The Defence NBC Centre and the Wiltshire hazardous material working group have, after discussion and field trials, developed a simple, comprehensive, and cost-effective coordinated response to the management of chemical casualties. The management concept is an aggressive response at the incident site(s), with a multidisciplinary approach resulting in decontamination and resuscitation on site; a backup decontamination facility is placed outside each A&E department, with the equipment and procedures being identical to those used at the site. The levels of protection stipulated for the site are chemical suits, beryl rubber gloves, and breathing apparatus for any medical staff within the inner cordon; at the hospital, A&E staff dealing with contaminated casualties require the same level of protection. If no direct contact will occur with contaminated clothing, a double pair of surgical gloves may be used to undertake procedures, instead of the heavier beryl rubber gloves. It is recognised that national recommendations are being developed by the Ambulance Service and the Association of chemical incident procedures subgroup.

Deliberate self harm

**Editor,—Ryan et al** present a valid case for the use of overnight wards in the management of deliberate self harm (DSH). From the data presented, the use of such wards reduces the need for psychiatric assessment of these patients. My own experience of providing a DSH service which offers assessment for patients who harm themselves indicates that the provision of an observation ward improves the quality of psychiatric assessment and integrates the patient into the ward processes. The contrast between working in casualty departments which do and do not admit DSH patients to an observation ward is often striking. Emergency assessments of DSH patients who are not deemed to warrant admission to a medical bed are frequently requested. In the absence of overnight observation beds, this often means attempting to address complex ‘multiple psychiatric and social problems’ during the small hours of the morning, while the patient is still in crisis.

When DSH patients are admitted overnight, then a more meaningful assessment can be made that night, with full access to social and psychiatric support services. Patients will have had time to reflect upon recent events once they pass through a period of crisis. It is then possible to target appropriate interventions at those who will benefit most and patients can leave hospital with the appropriate follow up arrangements already in place.

There are in excess of 100 000 annual DSH admissions in the United Kingdom, and it is believed that 15-20% of these patients will be admitted within the following year. The provision of appropriate psychosocial intervention has the potential to both reduce the demands put upon A&E departments through readmission and to improve the quality of patient care offered. I believe that observation wards facilitate this process and would urge A&E departments to consider their use in cases of DSH.

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