MEDICAL PRACTICE

Contemporary Themes

Management of attempted suicide in Oxford

KEITH HAWTON, DENNIS GATH, EDWARD SMITH

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In 1973 a new service was set up in Oxford for patients referred to the general hospital after self-poisoning or self-injury. One innovation was that nurses and social workers were to play a bigger part in the assessment and treatment of patients. We describe how the change has worked in practice.

In the early 'seventies official DHSS policy was that all patients who had attempted suicide should be seen by a psychiatrist.^{1,2} There was growing concern, however, that this policy was not working well. One reason was that rates of attempted suicide had risen steeply.³⁻⁷ Increasing demands were made on psychiatrists' time, and patients were kept waiting in much-needed medical beds for psychiatric assessment that sometimes had to be only cursory. Another reason was that the proportion of patients who had attempted suicide and who were suffering from psychiatric illnesses appeared to be decreasing. Nowadays, most of them are not psychiatrically ill but are unable to resolve distressing social problems. These trends have suggested that the need for specialist psychiatric care for these patients might be diminishing.

For these reasons new approaches have recently been introduced in several centres to provide more efficient services for patients who have attempted suicide.⁸ In Oxford it was decided to set up a multidisciplinary psychiatric team in which trained non-medical staff would carry out much of the assessment and treatment, under close supervision from a senior psychiatrist.

The purpose was to provide more appropriate help for the patients with the minimum delay.

How the service works

THE PSYCHIATRIC EMERGENCY TEAM

The psychiatric emergency team is located in the one general hospital to which patients who have attempted suicide are referred.

The main work of assessing these patients is carried out by five nurses with previous psychiatric experience, a nursing assistant, and a social worker, with help from a psychiatric registrar and sometimes a trainee general practitioner. Senior registrars from local psychiatric hospitals attend in rotation each afternoon to provide senior psychiatric cover. The whole team is supervised by a consultant psychiatrist, who is also responsible for the psychiatric consultation service in the general hospital.

This team is fairly large, but it has other functions apart from caring for all patients who have attempted suicide who are referred by the physicians. For example, to evaluate the service detailed case records and data sheets are kept for all patients. Teaching is provided for junior staff, clinical medical students, student nurses, and social workers in training. The medical staff have duties in other hospitals.

Staff training

Much importance is attached to training non-medical staff to assess and treat patients who have attempted suicide. Several methods are used: manuals explaining principles of assessment and treatment are provided^{9,10}; seminars are given on suicidal behaviour and related topics, such as depression; interviewing techniques are demonstrated with live and tape-recorded interviews; and trainees' interviews are tape-recorded for discussion with supervisors and other trainees.

PROCEDURE FOR ASSESSING PATIENTS WHO HAVE ATTEMPTED SUICIDE

The service is available 24 hours a day, seven days a week. As non-medical members of the team are available at short notice, assessment

University Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX

KEITH HAWTON, MA, MRCPsych, clinical lecturer in psychiatry
DENNIS GATH, FRCP, FRCPsych, reader in psychiatry

John Radcliffe Hospital, Oxford OX3 9DU

EDWARD SMITH, FRCPed, FRCPsych, consultant psychiatrist

of patients usually begins within an hour or two of a request being made by a doctor.

Technique of assessment—Staff are trained to carry out a systematic interview in which the aim is not only to estimate suicidal risk reliably but also to evaluate the full range of problems facing the patient and possible ways of tackling them. Relatives and friends are interviewed, at first separately and afterwards with the patient. The general practitioner is contacted for an initial discussion of the patient's problems.

Senior cover meeting—Each afternoon a senior registrar and the emergency team review current patients. Assessments of new patients are discussed and treatment plans agreed in a multidisciplinary setting. Another important function of the meeting is teaching.

The time required to discuss a patient depends on the experience of the assessors and the complexity of the clinical problem. When the assessor has had considerable experience of this type of work the case can often be reviewed briefly.

METHODS OF TREATMENT

Treatment provided by the team consists largely of brief counselling focused on current problems. Usually it is provided on a flexible outpatient basis by the member of staff who made the assessment. Occasionally patients are visited in their own homes. Day care is available as is group therapy for selected patients. Up to one-third of the patients are offered access to the service through a direct telephone line.

ADVANTAGES OF THE MULTIDISCIPLINARY TEAM

In the past six years experience in Oxford has confirmed that most patients who attempt suicide are not psychiatrically ill but distressed by interpersonal and social problems. For this reason multidisciplinary staffing has been an advantage—for example, at senior cover meetings nurses, social workers, and psychiatrists draw on their own training and experience in contributing to case discussions. Similarly, in treatment, most patients are suitable for counselling by nurses and social workers, while the few who are psychiatrically ill are allocated (if not already undergoing psychiatric treatment) to the team psychiatrist.

Effectiveness of the emergency service

WORK LOAD

Numbers of patients assessed—During the three years 1976-8 the emergency team assessed 2512 patients who had attempted suicide. On average there were two or three new referrals each day (range 0-15). In 1978 there were 796 assessments, of which 58% were made by nurses, 10% by the social worker, 16% by the medical staff, and 15% by temporary staff in training. Thus over two-thirds of assessments were made by non-medical staff.

Numbers of patients offered treatment—Also during 1976-8 the emergency team offered further care after assessment to 47% of patients, mainly in the form of outpatient counselling. Other forms of management were: discharge to the care of the general practitioner with advice on management, 23%; referral to a psychiatric hospital, 21% (9% as inpatients); other forms of care, 5%; and self-discharge without arrangements for care, 4%.

TURNOVER OF MEDICAL BEDS

In 1972-3, during a six-month period shortly before the setting up of the emergency team, 353 patients who had attempted suicide were admitted to the general hospital; of these, 64% spent one night or less in hospital, 18% two nights, and 17% three nights or more. In a corresponding period five years later 434 patients were admitted, of whom 83% remained one night or less, 7% two nights, and 9% three nights or more ($\chi^2 = 38.6$, $P < 0.001$). This sizable reduction in bed occupancy may have been partly due to changes in the substances used in self-poisoning, but probably the promptness of the psychiatric emergency service also played a part. Physicians in the general hospital often comment that the service has greatly speeded up the clearance of medical beds.

RELIABILITY OF THE ASSESSMENT PROCEDURE

In daily clinical practice over the past six years senior psychiatrists have supervised hundreds of assessments made by non-medical staff. Experience has shown clearly that non-medical staff with adequate experience and training are able to make such assessments reliably. This finding based on experience has been confirmed by a systematic study in which assessment interviews carried out by non-medical staff were compared with those made by junior medical staff, and found to be equally satisfactory in all respects.¹²

REPETITION RATES FOR ATTEMPTED SUICIDE

It is not known whether the work of the emergency service lowers rates of repetition of attempted suicide. This question could be answered only by a trial in which patients were randomly allocated to this service or to a control form of management. Evidence concerning the work of the non-medical staff, however, is encouraging.

For all patients assessed by the psychiatric emergency team the latest repetition rate for attempted suicide was 15.4% in one year. There was no significant difference in repetition rates between patients assessed by non-medical staff and those assessed by medical staff. The overall figure was similar to that previously found in Oxford at a time when all patients were assessed by psychiatrists.¹³

The Oxford figures are not directly comparable with those of other areas because of differences in migration rates and other influences. The Oxford figure, however, is similar to that reported in Edinburgh, where all patients are assessed by psychiatrists,¹⁴ and considerably lower than rates reported from elsewhere.¹⁵

ATTENDANCE AT OUTPATIENT CLINICS

Some indication of the effectiveness of assessment procedures may be given by rates of subsequent attendance at outpatient clinics, although this is obviously a crude measure. In the first six months of 1978, of the patients to whom the Oxford emergency service offered outpatient care, 88% attended for at least an initial interview. This figure is substantially higher than those reported by other observers.^{14 16-18} One reason for the high attendance rate may be continuity of care; patients generally prefer to be treated by someone in whom they have confided during initial assessment.

CONSUMER SATISFACTION

In the course of research, systematic inquiry has shown that most patients were satisfied with the assessment procedure and treatment carried out by non-medical staff. The explanation probably lies in the enthusiasm and commitment of staff who have opted for this kind of work. General practitioners also appeared well satisfied. In the early stages of the service some hospital doctors were apprehensive about the role of non-medical staff, but most now regard it as a valuable development.

Conclusions

After six years' experience of a service in which most assessments and treatment of patients who have attempted suicide are undertaken by non-medical members of a multidisciplinary team, the main conclusions can be summarised as follows.

- (1) With suitable experience and training, non-medical staff can carry out assessments and treatment reliably.
- (2) The care offered by such a team seems well suited to the needs of the patients, most of whom are not psychiatrically ill but distressed by social problems.
- (3) Patients generally express satisfaction with the service; and rates of attendance at outpatient clinics are high.
- (4) The service provided is much prompter than usual. Bed occupancy statistics indicate reduced pressure on medical beds.
- (5) Senior psychiatrists, although concerned in supervision, have fewer demands on their time.

These conclusions indicate that non-medical staff might fulfil a similar role in other settings, particularly district general

hospitals. We estimate that, in a district general hospital receiving 750 to 1000 referrals of patients who have attempted suicide a year, an emergency team could be adequately staffed by two or three trained nurses and a social worker. A team of this size could probably carry out all initial psychiatric and social assessments and offer subsequent treatment in many cases. A visiting senior psychiatrist could provide regular supervision.

In some district general hospitals with existing psychiatric units setting up such a team would not present great difficulties. In other hospitals lack of nurses might be an obstacle, but the potential saving in medical beds and specialists' time would probably justify special measures to establish new nursing posts and recruit suitable applicants.

An essential requirement would be that nurses and social workers selected for this work should receive special training. While the assessment of most patients who have attempted suicide does not call for the clinical skills of a trained psychiatrist, none the less thorough training is needed to provide a sound knowledge and understanding of suicidal behaviour and its determinants, and to develop interviewing techniques for eliciting information from patients and relatives. Such training could be provided by secondment to specialist units, and could include evaluation to ensure that trainees attained a satisfactory level of competence.

Our overall conclusion is that in areas where the present services for patients who have attempted suicide are being reappraised, serious consideration should be given to the possibility of establishing a small multidisciplinary team including suitably trained non-medical staff in the district general hospital. Such a team would probably enhance the quality and efficiency of service at a relatively low cost.

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Clinical Topics

Work of a district ethical committee

M J DENHAM, ANN FOSTER, D A J TYRRELL

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Many ethical research committees were created in Britain after the publication in 1967 of the Royal College of Physicians report *Supervision of the Ethics of Clinical Investigation in Institutions*. The report, however, did not give specific guidance on the structure or functioning of such committees since it considered that what might be appropriate in one institution might be inappropriate elsewhere. A similar choice faced regional research committees, which resulted in a wide variation in their structures.¹ Since 1967 publications or reports have

discussed either special ethical problems²⁻⁶ or the work of a large area ethical committee.⁷ Little has been written of the work of district-based committees. We therefore thought it appropriate to describe how the Harrow District Ethical Committee has evolved its own structure, function, and expertise during the eight years of its existence.

Background, constitution, and aims of the committee

When first constituted, the Northwick Park Hospital Ethical Committee considered projects from both the hospital, a National Health Service establishment, and the Clinical Research Centre, which, although integrated with the hospital, is administered by the Medical Research Council. After the NHS reorganisation in 1974 area health authorities became responsible for clinical research conducted in all premises under their control, so the ethical committee began to consider research projects in the community and changed its name to the Harrow District Ethical Committee. The responsibility of the committee to the AHA emphasises its independence from any medical establishment within the hospital.⁸

Northwick Park Hospital and Clinical Research Centre, Harrow, Middlesex HA1 3UJ

M J DENHAM, MD, FRCP, chairman of ethical committee, consultant physician in geriatric medicine

ANN FOSTER, BA, secretary to the committee

D A J TYRRELL, MD, FRs, chairman of the scientific advisory group, consultant physician