General hospital services for deliberate self-harm

Haphazard clinical provision, little research, no central strategy

For at least 20 years self-poisoning has been the commonest reason for acute medical admission of women and the second commonest for men (after coronary heart disease) [1]. It accounts for 11% of all acute medical admissions in London [2]. Hopes that deliberate self-harm was on the wane in the 1980s have proved ill-founded; each year there are still at least 100,000 admissions in England and Wales and probably as many as 150,000 hospital attendances throughout the UK and Ireland. Ten percent or more of patients who harm themselves will eventually die by their own hand [3], 1% within the first 12 months [4]. There are therefore annually over 1,000 suicides in England and Wales—a quarter of all cases—which have been preceded by non-fatal self-harm in the previous year.

Considering the scale and importance of deliberate self-harm, it has attracted extraordinarily little interest in recent years.

Clinical services

High quality clinical services for these patients are hard to find. Few hospitals follow the guidelines for good practice recommended in 1984 by the Department of Health and Social Security. A recent national survey found that only a quarter of responding health districts had a multidisciplinary team with responsibility for deliberate self-harm services [5]. In many hospitals one third or more of all attenders are discharged directly from the accident and emergency department [6], often without being assessed by staff with adequate training and supervision. Assessment of patients who are referred for a specialist opinion is usually left to junior doctors on psychiatric or general practice training schemes, working under indifferent supervision and seeing referrals in between other duties. Nearly 20 years ago Blake and Mitchell [7] highlighted the inconsistencies which resulted in one city from this haphazard approach; we have no doubt that a national survey conducted today would paint the same dismal picture.

Research

Clinical services are neglected because of the widely held view that there are no interventions which reduce either repetition of self-harm or subsequent suicide. Certainly, the research evidence is unsatisfactory. Each of the five UK randomised intervention studies [8–12] showed that treatment improved psychological and social adjustment, but none found a significant difference between groups in repetition rate or suicide. However, in each of the five studies the sample was so small that statistical power was too low to prove that repetition and suicide rates were not influenced. With the evidence so inconclusive, the jury of clinicians and service purchasers has been too hasty in reaching its verdict.

In these circumstances it is regrettable that recent research is so sparse. When NHS research and development priorities were set for mental health, deliberate self-harm did not appear among the 31 topics identified for funding at national or regional level. The other major funding bodies spend little on deliberate self-harm, and we know of no currently funded intervention trials. Epidemiological research is also neglected and no national figures are collected. Since the closure of the MRC Social Psychiatry Unit in Edinburgh, UK evidence on changes in clinical epidemiology is available (extraordinarily) only from the monitoring system for Oxford.

Strategy

There is a policy vacuum at the centre. Since 1961 (when attempted suicide ceased to be a legal misdemeanour) the management of deliberate self-harm has been the subject of guidelines from government health departments. However, the most recent guidelines—now 10 years old—do not prescribe standards of clinical practice and are too loosely drawn to have made any impact on service provision [13]. The situation contrasts sharply with the official interest shown in the much smaller (but higher profile) problem of suicide and deliberate self-harm in prisons [14,15].

The two measurable mental health targets in The health of the nation [16] both concern reduction in suicides. Little is known about how to influence population suicide rates and the strategy outlined in the mental illness key area handbook [17] concentrates on
general improvement in psychiatric services. Deliberate self-harm services are hardly mentioned despite the fact that non-fatal self-harm is the most common reason for contact between future suicides and the specialist services.

**What is to be done?**

Clinical care is unlikely to improve until purchasers of health services insist on better treatment for self-harm patients. There are readily definable standards which are amenable to measurement [18]. Such standards should be included in contracts for accident and emergency, general medical and psychiatric services. A proportion of the mental health budget should be earmarked for deliberate self-harm services which should be designed and delivered in collaboration with providers of non-psychiatric health care, as well as with other statutory and voluntary agencies.

Research is badly needed. We require more extensive epidemiological data, based on centres with differing social characteristics and clinical services. Five suggestive but inconclusive clinical trials have so far left people unconvinced that active intervention benefits anybody other than the minority who are mentally ill. The time is ripe for a study large enough to settle the issue.

The Department of Health could usefully take action in two areas. First, it should reverse the disastrous decision made by its advisory working group on mental illness and find additional funding for suicide and deliberate self-harm within the research and development programme. Second, it should produce new guidelines for service purchasers and providers. We do not need an anodyne commentary on acceptable practice but a clear and specific blueprint for high quality services set in the context of a comprehensive suicide prevention strategy.

The problem of deliberate self-harm will not go away because it is neglected. More than a million people have been admitted to hospital for self-poisoning since the last official recommendations on its management were published in 1984 [13]. That figure alone argues for better provision, more research and a stronger policy from the Department of Health.

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