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A dedicated district poisons treatment unit: response to the College guidance on the management of deliberate self-harm

R. C. Scorer, P. Beck, J. Bisson, S. White and P. A. Routledge

Aims and method An examination of the activities of a district-wide dedicated admission unit for poisoned patients in Cardiff, Wales, between 1987 and 1997. Number of admission episodes, gender, drugs taken, intent, psychiatric diagnosis and disposal were recorded.

Results Although the number of admission episodes almost doubled over the 10-year period, the median length of stay fell by almost half.

Clinical implications The results suggest that a dedicated unit is a cost-effective model for the management of poisoned patients.

As a result of the College report on the management of deliberate self-harm, a six-bedded dedicated poisons treatment unit ward was opened in 1986 to serve the population of South Glamorgan (now Southern Bro Taf). Over the last 10 years, the number of admission episodes has almost doubled from 933 to 1588. However, having a single centre in a city or district facilitates rapid psychiatric or social evaluation, and the average length of stay has fallen from 34 to 18 hours over the same period, so that no extra beds have been necessary. A dedicated unit has ensured that nurses dealing with such patients have psychiatric nursing experience and that medical, nursing and social work staff can receive regular in-service training in the management of deliberate self-poisoning. We also hope that the increased opportunities afforded for research will help in the prevention of poisoning and in developing more effective patterns of care for patients who have deliberately harmed themselves.

The study

In 1983, a multi-professional working party was set up by the Royal College of Psychiatrists at the request of the Department of Health and Social Security (DHSS). Its recommendations were approved by the College's Council in June 1983 and published in the *Bulletin of the Royal College of Psychiatrists* in November of the same year (Royal College of Psychiatrists, 1983). One important recommendation in this report was that patients should be admitted to one or two designated medical wards, to special beds in a short-stay ward or to a poisoning treatment

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centre in a district general hospital. One year later, a committee was set up by the then South Glamorgan District Health Authority to address the implications of the report. This committee recommended that a poisons treatment unit should be established at Llandough Hospital, and a six-bedded ward was refurbished and opened in 1986. In 1987, The National Poisons Information Service (Cardiff Centre) was relocated in the unit and a database of in-patient activity was developed. We report on the activities of the treatment unit in the 10 years since then and discuss how the College's guidance was acted upon in South Glamorgan to try to improve the care of patients with self-poisoning in the district.

Organisation of the unit

Patients aged 14 years or more are admitted under the care of one of five medical firms who are also on call for general medical emergencies. Most are transferred from the district's accident and emergency unit in Cardiff Royal Infirmary two miles away, although some are admitted directly. Patients are managed medically according to agreed clinical guidelines before undergoing a psychosocial assessment, normally on the next day. Assessments are usually conducted initially by a psychiatrist in training (in a private interview room), who will refer to the on-call senior registrar or consultant for the day in difficult cases. One designated consultant psychiatrist provides advice on policies and procedures within the unit and training is given to each new intake of junior medical staff on psychiatric issues associated with deliberate self-harm.

The nurse manager of the unit is a registered mental nurse who also has a general training qualification and provides advice to other wards that on rare occasions have to admit self-poisoned patients. The nurse manager and his or her staff (two trained nurses and one nurse in training on each shift) liaise with psychiatrists and the social work department to ensure that information about discharged or transferred patients is sent promptly to the general practitioner. All admissions and relevant data are recorded daily in a database by members of staff of the National Poisons Information Service (Cardiff Centre) and these data are used to report on the patterns of admission and disposal.

Medical and nursing staff on the unit provide regular undergraduate and postgraduate training to healthcare professionals on suicide and attempted suicide through workshops, seminars and invited guest lectures.

Activities between 1987 and 1997

In 1987, 802 patients were admitted to the unit after a total of 933 episodes. This constituted 10% of all acute medical admissions in South Glamorgan and over 90% of all admissions for self-poisoning in the district. The number of admission episodes has risen steadily since that time, and by 1997 a total of 1292 patients were involved in 1588 admission episodes (Fig. 1). In 1987, females constituted 63% of the admission episodes, but by 1992 this figure had fallen to 53% and has remained relatively constant since then (Fig. 2). In 1997, 20.7% of admissions represented repeats, compared with 13.6% in the years 1987/88.

Analgesics are the most common agents taken in overdose (taken in 51% of admission episodes in 1987/88 and 57% in 1997), with paracetamol being the single most-frequent drug implicated in self-poisoning episodes (52% of all episodes involving analgesics were associated with paracetamol in 1997). Hypnotics and anxiolytics were the next most frequently taken agents (involved in 33% of episodes in 1997), but antidepressant poisoning rose in frequency over the 10-year

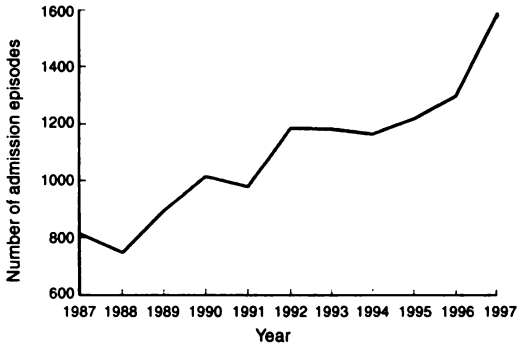

Fig. 1. The number of admission episodes for self-poisoning between 1987 and 1997.

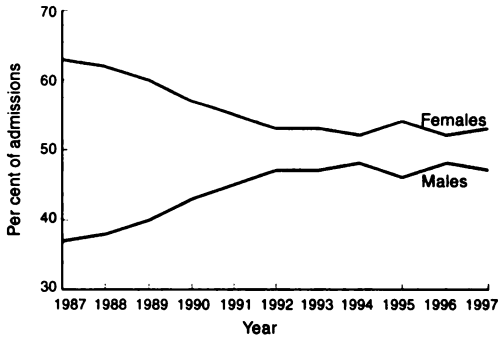

Fig. 2. The proportion of admissions involving males and females from 1987 to 1996.

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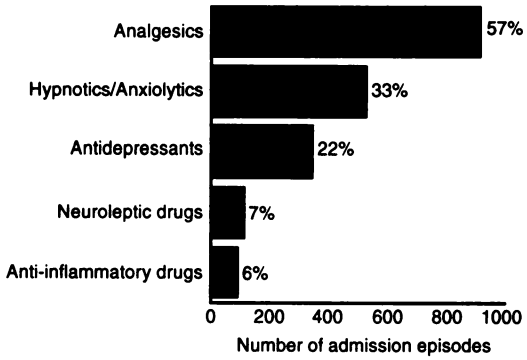

Fig. 3. Number (and percentage) of admission episodes associated with the five most common groups of agents taken in overdose. (Many patients took more than one substance. Data from admission episodes in 1997.)

period to contribute to 22% of admission episodes in 1997 (Fig. 3) compared with only 11% in 1987/88 (Bialas *et al*, 1996).

Fifty-five per cent of patients were reviewed by a psychiatrist in 1997 and coded diagnostically. Mood disorders (ICD–10 codes F30–39) were the commonest psychiatric disorders in 1997, with 35% of the coded admissions allocated to these diagnoses in 1997. Seventeen per cent of coded admissions in 1997 were not considered to have a psychiatric disorder.

In 1997, 22.7% of coded admission episodes were thought to have deliberate suicidal intent, 67.6% to be deliberate non-suicidal attempts and 9.7% to be accidental. Over the period of this report the median stay in the unit has fallen progressively from 34 hours in 1988 (figures for 1987 are not available) to 18 hours in 1997. The largest proportion of patients (27%) were discharged home with no follow-up, but 25% were discharged home with a psychiatric out-patient appointment and 11.8% were admitted to psychiatric in-patient care in 1997 (compared with 6.8% for the combined years of 1987 and 1988).

Discussion

The College working party reported at a time when the increase in deliberate self-harm seen in the 1960s and 1970s had seemed to level off and a reduction in the size of the problem may even have occurred (Hawton, 1986; Hawton *et al*, 1994; McLoone & Crombie, 1996). Since the beginning of the 1990s, the numbers have risen again to those seen 20 years previously and this is mirrored in our own admission rates. The change in the ratio between females and males has been reported before and our present ratio of 1.3:1 reflects the national trend. Although only 5–8% of such patients have a psychiatric illness that requires in-patient treatment, the social difficulties that precipitate the majority of such admissions and the accompanying alcohol intake seen in more than one-third of our patients are occasionally associated with disruptive behaviour. It is therefore valuable to manage such individuals in an area away from general medical patients with other conditions and where the support services can be co-ordinated and delivered efficiently (Jenkins *et al*, 1994).

The incidence of repetition of self-harm also appears to be increasing in our area. This may be related to the increase in proportion of patients with personality disorder or alcohol or drug misuse, because these factors are known to be associated with an increased repetition rate. Unemployment, a criminal record and being single, divorced or separated are also associated with an increased risk of repeated deliberate self-harm and several of these factors may be increasing in frequency in society. Such a trend is a cause for concern because such patients are at a very high risk of eventual suicide. Alcohol and drug misuse are particular risk factors for suicide following self-harm in young people. Alcohol had been taken in 54% of admission episodes, and drugs of misuse (e.g. amphetamines, ecstasy, strong opiates or solvents) in a further 7% in 1997.

Since the 1983 guidelines, an important report on the prevention of suicide has been published (Jenkins *et al*, 1994). This acknowledges that primary prevention of deliberate self-harm is difficult but that special services may reduce repetition and have positive effects on psychological and social functioning, particularly for female patients.

The concentration of deliberate self-poisoning services on a single site aids the teaching of undergraduate and postgraduate nursing and medical staff in the medical and psychiatric aspects of the care of self-poisoned patients. Guidelines for treatment act as teaching tools as well as standards for clinical management. Management of patients is made more efficient by having only one site that psychiatric and other support services have to visit, and voluntary services also benefit from having to liaise with only one centre. A self-harm liaison committee ensures that hospital and community issues are addressed in a coordinated fashion. Research into the epidemiology and management of poisoning is also facilitated by a dedicated centre for self-poisoning (Parker *et al*, 1990; Janes & Routledge, 1992; Bialas *et al*, 1996). Hypotheses can be tested and data gathered more rapidly and efficiently in such circumstances.

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Conclusions

The benefits of a dedicated poisons treatment centre were highlighted 25 years ago (Kennedy, 1972). Despite that, and despite publication of the College's guidance 16 years ago, few districts have used the model of a specialised unit and patients are still managed on general medical wards or in accident and emergency departments in many cities. A single centre in a city facilitates the psychiatric or social evaluation that is essential (Royal College of Psychiatrists, 1983). It ensures that nurses in charge of the beds have psychiatric nursing experience and that medical, nursing and social work staff can receive regular in-service training in the management of deliberate self-poisoning. Thus, liaison and training are improved and we hope that the increased opportunities for research will help in the prevention of poisoning and in developing more effective patterns of care for patients who have deliberately harmed themselves.

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GPs' views on discharge summaries

John Dunn and Stephen Burton

Aims and method After gaining the impression that our discharge summaries were too long for local general practitioners (GPs), we proposed to produce an abbreviated summary. We sent a questionnaire to a sample of GPs asking which aspects of the current summary were helpful.

Results Although many GPs considered the summary overly long, a majority considered all the items to be at least 'very helpful'.

Clinical implications Although previous work on discharge summaries has indicated a demand for brief, focused reports it is important to establish local GP priorities before planning changes.

Effective communication between psychiatrists and general practitioners (GPs) is clearly essential in the care of people with mental health