

Better Services for People who Self-Harm
Data Summary – Wave 2 Baseline Data
March 2007

Edited by Lucy Palmer, Philippa Strevens & Helen Blackwell
selfharmproject@cru.rcpsych.ac.uk

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Executive Summary & Recommendations

Between September and December 2006, over 250 staff and 72 service users completed separate questionnaires relating to emergency care for people who self-harm. Service user respondents were invited to comment on all aspects of care, from initial contact with ambulance staff, through triage or initial assessment, physical treatment, psychosocial assessment and discharge. Staff were asked their opinion on the quality of treatment provided and their views on self-harm, as well as their training and support needs.

Respondents

Two-thirds of the service users responding to the user survey were female and eighty-seven percent were of white British origin. For 31% of respondents this was the first use of emergency services following self-harm.

Forty-six percent of staff respondents work in the ED, 44% in mental health and 7% for the ambulance service.

Feedback from service users and staff across the 8 participating services was remarkably consistent, highlighting common themes across most teams, as described below:

Staff attitudes

The attitude and behaviour of staff were the most significant factors affecting service users' experience of care. Taking all staff groups together, service users rated 46% of staff as 'excellent' or 'good', 27% of staff as 'average' and 27% as 'poor' or 'very poor'. Feeling respected, supported and not judged had a very positive effect on service users, particularly on their ability to cope on leaving the ED.

When staff groups are looked at separately, it is interesting that 67% of those who had used the ambulance service rated ambulance staff as 'excellent' or 'good'. This is despite the fact that ambulance staff, when asked about their understanding of self-harm, rated themselves as less knowledgeable than any other staff group.

The vast majority of staff (94%) stated that they 'would not act in a threatening way towards a person who has self-harmed'. However, 28% of staff stated that they 'do not know enough about self-harm to communicate effectively with this patient group'. Furthermore, 56% of staff felt that people who self-harm regularly are not treated as well as 'one-off' self-harm patients. Three-quarters of staff felt that repeated attendances in ED by someone who self harms can cause a sense of frustration and failure in staff and over half felt that high numbers of self-harm admission impacts on staff morale. Furthermore, 36% of staff feel that patients who have self harmed receive less support and respect than other patients.

Physical treatment

Thirty-five percent of service users rated the physical treatment they received as 'excellent' or 'good', and 26% rated it as 'average'. A further 32% of service users rated the physical treatment received as 'poor' or 'very poor'. Findings from the staff survey appear to uphold the view that physical treatment needs to be improved, with 13% of staff rating the quality of physical treatment received by people who self-harm as worse than that received by patients with non self-harm injuries. A significant minority of service users felt they needed, but were not offered, pain relief whilst waiting for treatment (31%) and 19% said that pain relief during treatment was inadequate.

Information, communication and consent

Information and communication were themes running throughout the user experience. Again there were variations at different stages of people's contact with services. Fifty percent reported that ambulance staff checked if they agreed to what was happening. When treated in the ED, only 16% of people remembered being asked if they agreed to each treatment.

Service users stressed the importance to their mental wellbeing of occasional but regular contact with staff whilst waiting – for reassurance, safety and updates about the process. Sixty-two percent of respondents reported that they were not checked on whilst waiting for treatment and there were many comments about the anxiety and sense of hopelessness that this lack of contact can contribute to.

User responses echoed those of staff in asking for fuller communication between services. For example, some people found it distressing to be asked the same questions by each staff group. A third of staff rated communication between ambulance and ED staff as good. However, 17% of staff rated communication between ED and mental health staff as poor and 30% felt that communication between ambulance and mental health staff could be improved. Sixty percent of staff felt that ED staff would benefit from better access to information about patients' mental health (e.g. through shared notes, or joint access to an IT system).

Ten percent of users would have appreciated help with communication (for example interpretation). A quarter of respondents reported that specific personal, cultural or religious needs were not taken into account, for example being examined by a staff member from a specific gender.

Mental health needs

Sixty-seven percent of service users were seen by a mental health professional while in hospital and 58% of those felt that they were given the opportunity to talk about the reasons for their self-harm. Comments about psychosocial assessment reflected both positive and negative experiences, but service users consistently stressed the importance of being listened to and taken seriously. Forty-two percent of mental health staff felt that they would like further training on 'how to conduct a specialist psychosocial assessment'.

Thirty-seven percent of users reported being asked about their mental health at triage (or at first contact with ED staff if this was not with a triage nurse).

Physical environment and facilities

Interestingly, service users generally rated the physical environment better than staff members did. Users' comments, however, underlined the importance of privacy during physical treatment and when talking about their mental health. Staff raised concern about the lack of privacy and calmness in the waiting areas. A third of services sometimes struggle to find a private place for psychosocial assessments, as rooms are often required for other purposes. Some staff expressed the desire to create a separate area for people who self-harm. Sixty percent of staff felt that the ED is not an appropriate place for people who self-harm and 75% felt that if a person does not have serious injuries, it would be better for them to be treated somewhere other than the ED.

Choosing not to use emergency services

The service user survey asked respondents if they had chosen not to use emergency services on occasions in the past after self-harming, and if so why. Significant numbers had not gone to the ED on occasions because the injury was not serious enough (42%). However, 37% of users said they had avoided emergency services because of previous negative experiences, and 30% had decided not to use emergency services because of the fear of being 'sectioned'.

Staff training, education and awareness

The most persistent theme for staff was the urgent need for more education, awareness raising and training in this area. Ambulance staff reported the most chronic lack of training and education - 82% described training in 'understanding self-harm' as insufficient. Ninety-four percent of ambulance staff felt that they had not been given sufficient education in how to assess a person's risk, hopelessness and suicidal intent, and 82% felt ill-equipped to assess mental health needs. Almost half of the ED staff surveyed requested more information about 'understanding self-harm'. Two-thirds reported insufficient understanding of the care pathway, and a similar number would like more training on assessing mental capacity. Over half of the mental health staff surveyed want more training in using psychological therapies with people who self-harm and almost a third described their understanding of self-harm as insufficient. Staff from all disciplines reported a lack of education in terms of understanding the impact of cultural differences on self-harm. Two-thirds of all staff stated that they would like more education on mental health and self-harm during their initial training, with this being most pertinent for ambulance and emergency department staff. Others felt strongly that induction training and refresher training should be improved.

Many of the participating wave 2 teams are prioritising staff education. Appendix 2 describes in more detail some of the action that wave 1 teams have been taking to address this issue.

Staff support and supervision

Three quarters of ambulance staff rated their supervision and de-briefing opportunities as insufficient, as did a similar number of emergency department staff. Mental health staff were generally more satisfied with their level of supervision.

Staff morale

Three quarters of staff felt that people repeatedly attending the ED following self-harm can cause a sense of frustration and failure in staff. Similarly, over half of all staff felt that high numbers of self-harm attendances can affect staff morale. Three-quarters of ED staff, 60% of mental health staff and 43% of ambulance staff felt that there are insufficient numbers of staff in their department.

Joint working between different departments

Many staff felt that information from ambulance crews could be better incorporated into handovers and over half felt that information about patients' mental health should be more accessible, for example through shared notes. Whilst some staff were in favour of joint access to an IT system, service users were not surveyed on this. Future audits will ask service users for their views on this sensitive issue.

Overall

Staff and service users alike have made it clear that improvements are needed in many areas, most notably staff knowledge, confidence and attitudes. The recommendations overleaf have been developed jointly by both and the wave 2 teams have demonstrated a commitment to making positive changes over the coming months.

Recommendations

Problem: Service users experience negative attitudes from some members of staff

Action taken by the 'Better Services for People who Self-Harm' programme:

The Central Project Team (CPT) has produced the following tools for its members:

- The leaflet 'Understanding self-harm', written by service users for emergency staff, exploring the reasons why people self-harm and providing practical advice on helpful and unhelpful responses to self-harm
- Two PowerPoint slide sets based on the above information leaflet
- Online training packages for staff working with people who self-harm

The College Education and Training Unit will be developing a range of training packages for staff (2007/08). For further information, contact Helen Blackwell:

Tel: 020 7977 4992, Email hblackwell@cru.rcpsych.ac.uk

Recommendations for services

1. Trust managers should formulate a training and support strategy for all staff working with people who self-harm. Service users should play an integral role in the planning and delivery of the strategy. The strategy might include:
 - a) Distributing the 'understanding self-harm' leaflet to all staff
 - b) Providing a session on self-harm and basic mental health awareness in the induction of all staff
 - c) Mental health staff/service users delivering the 'understanding self-harm' slide sets, or similar tools
 - d) Providing staff with workshops delivered by those with a specialist knowledge of self-harm (e.g. mental health workers, national and local self-harm services, mental health user groups)
 - e) Educating staff on the impact of cultural differences on self-harm (e.g. through an expert organisation such as the Newham Asian Women's Project)
 - f) Providing ambulance service and ED staff with support and advice from the mental health team
 - g) Developing a policy on the support and supervision of staff who are working with people who self-harm
 - h) Reviewing the training and support needs of staff on an annual basis
2. Common foundation year training for all nurses should include more in-depth mental health awareness training and specialist courses for nurses working in ED should provide training specifically around self-harm
3. Trust managers to develop departmental/interagency policies on self-harm which highlight the fact that discriminatory comments and behaviour are unacceptable. The policies should be in line with NICE guideline
4. Emergency department staff to facilitate the use of advance statements/crisis cards which enable a person to write down their treatment needs and preferences (in advance or on arrival in the emergency department)
5. Managers to ensure that the Trust's complaints procedure and information about advocacy services is clearly visible and understood
6. Services to offer an overnight bed, where possible, if a person is being discharged at night to an environment in which they feel physically or mentally vulnerable

Problem: A significant minority of service users continue to report unsatisfactory physical treatment and pain relief

Recommendations for services:

7. Patients to be offered the same physical healthcare and level of dignity and respect they would receive if their condition was not due to self-harm
8. Staff to ensure that all patients experiencing pain are offered pain relief at the earliest opportunity, unless there is a clinical reason not to do so. If pain relief is requested but cannot be administered, the reason that pain relief is not being offered should be clearly explained to the patient. Patients should never be refused pain relief as a punitive measure or deterrent against future self-harm

Problem: Arrangements for providing information and gaining consent do not meet the needs of the majority of service users

Action taken by the 'Better Services for People who Self-Harm' programme:

The CPT has produced a checklist for its members to display in staff areas across the ED, reminding staff to:

- Ask if the individual would like someone with them and/or offer to contact someone **if** the person wishes
- Ask the person what would help them to feel safe
- Check that the hospital environment is safe (e.g. remove sharps, and ask if the person would prefer to wait in a quieter area, if this is possible)
- Check if the person has any cultural, communication or individual needs
- Update the person on treatment, waiting times etc, to avoid isolation

The CPT is producing a first aid leaflet with basic wound care information

The CPT is developing an online case study training exercise to improve staff members' understanding of consent and capacity issues (Summer 2007).

Recommendations for services:

9. Teams to implement standard procedures to make contact and update patients at regular intervals from the point of registration to discharge
10. Staff to check that the patient understands, and agrees to, each treatment being provided. If the patient lacks the capacity to consent, ensure that they are provided with full information about treatment, and that their capacity is regularly reassessed (see the self-harm standards and the NICE guideline for more details)
11. Managers to ensure that staff are given protected time to receive regular training and guidance on issues around consent, capacity and confidentiality, including training from a service user's perspective
12. Staff to check if the service user needs help with communication/interpreters
13. Staff to take seriously a service user's request to be treated by a professional of a specific gender and to facilitate this request where possible, without insisting the patient explains their reasons why, which may be very personal
14. As per the NICE guideline, staff to consider offering advice and instructions on the self management of superficial injuries, including the provision of tissue adhesive
15. Information on local services, emergency contact numbers, and details of national helplines to be on display or readily available and provided to patients
16. Staff to inform service users about who will be given information about their visit to the ED

Problem: A significant number of service users feel that the initial and psychosocial assessment place insufficient emphasis on their own views and needs

Action taken by the 'Better Services for People who Self-Harm' programme:

The CPT will commission a study (2007/08) which explores 'what do people who self-harm want and need from a psychosocial assessment in the ED?' This will include:

- Analysis of existing data
- A survey open to all service users and staff in the U.K.
- A workshop / teleconference for staff and service users

This will culminate in a report and information leaflets and slide sets for staff

Recommendations for services:

17. Triage (or other initial assessment) to assess patients on the basis of mental health needs as well as physical condition
18. All people who self-harm to be offered a psychosocial assessment
19. Staff to ensure that users' views are sought and clarified throughout assessments
20. Service user-led training in interview skills to take place for trainee psychiatrists, trainee social workers, and mental health nurses in preceptorship
21. A written summary of aftercare plans to be given to service users on leaving the hospital

(Further recommendations to follow upon completion of the above-mentioned study)

Problem: Many emergency departments are not currently equipped to provide patients with the necessary privacy, safety and calm environment

Recommendations for services:

22. Managers to assess waiting and treatment areas for safety
23. Managers to ensure that triage is conducted in a confidential area
24. Service users to be offered the choice between waiting in the general area or in a quiet area, where possible
25. Service users to be asked if there is anything which would help them to remain safe whilst in the ED
26. Managers to assess the area in which psychosocial assessment takes place for safety and privacy
27. Services to involve service users (not just people who self-harm) in the planning of improvements to the environment

Action taken by the 'Better Services for People who Self-Harm' programme:

- Following discussion on the project's email discussion group, the CPT provided its members with laminated assessment tools that incorporate emotional distress as well as physical severity

Comments on these recommendations or ideas for future ones?

Email us at selfharmproject@cru.rcpsych.ac.uk or write to us at:
Royal College of Psychiatrists' Centre for Quality Improvement
4th Floor, Standon House
21 Mansell Street
London, E1 8AA

Introduction

The issue

Self-harm is one of the top five causes of acute medical admission in the UK each year. The quality of care for those who self-harm depends on the quality of joint working between emergency departments and mental health services and this currently varies across the UK. Although there are, of course, areas of good practice, many people who attend an emergency department as a result of self-harm find the experience distressing.

The project

This service is one of 40 in the UK that has signed up to the 'Better Services for People who Self-Harm' national quality improvement programme. Each service has formed a local team comprising of service users and practitioners from emergency departments, local ambulance services and their associated mental health services.

The project team and partners

The central project team is based at the Royal College of Psychiatrists' Centre for Quality Improvement and consists of three members of staff, one of whom is a service user advisor. Other partners include:

- The Faculty of Accident and Emergency Medicine and the College of Emergency Medicine
- The Royal College of Nursing
- Mind
- The NICE National Collaborating Centre for Mental Health

This project is partly funded by the Health Foundation, an independent charity – see www.health.org.uk for more information on their work.

The quality standards

A manual of quality standards, based on the NICE self-harm guideline as well as documents from the Royal College of Psychiatrists, the Joint Royal Colleges Ambulance Liaison Committee and the Department of Health was developed. The standards were then used to form the basis of the data collection tools, allowing teams to measure their performance before and after quality improvement interventions. Appendix 1 contains a full list of these standards and recommendations, allowing teams to see how well they are performing against each of them.

The layout of this report

Between September and December 2006, local teams measured their performance against the standards using the following methods:

1. A 'case flow audit' of patients
2. A survey of service users
3. Staff training, support and supervision survey
4. Staff attitudes and opinions survey
5. A policy checklist

How do we compare to other teams taking part in wave 2?

You can use this report to compare your performance to other teams in the programme by cross-referencing it with the data in your local report.

How do we compare to the teams that have already taken part?

A total of 30 teams participated in wave 1 and collected similar data in early 2006. We have included some references to their data throughout this report, for your reference. Overall, there is little variation between the teams taking part in the two different waves. The full baseline report for wave 1 teams can be downloaded from the publication section of the project's website www.rcpsych.ac.uk/cru/auditselfharm.htm

Notes about the report

- Percentages are presented without extra decimal points (e.g. 56%, rather than 56.4%), meaning that some totals will be 99% or 101%.
- For some questions, respondents were asked to tick as many boxes as apply; which means that the total can exceed 100%
- Due to the very large number of comments, not all could be included – we have therefore noted how many comments were made and selected a few to be representative. Comments have undergone a standard spell check

Important!

You should interpret the data contained in this report in the context of the **methods** used and the **number** and **representativeness** of respondents. The larger the sample size, the clearer the picture. That said, even small sample sizes can produce some revealing and informative findings – particularly when exploring the qualitative comments.

Abbreviations

The free text contained in this report is generally presented exactly as it was entered by local staff, which includes many abbreviations. The most likely definitions of the abbreviations used are listed below:

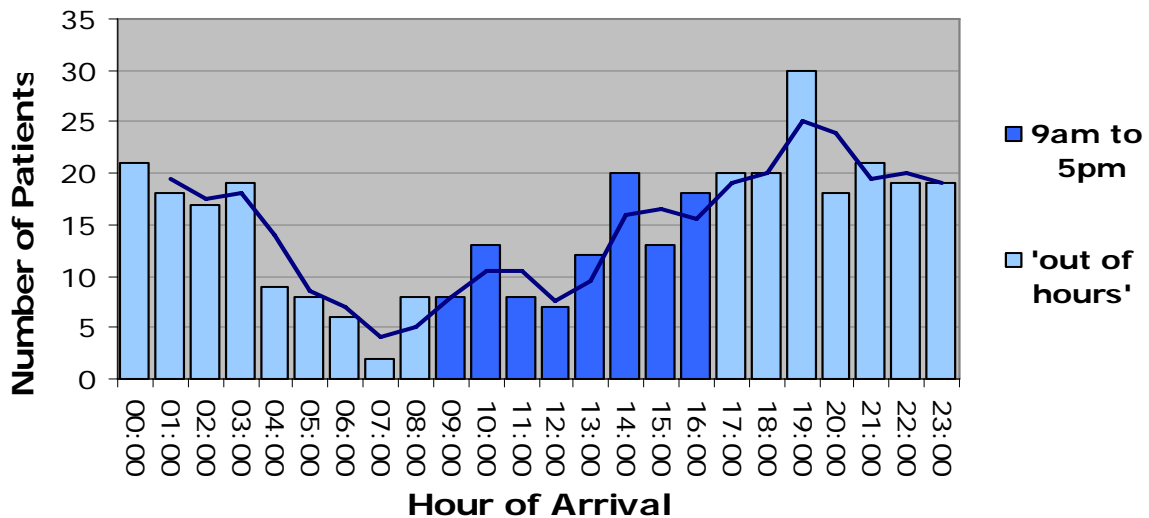
A&E	Accident and Emergency
AAU	Acute Admissions Unit
CBT	Cognitive Behavioural Therapy
CHTT	Crisis Home Treatment Team
CMHT	Community Mental Health Team
DNA	Did not attend
DSH	Deliberate self-harm
EAA	Emergency Assessment Area
ED	Emergency Department
ITU	Intensive Therapy Unit/Intensive Treatment Unit
MAU	Medical Assessment Unit/Medical Admissions Unit
MDT	Multi-disciplinary team
MHLT	Mental Health Liaison Team
MHT	Mental Health Team
OOH	Out-of-hours
SHO	Senior House Officer

Waiting Times and Outcomes

6 UK teams collected data on **emergency admissions** for self-harm between September and December 2006. A total sample of 354 patient pathways were recorded. Some teams were not able to record all of the relevant details about times in the case flow audit; therefore some of this data is difficult to interpret.

Time of arrival

Hour of arrival at the Emergency Department (ED) for 354 patients



31% of patients arrived between 9am and 5pm

Wave 1 comparison:

When we recorded data for 1,855 self-harm patients across the 30 wave 1 teams in 2006, there were strikingly similar results. Twenty-nine percent of the 1,855 patients arrived at the ED between 9am and 5pm.

Triage

<u>Type of triage that took place</u>	
It was an immediate 'Meet and Treat'	21%
A standardised triage assessment tool (such as the Manchester Triage system) was used	64%
The person was triaged but no tool was used	13%
Not recorded	1%
Not Applicable	1%

Wave 1 comparison:

Results were fairly similar. Of the 1,855 patients in wave 1:

- 17% were triaged using 'meet and treat'
- 55% used a standardised assessment tool, and
- 21% were triaged without a formal tool.

Patient Outcome (Tick as many as appropriate)	
Admitted to hospital ward/unit (not including an overflow trolley area attached to the ED)	41%
Admitted or referred back to psychiatric ward	11%
Discharged home – no follow up	6%
Offered follow up with liaison mental health team/CMHT	20%
Discharged but own appointment with mental health team worker	12%
Discharged – letter sent to GP	38%
Referred to drug/alcohol/ specialist service	3%
self-discharged <u>prior to</u> physical treatment (against medical advice)	4%
self-discharged <u>prior to</u> psychosocial assessment (against medical advice)	5%
Not recorded/unknown	1%
Other	11%

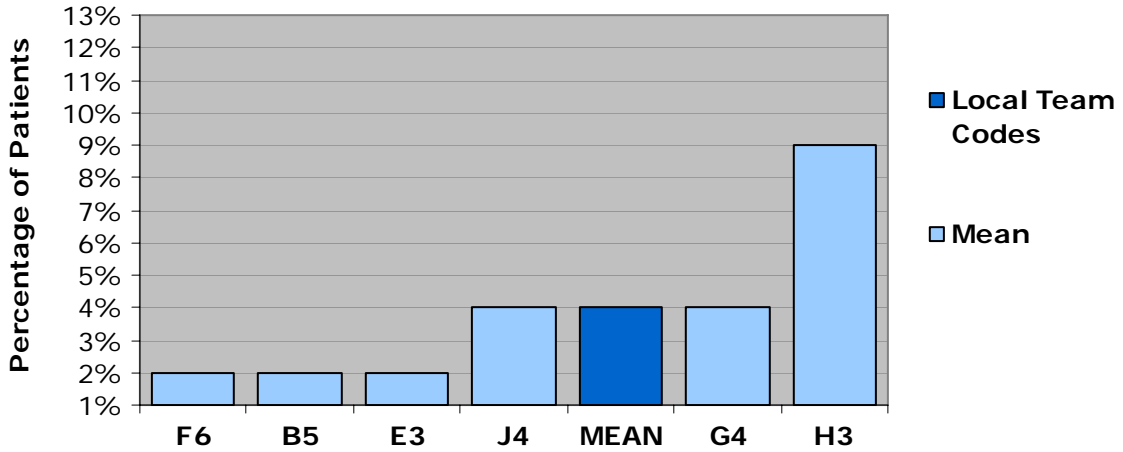
Common 'other' outcomes listed

- Referred to the home treatment team
- Offered advice on specialist services (e.g. addictions, bereavement counselling)
- Set up crisis plan
- Appointment made with social worker
- Offered advice on voluntary sector/user groups
- Declined any follow up
- Removed by police

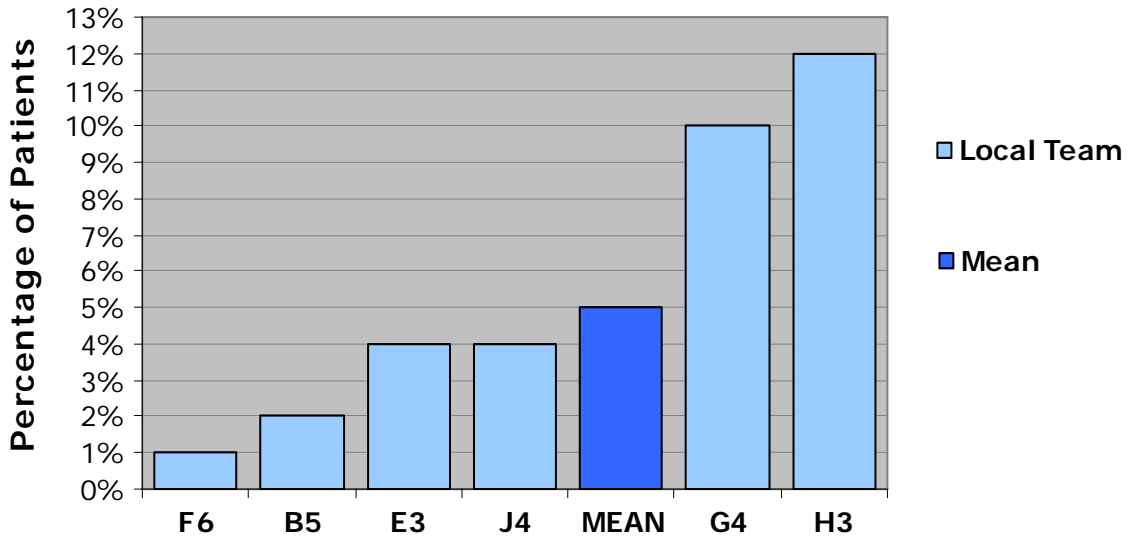
Self-Discharge

The charts below allow teams to compare themselves directly with mean average of the wave 2 teams. Please refer to your team's unique code, or contact the central project team for details.

Comparison between teams of percentage of patients self-discharged prior to physical treatment



Comparison between teams of percentage of patients self-discharged prior to psychosocial assessment



Wave 1 comparison:

Of the 1,855 patients in wave 1, identical results were found

- 4% discharged themselves prior to **physical treatment** (against medical advice)
- 5% discharged themselves prior to **psychosocial assessment** (against medical advice)
- 10 hospitals recorded no self-discharges before physical treatment
- 4 hospitals recorded no self-discharges before psychosocial assessment

Figure 2: Comparison between (WAVE 1) teams of percentage of patients self-discharged prior to physical treatment

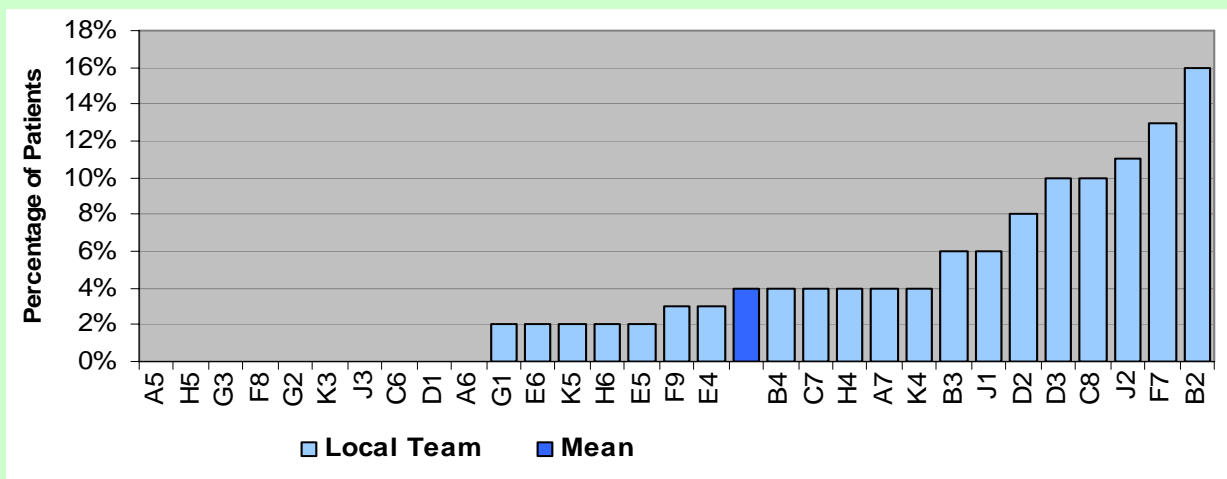
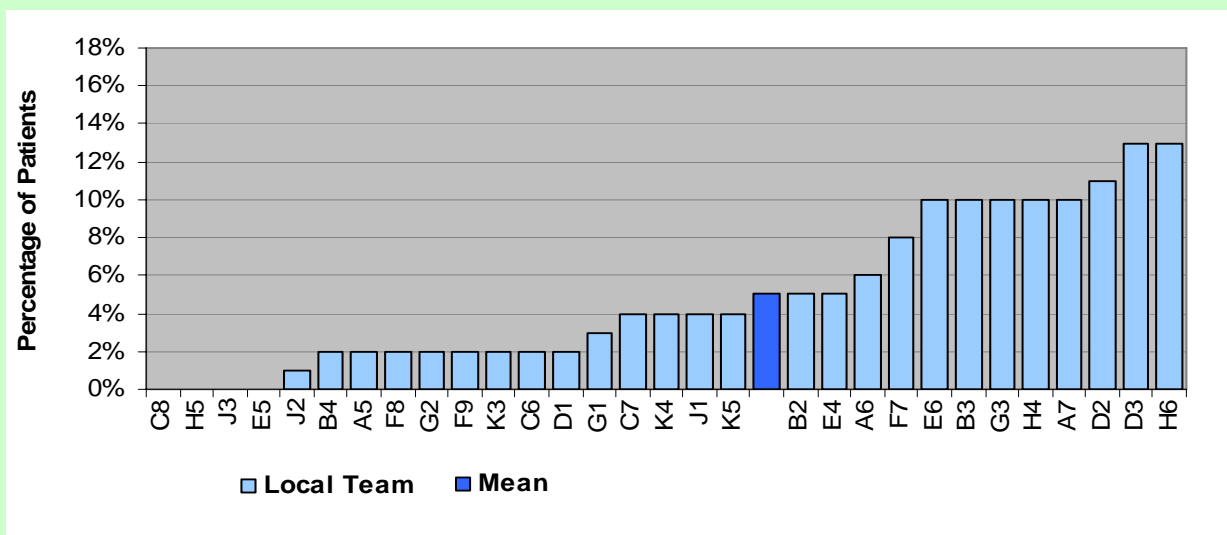


Figure 3: Comparison between (WAVE 1) teams of percentage of patients self-discharged prior to psychosocial assessment



The Service User Experience

The following is a summary of the service user responses. In total, **72 service users** completed the questionnaire below.

Key to abbreviations:

DK/CR = "Don't Know/Can't Remember" - N/A = "Non-applicable"

Contact with ambulance staff

Q1	Did the ambulance staff:	Yes	No	N/A	DK/CR
	Explain to you what they were doing and why?	50%	17%	12%	22%
	Check that you agreed to whatever they were doing?	43%	27%	12%	18%

Self-Harm: 2.1, 3.2. NICE: 1.1.1.6 & 1.1.3.4 Healthcare Commission: C7, C13 a & b, C17

Q2 If an ambulance was called but you refused transport or treatment, please say why

- *Scared to go to hospital because of nurses and doctors reactions from past*
- *I have never refused transport*
- *At first I refused but after a long talk from paramedics I agreed*
- *I did not want to waste anyone's time*
- *I was told they would call the police if I didn't go with them*
- *Ambulance man was rude and said I was an attention seeker*

Do you have any comments on your experience of ambulance services on this occasion?

Q3 POSITIVE COMMENTS:

Staff attitude (29 comments in total)

- *The ambulance woman talked to me sympathetically which I did not think she would as I had self-harmed and it was my own fault*
- *The ambulance staff were fantastic. Very supportive and understanding*
- *Caring, did not ask intensive questions*
- *They were very nice and kind although one of the staff couldn't understand wanting to take your own life, but was not horrible at all just not being able to imagine being in that position*
- *It was my first experience and I was treated with respect*
- *I didn't feel as if they were judging me which is very important*
- *The ambulance staff were caring and wonderful*

Speed of response (2 comments in total)

- *The ambulance came quickly*

Q4 NEGATIVE COMMENTS AND/OR SUGGESTIONS FOR IMPROVEMENT:

Staff attitude (25 comments in total)

- *Were a bit patronising*
- *They did not seem to care I heard one say 'we could be out helping someone who really needs it'*
- *One of them said 'what is it this time'? Maybe they had read my records, even though it's been over a year since I attended, this was quite upsetting as I already felt bad about being there. He became a bit more friendly later on.*
- *The paramedic said something along the lines of 'it was a selfish thing to do'*
- *Their attitudes towards self inflicted injuries is disgusting - they are rude and dismissive and have no idea obviously*
- *Recommendation – a course in basic manners*
- *Their attitude was wrong. He talked about people dying and asked why I wanted to kill myself. They should keep their opinions to themselves.*
- *They didn't seem to have real knowledge on mental health/self harm*

Rough handling (3 comments in total)

- *Very abusive- grabbed my arms and trawled me into ambulance. Arms all bruised*

Speed of response (2 comments in total)

- *Time for ambulance - 90 minutes*

First contact with staff in the Emergency Department

Q5	Did you go to A & E (the emergency department)?	
	Yes	100%
	No	0%

Q7	Were you asked about your mental distress as well as your physical health?	
	Yes	37%
	No	38%
	DK/CR	25%

Self-Harm: 6.2 & 9.1. NICE: 1.1.1.1. & 1.1.1.4. Healthcare Commission: C17

Q8	If you needed an interpreter or help with communicating, was this offered?	
	Yes, I needed and was offered help	7%
	No, I needed help but was not offered any	10%
	I didn't need help	74%
	I don't know / I can't remember	10%

Self-Harm: 2.5. Healthcare Commission: C16

Do you have any comments on your first contact with staff in A&E on this occasion?

Q9 POSITIVE COMMENTS:

Staff attitude (37 comments in total)

- *They treated me with respect and kindness - very sympathetic*
- *Treated me like any other patient*
- *They took it seriously*
- *Understanding triage nurse who wasn't patronising*
- *Receptionist, nurse and doctor were all lovely*
- *The receptionist and triage nurse were friendly, and appeared non-judgemental*
- *Respected my wishes not to speak to anyone about what I'd done. They recognised me from previous visits, and were still nice to me.*
- *They weren't rude*
- *No-one said 'oh no, not you again'*
- *Pleasant manner - did not make me feel bad for self-harming*

Speed of response (7 comments in total)

- *They took me right through to the cubicles straight away*
- *Dressed wounds quickly*
- *I was upset, so moved quicker through triage*

Safe and private environment (4 comments in total)

- *Took me to a safe area*
- *Shown into a waiting area away from other patients*
- *Got me a separate room, saw me quickly*

Others (5 comments in total)

- *I took a form I've designed so that I don't have to stand in reception and say what's happened - this was received well*
- *I just felt guilty that someone who may have really needed help could have the cubicle I was in*

Q10 NEGATIVE COMMENTS AND/OR SUGGESTIONS FOR IMPROVEMENT:

Staff attitude (13 comments in total)

- *A "you're wasting our time attitude" one nurse made a comment "it's supposed to hurt you DID do it". Maybe a more empathetic attitude would help or being more open to talking about the self harm rather than just treating the physical symptoms.*
- *Desk staff were not very nice*
- *There were three or four nurses talking in a room in reception and seemed to be too busy chatting to help and they didn't seem to be busy - only two people in waiting area*

Waiting in the Emergency Department

Q11	Did you wait in the Emergency Department (A&E) at any point during your visit?	
	Yes	75%
	No	25%

Q12	Were you asked if you would like someone with you at any point during your visit (e.g. friend, relative, advocate)?	
	Yes	9%
	No -	58%
	I already had someone with me	26%
	I don't know / I can't remember	6%

Q13	While you were waiting, did a member of staff check from time to time that you were okay?	
	Yes	28%
	No	62%
	DK/CR	9%

Self-Harm: 2.3. Healthcare Commission: C14, C16.

Wave 1 comparison:

Of the 206 service users surveyed across the 30 wave 1 teams, 48% were checked on from time to time and 39% were not.

Q14	If you felt you needed it, were you offered pain relief <u>whilst waiting for treatment</u>?	
	Yes, I needed pain relief and <u>was</u> offered it	8%
	No, I needed pain relief but <u>was not</u> offered any	31%
	I needed pain relief but it was explained that due to medical reasons I could not be given any	6%
	I <u>did not need</u> pain relief	45%
	I don't know / I can't remember	10%

Healthcare Commission: C7e, C13b

Wave 1 comparison:

A similar number of service users (26%) felt that they needed but were not offered pain relief.

Do you have any comments about waiting on this occasion?

Q15 POSITIVE COMMENTS: (7 comments in total)

- *There was a male nurse, which I personally find very difficult but he was absolutely fantastic in his approach. Well done.*
- *They allowed me to wait in a cubicle instead of in the main waiting area*
- *I felt that I had an appropriate waiting time and didn't feel victimised due to my presenting condition.*
- *Some of the staff were nice. An auburn haired nurse was generally very friendly and smiley, which was really reassuring and cheering.*
- *One member of staff was nice*

Q16 NEGATIVE COMMENTS AND/OR SUGGESTIONS FOR IMPROVEMENT:

Waiting time (12 comments in total)

- *A long time, I thought as I had done this to myself, I should have to wait.*
- *It has been reported up to 13 ambulances often have to wait to be processed - they need more staff and resources*
- *I was possibly left a little too long at one point - I was bleeding quite heavily (non- life threatening) and I was left until it slowed enough to stitch. I bled right through the temp dressing and needed to move (I was supposed to lie still) to reach the call button, which set everything off again! I'm not blaming the staff, they were under pressure.*
- *They always seem to make people with self-harm injury wait until the very last person*
- *I decided not to bother waiting*

Lack of update/information (11 comments in total)

- *When in a cubicle I was ignored until the following day, not even offered a drink*
- *I was frightened and felt very alone in the waiting area*
- *They could let you know what's going on. I did wonder if they'd forgotten I was there (I don't think this is because of self-harm, just a general thing). Maybe they are aware you're still there but when no-one says anything to you for several hours it feels like you've been forgotten.*
- *It would have been nice if they had treated me as other people were treated, checking how I was if I was any more distressed or in pain etc*
- *I was left without any kind of observation but I feel that this is the staff's way of showing contempt for your self-harming*
- *I was left in a cubicle in the A&E the whole time I was in hospital. I was being violently sick and yet no one was keeping an eye. I had to repeatedly call out for help. I do not understand why you cannot be treated with dignity and transferred to a ward.*

Lack of privacy/poor environment (6 comments in total)

- *All other patients were staring at me*
- *Small waiting area with limited seating*
- *Too noisy, not private enough. It added to my distress, people kept asking me questions as it was obvious what I had done*

Staff attitudes (5 comments in total)

- *A few of the nurses were just standing around joking and laughing amongst themselves. I overheard one say 'its alright it is only her back again. A pity she didn't do it properly' and they laughed*
- *Doctors took phone calls from the surgeons about me, and I was spoke about in very negative terms*
- *Staff didn't want to be bothered once they found out it was an overdose*

Lack of pain relief (2 comments in total)

- *Had to request pain relief several times before I got any and then it was not appropriate for my level of pain*
- *It's 2 hours later and pain relief still hasn't arrived*

Receiving physical treatment for your self-harm

Q17	Do you feel you were given enough information about:	Yes	No	DK/CR	N/A
	The nature of your injury/condition?	35%	43%	6%	16%
	The different treatment options available to you?	25%	55%	3%	17%
	The likely effect of the treatment (benefits, any side effects etc?)	28%	42%	11%	20%
	Updates on what was happening, waiting times etc?	31%	62%	0%	8%

Self-Harm: 2.1, 3.3. Healthcare Commission: C16

Q18	If you had any specific personal, cultural or religious needs, where they taken into account? For example, it might have been important for you to be seen by a staff member of a specific gender due to religion or a difficult past experience	
	Yes	3%
	No	25%
	N/A	67%
	DK/CR	5%

Self-Harm: 1.5. NICE: 1.1.1.3. Healthcare Commission: C7e, C13a

If yes, please specify below how your needs were met

- *Male staff asked if I was ok with them and got female staff when appropriate*
- *Having a female with me in the room when having sutures done by a male doctor*
- *I found due to the nature of my depression it would be a lot easier speaking to female*

If no, please specify below what could have been improved

- *I asked for my mum to come into the cubicle with me, the psychiatrist said no.*
- *I have difficulty seeing males due to past abuse which triggered the self harm in the first place but not asked if I preferred female or male.*
- *Someone asking if I had any religious needs would have been nice*

Q19	Were you given the choice about whether or not to have each treatment?	
	Yes	16%
	No	44%
	N/A	13%
	DK/CR	27%

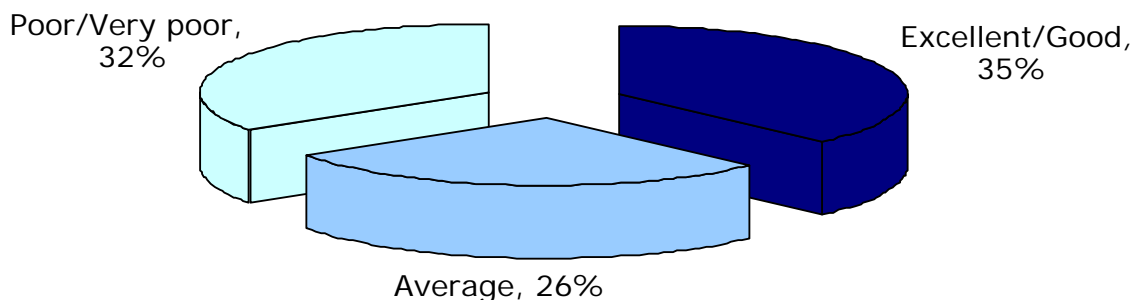
Self-Harm: 3.2. NICE: 1.1.3.4. Healthcare Commission: C13b

Q20	If you needed to have painful treatment (e.g. stitches) or if your injury was painful, were you given enough pain relief, such as pain-relieving tablets or anaesthetic?	
	Yes, I needed pain relief and was offered it	15%
	No, I needed pain relief but was not offered any	19%
	I needed pain relief but it was explained that due to medical reasons I could not be given any	8%
	I did not need pain relief	45%
	I don't know / I can't remember	13%

Self-Harm: 1.4. NICE: 1.1.1.10. Healthcare Commission: C7e, C13a.

Q21	Overall, how do you rate the quality of physical treatment that you received?	
	Excellent	9%
	Good	26%
	Average	26%
	Poor	13%
	Very Poor	19%
	I don't know / I can't remember	9%

Figure 1: Percentage of service users who rated physical treatment as 'Excellent/Good', 'Average', or 'Poor/Very Poor'



Do you have any comments about your physical treatment on this occasion?

Q22 POSITIVE COMMENTS (5 comments in total)

- *The nurse giving the stitches was very kind. Although he didn't understand, he was not disapproving and tried to talk to me about the good things in life*
- *I was seen promptly*
- *On the whole they are good at the physical side*
- *The actual doctor and nurse who treated my wounds were supportive and caring in their approach*
- *The doctor who treated me did so with respect*

Q23 NEGATIVE COMMENTS AND/OR SUGGESTIONS FOR IMPROVEMENT:

Staff attitudes/behaviour (14 comments in total)

- *The surgeon was very rude - two were actually. I ended up walking out at one point and may have done again if the psychiatric liaison nurse hadn't advocated*
- *They said 'we are here to save lives not for people who try to take their life'*
- *It was made very clear by the nurse that I was wasting their time and there were other people who really needed hospital treatment*
- *They made me feel as if 'you did this to yourself so we will not be in a hurry to look after you'. They should be trained in how to talk to you*

Lack of privacy (7 comments in total)

- *Didn't like doctors discussing what I did in front of other patients*
- *Was made to stay on a trolley in corridor. Refused my medication.*
- *Had to drink charcoal in the middle of the emergency department and was embarrassed because everyone could see me. I wasn't offered a cubicle or room*
- *No privacy talking about problems - just behind a curtain*

Dissatisfied with physical care (7 comments in total)

- *I was told by the time the pain relief started to work I could have the stitches in over and done with*
- *The doctor told me I'd be better off dead - He refused to treat me and gave me a lecture instead*
- *The staff were not caring about my feelings nor were they gentle when stitching my wounds and the wounds were not frozen before stitching*
- *I had 4 open wounds stitched with no local anaesthetic*

Lack of information/contact with staff (5 comments in total)

- *I wasn't given anything to eat or drink. No updates on how long anything would take*
- *Some information about what it was that I was given would have been good - I was just given a handful of pills - no-one said anything about what this was. They didn't tell me anything about the x ray results, they just said to go home, which is fine, but it would be helpful if people tell you the outcome, just to put your mind at ease.*
- *Just left in cubicle for 2 hours then woke to sit in corridor drowsy, feeling sick while lots of beds were available*
- *Not enough information on waiting times etc. No special person to speak to i.e. someone from similar background or psych staff.*

Speaking to a Mental Health Professional

Q24	Were you seen by a mental health professional while you were in hospital?	
	Yes	67%
	No	30%
	DK/CR	3%

Wave 1 comparison:

Of the 206 wave 1 service user respondents, a higher number (81%) saw a mental health professional

Q25	Were you given the opportunity to talk about your self-harm and what led to it?	
	Yes	58%
	No	38%
	DK/CR	4%

Self-Harm: 6.2. NICE: 1.1.1.4. Healthcare Commission: C17.

Q26	Were you involved in thinking through what care you might need after leaving hospital?	
	Yes	41%
	No	49%
	N/A	1%
	DK/CR	9%

Self-Harm: 3.1, 19.1 & 19.2. NICE: 1.1.1.6. Healthcare Commission: C17

Q27	Did you feel that you were offered the appropriate aftercare?	
	Yes	47%
	No	53%

Self-Harm: Standards 20, 22 & 23. NICE: 1.11.1.4 & 1.11.1.5. Healthcare Commission: C18 & C19

If no, please say how this could have been improved

Provide better follow up (16 comments in total)

- *I didn't feel able to talk to the mental health team at the time they came to see me, so that was end of help*
- *Aftercare wasn't mentioned. No support offered or repeat medication given. Told to go to my GP. Nobody cared.*
- *All I am offered is more pills. It is clear that pills just numb my emotions and feelings that lead me to more self harm, just to FEEL.*
- *To be directed to good services which actually offer concrete practical help, referred to counselling etc*
- *Admission to hospital or given a choice to see own psychiatrist or someone who understands self-harm*
- *Would have liked follow up in community or support group information*
- *I thought I was [offered aftercare] but the follow up phone call was never made*

Provide help getting home or an overnight stay (5 comments in total)

- *After treatment I was discharged with not even transport to get home (34 miles)*
- *Just sent home in bare feet, no purse, money, house keys, nothing*
- *You need to see someone straight away and not be left to your own devices. If you are still feeling low, which I was, then there's the probability that you will self-harm again straight away*

More information and support before leaving the ED (6 comments in total)

- *A leaflet*
- *I did not know there was aftercare - information would have been good*
- *Information on dealing with suicidal thinking*
- *I needed someone to take me seriously, listen to me and put me in contact with services/person who would really help me with my problems*

Other comments

- *There should be a centre where you can go before you get to the stage of hurting yourself*
- *I didn't want any aftercare from the hospital, I was going to contact my CPN the next day*

Positive comments

- *I badly didn't want to go into the local mental hospital so instead of sectioning me, they let me stay another night with 24 hour watch before releasing me to the local CMHT. Then it was decided that my husband would take time off to look after me.*

Q28	Would you have liked more information on any of the following? (tick as many as apply)	
	Information about local self help groups	65%
	Information about advocacy services	35%
	Information about who to contact in an emergency	69%
	Details of telephone helplines	41%
	Leaflets about self-harm	67%
	Other (please specify) <ul style="list-style-type: none"> • How to access a crisis team if you need to • How to access more help 	14%

Self-Harm: 2.7. Healthcare Commission: C14 & C16

Q29	Do you feel that your views were taken into account when mental health professionals were considering whether you were at risk of self-harming again?	
	Yes	42%
	No	44%
	DK/CR	14%

Self-Harm: 3.1. NICE: 1.1.1.6. Healthcare Commission: C17

Q30	Were you informed about who else would be told about this experience of self-harm and visit to A & E? (e.g. GP, mental health team)	
	Yes	35%
	No	55%
	DK/CR	10%

Self-Harm: 4.4. Healthcare Commission: C9, C13c and C16

Q31	Were you given a copy of the plan for your care after you leave hospital?	
	Yes	9%
	No	87%
	DK/CR	4%

Do you have any comments about your assessment on this occasion?

Q32 POSITIVE COMMENTS:

The opportunity to speak openly to supportive staff (7 comments in total)

- *The mental health team in the hospital very much wanted the best for me*
- *The crisis team listened to me and took my needs into account*
- *Mental health female nurse was very kind, not too medical an assessment as before when a doctor did it, she did it slowly not rushed. Doctors, especially medical doctors, should watch the mental health nurses*
- *I felt safe with this nurse; I felt they understood me and did not think I was "attention seeking". I could talk about family problems without telling my family*

Clear information (3 comments)

- *She wrote it all down for me - I was given fantastic amount of information and numerous leaflets*

Q33 NEGATIVE COMMENTS AND/OR SUGGESTIONS FOR IMPROVEMENT:

A more supportive and collaborative discussion (11 comments in total)

- *They tend to ignore 50% of what I'm saying*
- *The psychiatrist was just a pig and didn't hear a word that I said - he was more into putting me down and making me feel worse about myself*
- *I had tried to kill myself and my feelings weren't considered*
- *I felt that my mental health was falling apart and nobody asked me did I want to speak to a mental health professional. They need to take time and listen to people.*

- *My assessment gave me no new lines of help, it was just the same as the other times, not really helpful - no new information to help cope with problems*

Clear information and advice about aftercare (10 comments in total)

- *Not told anything, or if unwell when got home what to do or who to phone.*
- *No immediate aftercare or care plan - had to return the following day*
- *No information, counselling, referral or contact with mental health*
- *Mental health doctor did not know what to do, wasn't prepared to make a decision*
- *Follow up information and contacts, professional follow-ups are needed*

Poor communication (3 comments in total)

- *They did not know I had a crisis/care plan at A&E already - asked me if I had done it before when my notes would have said loads of times. Did not know of the services I am using - said they did not come from the area. Did not make follow up phone call to the day centre I use although we agreed to it.*
- *Communication between professionals (and hospitals) is very poor*

Lack of privacy (2 comments in total)

- *Horrible experience sitting in the middle of the emergency department with no privacy being sick. I felt they took away my dignity.*

Confidentiality issues (1 comment in total)

- *I found out weeks later that the GP knew and I was annoyed as I did not want him to know*

Attitudes and behaviour of staff

How would you rate the attitude and behaviour of the following staff towards you? (Think about how respectful and supportive they were towards you)

Q34	Excellent	Good	Average	Poor	Very Poor	N/A	D/K or CR
Ambulance staff	20%	29%	15%	3%	6%	18%	9%
Reception/admin staff in A & E	10%	16%	29%	19%	6%	9%	10%
Triage nurse	15%	16%	33%	13%	1%	7%	13%
The people who gave you physical treatment	15%	30%	20%	23%	8%	3%	2%
The person who gave you a detailed psychosocial assessment	19%	23%	19%	4%	16%	13%	6%
Other (please state who) and add any comments	15%	15%	15%	0%	31%	15%	8%

Self-Harm: 1.3. NICE: 1.1.1.1. Healthcare Commission: C7e & C13a

Staff Ratings – Key



Figure 2: Ambulance Staff Ratings:

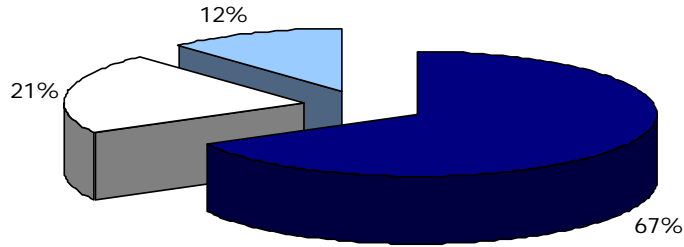


Figure 3: Reception Staff Ratings:

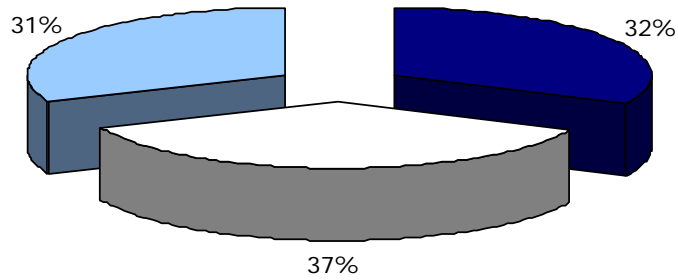
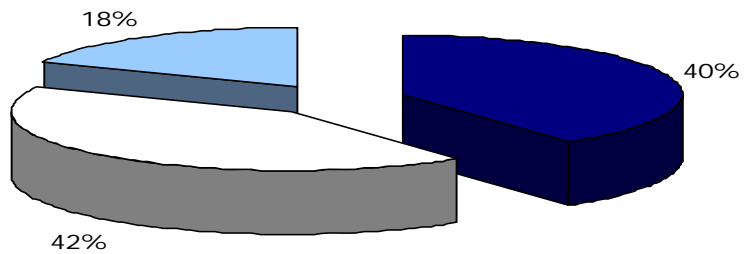


Figure 4: Triage Staff Ratings:



Staff Ratings – Key



Figure 5: Physical Treatment Staff Ratings:

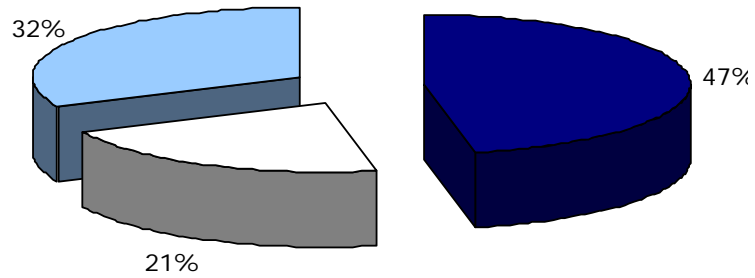
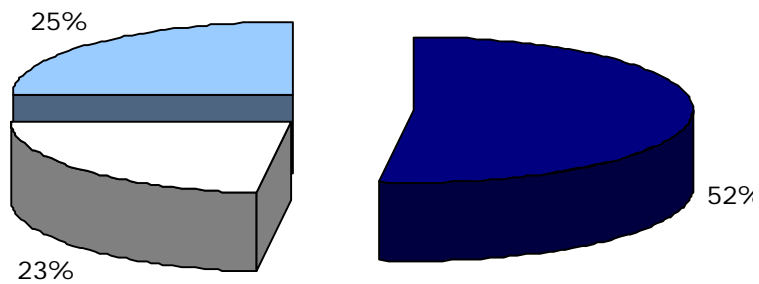


Figure 6: Psychosocial Assessment Staff Ratings:



Do you have any comments about your experience with staff on this occasion? Please be clear about which staff group you are referring to.

Q35. POSITIVE COMMENTS

Staff attitudes (19 comments in total)

- *Just that all of them were fantastic, despite what I'd feared and dealt with my feelings of mortification very well*
- *I felt it was a very positive experience (as much as it could be). I was treated with respect and felt I could trust the staff on duty*
- *One doctor and one male student nurse were willing to sit and talk with me.*
- *Relief at talking to someone from mental health*
- *I was well informed and also felt that I was being listened to*
- *Nurse apologised for not enough support and felt frustrated for me*
- *The police was called at the same time as the ambulance. The police who attended were excellent, willing to listen and gave empathy to the emotional pain I was going through.*
- *The triage nurse saw I was crying and put me further up the triage queue and let me wait in a cubicle*
- *The triage nurse was very kind and supportive I did not feel judged or humiliated by staff, they asked pertinent questions and exhibited excellent communications skills*

Q36. NEGATIVE COMMENTS AND/OR SUGGESTIONS FOR IMPROVEMENT

Staff attitudes (24 comments in total)

- *After being left bleeding in a side room for hours one nurse said to an ambulance driver "it's been f***ng OD city in here tonight"*
- *Perhaps ALL people who may be involved with someone who's experiencing emotional pain, needs to have at the very least training. This is to make them aware that self harming is not someone who is seeking attention, or who needs more pain, but someone who is experiencing severe emotional pain. This internal pain is much worse than having a stone in the kidneys and cracked ribs together..... I know, I have had those two things. The stone in the kidneys meant I couldn't move at all because of the pain. But after going into hospital and being treated with respect from the staff, after the stone was removed I recovered and the pain was gone. With emotional pain it is there day and night, sometimes it's less intense than at other times, but never the less, the pain is always there.*
- *I would rather bleed than feel the way the hospital staff made me feel. Staff need to learn that I did not want to hurt myself in the first place.*
- *It made me feel I should not have come here. A&E staff need to know how they make people feel – they need training in mental health issues.*
- *Mental health nurses should be in A&E doing all the overdoses and asking all the questions even the medical questions*
- *We are sick, have an illness, and would like this to be recognised - treated like a person*
- *People who have self-harmed could help in training of these staff, so they know how to treat us. Nominated trainers or peer advocate person to deal with all self-harmers to see how they need help and be able to do referral to self-help organisations or services. Better trained staff in caring attitudes, also be kind when treating the wounds.*

Lack of contact/information (9 comments in total)

- *To have advice given on myself or aftercare*
- *More information on waiting times*
- *Just a bit more information about what is happening - don't assume that patients know what's going on and don't under estimate the anxiety and confusion that can be caused by not updating patients on anything*
- *Ignoring patients really stresses them out!*
- *Could have done more checking on me, more information about other types of help - there should be a trained person who delivers information on self-harm to self harmer.*

Others

- *Poor staffing levels. However, the staff work well under pressure*
- *Mental [health] nurses [should be] in A&E all the time*

Environment and Facilities in the Emergency Department

Q37	Overall how would you rate the rooms/areas that you waited in or were treated in? (Think about comfort, safety, calmness and privacy)	
	Excellent	13%
	Good	21%
	Average	30%
	Poor	10%
	Very Poor	21%
	I don't know / I can't remember	4%

Self-Harm: 5.1, 5.2 & 5.6. NICE: 1.4.2.3, Healthcare Commission: C20

Q38 Do you have any comments on the rooms/areas you waited in, or suggestions for improvement? Please be specific about which room or area you are referring to.

Privacy and calmness (26 comments in total)

- *Casualty waiting rooms very poor - no privacy and doctors openly talk about each patient which can be clearly heard to all people*
- *The hospital A&E cubicle was just sectioned off by a curtain. Was hard to talk, knowing other people could hear*
- *Reception nurse asked me what's wrong in front of all the reception area.*
- *Main waiting area, everyone can see your wounds and stare at you. In the cubicle the nurses were telling me off and everyone could hear them*
- *Very stressful and noisy - in my mental state it was very threatening having to sit in the main [waiting] area*
- *I would have liked somewhere more private where I could have talked*

Comfort and cleanliness (11 comments in total)

- *It was too warm*
- *A separate space which is quiet, calm and safe would be better than a crowded, noisy waiting room*
- *There weren't enough seats available for anyone*
- *I wasn't allowed to sleep through the night - left to sit on chair all night very drowsy, cold, shakes while lots of beds available*
- *It's not staff's fault - it was a lack of facilities*
- *Cubicle was filthy with blood splatterings on the floor, an overflowing clinical waste bin, a raggy curtain, used syringes on a tray and altogether disgusting*
- *The room where I saw the doctor had a terrible smell*
- *There is no reasonable space for waiting in A&E*
- *Physical environment's dirty*

Other (6 comments in total)

- *Poor staffing levels*
- *I realise the glass barrier is a safety feature but it does also create a physical barrier between service users and receptionists*

Q39	Was this your first experience of using emergency services following self-harm?	
	Yes	31%
	No	69%

Q40	Have you ever had contact with mental health services prior to this visit?	
	Yes	79%
	No	21%
	DK/CR	0%

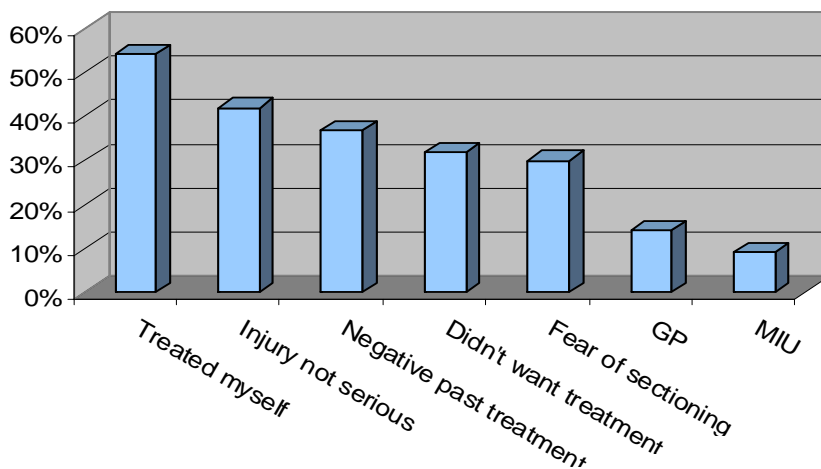
Do you have any additional comments that you would like to make about the service you received, or any suggestions for improvement? If you have been to this Emergency Department (A&E) more than once in the past 18 months you may wish to comment on previous visits.

- *Some visits to A&E are far more positive than others. It often depends on which staff are working and their attitudes, understanding and response towards self-harm.*
- *I have been in A&E about 5 times in the last 18 months. Even one of the nurses said "oh no not you again". No one cares about the tears and stress and fear, especially when threatened with sectioning. On one occasion after a massive OD I waited 2 days for treatment. More and more training should be given about mental health.*
- *I have been told "I have better things to do than stitch you up". I am always insulted. "There are sick people here". I'm a quiet patient. Always leave before the psychiatrist comes so I don't get assessed.*
- *Staff understand reasons behind self-harm. Weekend services are unavailable but no care after Friday night at 5 pm offered. No weekly night time help - have no helpline numbers or community nurses for evenings*
- *Staff should be trained in dealing with people who self-harm. On another occasion at this hospital the comment was made "you shouldn't have taken tablets. At times I*

wish nurses would experience the mental distress that people who self-harm experience, then they might be more empathetic. They don't realise that you have tried to get help and left with the feeling that if people who are mental professionals don't think your life is precious then why should you.

Q41 If you have self-harmed in the past but NOT used emergency services, why was this? Tick as many as appropriate	
The injury wasn't serious enough	42%
I treated myself	54%
I didn't want the injury or illness to be treated	32%
I went to my GP	14%
I went to a minor injuries unit	9%
I've had a negative experience of services before	37%
I was worried I might be sectioned	30%
Other <ul style="list-style-type: none"> • Guilt for taking a bed that could be used for someone who really needed it • I was frightened that social services would become involved as I have a little girl • I will never use voluntary A&E again in my life • Already an inpatient 	12%

Figure 7: Breakdown of reasons why people have chosen not to use emergency services following self-harm:



Wave 1 comparison:

Of the 206 wave 1 service user respondents, a very similar number (30%) avoided emergency services because of previous negative experiences or because they were afraid of being 'sectioned'.

Staff Training, Support and Supervision

The following questionnaire was available online from September to the end of December 2006. **A total of 251 staff** completed the questionnaire, the results are summarised below, along with all of the comments made.

Which hospital do you work for/with?	
Kingston Hospital, Surrey, England	11%
Leeds General Infirmary, Leeds, England	16%
Mater Hospital, Belfast, N.Ireland	22%
Royal Albert Edward Infirmary, Wigan, England	1%
Royal Cornwall Hospital, Truro, England	9%
Royal Victoria Hospital, Belfast, N.Ireland	17%
South Tyneside District Hospital, Tyne and Wear, England	25%

Which service/department do you work for?	
Ambulance Service	7%
Emergency Department	46%
Mental Health Service	44%
Other	4%

Table 1: Percentage of staff who rated their training as insufficient, separated into the 3 main staff groups.

N.B: Where over 2/3 of staff rated training as insufficient, this is highlighted in **bold**

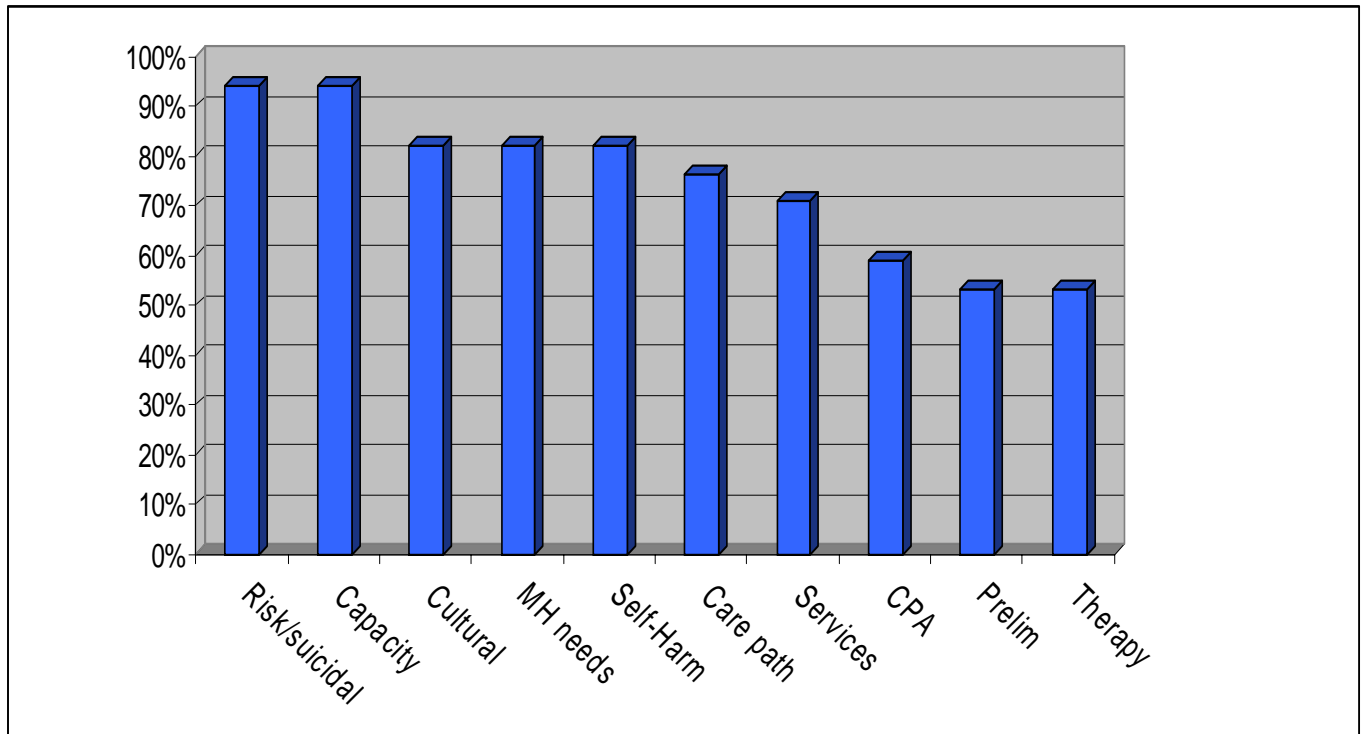
Percentage of staff who rated their training as insufficient in:	AMB	ED	MH
A basic awareness of mental health	47%	27%	5%
A basic awareness of risk	47%	30%	9%
How to assess mental health needs	82%	56%	10%
How to assess risk, hopelessness and suicidal intent	94%	55%	18%
How to assess mental capacity	94%	58%	28%
Understanding why people self harm	82%	46%	29%
The impact of cultural differences on self-harm	82%	79%	66%
The basis of the Care Programme Approach (CPA)	59%	88%	31%
Understanding the role of local services	71%	63%	23%
Basic understanding of the Mental Health Act and relevant common law	29%	51%	10%
How to conduct <u>preliminary</u> assessments	53%	44%	15%
How to conduct <u>specialist</u> psychosocial assessments	41%	72%	42%
How to refer/discharge a patient appropriately	41%	39%	9%
How to assess the <u>social needs</u> of the person	47%	48%	25%
Understanding the care pathway	76%	69%	25%
Using psychological therapy with people who self-harm	53%	74%	56%

Self-Harm: 25.1, 25.2, 26.1 – 26.7, 27.1, 27.3 & 27.4. NICE: 1.1.2.1. Healthcare Commission: C11

Ambulance Staff

AMBULANCE: Which of these job titles best describes your role?	
Paramedic	53%
Ambulance Technician	41%
Area Services Manager	0%
Care Assistant	0%
Emergency Care Practitioner	0%
Operations Manager	6%
Other	0%

Figure 8: Top 10 training needs for ambulance staff:



- | |
|---|
| 1. How to assess risk, hopelessness and suicidal intent |
| 2. How to assess mental capacity |
| 3. The impact of cultural differences on self-harm |
| 4. How to assess mental health needs |
| 5. Understanding why people self harm |
| 6. Understanding the care pathway |
| 7. Understanding the role of local services |
| 8. The basis of the Care Programme Approach (CPA) |
| 9. How to conduct preliminary assessments |
| 10. Using psychological therapy with people who self-harm |

Ambulance Staff

Would you have liked to have received more education on mental health and/or self-harm during any of the following? Please select as many as applicable	
Your initial basic training	76%
Your induction with the Trust	12%
Any refresher training you have received	76%

What other training or education (if any) would you like?

- *I would like to spend a couple of days shadowing a mental health professional and see their treatment first hand*
- *There is minimum training for ambulance staff in mental health - maybe time could be spent on an acute mental health ward*
- *Awareness of local services, their admission criteria and working times*
- *More understanding of mental health issues and how to spot them*
- *A more effective way of reporting concerns and getting assistance in emergency situations*
- *What support is available when a patient refuses to travel to hospital*
- *How to manage a patient who has self-harmed*

If you would like more training or education in mental health and/or self-harm, how would you like this to be delivered? Please select as many as applicable	
Learning from service users	35%
In-house lectures/seminars	35%
Group workshops/case studies	24%
Interactive, web-based learning exercises	24%
Multi-agency training	35%
Shadowing mental health colleagues	47%
External courses run by professional bodies	29%
Higher education/university modules	12%
Study days	24%
Regular updates/feedback on performance	29%
Other <ul style="list-style-type: none"> • Protocol based referrals for patients not wishing to be transported to hospital • All of the above is used for 'medical' training of paramedics-why not for mental health? 	12%

Ambulance Staff

Please rate the support and supervision you have received relating to caring for people who self-harm.	Sufficient	Insufficient	N/A
Clinical supervision: to discuss the emotional impact of working with self-harm	18%	71%	12%
Reflective supervision - to get feedback on how a specific situation was managed	12%	82%	6%
De-briefing opportunities: allowing staff to de-brief promptly following a <u>specific incident</u> that has been traumatic for you	18%	76%	6%
General support from colleagues	59%	35%	6%

Self-Harm: 29.1 & 29.2. NICE: 1.1.1.2. Healthcare Commission: C5b

What other support or supervision (if any) do you need to help you work the most effectively with people who have self-harmed?

- *Better awareness of the follow through process of patient care from 999 call to psychiatric admission*
- *The process that will happen at hospital, in order to be able to explain to them before arriving at hospital*
- *Next to none or no interest in how staff or particularly new staff cope. This is the perception that senior management has for those 'at the sharp end'*
- *Even to have the introduction of a self help team, comprised of grass roots members of staff*

Any other comments?

- *Better access/awareness of procedures/other health carers in relation to the care of such patients*
- *As said there is NO training for paramedics in mental health (there is 1 hour spent on our basic training but that is almost exclusively used for discussion of the MHA and 'sectioning' patients.) There are many paramedics within the service who still truly believe that scizophrenia is an illness where the patient is suffering from multiple personalities! As a group paramedics like to be fully knowledgeable about subjects-especially when they have such an impact upon our work*
- *We would like to learn but the emphasis is on immediate medical care and a new change of direction is required*
- *Perception is that management only act out a concern for staff - rarely does anything get done*

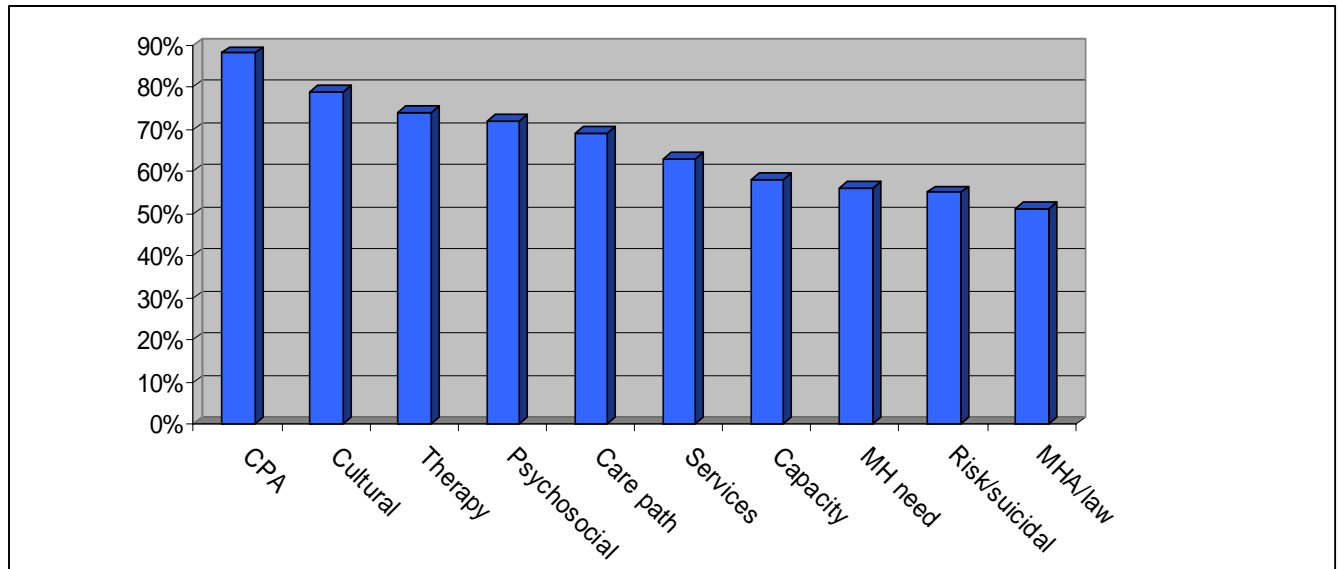
Wave 1 comparison:

The 136 wave 1 ambulance staff strongly echoed the views described above, with many rating training, support and supervision as inadequate.

Emergency Department Staff

EMERGENCY DEPARTMENT: Which of these job titles best describes your role?	
Qualified Nursing Staff	57%
Unqualified Nursing Staff	3%
Consultant/Associate Specialist	10%
SpR/SHO/F2/Staff Grade	26%
Receptionist/Admin/Clerical	2%
Domestic/Security/Porter	0%
Other	2%

Figure 9: Top 10 training needs for ED staff:



1. The basis of the Care Programme Approach (CPA)
2. The impact of cultural differences on self-harm
3. Using psychological therapy with people who self-harm
4. How to conduct specialist psychosocial assessments
5. Understanding the care pathway
6. Understanding the role of local services
7. How to assess mental capacity
8. How to assess mental health needs
9. How to assess risk, hopelessness and suicidal intent
10. Basic understanding of the Mental Health Act and relevant common law

Wave 1 comparison:

The 455 ED staff surveyed in wave 1 gave similar responses, with CPA, cultural differences, assessing capacity and conducting psychosocial assessments the most commonly requested areas in need of further training.

Emergency Department Staff

Would you have liked to have received more education on mental health and/or self-harm during any of the following? Please select as many as applicable	
Your initial basic training	61%
Your induction with the Trust	53%
Any refresher training you have received	56%

What other training or education (if any) would you like?

Better mental health awareness and self-harm (12 comments in total)

- *General overview of the types of mental health problems in patients who present at A&E and how best to work with them*
- *Understanding why people self-harm*
- *Secondments or rotation for psychiatric nursing*

Availability and accessibility of other services (11 comments in total)

- *Services available in the hospital and community environment especially out of hours and how to contact them*
- *Training on services as they change/develop*
- *Information about local referral criteria*
- *Specialist input from community teams with regard to follow-up outside of hospital*

Policy and clinical guideline updates (5 comments in total)

- *Mandatory annual updates on mental health issues, developments, key documents, clinical evidence and recommendations*
- *Knowledge of any proformas or protocols the trust uses for repeat deliberate self harm attenders*

If you would like more training or education in mental health and/or self-harm, how would you like this to be delivered? Please select as many as applicable	
Learning from service users	33%
In-house lectures/seminars	58%
Group workshops/case studies	32%
Interactive, web-based learning exercises	23%
Multi-agency training	32%
Shadowing mental health colleagues	24%
External courses run by professional bodies	28%
Higher education/university modules	18%
Study days	51%
Regular updates/feedback on performance	35%

Emergency Department Staff

Please rate the support and supervision you have received relating to caring for people who self-harm.	Sufficient	Insufficient	N/A
Clinical supervision: to discuss the emotional impact of working with self-harm	32%	61%	7%
Reflective supervision - to get feedback on how a specific situation was managed	23%	73%	3%
De-briefing opportunities: allowing staff to de-brief promptly following a <u>specific incident</u> that has been traumatic for you	24%	69%	7%
General support from colleagues	72%	25%	3%

Self-Harm: 29.1 & 29.2. NICE: 1.1.1.2. Healthcare Commission: C5b

What other support or supervision (if any) do you need to help you work the most effectively with people who have self-harmed?

Better access to mental health services (11 comments in total)

- *Working in the frontline of a busy emergency department we require the help and close support of our colleagues in the psychiatric services*
- *On site Consultant led team approach for in hour presentations and interaction with referring A&E Doctors and Nurses*
- *Better input from Mental Health services: faster assessment and faster bed management when patients need admission*

Improved support, supervision and de-briefing (7 comments in total)

- *I wouldn't feel comfortable approaching a busy senior in the middle of a shift to have a chat about how a certain case has just left me feeling personally. Also, feedback regarding situations is again usually practically based and is more regarding management choices made, not personal reflection.*
- *We need to be debriefed on cases to be able to know the best way to be dealing with the patient for the best outcome*
- *There is no provision for clinical supervision relating to self-harm*
- *Feedback from the person referred to - Was my referral sufficient? Could I have done something differently?*

Increased knowledge and confidence in working with people who self-harm (6 comments in total)

- *Communication with self harmers during their time in the ED*
- *A better understanding of mental health issues and self-harm*
- *It would be useful to understand why that person is a self harmer as they often present frequently yet in A&E we are not made aware of the reasons why this person self harms their triggers or causative factors*

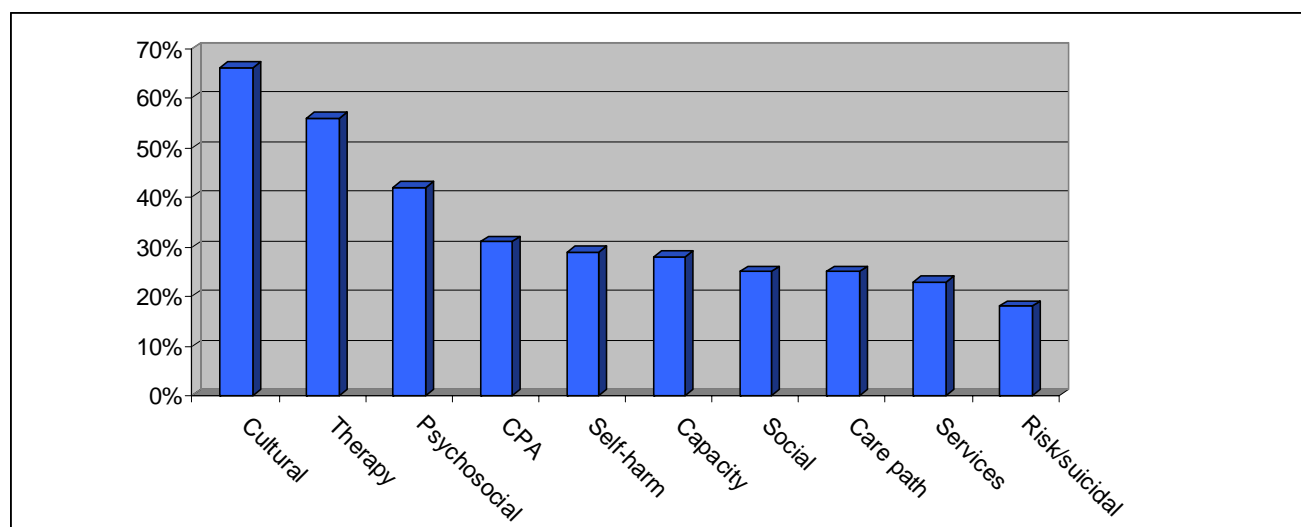
Wave 1 comparison:

The 455 wave 1 ED strongly echoed the views described above, with 65% rating supervision as inadequate.

Mental Health Staff

MENTAL HEALTH: Which of these job titles best describes your role?	
Qualified Mental Health Nurse	49%
Unqualified Mental Health Nurse	14%
Consultant Psychiatrist/Staff Grade/Associate Specialist	8%
Training Grade Doctor (SpR/SHO/ST)	10%
Admin/Reception/Clerical/Secretary	3%
Therapist/Psychologist/Psychotherapist	5%
Social Worker	1%
Others	11%
Patient Advice and Liaison Worker x 4 Student nurse x 3 Discharge Planning Worker x 1 Modern Matron x 1 Practice Development Lead x 1 Medical Student x 1	

Figure 10: Top 10 training needs for Mental Health staff:



1. The impact of cultural differences on self-harm
2. Using psychological therapy with people who self-harm
3. How to conduct specialist psychosocial assessments
4. The basis of the Care Programme Approach (CPA)
5. Understanding why people self-harm
6. How to assess mental capacity
7. How to assess social needs
8. Understanding the care pathway
9. Understanding the role of local services
10. How to assess risk, hopelessness and suicidal intent

Mental Health Staff

Would you have liked to have received more education on mental health and/or self-harm during any of the following? Please select as many as applicable	
Your initial basic training	55%
Your induction with the Trust	44%
Any refresher training you have received	45%

What other training or education (if any) would you like?

Increased knowledge and confidence in working with people who self-harm (9 comments in total)

- *Management of people who self harm on a ward environment, especially regarding other patients*
- *Preventative measures related to self harm and harm minimisation*

Talking therapies for this client group (9 comments in total)

- *Psychodynamic*
- *Dialectical behavioural therapy (DBT) and brief intervention therapy*
- *Cognitive behavioural therapy(CBT), and Mentalisation based therapy (MBT)*

Others

- *Personality disorders*
- *Support services*
- *Training in training others*
- *More nurse training education rather than at trust level*
- *Specialist age groups (old age and child and adolescent)*
- *Education on the views of users and carers*
- *Impact of self harm on family relationships*

If you would like more training or education in mental health and/or self-harm, how would you like this to be delivered? Please select as many as applicable	
Learning from service users	45%
In-house lectures/seminars	51%
Group workshops/case studies	42%
Interactive, web-based learning exercises	26%
Multi-agency training	35%
Shadowing mental health colleagues	31%
External courses run by professional bodies	39%
Higher education/university modules	27%
Study days	44%
Regular updates/feedback on performance	41%

Mental Health Staff

Please rate the support and supervision you have received relating to caring for people who self-harm.	Sufficient	Insufficient	N/A
Clinical supervision: to discuss the emotional impact of working with self-harm	51%	45%	5%
Reflective supervision - to get feedback on how a specific situation was managed	55%	40%	5%
De-briefing opportunities: allowing staff to de-brief promptly following a <u>specific incident</u> that has been traumatic for you	53%	40%	7%
General support from colleagues	91%	6%	3%

Self-Harm: 29.1 & 29.2. NICE: 1.1.1.2. Healthcare Commission: C5b

What other support or supervision (if any) do you need to help you work the most effectively with people who have self-harmed?

Improved supervision and de-briefing (13 comments in total)

- *We rely on ventilating and de-briefing with fellow work colleagues and sometimes this is not enough. It leads to stress within the staff group and poor morale at times.*
- *Specialist supervision for complex cases*
- *External supervision would be useful*
- *Emotional support when dealing with distress over a prolonged period*

Increased knowledge and confidence in working with people who self-harm (9 comments in total)

- *Reasons behind self-harm and how to respond to it*
- *Reducing stigma*
- *Need education and practical experience before requiring supervision*

More multi-disciplinary working and decision making (3 comments in total)

- *Working alongside other qualified members of staff, bouncing ideas from each other, to ensure that positive risk taking is relevant to the person following assessment, particularly during the night at A&E*

Other (6 comments in total)

- *Crisis service or self harm service*
- *Talking with colleagues of similar experience is probably the best way to gain support and supervision*
- *A service user led training session would be a great learning experience*

Mental Health Staff

Any other comments?

- Talking with colleagues of similar experience is probably the best way to gain support and supervision
- External or group supervision would be useful
- I remain concerned that in seeking views of carers we end up taking away society's responsibility to support those who find it so difficult to cope with life's challenges that they turn to self harm to relieve tension, hurt, anger etc..
- A service user led training session would be a great learning experience.

Wave 1 comparison:

The 329 mental health staff surveyed for wave 1 cited exactly the same training needs as the wave 2 staff.

Two-thirds were satisfied with their clinical supervision, compared to only 51% of wave 2 teams.

Other Staff

Q5	Other: Which of these job titles best describes your role?	
	Advocate	0%
	CDU staff	0%
	General Practitioner	0%
	MAU staff	33%
	Pharmacist	11%
	Social Worker	0%
	Toxicologist	0%
	Voluntary Organisation worker	11%
	Other Medical student x 3 Service manager x 1	44%

Training/Education/Awareness Please rate the education/training you have received in the following areas relating to self-harm.	Insufficient
A basic awareness of mental health	0%
A basic awareness of risk	11%
How to assess mental health needs	44%
How to assess risk, hopelessness and suicidal intent	33%
How to assess mental capacity	33%
Understanding why people self harm	11%
The impact of cultural differences on self-harm	56%
The basis of the Care Programme Approach (CPA)	56%
Understanding the role of local services	11%
Basic understanding of the Mental Health Act and relevant common law	22%
How to conduct <u>preliminary</u> assessments	33%
How to conduct <u>specialist</u> psychosocial assessments	33%
How to refer/discharge a patient appropriately	0%
How to assess the <u>social needs</u> of the person	11%
Understanding the care pathway	33%
Using psychological therapy with people who self-harm	44%

Self-Harm: 25.1, 25.2, 26.1 – 26.7, 27.1, 27.3 & 27.4. NICE: 1.1.2.1. Healthcare Commission: C11

Would you have liked to have received more education on mental health and/or self-harm during any of the following? Please select as many as applicable	
Your initial basic training	44%
Your induction with the Trust	11%
Any refresher training you have received	56%

If you would like more training or education in mental health and/or self-harm, how would you like this to be delivered?	
Please select as many as applicable	
Learning from service users	22%
In-house lectures/seminars	44%
Group workshops/case studies	22%
Interactive, web-based learning exercises	11%
Multi-agency training	22%
Shadowing mental health colleagues	33%
External courses run by professional bodies	11%
Higher education/university modules	0%
Study days	56%
Regular updates/feedback on performance	33%

Please rate the support and supervision you have received relating to caring for people who self-harm.	Sufficient	Insufficient	N/A
Clinical supervision: to discuss the emotional impact of working with self-harm	56%	44%	0%
Reflective supervision - to get feedback on how a specific situation was managed	44%	44%	11%
De-briefing opportunities: allowing staff to de-brief promptly following a <u>specific incident</u> that has been traumatic for you	44%	44%	11%
General support from colleagues	67%	22%	11%

Self-Harm: 29.1 & 29.2. NICE: 1.1.1.2. Healthcare Commission: C5b

What other support or supervision (if any) do you need to help you work the most effectively with people who have self-harmed?

- *It is very important that staff working with self harm have the opportunity to reflect and process and space to do this. It is natural to feel disgust, shock, horror etc at times working with self harm. If staff do not have the space to process these natural human feelings, there is a danger that they will get projected onto the people they work with.*

Staff Attitudes and Opinions

The following questionnaire was available online from September 2006 to the end of December 2006.

A total of 222 staff completed the questionnaire; the results are summarised below:

Q2	Which service/department do you work for?	
	Ambulance Service	6%
	Emergency Department	47%
	Mental Health Service	43%
	Other	4%

How would you rate the quality of the care that self-harm patients generally receive in your department, compared to other patients with NON self-harm injuries?	Better	Same	Worse	Don't Know N/A
Quality of physical care	6%	73%	13%	8%
Respect and support received from staff	5%	52%	36%	7%

Self-Harm: 1.2. NICE: 1.1.1.1. Healthcare Commission: C7e & C13a NICE: 1.1.1.2.

Wave 1 comparison:

When 960 wave 1 staff were asked about the quality of physical care, 21% rated it as worse, compared to 13% in wave 2.

When asked about respect and support, 41% of wave 1 teams rated it as worse, which is a similar to the wave 2 responses.

How would you rate the following?	Good	Average	Poor	Don't Know
Communication between ambulance and ED staff	36%	33%	4%	27%
Communication between ED and mental health	28%	41%	17%	13%
Communication between ambulance and mental health staff	6%	23%	30%	41%

Wave 1 comparison:

Wave 1 staff rated communication between ED and mental health staff much better than those in wave 2 (69% of wave 1 teams felt that communication was good, compared to just 28% in wave 2).

Any comments on how communication, handovers and information sharing could be improved?

The Ambulance Staff Perspective

Ambulance notes should be better incorporated (4 comments in total)

- *Difficulties are encountered regarding trying to explain certain environmental factors/indicators we experience or observe 'at the scene'*
- *A general lack of interest from A&E staff (occasionally) regarding history of patient outside of basic observation*
- *Most ED (and ambulance) staff are only interested in patients physical condition. There is NEVER any communication between ambulance staff and mental health staff*
- *More notice should be taken of ambulance staff's concerns and of what they have seen and heard at the pick up address. Sometimes the patient is acting more normally when we arrive at the hospital than at the pick up address, sometimes it has been said to me 'are you sure as she seems ok now'.*

Other comments (3 in total)

- *Improved knowledge of mental health guidelines and treatment procedures in Leeds*
- *Often on handing over a mental health patient to the receiving hospital I get the impression that nurses in the ED see such patients as 'time wasters' and not as important as patients with physical complaints*
- *A more private environment for handover*

The Emergency Department Staff Perspective

Better access to mental health services, especially out of hours (12 comments in total)

- *Not having to leave a message on an answerphone - talking to a mental health nurse directly so we can inform the patient of a time and not leave them waiting indefinitely*
- *Need improved out of hours services and back up from mental health team*
- *Mental health staff should be based in department*
- *Since the introduction of Crisis Resolution Team (CRT), the assessment of mental health patients can be longer and can require 2 assessments from the mental health team, by psychiatry and then the crisis resolution team.*
- *Being able to access patient's mental health records*

The Emergency Department Staff Perspective

Better communication (12 comments in total)

- *Staff do not participate in communication as two way process.*
- *More face to face communication with mental health staff*
- *Ambulance and mental health staff rarely or never get the opportunity to communicate with each other as there are no permanent mental health staff in the department*
- *Nursing staff receive very little feedback or information about care plans from the mental health staff after referral*
- *Mental health teams/crisis teams could be more approachable*
- *More group working, group education sessions and feed back meetings*

Better working arrangements and documentation (11 comments in total)

- *We need a more structured care pathway and standardised assessment and referral protocol*
- *Ambulance staff could have a checklist of questions needing to be asked of deliberate self harmers to give a better picture to ED e.g. were they alone, when did they last self harm , do they have a CPN etc*
- *To focus on the emotional problems relating to the episode equally in our documentation of the patient following handover from paramedics*
- *A summary of all frequent attenders and their diagnosis and care pathways should be compiled and signed by the consultant and updated after each new attendance and kept in a folder in A&E reception to aid early and correct management*
- *Sometimes it isn't obvious from a handover whether the patient is on a section or not and the appropriate paper work has not arrived*
- *We should have details regarding the time that tablets were ingested*

Alternative provision for people who self-harm, other than the ED (5 comments in total)

- *Patients in psychiatric units who require medical assessment should not attend the ED*
- *Patients to go to a place where they could be cared for by mental health staff and not general nurses*
- *There are problems in the community for the ambulance staff to access psychiatric services frequently, leading to admissions to ED that could have been solved at home*

Other comments (4)

- *More non-judgemental information*
- *More social service input*
- *Better understanding of self-harm*
- *Better cover for specialist age groups (older aged people and young people)*

The Mental Health Staff Perspective

Better training (13 comments in total)

- *Communication should be linked with the training programme and the staff involved should be encouraged to get to know each other*
- *Involving the users and carers, and giving staff training to help them improve their interaction with patients and their families*
- *Greater understanding of why people self-harm*
- *Increased training/education provided between mental health staff and general nurses, A& E etc*
- *By training non mental health staff in mental health triage and communication skills*
- *Perhaps each department should try observing how the other works?*

Better handover systems (13 comments in total)

- *Better documentation - information collected should be passed on properly*
- *More information taken by A&E - sometimes only the nurse has seen the patient and hands over patient immediately to mental health team*
- *Discussing needed information and not allowing personal feelings being discussed*
- *Ambulance team and A&E staff need to communicate well as ambulance staff have usually left by the time mental staff become involved.*
- *Transfer letter and liaison nurse report is needed*
- *Standardised handover forms which would require a minimum amount of information as well as risk information*
- *Written handover by ambulance received with patient on all occasions*
- *Access to patients notes out of hours - would require computerisation of notes*

Better initial assessment/triage (3 comments in total)

- *Better triage of clients*
- *The first contact with the service user should get basic minimum information before seeking an expert opinion*
- *Include information relating to previous history of person so that understanding and empathy can be demonstrated toward person who self-harms*

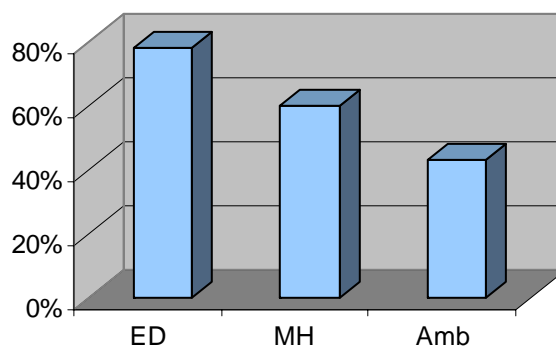
Other comments

- *On some occasions information sharing should be more discreet*
- *Understanding of each others roles and demands made on team*
- *There is a clear need for a dedicated service for psychiatric patients in the hospital - at present what we have is very limited*
- *Accident and emergency department staff ring the crisis team during the night to assess patients who are obviously under the influence of alcohol and illicit substances who have self harmed and are not fit enough to be assessed accurately, they consistently play down how drunk the person is, just to get them passed onto mental health services.*

Please read through the following statements and tick the option that most closely reflects your own general thoughts regarding working with people who self-harm. Some statements may not be applicable, or you may not be sure - if so, please select the 'Don't Know/N/A' option	Agree	DK/ N/A	Disagree
The patient care pathway is clear and understood	29%	41%	30%
Information from ambulance crews is sufficiently incorporated into handovers	38%	37%	25%
ED staff have sufficient access to information about patients' mental health (e.g. through shared notes, or joint access to an IT system)	13%	27%	60%
I am clear about the roles of Ambulance, ED, and mental health teams	63%	14%	24%
There should be multi-disciplinary case reviews of people who attend regularly for self-harm	89%	9%	2%
There are sufficient numbers of staff in my department	22%	11%	66%
The ED is generally an appropriate place for this patient group	23%	16%	60%
If a person does not have serious injuries, it would be better for them to be treated somewhere other than the ED	77%	9%	14%
People who self-harm generally receive the appropriate referral or discharge	51%	22%	25%

Self-Harm: 1.1, 1.2, 1.3, & 24.1. NICE: 1.1.1.1. Healthcare Commission: C7e & C13a.

Figure 11: Percentage of staff who disagreed with the statement 'There are sufficient numbers of staff in my department'



Please read through the following statements and tick the circle that most closely reflects your own general thoughts in relation to working with people who self-harm. Some statements may not be applicable, or you may not be sure - if so, please select the 'Don't Know/N/A' option	Agree	DK N/A	Disagree
I can understand why a person might self-harm	84%	5%	11%
I would not act in a threatening or punishing way towards a person who has self-harmed	94%	2%	3%
I do not know enough about self-harm to communicate effectively with this patient group	28%	10%	61%
Working with people who self-harm is a rewarding experience	26%	30%	44%
I am aware of the emotional distress associated with self-harm and I take this into account when caring for the person	90%	5%	5%
When a person repeatedly attends the ED following self-harm, it causes a sense of frustration and failure in staff	73%	11%	16%
Staff morale is not affected by high numbers of admissions relating to self-harm	23%	17%	58%
People who self-harm do it primarily to seek attention	15%	22%	62%
People who self-harm regularly are treated as well as 'one-off' self-harm patients	23%	19%	56%

Wave 1 comparison:

More of the 960 staff in wave 1 felt that working with people who self-harm is a rewarding experience (39% compared to just 26% in wave 2).

Otherwise, responses from the 2 waves were very similar.

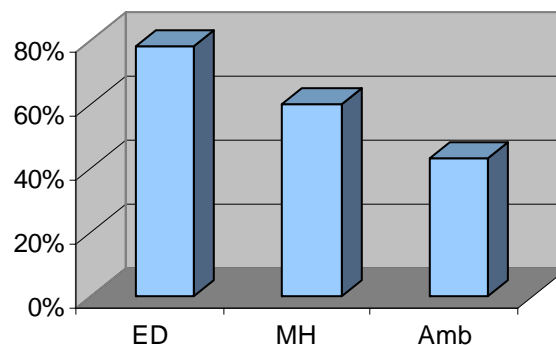
Any comments relating to the previous question?

Repeated attendances to self-harm (13 comments in total)

- *Ambulance crews are often irritated by patients with minor cuts / overdoses or claiming overdose when none taken - we often feel while they do need A&E they don't need an ambulance. We're frustrated at being tied up with this call when there are other more serious calls with no ambulance available*
- *Regular self harmers are seen as a 'waste of time' by ambulance staff...because staff don't understand how to deal with them*
- *Sometimes I find that the regular self harm patients get a slightly better initial response than new patients, just because I have built up a relationship with them over the years*
- *It can be difficult treating regular self harm patients without becoming frustrated*
- *The mental health service has failed them*

- *People who attend frequently are not always well received. When the ED is busy staff are very frustrated with people presenting with minor injuries. Patients who have self harmed do not get the time and understanding they need and not necessarily an appropriate staff member to assess them.*
- *Recurrent self harm patients are a challenging group who need more clinical time spent with them rather than less. There are many illnesses that are 'self-inflicted' e.g. smoking related lung disease or even heart attacks but we do not punish these patients. Medicine as a whole needs to realise that this is an illness like any other*
- *I don't feel that regular attenders get the same level of care*
- *We have 'regulars' who self harm in the ED, they are known well, we know that they'll have taken little, and it often feels like we just go through the motions with them. We feel they'll never change and so we just do what we have to do. In comparison when someone presents with a genuine attempt/first attempt and are clearly very distressed, I really feel for them. It has occasionally become a bit of a personal crusade to help them out and not only find out why they did it, but what we can do to fix things for them. Unfortunately it is a minority of DSH patients who I really feel very strongly about, and it's these cases that I really want to ensure decent follow up and future support. In reality, regular self harmers, who take small non dangerous overdoses frequently are viewed as 'not really trying to kill themselves', and treated thus, with a certain sense of futility, and we feel defeated and no longer even attempt to change things or offer help, we know they'll just go and do it again and again. I know it's not right, but in reality we all do it.*
- *Staff try to remain as professional as possible, but many of the regulars "play the system"*
- *I am aware that regular self harmers are perceived by some staff as time wasters and attention seekers, staff need more training around this issue*
- *Some are manipulative little feckers/ personality disorders. Others are genuinely suicidal or crying out for help. Hard not to get the two mixed up at times especially with high volumes of people.*

Figure 12: Percentage of staff who agreed with the statement 'People who self-harm regularly are treated as well as 'one-off' self-harm patients'



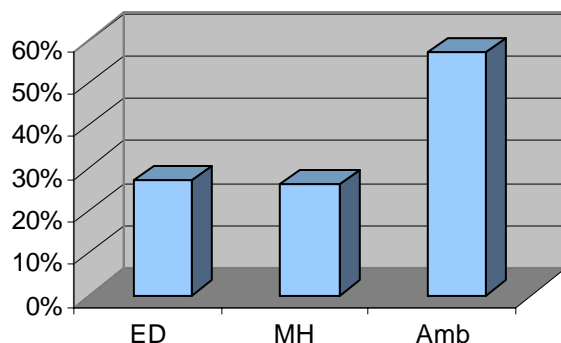
Resources (11 comments in total)

- *There is not always enough time to sit down with the patient to find out why they are self harming. They also feel intimidated in the emergency environment, whether they are in a cubicle or a closed room*
- *Patients who self harm need more than physical care and treatment which is normally all A&E staff have time to give, therefore psych' teams need more involvement in the care of these patients and much more promptly as often psych patients wait longer than non psych patients for specialist care meaning they can give abusive physically and verbally*
- *The last question I have agreed to, as I feel they do receive good care. However we may have protocols on these patients which prevents them from being admitted into the hospital system unless medically unfit for discharge i.e. if taken an overdose of paracetamol. The protocols we have may say only admit if levels are treatable, therefore discharge. This would not be the process for an infrequent DSH patient and may therefore be seen as not as well treated.*
- *I find it difficult to communicate freely with them regarding their reasons for self harming in the confines of a busy general ED.*
- *I have commented that working with self harm is not a rewarding experience as I feel that staffing levels do not allow us to spend the amount of time necessary to nip in the bud the thinking that leads our patients to self harm as the only solution to their problems*

Understanding self-harm (5 comments in total)

- *Attitudes, beliefs and values need challenging, to reduce stigma associated with self harm*
- *DSH clients are often viewed as time wasters especially on general med admission wards*
- *Lack of training and understanding of self harm leads to frustration in dealing with this client group where they can be labelled as attention seeking and distracting services from those who are 'genuinely unwell'*
- *self harm is often due to an unmet need within the patient make-up or emotional self image*
- *Many staff members become disillusioned in the treatment of this client base due to poor resources and lack of training specifically tailored for this group.*

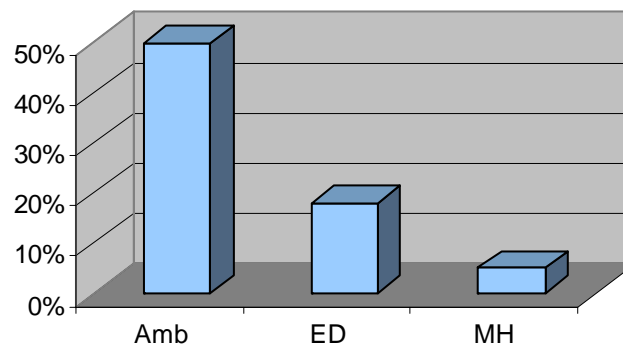
Figure 13: Percentage of staff who feel they do not know enough about self-harm to communicate effectively with this patient group



'Attention seeking' / Cry for help (4 comments)

- *Regarding the question 'people who self-harm do it primarily to seek attention' whether I agree or disagree is based on who makes the initial call if it is the patient in question the naturally the act of DSH is to seek attention as in the use of the term 'cry for help' however I would believe that the ACT of DSH has its own cathartic benefits for the patient.*
- *Patients seem to have many different motivations for their actions, and it's more how they interact with staff than what they have done which affects their care*
- *There is a certain element of persons with personality problems who consistently self harm to gain attention, they are under the influence of illicit substances and are frequently abusive in accident and emergency departments, Munchausen's syndrome being a key factor in some of these cases.*
- *In one way the person who self harms may be perceived to do so in order to seek attention, however this is due to primary emotional distress and maladaptive coping strategies (in my opinion)*

Figure 14: Percentage of staff who agreed with the statement 'People who self-harm do it primarily to seek attention'



Morale (4 comments)

- *I would not say that working with self harmers would be a rewarding experience but I would treat those who present mainly from the physical aspect of their attendance.*
- *Staff attitudes and morale is affected by types of attendances and volume of patient flow through*
- *Ed staff feel helpless to help these folk, who come to us because the mental health services fail them. DSH patients do include some very manipulative pts who really do just do it for the attention. This subgroup is exceptionally frustrating and as a result can get short shrift in the ED.*
- *Staff morale is not affected by a high number of self harm admissions - low staff morale is experienced but this I believe is because of lack of training and knowledge around the issue and a sense of frustration and inability to assist the client group.*

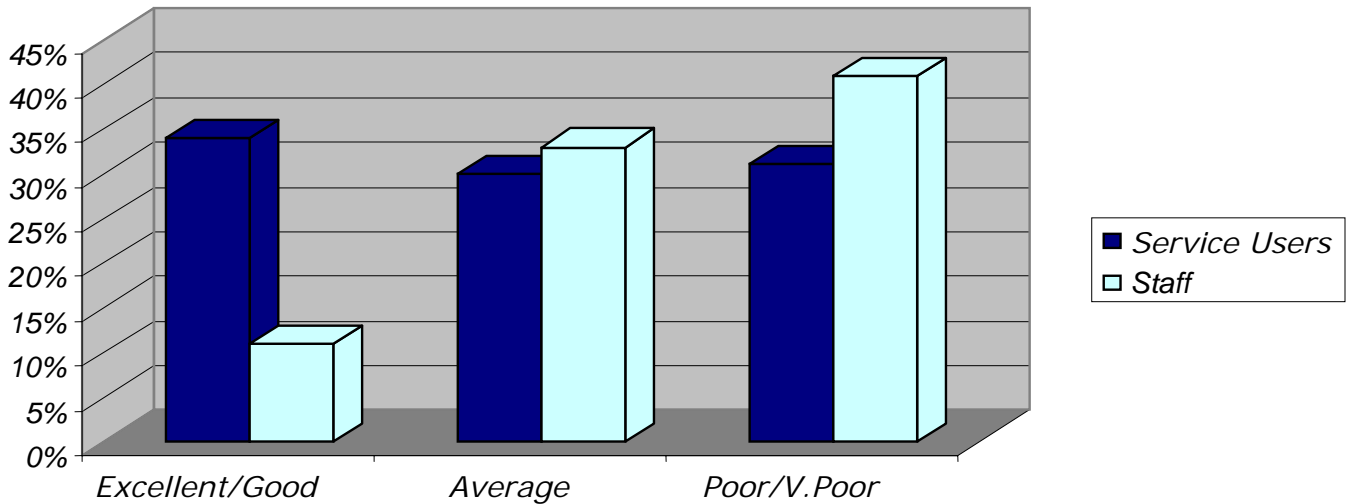
Environment and Facilities

How would you rate the <u>environment and facilities</u> in the ED?	Good	Average	Poor	Don't Know
Comfort/calmness	7%	34%	44%	14%
Safety	16%	36%	33%	13%
Privacy	9%	30%	47%	12%

Self-Harm: 5.1, 5.2 & 5.6. NICE: 1.4.2.3, Healthcare Commission: C20

Do you have access to a private room that can be used for conducting detailed psychosocial assessments?	
I don't know	15%
Most of the time	42%
Sometimes - but the room is often required for other purposes	27%
No - we frequently struggle to find a private room	15%

Figure 15: Staff ratings of the ED environment, compared to service users



Any comments on how the environment could be improved?

Comfort and calmness (8 comments)

- *I disagree with self-harm patients being treated in A&E as it's loud, busy, and confusing for a person even in a good frame of mind.*
- *EDs should have a designated comfortable and appropriately furnished room for assessments*
- *The area could be made cleaner and more comfortable especially as people have to endure very long waiting times - better facilities for refreshments made available*
- *Layout of the ED does not facilitate a calm, safe environment. The ED is very very busy and does not have facilities or staff to give detailed attention to this or any other group.*

Safety and privacy (30 comments)

- *Specialist nurse to fast track the assessment of patients who self-harm and a private room in which to do this*
- *The difficulty lies in the need for safety as well as privacy and I'm not sure the two are compatible.*
- *ED does not have areas for mental health professionals*
- *A more private room e.g. with a door rather than curtains, as people can hear everything via curtains*
- *Safety is only poor due to we do not have many staff on a shift able to sit and stay with the patient the whole time they are in the dept*
- *It would be of benefit to have a private room in which to hand over patients devoid of the stresses and distractions of a busy ED. This would help ensure the patient's condition is taken seriously and the patient has a positive reception in ED as opposed to being treated as a time waster as occasionally happens intentionally or otherwise.*
- *The police use the hospital as a substitute and use the 'place of Safety' rule to their advantage. This can at times leave staff in a vulnerable position where the departments are ill equipped for some patients who pose a grave risk.*
- *Specialised mental health suites with medical support away from the traditional ED*
- *Patients are often put in the waiting room where it's easy for them to wander off without people noticing*

Other

- *The environment needs to be somewhere else! I have great difficulty getting people to A&E even when there is an urgent medical need, because people find it such a negative experience. As mentioned before, if people could be treated elsewhere (including at home via the Emergency Care Practitioner Team) or at Minor Injuries Units, which are smaller and less intimidating, this would be preferable.*
- *Overall it requires better facilities*
- *Probably need a psychiatrist on site all night. If ED doctors do proper night shifts why don't they?*

Wave 1 comparison:

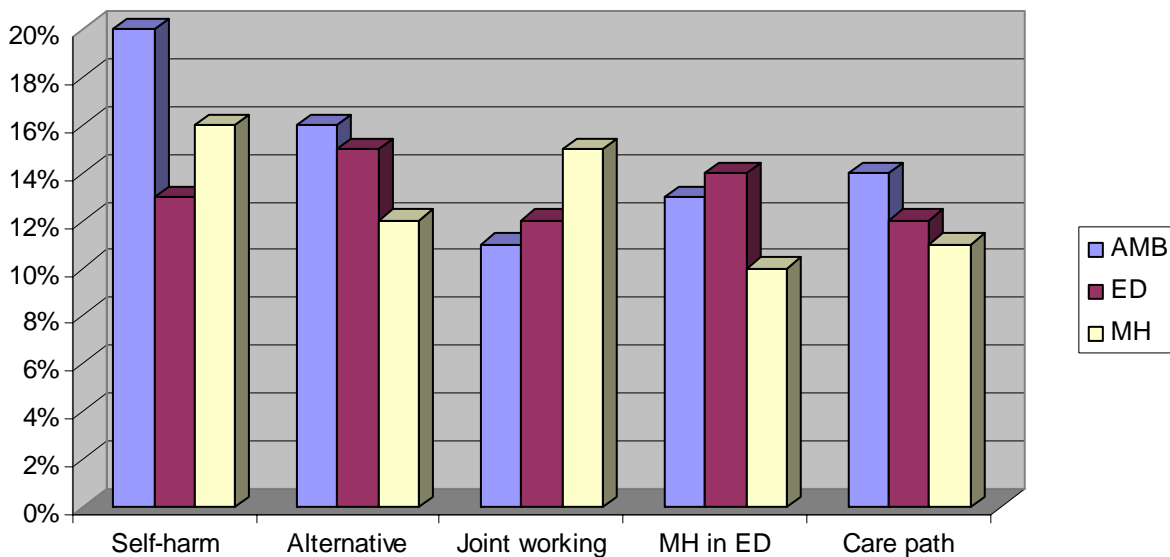
Responses from wave 1 were very similar, with a lack of privacy for triage and psychosocial assessment being common problems for the 30 wave 1 hospitals.

This project aims to support local teams in making improvements for staff and service users. Which of the following areas, if any, do you think should be prioritised within your team?

Please select as many as appropriate

Better access to mental health staff in the ED	(<i>'MH in ED'</i>)	12%
Better staff support and supervision		12%
Improve joint working between different staff groups	(<i>'Joint working'</i>)	13%
Improve staff understanding of self-harm	(<i>'Self-Harm'</i>)	14%
Better information for patients		12%
A clearer care pathway for patients -	(<i>'Care path'</i>)	12%
Finding alternative places of treatment, other than the ED –	(<i>'Alternative'</i>)	14%
Better aftercare		11%
Other (please state)		12%

Figure 16: Areas of service provision that staff think should be prioritised, broken down into staff groups (see above for full definitions)



Policy Checklist

Each of the 8 teams were asked to complete the following survey between September and November 2006; 7 were completed. Teams also had the option of commenting after each question – any comments are included below. Some of these questions relate directly to the Healthcare Commission's plan to monitor compliance with specific recommendations from the NICE guideline on self-harm. Where this is the case, we have put the abbreviation '**HC**' for your reference.

Please note – for your benchmarking information, we have also noted the percentage of the 30 wave 1 teams that had the policies in place during their initial audit.

Is there a joint arrangement between emergency departments (EDs) and local mental health services to ensure effective liaison psychiatric services, available 24 hours a day?	
Yes - a policy exists and this is generally adhered to	50%
No formal policy but this is common practice	33%
No formal policy and this does not happen	17%
% of the 30 wave 1 teams with this arrangement in place:	83%

Are the response times for psychosocial assessment in the table below generally met?	
Yes - almost always, even during 'out of hours'	17%
Yes - except for during 'out of hours'	33%
Very rarely or never	50%
<i>This question was not asked in wave 1</i>	<i>N/A</i>

Response times recommended by the Royal College of Psychiatrists and the British Association for Accident and Emergency (BAEM).

	Urban areas	Rural areas
First line attendance	30 minutes from the time of referral	90 minutes from the time of referral
Section 12-approved doctor attendance	60 minutes from the time of referral	120 minutes from the time of referral

Are there locally agreed protocols regarding the ambulance service taking the service user to an alternative appropriate service, rather than the ED? (HC)	
Yes - protocols exists and these are generally adhered to	17%
No formal protocols but this is common practice	0%
No formal protocols and this does not happen	83%
% of the 30 wave 1 teams with these protocols in place:	17%

Is there a policy on referrals from the emergency department to the mental health unit?	
No - all referrals go via the crisis team or liaison team	67%
Yes - a policy exists and this is generally adhered to	0%
No formal policy but this is common practice	33%
% of the 30 wave 1 teams with this policy in place:	69%

Is there a policy to ensure that all people who self-harm are offered a preliminary psychosocial assessment at triage or at the initial assessment? (HC)	
Yes - a policy exists and this is generally adhered to	17%
No formal policy but this is common practice	50%
No formal policy and this does not happen	33%
% of the 30 wave 1 teams with this policy in place:	72%

Is there a policy regarding the availability of the <u>mental health trust's IT system in the emergency department?</u>	
Yes - a policy exists and this is generally adhered to	17%
No formal policy but this is common practice	0%
No formal policy and this does not happen	83%
% of the 30 wave 1 teams which this policy in place:	21%

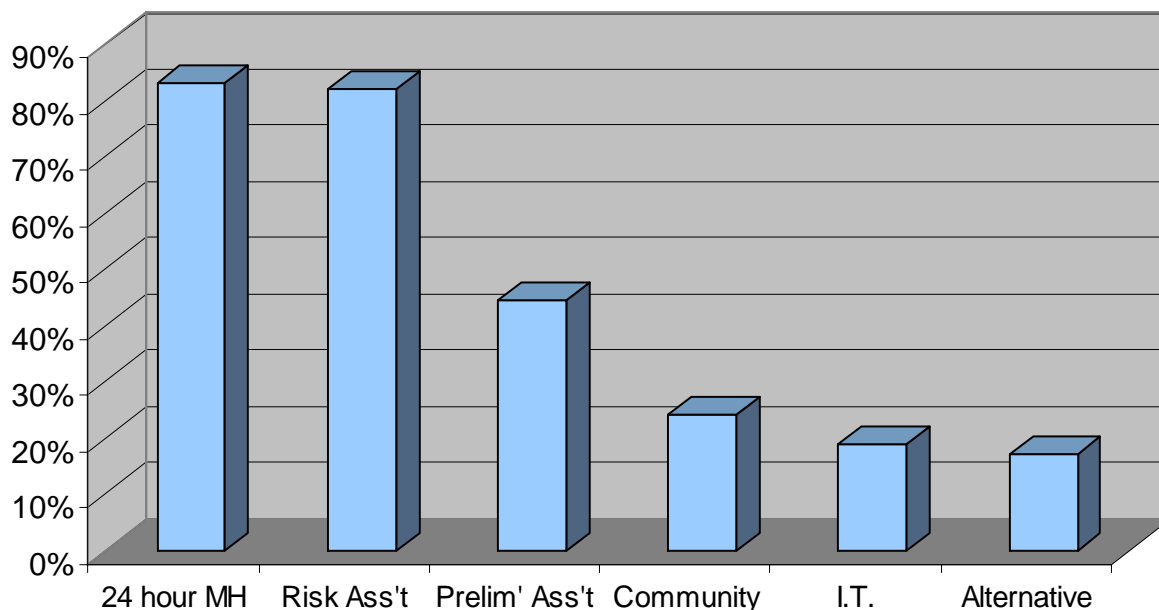
Do you have assessment checklists, risk matrices or a pro-forma for telephone referrals from the <u>emergency department</u> to <u>community mental health teams</u>?	
Yes - these documents exist and are generally adhered to	17%
No	83%
<i>% of the 30 wave 1 teams with these in place:</i>	31%

What triage system/s do you use for people who self-harm?	
Manchester Triage System	83%
Our own triage tool	0%
Other	0%
None - we use meet and treat	17%
<i>% of the 30 wave 1 teams that use the Manchester Triage System.</i>	52%
<i>N.B. 31% of wave 1 teams used 'locally devised tools'</i>	

Do people who self-harm have an assessment of their suicide risk? (HC)	
Yes , all	33%
Yes, most	50%
Yes, some	0%
No formal assessment	17%
<i>% of the 30 wave 1 teams with this arrangement in place:</i>	76%

Do the ambulance services you work with use activated charcoal?	
Yes	0%
No	83%
Unknown	17%
<i>% of the 30 wave 1 teams with this arrangement in place:</i>	17%

Figure 17: Average number of wave 1 and wave 2 teams combined (38 teams) with the following procedures/policies in place



Key

24 hour MH – Is there a joint arrangement between emergency departments (EDs) and local mental health services to ensure effective liaison psychiatric services, available 24 hours a day?

Risk Ass't - Do people who self-harm have an assessment of their suicide risk?

Prelim' Ass't - Is there a policy to ensure that all people who self-harm are offered a preliminary psychosocial assessment at triage or at the initial assessment?

Community - Do you have assessment checklists, risk matrices or a pro-forma for telephone referrals from the emergency department to community mental health teams?

I.T - Is there a policy regarding the availability of the mental health trust's IT system in the emergency department?

Alternative - Are there locally agreed protocols regarding the ambulance service taking the service user to an alternative appropriate service, rather than the ED?

Appendix 1: Standards and Criteria Measured

The following list details the 'Better Services for People who self-Harm' standards and criteria reviewed during this data collection period. The criteria are listed according to which data collection tool was used to measure them. By cross-referencing this with the data in the main body of the report, you can see how well you are performing against the standards. To view the complete manual of quality standards, including those standards and criteria not measured during this audit, see <http://www.rcpsych.ac.uk/cru/auditselfharm.htm>

The columns below represent:

No.	Criterion statement	Rating	Source
The unique criterion number given to each item	Describes the specific criterion	Describes the rating for each criterion: E = Essential D = Desirable	Provides a code to the original source (see box at the end of the section)

a) Criteria measured in the Service User Survey

No.	Criterion Statement	Rating	Source
1.3	Staff should not behave in a punitive, threatening, dismissive or judgmental manner towards people who self-harm	E	GPP
1.4	Adequate anaesthesia and/or analgesia should be offered to people who have self-injured throughout the process of suturing or other painful treatments	E	NICE
1.5	Staff should ask service users if there are any specific personal, cultural, religious or other factors that need to be considered when examining or treating the individual, and make reasonable efforts to accommodate this	E	GPP
1.9	People who self-harm should be given the choice of having a friend, relative or advocate present during assessment and treatment	E	GPP
2.1	Service users should be provided with clear and understandable information about the care process	E	DH1
2.3	A member of staff (preferably the named staff member) should keep in regular contact with the service user to ensure their safety and update them on waiting times and progress	E	GPP

2.5	There should be access to face to face interpreter services and, where appropriate, the person's preferred language should be recorded in notes. When face to face interpreters are not available, staff should use telephone interpreters, such as www.languageline.co.uk . Staff should not use patients' relatives as interpreters	E	DH2
2.8	Information should be available on how to complain or ask questions if a service user is unhappy with their treatment	E	DH1
3.1	Staff should engage service users in a therapeutic alliance and promote joint clinical decision-making on the basis of understanding and compassion	E	NICE
3.2	Staff should take into account that a person's capacity to make informed decisions may change over time. Whether it has been possible to obtain consent or not, attempts should be made to obtain consent before each treatment is initiated.	E	NICE
3.3	Information should be provided on the perceived risks and benefits of treatment, as well as any side effects	E	GPP
4.4	Service users should be told to whom information has been passed on	E	RCP2
5.1	The waiting environment should be safe	E	RCP1
5.2	The waiting environment should be comfortable and designed to minimise any distress	D	RCP1
5.6	There should be a designated private room that can be used for assessments	E	RCP1
6.2	When assessing people, healthcare professionals should ask service users to explain their feelings and understanding of their own self-harm in their own words	E	NICE
9.1	Triage staff should take account of the underlying emotional distress, which may not be outwardly exhibited, as well as the severity of injury when making decisions about priority for treatment	E	NICE
19.1	Clinicians should ensure that service users who have self-harmed are fully informed about all the service and treatment options available, in a spirit of collaboration, before treatments are offered	E	NICE
19.2	Service users should be encouraged to express their needs and preferences	E	SKH
19.6	'Aftercare sheets' should be given to patients who are being discharged	D	DH1

20. Temporary admission, which may need to be overnight, should be considered where necessary, for example:

20.1	For people who are very distressed	E	NICE
20.2	For people for whom psychosocial assessment proves too difficult as a result of drug and/or alcohol intoxication	E	NICE
20.3	For people who may be returning to an unsafe or potentially harmful environment	E	NICE

22. For people deemed to be at risk of repetition, consideration may be given to offering an intensive therapeutic intervention combined with outreach. The intensive intervention should allow:

22.1	Frequent access to a therapist when needed	E	NICE
22.2	Home treatment when necessary	D	NICE
22.3	Telephone contact	E	NICE

23. Outreach should meet the needs of the patient

23.1	Staff should actively follow up the service user when an appointment has been missed	E	NICE
23.2	The therapeutic intervention should be agreed with the service user and recorded as part of the care plan	E	GPP
23.3	The duration of the intervention should meet individual needs, but should be set at a minimum of 3 months	D	GPP NICE
23.4	For people who self-harm and have psychological problems, consideration should be given to the use of psychological treatments	E	GPP

b) Criteria measured in the Staff 'Training, Support and Supervision' Survey

25. All staff who have contact with people who self-harm (including receptionists, domestic, security personnel etc) should be provided with basic training/education in:

No.	Criterion Statement	Rating	Source
25.1	A basic awareness of mental health	E	GPP
25.2	A basic awareness of risk	E	GPP

26. In addition to the above, all staff involved in immediate emergency contact with people who self-harm should be provided with intermediate training/education in:

26.1	Assessing mental health needs	E	RCP1
26.2	Assessing risk, hopelessness and suicidal intent	E	RCP1
26.3	Basic understanding of the Mental Health Act and relevant common law	E	RCP1
26.4	Assessing mental capacity	E	GPP
26.5	Understanding why people self-harm (precipitating feelings and functions served) and the difference between self-harm and acts of suicidal intent	E	GPP
26.6	The impact of cultural differences on self-harm	E	GPP
26.7	The basis of the Care Programme Approach (CPA)	D	GPP

27. In addition to the above, all staff involved in advanced care (e.g. conducting specialist assessments and referrals) should be provided with advanced training in:

27.1	Assessing the social, psychological and motivational factors specific to the act of self-harm, and the associated needs of the individual	E	GPP
27.3	Emergency department doctors should have sufficient training so that they feel confident in making a mental health assessment and in making a referral	E	RCP3
27.4	Staff involved in making referrals should have a knowledge of local services; e.g. psychiatric services, self-harm support agencies in the voluntary sector, social work services, culturally specific services and crisis intervention services	E	RCP1
28.1	People who self-harm should be involved in the planning and delivery of training for staff	E	NICE
29.1	All staff providing treatment and care for people who have self-harmed should have regular clinical supervision to discuss and understand the emotional impact of working with people who self-harm	E	GPP
29.2	Staff should be able to discuss, with an appropriately qualified person, a specific incident of self-harm that has caused them distress	E	GPP

c) Criteria measured in the Staff 'Attitudes and Opinions' Survey

No.	Criterion Statement	Rating	Source
1.2	People who have self-harmed should be offered the same quality of care and range of treatments as any other patient, without unnecessary delay, and regardless of their willingness to accept psychosocial assessment or psychiatric treatment	E	NICE
5.1	The waiting environment should be safe	E	RCP1

5.2	The waiting environment should be comfortable and designed to minimise any distress	D	RCP1
5.6	There should be a designated private room that can be used for assessments	E	RCP1
24.1	Services should be staffed according to the relevant agreed guidelines for that organisation or service	E	DH3

d) Criteria measured in the Policy Checklist

No.	Criterion Statement	Rating	Source
30.4	Emergency departments and local mental health services should jointly plan effective liaison psychiatric services, available 24 hours a day	D	NICE

Joint protocols should be agreed between the services that treat people who self-harm, including:

31.3	Referral from the emergency department to the mental health unit, including response times	E	DH3
31.4	A policy regarding the availability of the mental health trust's IT system in the emergency department	D	RCP1
31.6	Assessment checklists, risk matrices or a pro-forma for telephone referrals from the emergency department to community mental health teams	E	DH3
31.8	Ambulance services should work with other organisations to develop care pathways for patients already known to the service, including service users being taken directly to mental health units, primary care, crisis intervention teams or to social services	D	DH3
9.2	Where physical and emotional distress co-exist, the highest appropriate triage category based on the combined scores should be applied, as per the Australian Mental Health Triage Scale	E	NICE
9.3	All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an act of self-harm	E	NICE

When a person who has self-harmed first comes into contact with services (emergency department or ambulance), a staff member should instantly evaluate immediate risk, including:

8.3	Is the person actively suicidal?	E	RCP1
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Key to Source Documents

The list below is included to assist you in exploring source documents more widely. This may help you in your action planning, and it may also provide further evidence of the need for extra resources.

DH1

Department of Health (2004) 'Providing patients with better information in emergency departments' toolkit <http://www.dh.gov.uk/assetRoot/04/08/13/48/04081348.pdf>

DH3

Department of Health (2004) Improving the management of patients with mental ill health in emergency care settings Checklist
<http://www.dh.gov.uk/assetRoot/04/08/91/97/04089197.pdf>

GPP

'Good Practice Point' – Recommended good practice based on the experience of the experts consulted

NICE

National Institute of Clinical Excellence (NICE) and the National Collaborating Centre for Mental Health (2004) The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care (National Clinical Practice Guideline Number 16) full guidance
<http://www.nice.org.uk/page.aspx?o=213665>

RCP1

Royal College of Psychiatrists (2004) Assessment following self-harm in adults, Council Report CR122
<http://www.rcpsych.ac.uk/publications/cr/council/cr122.pdf>

RCP3

Royal College of Psychiatrists & British Association for Accident and Emergency Medicine London (2004) Psychiatric services to accident and emergency departments
<http://www.rcpsych.ac.uk/publications/cr/council/cr118.pdf>

SKH

Skills for Health (2004) www.skillsforhealth.org.uk

The Healthcare Commission's 'Standards for Better Health'

The following list details the relevant Healthcare Commission's (HC) Core and Developmental 'Standards for Better Health'. By cross referencing this with the HC references throughout this report, you will be able to note which of the HC standards you are currently meeting, and which require extra work. This may help you in prioritising your action plans.

C5 Health care organisations ensure that

- a) They conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care;*
- b) Clinical care and treatment are carried out under supervision and leadership*

C7 Health care organisations:

- a) Apply the principles of sound clinical and corporate governance;*
- c) Undertake systematic risk assessment and risk management;*
- e) Challenge discrimination, promote equality and respect human rights*

C8 Health care organisations support their staff through

- a) having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services; and*
- b) Organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.*

C9 Health care organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

C11 Health care organisations ensure that staff concerned with all aspects of the provision of health care

- a) Are appropriately recruited, trained and qualified for the work they undertake;*
- b) Participate in mandatory training programmes; and*
- c) Participate in further professional and occupational development commensurate with their work throughout their working lives.*

C13 Health care organisations have systems in place to ensure that

- a) Staff treat patients, their relatives and carers with dignity and respect;*
- b) Appropriate consent is obtained when required for all contacts with patients and for the use of any patient confidential information; and*
- c) Staff treat patient information confidentially, except where authorised by legislation to the contrary.*

C14 Health care organisations have systems in place to ensure that patients, their relatives and carers

a) Have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services;

C16 Health care organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care.

C17 The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services.

C18 Health care organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.

C19 Health care organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.

C20 Health care services are provided in environments which promote effective care and optimise health outcomes by being

a) A safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation; and

b) Supportive of patient privacy and confidentiality.

D8 Health care organisations continuously improve the patient experience, based on the feedback of patients, carers and relatives.

Appendix 2: List of Wave 1 teams

WAVE 1 TEAMS - Name of hospitals collecting data from Jan–April 2006

Blackburn Royal Infirmary, Lancashire, England,
Countess of Cheshire Hospital, Cheshire, England
Craigavon Area Hospital, Co Armagh, N Ireland
Derbyshire Royal Infirmary, Derbyshire, England
Diana Princess of Wales Hospital, Grimsby, Lincolnshire, England
Furness General Hospital, Cumbria, England
Gloucestershire Royal Hospital, Gloucester, England
Great Western Hospital, Swindon, Wiltshire, England
John Radcliffe Hospital, Oxford, England
New Cross Hospital, Wolverhampton, West Midlands, England
North Middlesex Hospital, Haringey, London, England
Northern General Hospital, Sheffield, South Yorkshire, England
Queen Alexandra Hospital, Portsmouth, Hampshire, England
Queen Elizabeth Hospital, King's Lynn, Norfolk, England
Royal Bolton Hospital, Greater Manchester, England
Royal Devon & Exeter Hospital, Devon, England
Royal Sussex County Hospital, Brighton, East Sussex, England
Selly Oak Hospital, Birmingham, West Midlands, England
Southampton General Hospital, Southampton, Hampshire, England
Southern General Hospital, Glasgow, Scotland
St George's Hospital, Tooting, London, England
St Mary's Hospital, Paddington, London, England
St Thomas' Hospital, Lambeth, London, England
Staffordshire General Hospital, Stafford, England
Torbay Hospital, Torquay, Devon, England
University Hospital of North Durham, County Durham, England
Walsgrave Hospital, Coventry, West Midlands, England
West Middlesex University Hospital, Isleworth, England
Worthing Hospital, West Sussex, England
Wrexham Maelor Hospital, Wrexham, Wales

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Richard Pacitti
Carlos Perez–Avila
Guy Sanders
Katy Price*

If you would like to discuss any aspects of the 'Better Services for People who Self-Harm' programme, or take part in future audits, please contact the Central Project Team on the details below:

'Better Services for People Who Self-Harm' Project
Royal College of Psychiatrists' Centre for Quality Improvement
4th Floor, Standon House
21 Mansell Street
London E1 8AA

Tel: 020 7997 6643

Email: selfharmproject@cru.rcpsych.ac.uk

Web: <http://www.rcpsych.ac.uk/cru>

Philippa Strevens

Project Administrator

Email: pstrevens@cru.rcpsych.ac.uk

Helen Blackwell

Project Team Member/National Service User Advisor

Email: hblackwell@cru.rcpsych.ac.uk

Lucy Palmer

Programme Manager

Email: lpalmer@cru.rcpsych.ac.uk