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A Comparison of Social Workers and Psychiatrists in Evaluating Parasuicide

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SUMMARY Sixty parasuicide patients admitted to medical wards were assessed by social workers prior to routine psychiatric assessment. Both disciplines completed a rating schedule. The social workers' and psychiatrists' rating schedule responses were compared, and their decisions were examined against further information obtained by a research psychiatrist, which included standardized mental state assessment. Overall the results show that social workers can safely and reliably assess these patients, but they are more cautious. A management approach involving social workers as assessors of parasuicide patients is discussed.

Introduction

The Suicide Act 1961 (see HM(61)94) seems to be based on assumptions that all who commit 'parasuicide' acts intend to kill themselves and suffer from mental illness (Stanley, 1969). Although all such persons should be seen by a psychiatrist, Patel (1975) found that 36 per cent were not seen.

The Ministry of Health Report (1968) recommended that hospitals should have a psychiatrist available daily. In practice patients are seen either by trainee psychiatrists as part of their emergency or medical liaison duties, or by visiting psychiatrists associated with the hospital part-time who may not attend daily. Psychiatrists are often unable to spend sufficient time with patients because of work pressure, and trainee psychiatrists are often unfamiliar with alternatives available to deal with patients' social predicaments.

Recent work has attributed increasing importance to social and personal factors both in understanding and in treatment of parasuicide (Paykel *et al*, 1975; Gibbons *et al*, 1978). Interpersonal conflict, social isolation and major life events all contribute to the act. This suggests that social workers could have a fundamental role both in assessment and management. Despite direct recommendation (Ministry of Health, 1968), all patients do not receive social evaluation. Social workers' skills may be at least as relevant as psychiatrists' for parasuicides. Harris (1976) made a plea for this role, stating that social workers' training is well suited for this work, and that in using these skills their job satisfaction will increase.

The question is whether social workers can reliably and dependably carry out initial assessments of parasuicide patients or whether assessment by a psychiatrist is necessary. Are they capable of detecting the presence of severe mental illness? The present study was designed to compare assessment by social workers with assessment by psychiatrists in everyday hospital in-patient practice. The safety and reliability of diagnostic and management decisions was particularly examined.

Method

The study was carried out at Charing Cross Hospital. Seven social workers volunteered to join the study and carry out assessments in addition to their normal work. It was considered important to use a group of social workers with varying experience rather than test the skills of one individual. Four worked in the general medical department, and of these two had had one or more years' experience of

psychiatric social work and two none; three worked in the psychiatric department and had had at least one year's experience.

Responsibility for in-patient psychiatric assessment and management continued with the routine psychiatrists. This duty was shared by rota among the junior psychiatrists (four registrars and one senior house officer). An independent mental state examination was made by a research psychiatrist. Twenty patients were interviewed during a pilot study and a rating schedule was tested and modified.

Selection of subjects and assessment procedure

Each morning parasuicide admissions to medical wards (listed in the casualty book for the past 24 hours and 72 hours after weekends) were visited by the research psychiatrist in order of admission. The first two ready for assessment entered the study; any others were carried forward to the next working day. The number of patients admitted to medical beds varied from 0 to 5. Patients were asked to co-operate with the interviews by the research psychiatrist and social workers for the purpose of developing a better understanding and treatment of their problems. It was stressed that these interviews were confidential and for research purposes only. They were told that only the routine psychiatrist would be offering help and making decisions about their care. The social worker's assessment always preceded the routine psychiatrist's assessment, as the psychiatrist discussed actual management with the patient. Social workers undertook not to discuss patients they had seen nor to obtain information on their actual management. Both the social worker and the routine psychiatrist were asked to carry out a clinical assessment and fill out the rating schedule at the end of the interview.

The research psychiatrist interviewed the patient on the same day, using the ninth edition of the Present State Examination (PSE, Wing *et al*, 1974). The patient was asked to complete the 60 item version of the General Health Questionnaire (GHQ, Goldberg, 1972). This research examination was repeated at three month follow-up, when information was also obtained about the subsequent course and any further parasuicidal behaviour.

Analysis of standardized mental examination results

The GHQ yielded a simple score (GHQ scoring method). Goldberg advocates a cut-off score of 11 to distinguish between those patients whom psychiatrists would regard as probable cases of mental illness (above 11) from those they would not (11 and below).

The PSE was used to obtain a CATEGO diagnosis and to derive the patient's Index of Definition level of mental illness (Wing, 1976 and Wing *et al*, 1978) which incorporates cut-off points on the basis of rated symptoms. Eight levels are incorporated, and at the threshold (level 5) and above (levels 6–8) disorders are sufficiently well defined to apply the CATEGO programme of clinical classification.

Thus there were two reference ratings with standardized techniques, the GHQ which identified suitability for psychiatric referral and the PSE which indicated whether a psychiatric diagnosis could be made.

Analysis of the routine psychiatrists' and social workers' rating schedules

1. *Frequency counts:* These were carried out for each item on the ratings given by the two disciplines on the same sixty patients. These reflect the bias of each discipline in assessing patients recovering after parasuicide.

2. *Extent of agreement between the two disciplines:* This was calculated by cross-tabulation analysis on important individual items. Agreement on an item was calculated as the number of cases where agreement occurred expressed as a percentage of the number of patients in the series. (Significance was tested using the Kappa Statistic), e.g. N = 60. Agreement on whether to discharge or prolong stay in hospital was calculated as follows:

		Psychiatrists		
		Yes	No	
Social Workers	Yes	30	14	$\frac{30+13}{60} = 72$ per cent
	No	3	13	

Agreement = 72 per cent, disagreement 28 per cent. $P < .01$.

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Results

Sixty-five patients entered the study and full assessments of 60 were obtained (one refused additional research interviews, three discharged themselves before seeing the routine psychiatrist and one was not referred for in-patient psychiatric assessment).

The reason for admission from casualty was self-poisoning (59) and self-injury (1). Females numbered 37 and males 23. The mean age was 34 years and the age range 15 to 87 years. Information was obtained on 87 per cent at three-month follow up, and 68 per cent of the series were interviewed personally at this time.

Comparison of routine psychiatrists' and social workers' ratings

Tables I, IV and V show how the routine psychiatrists and the social workers rated this group of 60 patients on clinical, social and management decisions.

Table II shows the extent of agreement between routine psychiatrists and social workers on the individual items rated. Only the most relevant items are shown. The following discussion of results for the individual ratings takes into account the extent of agreement between the routine psychiatrists and social workers in the light of information provided by the research interviews.

TABLE I

Diagnostic and immediate management decisions frequency table of rating schedule answers

	Rating of 60 patients by:	
	Psychiatrists per cent	Social workers per cent
MENTAL ILLNESS		
Possibly or definitely present	43	65
PERSONALITY		
Abnormal or personality disorder	55	63
PHYSICAL ILLNESS		
Present	15	30
PSYCHIATRIST		
Necessary	73	82
Opinion necessary before discharge	58	53
* Needed as main worker	39	30
IMMEDIATE MANAGEMENT		
No further help needed	8	3
Discharge, offering help	65	52
Keep in hospital	27	45
Compulsory admission probably indicated	12	7

* n = 33, as item added after start of series.

No significant differences between the two disciplines on any item at P < .05 (Chi squared test).

Mental illness

Table III shows the results of standardized clinical evaluation. Social workers more often rated mental illness as present, and agreement between the two disciplines was low. Reference to Table III shows that disagreement largely arises in cases where the GHQ score falls in the mid-range (21–40); here social workers rated 79 per cent as mentally ill whereas the psychiatrists rated 35 per cent as ill.

The Index of Definition can be used as a standardized measure to determine whether illness is present. In 5 of 6 patients in whose case

TABLE II

Agreement of key diagnostic and management decisions

	Per cent agreement	Kappa	Significance
MENTAL ILLNESS			
Possibly or definitely present versus absent	60	.198	ns
PERSONALITY			
Abnormal or personality disorder versus normal	68	.397	< .01
PHYSICAL ILLNESS			
Present versus absent	82	.491	< .01
PSYCHIATRIST			
Necessary versus not in any role	81	.480	< .01
Opinion essential before discharge versus not	62	.225	< .05
IMMEDIATE MANAGEMENT			
Keep in versus discharge	72	.406	< .01

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TABLE III

Results of standardized clinical evaluation

GHQ (n = 54*)			
Number with score above 11	51		
Mean score (SD 15)	36		
Percent rated mentally ill			
Score range	0–20	21–40	41–60
Psychiatrists	22	35	77
Social workers	33	79	77
PSE Index of Definition levels (n = 60)			
Percent of series			
Below threshold (levels 1–4)	33		
Percent of series at			
Threshold and above (levels 5–8)	67		

* GHQ scores were not obtained on 6 patients.

psychiatrists rated mental illness and the social workers did not, there was PSE evidence of mental illness at threshold and above levels. In only 10 of 18 cases where the social workers but not the psychiatrists rated mental illness did the patients reach the threshold or above Index of Definition levels. This is to be expected and only confirms that psychiatrists are better at applying their rules for identifying mental illness than social workers, and are making diagnoses in line with the CATEGO criteria. It leaves open the question whether such patients should be regarded as ill. However, for more severely ill patients there was no difficulty. The 4 with Index of Definition levels of 7 or 8 were rated as ill by both disciplines, and both disciplines correctly rated the two patients in the study who did not fall into the depressive category but were diagnosed as phobic and paranoid respectively by CATEGO.

Personality assessment

Personality was judged to be abnormal or disordered in over half the series by both disciplines, and agreement was significant.

Need for a psychiatrist

The need for involvement by a psychiatrist in addition to the assessing social worker received high ratings by both disciplines, and agreement was significant. Similar ratings were given by medical and psychiatric social workers (83 per cent and 81 per cent). Individual social workers varied from a 100 per cent indication (no psychiatric experience) to a 13 per cent indication (with psychiatric experience).

Role of the psychiatrist

Both disciplines showed a similar tendency to use the psychiatrist as an adjunct rather than as the main worker.

Urgency for a psychiatric opinion

Similar ratings were obtained on this item. Both disciplines indicated that a psychiatrist's opinion was needed before discharge in rather more than half the series. Agreement was low.

If we postulate that a psychiatrist is only required before discharge where his particular skills are demanded urgently, e.g. (i) immediate prescription of physical treatment, (ii) diagnostic confusion, (iii) urgent or compulsory psychiatric admission, then we can consider the reliability of social workers making these judgements as compared to psychiatrists.

There were 10 assessments where only social workers rated a psychiatrist necessary before discharge; of these 8 (80 per cent) were at threshold or above levels on the Index of Definition. After three months, 5 of the 10 had received treatment which supported the social workers' judgements: Two had been re-referred to psychiatrists by the medical team before discharge, two had required emergency psychiatric admission for treatment of the same depressive disorder, and one continued an out-patient course of electroplexy. Of the remaining 5, 4 had not received treatment and were improved or well at follow-up, as indicated by a reduction of their neurotic scores and the patients' own report. A vagrant alcoholic was reported unchanged.

There were 13 assessments where only psychiatrists recommended an opinion before discharge; of these 10 (77 per cent) were at threshold or above levels on the Index of Definition. Two received in-patient psychiatric treatment with effect, thus supporting the psychiatrists' judgements. However in 8 cases the patient was well or improved without any treatment, supporting the social workers' initial judgements. It is difficult to clarify the issue

on the other three patients. None had psychiatric intervention in the early stages of follow-up, and although there was marked psychiatric disturbance in the ensuing weeks they were much improved at follow-up.

Overall, follow-up tends to support the social workers' original judgements as being equally valid with those of the psychiatrists.

Immediate management

It was rare for either discipline to rate patients as suitable for discharge without further help. Both disciplines opted for discharge offering psychiatric and/or social help as the most useful choice. While social workers were more cautious about discharging patients from in-patient care, significant agreement was obtained on whether to prolong stay in hospital or to discharge.

Three patients discharged after psychiatric assessment required emergency admission within the following three weeks for the same psychiatric disorder as was apparent after the overdose. Two patients were re-referred to the psychiatric department before discharge by the medical team, who were worried about discharging them. None of these five patients had been recommended for discharge by the social workers.

Compulsory detention

Both disciplines gave a low recommendation for compulsory detention, only one patient was detained and both disciplines had indicated the need for this.

Further help

The most popular category of help was psychiatrist plus social worker and there were low indications for either discipline as exclusive helpers.

TABLE IV

Decisions on type of helper needed frequency table of rating schedule answers

	Psychiatrists per cent	Social workers per cent
HELPER RECOMMENDATION		
Psychiatrist only	13	3
Social worker only	13	20
Psychiatrist or social worker	8	7
Psychiatrist plus social worker	58	67
SOCIAL WORKER RECOMMENDATION		
Necessary	68	88
Local authority based help	42	7**
Hospital based help	28	65**
Other organization	7	23*
Immediate social assistance	17	28

Significant difference between psychiatrists and social workers ratings:
* P < .05 (Chi squared test)
** P < .001

TABLE V

Ratings on the parasuicide act and assessment interview frequency table of rating schedule answers

	Rating of 60 patients by:	
	Psychiatrists per cent	Social workers per cent
SUICIDAL INTENT		
Present in some degree	45	67
MAIN MOTIVE		
A will to die	12	20
A plea for help	20	25
Temporary escape	42	32
Manipulation of persons in immediate environment	18	17
REPETITION		
Risk of parasuicide/suicide in near future	65	70
VALUE OF INTERVIEWING THIRD PARTY		
Useful or essential	63	67
PATIENT RELIABILITY AS HISTORIAN		
Totally unreliable or dubious	30	23
MOTIVATION FOR IMPROVEMENT		
Moderate or strong	73	72

No significant differences on any item between the two disciplines at P < .05 (Chi squared test).

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Psychiatrists showed a preference for Local-Authority-based social workers, while social workers showed a preference for hospital-based social workers. Recommendations for other organizations, e.g. Prisoners' Aid Society, were generally low, but social workers recommended them more often. The need for immediate social assistance received low recommendations from both disciplines.

Suicidal intent, motive and future risk

Suicidal intent of some degree was rated more frequently by the social workers. The motive most frequently attributed to the patients by both disciplines was temporary escape from an unbearable situation. Both rated a will to die as the main motive infrequently.

Both gave high predictions of further suicidal behaviour. Seven patients repeated the act non-fatally; psychiatrists predicted five, social workers six. One committed suicide, and both assessors had indicated the likelihood of a further attempt.

Interview factors

Both disciplines indicated that the interviewing of a third party i.e. relative or friend, would be useful or essential for about two-thirds of the series. Both rated less than a third of the series as being unreliable historians. One patient proved at follow-up to have given a totally fallacious history, which the social worker had detected.

Personal and situational factors

The presence or absence of 17 factors was examined. The first section involved personal factors e.g. physical illness, the second interpersonal factors, e.g. social isolation, and the third material factors, e.g. housing problems.

Psychiatrists rated all items less frequently, but only three differences in frequencies reached statistical significance (forced separation, general relationship problems and family problems). The mean agreement on the presence or absence of the 17 items was 78 per cent. Four items failed to reach a 70 per cent agreement (general relationship problems, family problems, unemployment or work problems and financial problems).

The item on physical illness was examined in more detail. It was rated as present in a minority of patients. The two disciplines agreed on its presence in seven patients. Disagreements were examined against follow-up information, and it was found that social workers were usually correct. There were ten patients in whom only the social workers had rated physical illness as present (disabling arthritis (2), Parkinson's disease (1), hypochondriasis (1), hypochondriacal delusions (1), post-influenza depression (1), gynaecological disorders (2) and alcoholism with physical symptoms (2)). Only one patient was rated ill by the psychiatrist only (alcoholism with physical symptoms).

Two epileptics, misdiagnosed on admission as cases of overdosage, and referred as such for psychiatric opinion, were rated by both disciplines as physically and not mentally ill.

Discussion

The study employs an unbiased continuous sample of parasuicide patients who remain in hospital long enough for psychiatric assessment. Patients who discharge themselves prematurely are generally not seen by a psychiatrist and are in that sense irrelevant to the proposition being tested in this study. Unfortunately, our methodology only allowed the research psychiatrist to gain follow-up information on what actually happened after the routine psychiatrist had advised on management. The next step would be a randomized trial of assessments by psychiatrists and social workers.

In general, social workers have shown themselves to be more cautious. They exclude mental illness less often, and the main difference is that they tend to define the group of patients with a moderate number of depressive and neurotic symptoms (GHQ 21–40) as being mentally ill. Their bias towards prolonging stay in hospital would probably have been reduced had they needed to take into account pressure to discharge patients due to scarcity of available beds.

Both disciplines have rated the major role of the psychiatrist as offering an out-patient consultation. Social workers did not rate the main problem as psychiatric nor the need for a

psychiatrist to be urgent any more frequently than did the psychiatrists.

The results demonstrate that social workers assess parasuicide patients as safely and reliably as do junior psychiatrists and at the same time offer other skills when choosing appropriate help. Social worker participants in this study felt that their relatively more frequent recommendation for hospital social worker help arose from the assumption that a hospital social worker would interview the patient before discharge. They attached therapeutic importance to this interview in the belief that patients were more likely to use help at a time of high risk from a social worker they had already encountered. Social workers were aware of the great pressures under which local-authority-based social workers work. Perhaps more realistically they did not consider them as alternatives to hospital social workers to follow-up the patient.

Study of personal and situational factors preceding the act has shown the greater significance social workers attach to relationship difficulties, family problems and forced separation. These are generally considered important in the aetiology of parasuicidal behaviour and relevant to social workers' skills. While the social workers' orientation appears to be an advantage here, it equally holds that psychiatrists should receive better training in this orientation.

In the light of these findings, an alternative assessment procedure is suggested for these patients. In hospitals where staffing of social workers is relatively ample in comparison to the availability of psychiatrists, social workers could undertake to deal with some or all of the referrals. It would be necessary for a psychiatrist to be available for consultations about urgent problems. An interview with a psychiatrist must be possible when the social worker or medical team feel this is indicated. It is envisaged that the consultation rate would drop as the social workers' expertise grew.

We suggest an approach which would include meetings, perhaps weekly, between psychiatrists and social workers. This would provide a forum for mutual exchange of information and for discussion of difficulties, thus giving a useful learning experience for both disciplines. This study, which compared social workers and trainee psychiatrists points strongly to such a need on both sides.

Note

Detailed follow-up results of the mental state examination by the research psychiatrist are described elsewhere (Newson-Smith and Hirsch, 1979).

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