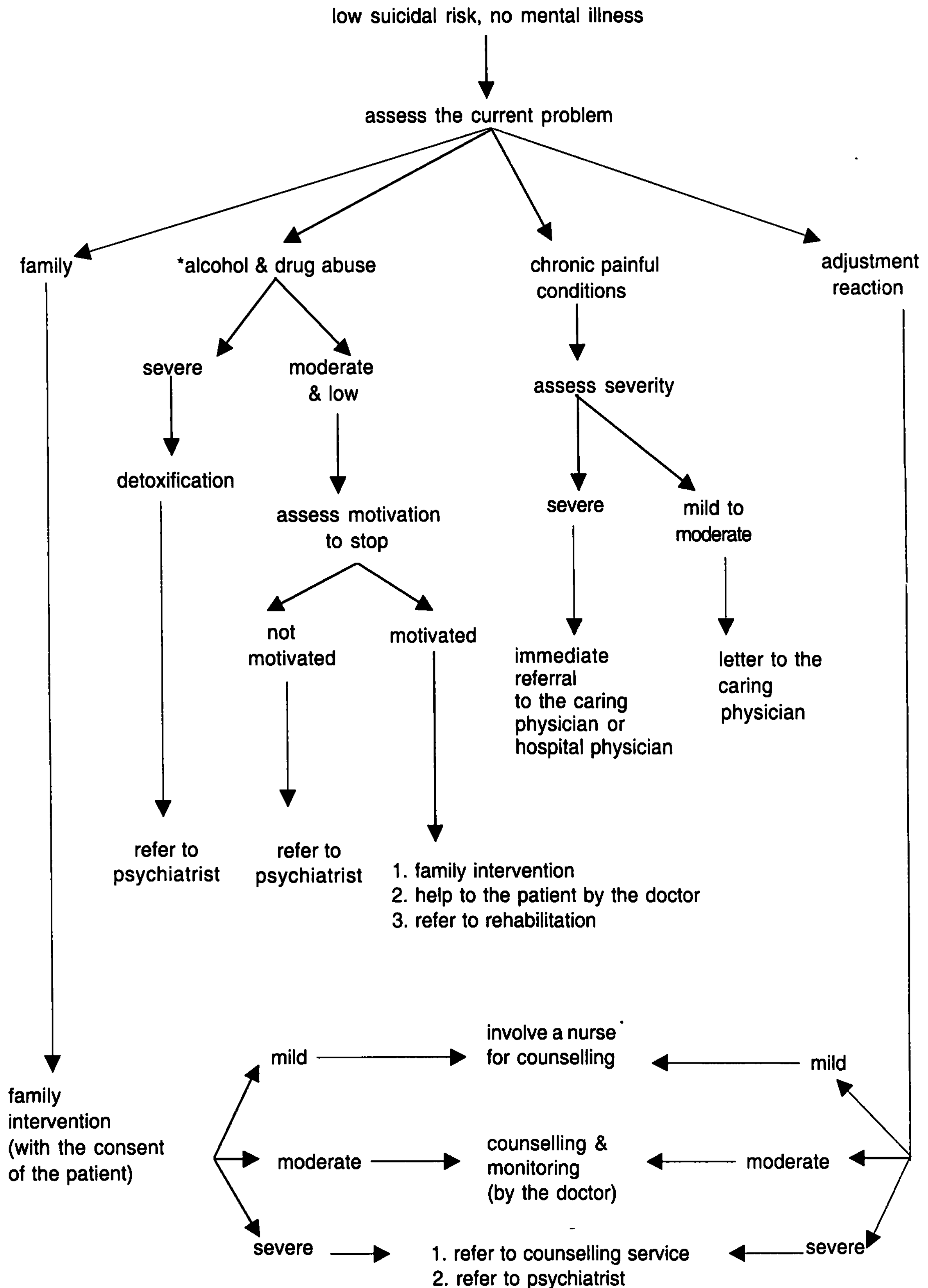


Chart IV

4.3 Management of a patient without a major psychiatric illness



* Alcohol and drug abuse are mentioned here and not under mental illness.

4.4 Problem solving counselling

Problem solving counselling could be used by doctors as a tool to help patients who are without major psychiatric disorders.

Practice under supervision is needed to master the skills.

The following is a guide to learn problem solving counselling skills.

i identification of the real problem

Often the focus is on the apparent problem and the real issue is hidden. The doctor should be able to guide the patient to identify the real problem.

ii Once the real problem is identified, several options need to be generated to face the problem. The doctor should facilitate the process since the patient has a very narrow range of options, one of which is DSH.

iii Once the options are generated, each option should be considered carefully by weighing the advantages and disadvantages.

iv Only one option is chosen by the patient with the help of the doctor.

v The chosen option should be examined carefully to formulate a practical plan of action.

vi The path of action plan is identified with the knowledge on possible risks and difficulties.

vii Once decided on the action plan, the doctor should help the patient to carry out the plan and help to monitor the progress.

If the desired outcome is not reached or blocked, examining steps in the process will help to identify the error, hence corrective measures could be taken at the proper level.

4.5 Final decisions and documentation

Once the doctor decides on further management, it should be discussed with the patient and if necessary, with the family (with the consent of the patient). The negotiated treatment plan should be documented on the Bed Head Ticket, before discharging the patient. The doctor should ensure the proper aftercare and if necessary the follow up.

4.5 Ethical issues

When a doctor addresses the psycho-social issues of patients, the patient or the family might misinterpret the process in the present cultural context. Hence adherence to ethical principles and documentation are very important factors in the assessment.

The outcome of a properly conducted psycho-social assessment of a DSH patient is of immense value to the patient. He will be ever be grateful to the doctor for helping him to organize his life in a better manner. The whole process in turn is a satisfying exercise to the doctors.

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ANNEX I

SUICIDE INTENT SCALE (PIERCE)

Circumstances related to the act:

Item	Score	Description
1. Isolation	0	Somebody present
	1	Somebody nearby or in contact
	2	No one nearby or in contact
2. Isolation	0	Timed so that intervention is probable
	1	Timed so that intervention is not likely
	2	Timed so that intervention is highly unlikely
3. Precaution against discovery and/or intervention	0	No precautions
	1	Passive precautions (eg: door shut but unlocked)
	2	Active precautions (eg. door locked)
4. Acting to gain help during or after attempt	0	Notified potential helper
	1	Contacted but did not specifically notify
	2	Did not contact or notify
5. Final acts in anticipation of death	0	None
	1	Partial preparations or ideation
	2	definite plans made (eg. will)
6. Suicidal note	0	Absence of note
	1	Note written but torn up
	2	Presence of note

Self Report

Item	Score	Description
7. Patient's statement of lethality	0	Thought what he had done would not kill him
	1	Unsure whether what he had done would kill him
	2	Believed that what he had done would kill him

Item	Score	Description
8. Stated intent	0	Did not want to die
	1	Uncertain or did not care if he lived or die
	2	Did want to die
9. Premeditation	0	Impulsive, no premeditation
	1	Considered act for less than 1 hour
	2	Considered act for less than one day
	4	Considered act for more than one day
10. Reaction to the act	0	Patient glad he has recovered
	1	Patient uncertain whether he is glad or so
	2	Patient sorry he has recovered
Risk		
11. Predictable outcome in terms of lethality of patient's act and circumstances known to him	0	Survival certain
	1	Death unlikely
	2	Death likely or uncertain
12. Would death have occurred without medical treatment	0	No
	1	Uncertain
	2	Yes
Total Score		

Scale		
	0 - 3	Low suicidal intent
	4 - 10	Medium suicidal intent
	> 11	High suicidal intent

Source: Suicide intent scale - David W. Pierce[16]

ANNEX 2

WORKSHOP ON PSYCHO-SOCIAL ASSESSMENT OF DELIBERATE SELF HARM (DSH) PATIENTS

Trends in DSH- Local and Global The DSH patient in the hospital	Lecture discussion	20 min.
Physicians', Surgeons' and Paediatricians' views on what has been encountered	Participatory work	30 min.
A model of intervention	Lecture discussion	20 min.
TEA		
Mental State Examination	Lecture and practice role play	45 min.
Categorization of problems	Small Group Discussion with case scenarios	45 min.
Modes of interventions and services available	Lecture discussion	30 min.
What can be offered to each patient	Group work and presentation by the participants 15 min. preparation 5 min. preparation	55 min
Remarks on the presentations		
Recommendations		
Vote of thanks		