

# Guidelines for psychiatric and psychosocial management of deliberate self harm (DSH) patients in hospital setting

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## Introduction

There is an alarmingly high rate of suicide in Sri Lanka with a fairly big overlap with attempted suicide<sup>1</sup>. A decade ago, Sri Lanka ranked first in the list<sup>2</sup>. Although no country collects national statistics on attempted suicide<sup>3</sup>, data from studies in centers with definite catchment areas in several countries indicate that hospital discharge rates for attempted suicide rose sharply during 1965-1980, when rates of suicide were also rising<sup>4</sup>.

Many of the patients admitted to hospitals may not have been adequately assessed prior to discharge. Even in developed countries, planning and delivery of services to DSH patients is in a state of disarray<sup>5</sup>. Provision of better services for those who attempt suicide will help in the reduction of rate of suicide. Hence this became a target for health in United Kingdom<sup>5</sup>. World Health Organization has shown concern in training health professionals in management of DSH patients<sup>6</sup>.

Although DSH is a high priority in Sri Lanka, there is no assessment system or document policy in management of these patients<sup>7</sup>. Little help given to patients who have harmed themselves could bring about major changes in their lives.

The evidence shows that non-psychiatric professional groups such as junior physicians, nurses and social workers given a suitable training, could carry out a proper psychosocial assessment<sup>8</sup>. This is particularly true for Sri Lanka, where only 26 psychiatrists are available for 18 million population<sup>2</sup>. Psychiatrists should be responsible for the quality of the training of medical and non-medical personnel and be available regularly for supervision and staff support<sup>9</sup>.

Working with patients who have harmed themselves over a decade prompted the principal author to design this guideline. Experience gathered in working with DSH patients in two contrasting settings in Sri Lanka and in the United Kingdom, helped to formulate a professional and practical approach.

The book was prepared with the aim of imparting necessary knowledge to house officers, senior house officers and registrars (assessors). A workshop at the hospital of approximately five hours duration with discussions on theoretical aspects, developing skills in obtaining relevant histories, assessing the mental state and practice on decision making will be a complementary exercise.

This article attempts to describe the guideline for assessment and management of DSH patients in the hospital setting in a developing country.

## Layout of the book

Introductory section attempts to engage the reader on the need of the psychiatric and psychosocial assessment of DSH patients. This is followed by the knowledge required by the assessors on nomenclature, global situation of DSH in relation to Sri Lanka and the current approach of medical staff to these patients.

The setting of the assessment and the components of the assessment are described next. The components are:

- a) Assessment of the suicidal intent of the patient
- b) Assessment for presence and if so the severity of mental illness
- c) Assessment of the extent of current problems
- d) Assessment of the coping strategies of the person
- e) Assessment of the availability of support systems to the patient
- f) Planning management, taking into consideration person's psycho-social issues
- g) Negotiation of the plan with the patient.

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Subsequent to the description of the assessment, a guideline is provided to carry out a mental state examination. This component is taught in all medical schools in the country and preferably a workshop at hospital setting would reinforce the previous training.

Once the assessment is complete, a guideline is provided in preparation of a summary of problems identified in the patient.

A quantitative assessment of the suicidal intent is made possible by including the scale devised by Pierce<sup>10</sup>. This facilitates a decision regarding immediate management of the patient by identifying the high-risk group.

The vital area which is the management section is presented in a flow chart. It is designed to summarize the management options depending on the predominant problems as follows:

- in the presence of a psychiatric disorder
- in the absence of a major psychiatric disorder, with psycho-social problems.

Both these components are addressed with reference to current suicidal risk of the patient.

Finally, emphasis is on negotiating the management plan with the patient as well as the family if applicable, to ensure compliance in further care and prevention of similar episodes.

**Table 1. Summary of problems identified in the assessment of DSH patients**

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

## Discussion

The book is prepared as user friendly to the assessor and can be used by all medical personnel and non-medical staff who are involved in managing patients with DSH.

Introduction is useful to sensitize the assessor on the need of psychosocial assessment and also provides factual knowledge. This needs to be revised in the future since the facts would change over time. Current approach of medical staff to patients emphasizes the need to change attitudes to provide optimum care.

Assessment presented in a sequential manner serves as a self-training exercise for non-psychiatric professionals enabling them to carry out a detailed assessment with minimum omissions. The book is best used in combination with a training workshop, which is the form of training that was shown to have significant change in knowledge and attitudes on suicide prevention as described by Michel K and Valach L<sup>11</sup>.

Pierce suicide intent scale gives the quantitative assessment of the suicidal intent<sup>10</sup>. Structured components will enable the staff with minimal time spent on training to assess patients in a similar manner to a trainee psychiatrist as described by Burn, et al<sup>2</sup>. Formulation of the assessment based only on the questionnaire has to be avoided to ensure optimum doctor patient relationship.

Tabulating the findings with inclusion of all components of the assessment (psychiatric, medical and psycho-social), will facilitate decision-making regarding the management.

The only section that is not dealt in the book is the available support services of the region. The reader is expected to find this out by himself. If a workshop is arranged in the hospital, this knowledge could be strengthened further.

Finally, a proper decision regarding further management is described by a flow chart. Practice under supervision will be an additional advantage if resources are available at a local level.

This book could be considered the corner stone in managing DSH patients in the hospital setting in a developing country. Long term care and prevention of this overlooked tragedy need to be addressed separately.

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