Better Services for People who Self-Harm

Aggregated Report
Wave 3 Baseline Data

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CONTENTS **PAGE**

Executive Summary and Recommendations........................... 5

Introduction and Data Collection Methods.............................. 10

Waiting Times and Outcomes.. 13

The Service User Experience... 17

The Staff View... 33

Policy Checklist.. 59

Appendix 1 – List of Standards and Criteria Measured.......... 71

Appendix 2 – National Themes emerging from the Surveys.. 79

Appendix 3 – PDSA Form.. 87

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Executive Summary & Recommendations

Between September and December 2007, 395 members of staff and 81 service users from 11 UK hospitals 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 also asked their opinion on these aspects of care, as well their views on the training and support they receive.

Respondents

Three-quarters of the service users responding to the user survey were female and 90% were of white British origin. For 17% of respondents, this was the first use of emergency services following self-harm. Forty-nine percent of staff respondents work in mental health, 35% in the ED, 7% in the ambulance service, and 9% work in other services. The views of service users and staff across the participating services highlighted the following common themes:

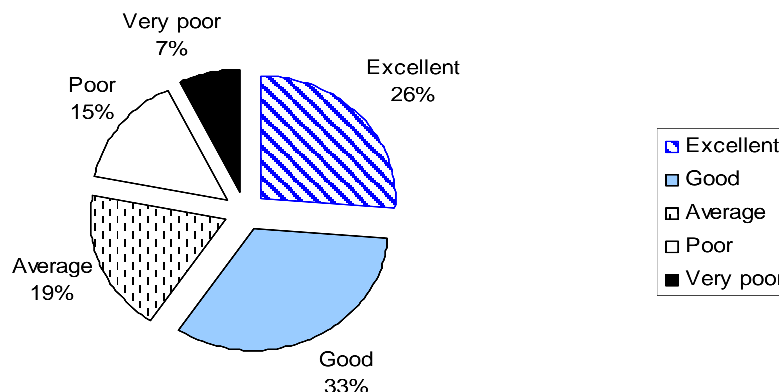
Staff attitudes

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 59% of staff as 'excellent' or 'good', 19% of staff as 'average' and 22% as 'poor' or 'very poor'. Feeling respected, supported and not judged was very important to service users and had a very positive effect on their ability to cope once leaving the Emergency Department (ED).

When staff groups are looked at separately, 71% 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.

Over a quarter of staff (26%) stated that they 'do not know enough about self-harm to communicate effectively with this patient group'. Furthermore, 35% of staff felt that people who self-harm regularly are not treated as well as 'one-off' self-harm patients. Two-thirds 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. A fifth of staff felt that people who have self harmed receive less support and respect than other patients.

Chart 1: Average ratings of all staff in terms of their attitude and behaviour



Physical treatment
Forty-two percent of service users rated the physical treatment they received as 'excellent' or 'good', and 18% rated it as 'average'. A further 26% 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 12% 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, or receiving treatment (23%).

Information, communication and consent
Information and communication were themes running throughout the user experience. When treated in the ED, 35% 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. Fifty percent of respondents reported that they were not checked on whilst waiting for treatment and several respondents commented on how anxious and hopeless this can make them feel.

Service users, like staff, felt that fuller communication between services was required. A third of staff rated communication between ambulance and ED staff as excellent or good. Twelve percent of staff rated communication between ED and mental health staff as poor and 23% felt that communication between ambulance and mental health staff could be improved.

Thirteen percent of service users felt that cultural, communication or personal needs could have been better met. For example, some suggested that staff could have more understanding of the emotional distress associated with self-harm.

Mental health needs
Forty-two 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).

Sixty-three percent of service users were seen by a mental health professional whilst in hospital and 68% of those felt that they were given the opportunity to talk about the reasons for their self-harm. However, almost half of service users did not feel that their views were taken into account when professionals were considering whether they were at risk of self-harming again. Comments about psychosocial assessment reflected both positive and negative experiences, but service users consistently stressed the importance of being listened to and taken seriously.

Around half of the staff surveyed felt that access to mental health staff is sufficient during working hours, but 28% described out-of-hours access as poor or very poor. Twenty-one percent of mental health staff and 59% of ED staff felt that they would like further training on 'how to conduct a specialist psychosocial assessment'. When training grade mental health doctors were asked about their training around psychosocial assessments, 59% rated this as insufficient, as did 63% of non-mental health training grade doctors.

Two-thirds (68%) of the service user respondents felt that they did not receive the appropriate aftercare.

Physical environment and facilities
Over half of the service users surveyed felt that the physical environment of the ED was safe, but less than a third felt an ED environment offers enough privacy. A third of staff described the environment as poor or very poor. When asked whether they thought the ED was an appropriate place for this patient group, a fifth of staff agreed, a fifth disagreed and almost half were unsure. Some staff felt that once physical care has been provided, it would be better for people who self-harm 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 (43%). However, 43% of users said they had avoided emergency services because of previous negative experiences, and the same number had decided not to use emergency services because of the fear of being 'sectioned'. For 45% of respondents, the embarrassment of attending the ED had deterred them.

Staff training, education and awareness
As with previous self-harm audits, 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 - 81% described training in 'understanding self-harm' as insufficient. The same number of ambulance staff felt that they had <u>not</u> been given sufficient education in how to assess a person's risk, hopelessness and suicidal intent, and 74% 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 half would like more training on assessing mental capacity. One third of the mental health staff surveyed want more training in using psychological therapies with people who self-harm. Staff from all disciplines reported a lack of education in terms of understanding the impact of cultural differences on self-harm. Half 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 (37%) and refresher training (66%) should be improved.

Staff support and supervision
Over two-thirds 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
Two-thirds of staff felt that people repeatedly attending the ED following self-harm can cause a sense of frustration and failure in staff. Similarly, a third of staff felt that high numbers of self-harm attendances can affect staff morale.

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.

Overall
Staff and service users alike expressed the view that improvements are needed in many areas, most notably in the training, support, confidence and attitudes of many staff who work with people who self-harm.

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

- 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.
- Three online training exercises: i) 'understanding self-harm, ii) 'working with people who self-harm' and iii) understanding consent and capacity.
- A PowerPoint slide set designed to help staff understand consent and capacity.
- A checklist for members to display in the ED, reminding staff to ask if the individual would like someone with them; ask the person what would help them to feel safe; check if the person has any cultural or personal needs and update the person to avoid isolation.
- Laminated assessment tools.
- A template for a local support booklet, to be adapted locally and given to service users.
- A poster to go on display for service users, listing various helplines.
- A list of alternatives to self-harm, to be given to service users.
- A first aid leaflet with basic wound care information.

These can be found at www.rcpsych.ac.uk/selfharmaudit.htm.

If you have any suggestions for other interventions or examples of your own innovative practice, please contact us.

The recommendations overleaf have been written in response to the collective findings of the teams that have taken part in the programme to date. The recommendations were written by the 'Better Services' central project team and steering group (a combination of staff and service users) with input from some wave 1 members.

	Instant Remedies	Medium term aims	Long-term aims
Training and support for staff	• Distribute the information leaflet 'working with people who self-harm'* to all staff • Encourage staff to use the online training exercises* • Mental health staff/service users to deliver the 'understanding self-harm' slide sets*, at least twice a year • Display the staff reminder 'CHECKED' list in prominent areas around the ED, urging staff to update the patient, gain consent, check if they feel safe and find out if they have any individual or cultural needs*	• Trust induction package to focus on mental health and self-harm in more detail • Staff to receive specialist training in self-harm* • Staff to receive training or education on the impact of cultural differences on self-harm • Managers to review the training and support needs of staff on an annual basis	• Common foundation year training for all nurses to include more in-depth mental health and self-harm awareness • The mental health team to provide structured advice and support to ambulance and ED staff • National training curricula for ambulance and ED staff to include self-harm
Information and support for patients	• Display/distribute information on local services, emergency contact numbers and emergency helplines and understanding self-harm* • Facilitate the use of advance directives and crisis cards • Consider offering advice and instructions on the self management of superficial injuries*	• Nominate a named member of the ED staff per shift to make contact and update patients at regular intervals • Provide a written care plan which includes an emergency plan and details of who to contact in a crisis	• Establish better links with local voluntary sector organisations and user groups to explore joint working and signposting between services (e.g. the Samaritans referral system)
Mental health needs	• Local project team to review the triage/initial assessment tool to see if it incorporates emotional distress • Contact the central project team for examples of other triage tools	• Audit the number of people who self-harm and receive a psychosocial assessment	• Service user–led training in interview skills to take place for trainee psychiatrists, trainee social workers, and mental health nurses in preceptorship
Safety, privacy and dignity	• Offer patients the choice between waiting in the general area or in a quiet area, where possible • Ensure that assessment is carried out in a private area	• Managers to assess waiting and treatment areas for safety	• Services to involve service users (not just people who self-harm) in the planning of improvements to the environment

*These are provided by the national 'Better Services for People who Self-harm' team.

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
The 'Better Services for People who Self-Harm' national quality improvement programme brings together staff and service users to make positive changes. Each service forms 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 College of Emergency Medicine and the British Association for 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
The central project team and steering group created 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. A written consultation exercise and telephone conference with key stakeholder groups, including service users, healthcare professionals from emergency care, mental health and ambulance, and voluntary organisations took place to edit and finalise the standards. 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.

The layout of this report

Sections 1 – 4: Data Summary
Between August and November 2007, local teams measured their performance against the standards using the following methods:

1. An audit of patient notes*, to examine waiting times and patient outcomes.
2. A survey of service users to seek their views on the quality of care provided.
3. A staff survey focusing on training, support, and staff attitudes and opinions towards working with people who self-harm.
4. An audit of joint working arrangements and policy documents*

*Not all teams conducted a case flow audit or policy checklist (see each section for details)

Appendix 1: Lists of standards and criteria measured
Throughout this report are references to the 'Better Services for People who Self-Harm' quality standards, the NICE guideline and the Healthcare Commission's 'Standards for Better Health'. Appendix 1 contains a full list of these standards and recommendations, allowing teams to see how well they are performing against each of them.

Appendix 2: National themes arising from the staff and service user surveys
To assist those teams with a low response rate from the service user or staff survey, a summary of key themes arising from data previously received is included.

How do we compare to other services?

We recommend that you:

a) Look at your local report, and compare your results to those in main body of this report. That will give you an idea of how your feedback differed from other teams taking part in wave 3.
b) Look at appendix 2, which summarises the themes arising from the 40 members that took part in waves 1 & 2, allowing more comparison.

Notes about the report

- Hundreds of comments from staff and service users were received - these have been counted and categorised using thematic analysis and examples of common quotes are included throughout the report.
- Where comments are included, these are presented unaltered, apart from undergoing a standard spell check.
- Percentages are presented without extra decimal points (e.g. 56%, rather than 56.4%), resulting in some 'rounding up' of scores, meaning that sometimes total scores will appear to be 99% or 101%. For some questions, respondents were asked to tick as many boxes as apply; which means that the total might exceed 100%.
- 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.
- The service user survey results and the case flow audit data do not necessarily relate to each other.

Some charts in this report allow teams to compare themselves directly with mean average of the wave 3 teams. Please refer to your team's unique code, or contact the central project team for details (tel: 020 7977 6642).

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:

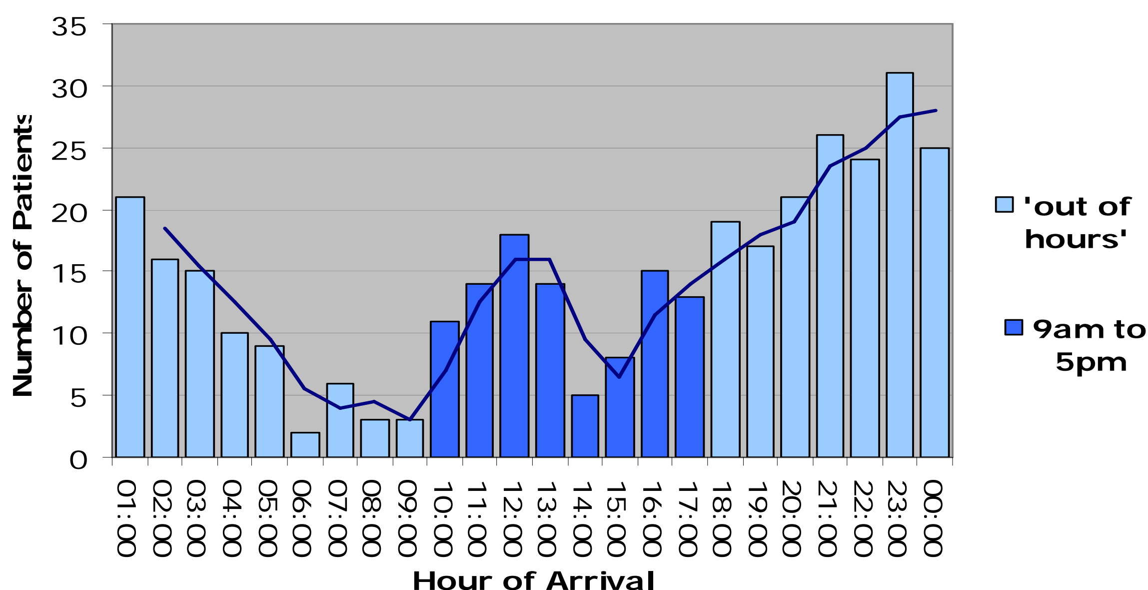
A&E Accident and Emergency
AAU Acute Admissions Unit
CBT Cognitive Behavioural Therapy
CMHT Community Mental Health Team
DBT Dialectical Behaviour Therapy
DNA Did not attend
DSH Deliberate self-harm
EAA Emergency Assessment Area
ED Emergency Department
ICU Intensive Care Unit
ITU Intensive Therapy Unit/Intensive Treatment Unit
LOS Length of stay
MAU Medical Assessment Unit/Medical Admissions Unit
MDT Multi-disciplinary team
MIU Minor Injuries Unit
MHLT Mental Health Liaison Team
MHT Mental Health Team
OOH Out-of-hours
SHO Senior House Officer

The Case Flow Audit

Seven UK teams collected data on **emergency admissions** for self-harm between September and December 2007. A total sample of 346 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

Figure 1: Hour of arrival at the Emergency Department (ED) for 346 patients



- 88 people (25%) arrived between 9am and 5pm
- 258 people (75%) arrived outside of working hours.

Comparison with previous data

These findings are very similar to those of the previous 38 'Better Services for People who self-harm' teams who were audited in 2006 and 2007, where 80% of people who self-harmed arrived out of hours.

Triage

1	<u>Type of triage</u> that took place	
	It was an immediate 'Meet and Treat'	3%
	A standardised triage assessment tool (such as the Manchester Triage system) was used	91%
	The person was triaged but no tool was used	2%
	Not recorded	1%
	Not Applicable	1%

Comparison with previous data
Of the 1,855 patients (across 30 teams) in wave 1:

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

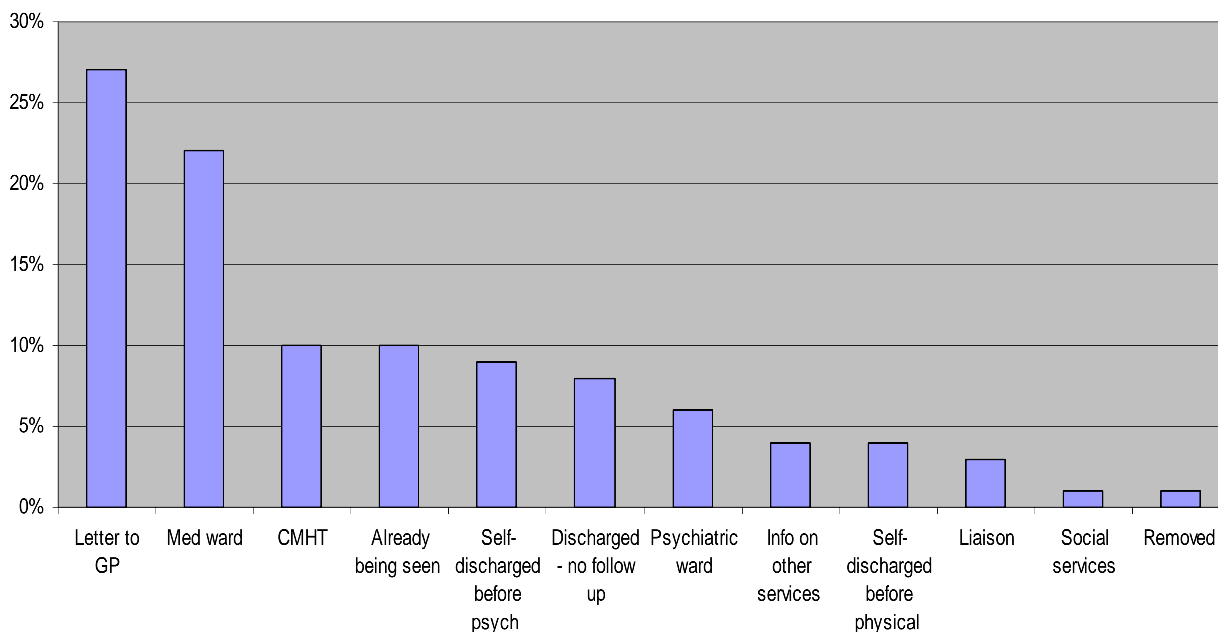
2	**Did the psychosocial assessment take place on:**	
	Day of arrival (e.g. before midnight)	29%
	Next day (e.g. after midnight)	13%
	Two days later or more	2%
	Unknown	26%
	Not Applicable - the patient did not receive a psychosocial assessment	29%

3	**Did the psychosocial assessment take place:**	
	Before discharge from the ED	31%
	On a ward after discharge from the ED	14%
	Other	2%
	Unknown	25%
	Not applicable - the patient did not receive a psychosocial assessment	26%

4	**If this patient waited overnight for assessment or discharge, did they stay in:**	
	A bedded area	36%
	The waiting area or relative's room	4%
	Other	6%
	Unknown	4%
	Not applicable - they did not wait overnight	48%

5. Patient Outcome (Tick as many as appropriate)	
Discharged - no follow up	8%
Discharged - referred to the CMHT	10%
Already being seen by healthcare professional - no further action	10%
Out patient appointment with liaison team	3%
Given information about the liaison team	0%
Referred to child and adolescent mental health services	0%
Referred to medical ward	22%
Referred to psychiatric ward	6%
Letter sent to GP informing them of self-harm	27%
Social services contacted	1%
Given information on other services (counselling, drug/alcohol services, Samaritans, RELATE etc)	4%
Self-discharged prior to physical treatment (against medical advice)	4%
Self-discharged prior to psychosocial assessment (against medical advice)	9%
Removed by security or police	1%
Not recorded/Not known	7%
Other	10%

Figure 2: Common outcomes for 346 people who were admitted following (from the 7 wave 3 hospitals)



Self-Discharge

The charts below allow teams to compare themselves directly with mean average of the wave 3 teams. Please refer to your team's unique code, or contact the central project team for details.

Figure 3: Comparison between teams of percentage of patients who self-discharged prior to physical treatment

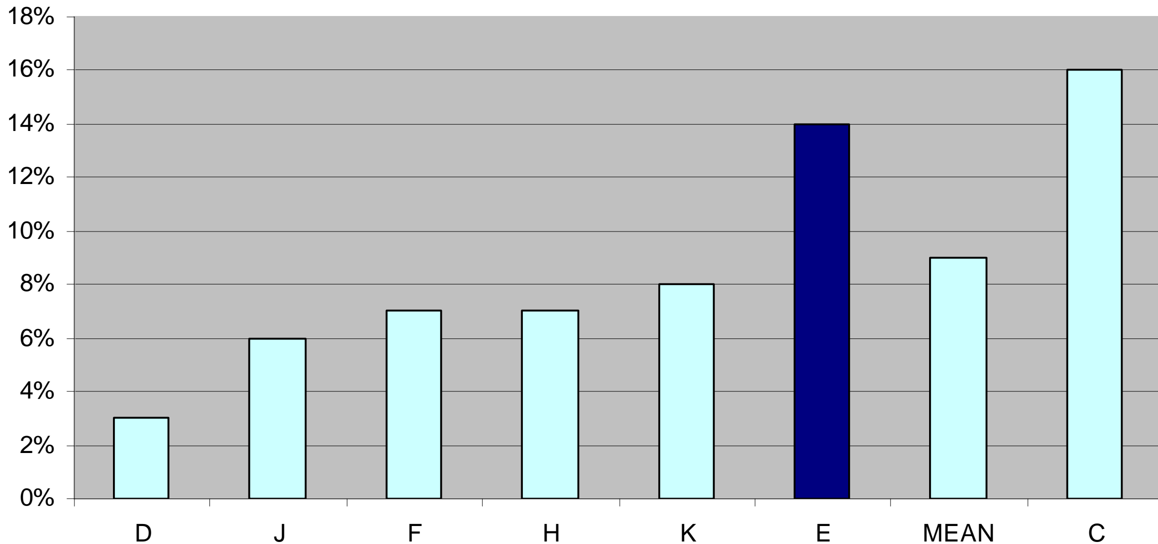
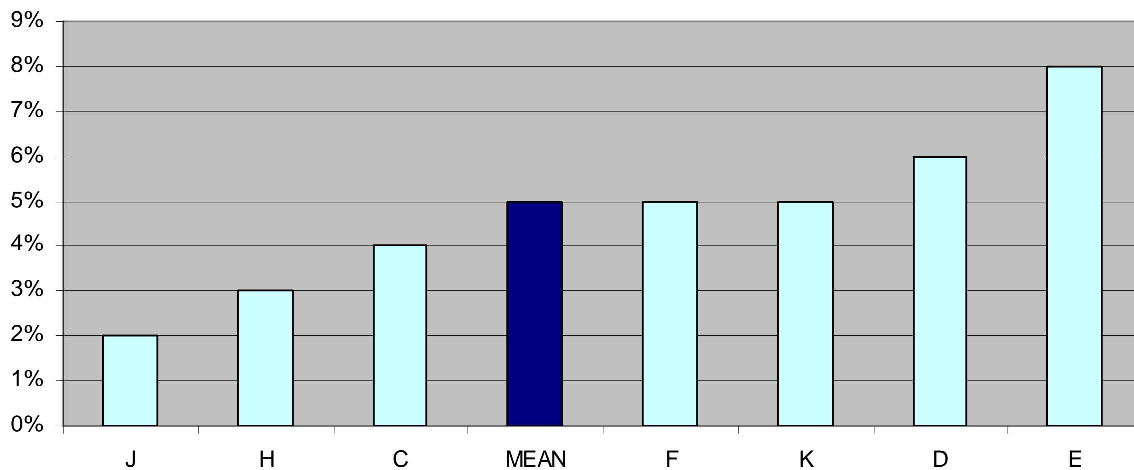


Figure 4: Comparison between teams of percentage of patients who self-discharged prior to psychosocial assessment



Comparison with previous data:
Of the 1,855 patients in wave 1, similar results were found:
- 4% discharged themselves prior to **physical treatment** (against medical advice)
- 5% discharged themselves prior to **psychosocial assessment** (against medical advice)

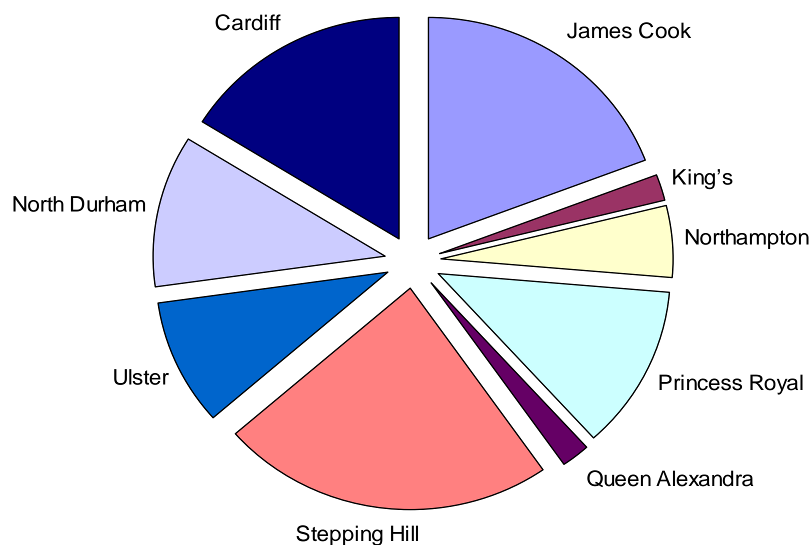
The Service User Experience

The following is a summary of the service user responses. Comments from service users have been counted and categorised using thematic analysis. Examples of common quotes are included below and remain unchanged, apart from a standard spell check.

In total, **81 service users** from the hospitals listed below completed the questionnaire:

Name of Hospital
James Cook University Hospital
King's College Hospital, London
Northampton General Hospital, Northamptonshire
Princess Royal University Hospital, Bromley, Kent
Queen Alexandra Hospital, Portsmouth, Hampshire
Stepping Hill Hospital, Stockport, Cheshire
Ulster Hospital, Belfast
University Hospital of North Durham
University Hospital of Wales, Cardiff

Figure 5: Breakdown of number of responses from each team:



Key to abbreviations:

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

Q1	How old are you?	
	16-18	9%
	18-64	90%
	Over 65	1%

Q2	When you arrived in the Emergency Department, were you asked about your mental distress as well as your physical health?	
	Yes	42%
	No	32%
	I don't know / I can't remember	26%

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

Q3	Throughout your time in the Emergency Department, did a member of staff check from time to time that you were okay and keep you updated on what was happening?	
	Yes	36%
	No	50%
	I don't know / I can't remember	14%

Q4	Were you given enough information about your injury/condition and the treatment you were being offered?	
	Yes	35%
	No	53%
	I don't know / I can't remember	12%

Q5	If you had any specific personal or communication needs (e.g. needs relating to language, ability, culture, religion or gender) where they taken into account?	
	Yes	6%
	No	13%
	I don't know / I can't remember	4%
	Not Applicable - I didn't have any	78%

Q6. If you had any needs, what were they?

Staff to take emotional distress into account (4 comments)

- They assumed that I was as articulate as I am when I am well. This was not the case. I needed more time and encouragement to communicate my emotional needs.

Other (3 comments)

- Special high chair because of 4 hip replacements was not provided.
- I had a crisis intervention plan that outlined my specific needs in this kind of situation this was not read.
- Spiritual needs.

Q7. Is there anything you would like to say, either positive or negative, about coming to hospital by ambulance, first arriving in the ED or waiting for tests or treatment?

Positive comments

Positive staff attitude (17 comments)

- I was treated with respect at all times by the ambulance crew and staff were dignified and very respectful.
- Ambulance staff were very friendly and I did not feel ashamed [or] degraded whilst with them.
- The doctor who followed up the treatment from the A&E department was kind, interactive and demonstrated good interpersonal skills which was needed during an emotional/mental breakdown crisis.

Speed of response (2 comments)

- I didn't go to hospital by ambulance. I walked to the hospital. On my arrival I told the receptionist I had cut myself and she asked if I had cut my wrists and I said yes and I was immediately attended to.

Good treatment (2 comments)

- Staff did deal with "physical" side of things efficiently.

Consideration of mental health needs (1 comment)

- Having explained that I suffer from bipolar I was given an interview room in which to wait as I was suffering from loud noise around me.

Negative comments

Negative staff attitude/discrimination (19 comments)

- I felt I was discriminated against as the staff attitudes to my overdose were very negative.
- I have had to go to the ED several times for injuries caused by self harm. I have been judged by hospital staff each time - the attitude seems to be that I don't have a right to medical treatment and/or respect because my injuries were self inflicted. My self harm is not a form of attention seeking but something I do, very privately unless I go too far, to help me to cope with everything else. There is little or no understanding of self harm and the reasons behind people's behaviour in EDs as far as I can tell.
- Some doctors/nurses were very judgemental, and seemed unhappy about giving treatment.
- I got the impression I was wasting their time.
- I believe that much of the derogative attitudes are due to a lack of understanding and a lack of wanting to understand as I have been told on several occasions along with my relatives 'we are general nurses we don't do mental health' and they are simply not willing to enter into any discussion or act upon any mental health concerns as they do not feel qualified or do not believe it is their job. All of this is very difficult to endure when you are at very low point.

Delay in treatment/staff not attending to needs (10 comments)

- Ambulance also took over half an hour to arrive.
- I was left alone in a side room for over 5 hours.
- There were long waits in between tests/treatment when no-one seemed particularly bothered about me.
- They do tend to put you to the back of the queue and you are left waiting for long periods of time in crowded waiting areas which sometimes leads to more agitation.

Lack of information provided (3 comments)

- When I got to hospital it took the staff a long time before they told me what was happening.

Lack of privacy (2 comments)

- There is a lack of confidentiality in the area where you book in - the whole waiting room can hear the conversation. When you decline to give details until seen by the triage nurse they make you wait behind others who arrive after you.

Distressing experience (2 comments)

- It made me feel bad, I felt agitated and nervous. Made me feel forgotten.

Treatment not helpful (1 comment)

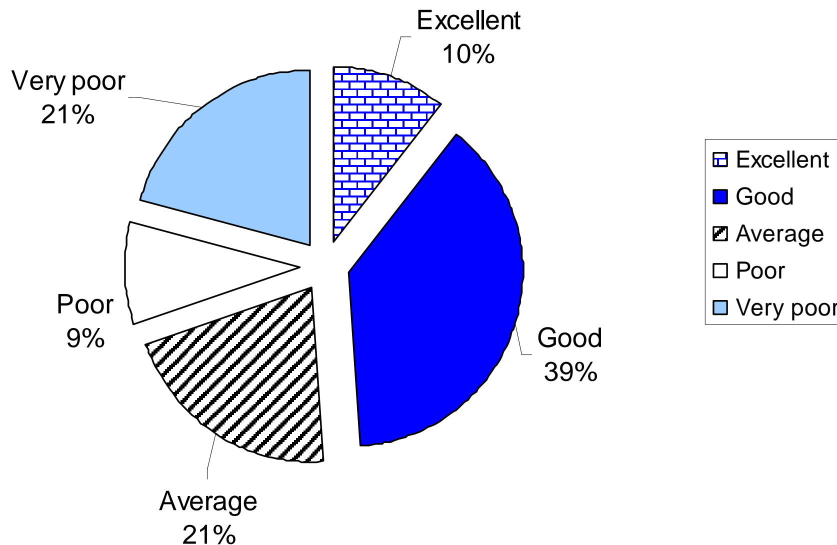
- Been in and out of hospital for a few years. I have been left for a long time and feel that the treatment was waste of time.

Q8	If you had physical treatment, were you given the choice about whether or not to have each treatment?	
	Yes	35%
	No	38%
	I don't know / I can't remember	9%
	Not Applicable - I didn't receive physical treatment	18%

Q9	If you needed pain relief at any stage (including while you were waiting), were you offered it?	
	Yes, I needed pain relief and was offered it	17%
	No, I needed pain relief but was not offered any	23%
	I needed pain relief but it was explained that due to medical reasons I could not be given any	14%
	I did not need pain relief	44%
	I don't know/I can't remember	3%

Q10	How do you rate the quality of physical treatment that you received?	
	Excellent	9%
	Good	33%
	Average	18%
	Poor	8%
	Very Poor	18%
	I don't know / I can't remember	3%
	Not applicable – I didn’t receive physical treatment	11%

Figure 6: How do you rate the quality of physical treatment that you received?



Positive comments regarding physical treatment

Good treatment given (5 comments)

- The treatment itself was good and effective.

Staff kind and reassuring (3 comments)

- The nurse was very kind and gentle.

Negative comments regarding physical treatment

Poor treatment given (5 comments)

- The nurses at triage have often left me bleeding and not done anything about it.
- I noticed a big difference in quality of physical treatment when admitted for a minor operation as apposed to care received when I have self-harmed. Also, I once had 35 stitches with no pain relief.

Delay in treatment (4 comments)

- Feel that the staff didn't care how I long I waited to be seen. I felt that I want to harm myself more.

Staff attitude/lack of concern shown (3 comments)

- The treatment…was administered by staff who made snide comments about my injury and the scars that were visible having rolled up my sleeves so they could treat my wound. I was made to feel ridiculous, unworthy or time and treatment and like a waste of space basically.

Q11	**Were you seen by a mental health professional while you were in hospital?**	
	Yes	65%
	No	34%
	I don't know / I can't remember	1%

Q12	**Were you given the opportunity to talk about your self-harm and what led to it?**	
	Yes	68%
	No	25%
	I don't know / I can't remember	7%

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

Q13	**Were you involved in thinking through what care you might need after leaving hospital?**	
	Yes	48%
	No	48%
	I don't know / I can't remember	4%

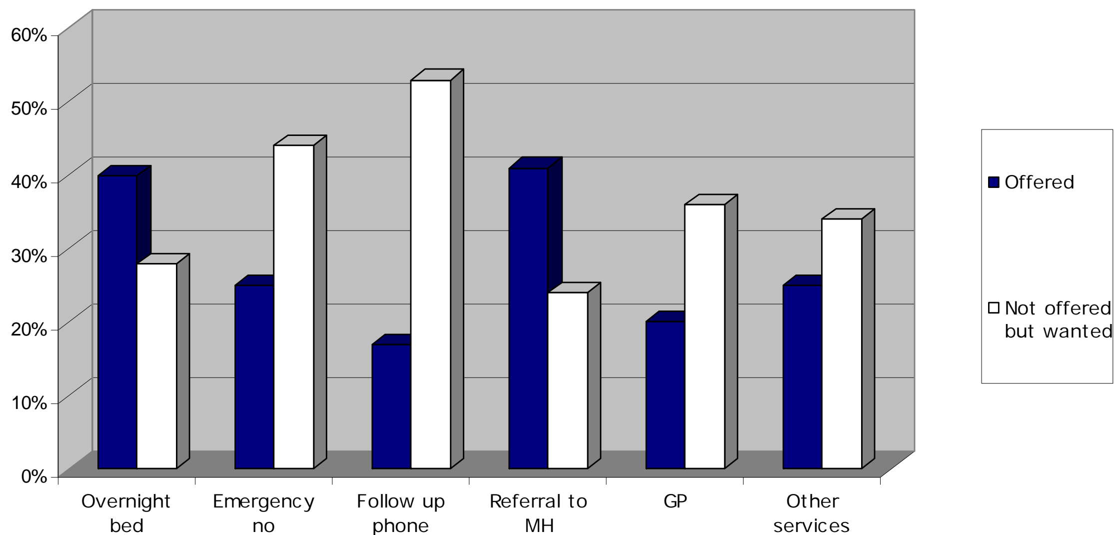
Self-Harm: 3.1, 19.1 & 19.2. NICE: 1.1.1.6. Healthcare Commission: C17

Q14	**Did you feel that you were offered the appropriate aftercare?**	
	Yes	38%
	No	58%
	I don't know / I can't remember	4%

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

Q15	**Were you offered any of the following?**	**Yes**	**No. I wasn't offered this but would have would have liked it.**	**N/A – I didn't need this**
	An overnight bed	40%	28%	31%
	Information on emergency numbers	25%	44%	30%
	Follow up telephone call	17%	53%	30%
	Referral to mental health services	41%	24%	35%
	Referral to GP	20%	36%	44%
	Referral to other services (such as RELATE, drug & alcohol services, social services)	25%	34%	41%

Figure 7: Which of the following were you offered? If not, which of the following would you have liked?



Q16. Any other comments about your aftercare?

Positive comments

Appropriate aftercare offered (6 comments)

- Had to go to GP for aftercare and have had excellent care.
- The referral to the mental health service and the counsellor I am seeing are excellent.

Needs understood (1 comments)

- I am a well known regular at the moment so they understand my need to be treated ASAP so I can get out.

Negative comments

Not enough input/aftercare (11 comments)

- I felt chucked out and left to sort out follow up myself.
- Mostly staff just stitched up the wounds and sent me home. On some occasions I have been seen by a mental health professional but very rarely.
- I was told on last two occasions [I] would receive a home visit from crisis team but no-one came.

Aftercare not timely enough (5 comments)

- I wasn't given any immediate follow up but was referred to the psychiatric liaison team after several weeks.
- I am currently being offered a week's inpatient care to look at my needs. I have asked for admission repeatedly and I wish this would have been offered sooner when I asked for admission.
- I was promised a phone call from my Community Psychiatric Nurse (CPN) and if he wasn't available at least from another CPN - two weeks later I am still awaiting this contact. This is despite counsellors, GP and psychiatrist speaking to him on my behalf. I have not been provided with a contact for crisis resolution team.

Needs not considered (3 comments)

- No-one bothers to see if you're ok after you leave the hospital, don't think anyone cares as they don't while you're at the hospital so guess it doesn't change when you leave. Feels like you're a worthless cause: why should they help.

Care offered was not appropriate (3 comments)

- Put me on a ward overnight, "because crisis team weren't there at night". Was unnecessary, pointless and annoying, gave no other help.

Discharged too early (2 comments)

- Discharged early after an acute stay.

Q17	**Would you have liked more information on any of the following? (tick as many as apply)**	
	Information about local self-help groups	64%
	Information about advocacy services	30%
	Information about who to contact in an emergency	55%
	Details of telephone helplines	43%
	Leaflets about self-harm	55%
	Other	15%

If you selected 'Other' please say below what you would have liked

Further referrals/support (6 comments)

- Not sure at the time. Looking back I think I needed someone to take time to talk to me about these things over a period of time.
- Referral to a service user group for substance misuse.

Didn't want any information/already had enough (5 comments)

- Had all the advice I could ask for.

More information about self-harm (2 comments)

- Guidance on how to avoid harm-inducing thoughts or to deal with them better (but I guess I need to see a psych for that, and I'm on the waiting list).

More information about follow-up (1 comment)

- Who was going to talk to me as follow-up. I sorted this myself the next day but felt at risk overnight.

Q18	**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	45%
	No	43%
	I don't know / I can't remember	12%

Q19. Is there anything, positive or negative, you would like to say about your psychosocial assessment? (A psychosocial assessment is when a member of the mental health team asks you, in detail, about how you are feeling, why you self-harmed and so on. The assessment normally lasts between 30 minutes and an hour).

Positive comments

Good assessment (8 comments)

- The psychiatrist who assessed me was very thorough and approachable.
- My assessment lasted two hours, best treatment I have ever had.

Staff caring and friendly (5 comments)

- The team who performed the assessment were very positive and friendly, helping me to feel comfortable. The team also were very respectful.
- The person who came to assess me was very friendly and patient.

Follow-up from assessment positive (4 comments)

- I had follow-up from the crisis team first of all and they were excellent. Later contact with the community mental health team was also very helpful.

Felt listened to (3 comments)

- The man was kind and listened carefully and patiently to what I said even though I was distressed.

Negative comments

Not offered enough help (9 comments)

- They can be limited to what they can do, they should give information about services which you can tap into yourself e.g. open mind centre and other services.
- I don't agree that the assessment should have ended with me being sent home. Staff did not really listen to what I was saying.
- I find that the assessment doesn't usually achieve anything and they can be difficult during the evening when the junior doctors do them.

No assessment took place (8 comments)

- I had no assessment at A&E.

Unhelpful attitudes from staff/ didn’t feel understood (6 comments)

- Doesn’t really help – it’s the same questions all the time but guess they try to understand but they don’t.
- I felt judged and didn't want to open up fully because I felt like I was being judged and laughed at.
- Very patronising.

Not asked enough/not given enough time (3 comments)

- I don’t remember having a psychosocial assessment. I always seem to be asked by my psychiatrist how I am feeling, but not about self-harm. I don’t think they listen anyway and just want me out of the way. It is difficult to explain things that I do anyway because sometimes I’m not sure myself why I do things and sometimes it doesn’t seem like it’s me doing things but someone else.
- This was not conducted properly - assessment lasted less than 5 minutes.

Delay in assessment (1 comment)

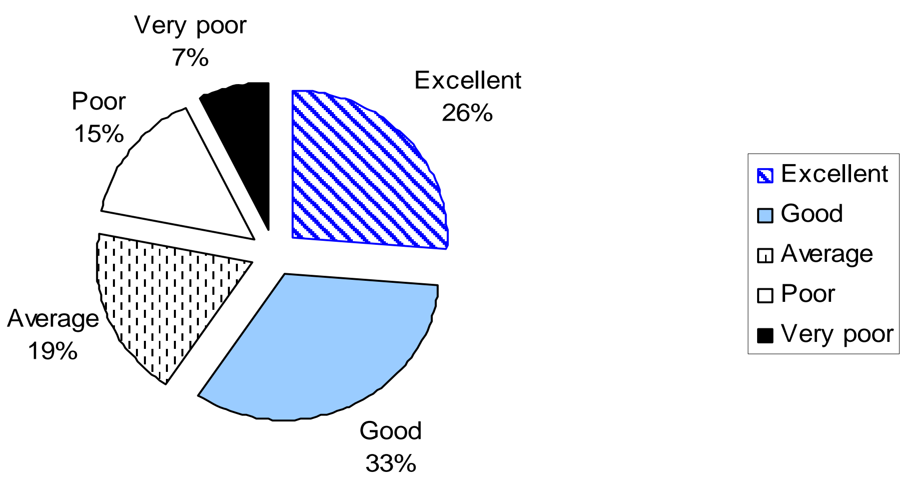
- I wouldn't talk to the mental health team as they had left me alone too long.

How do you rate the following staff in terms of their attitude, respect and behaviour towards you on this occasion?

Q20	Excellent	Good	Average	Poor	Very Poor
Ambulance staff	45%	26%	11%	15%	4%
Triage staff	18%	30%	25%	18%	9%
Reception staff at hospital	20%	43%	18%	16%	3%
The people who gave you physical treatment	16%	34%	21%	16%	11%
The person who conducted the psychosocial assessment	33%	31%	18%	9%	9%

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

Figure 8: Average ratings of all staff in terms of their attitude, respect and behaviour



Q21. Is there anything positive that you would like to say about the staff that you saw? Please be clear about which staff group you are referring to?

Positive staff attitude (41 comments)

- The ambulance people were marvellous and didn't think I was wasting their time self harming.
- Staff in hospital very caring and professional with their approach to the situation.
- Two nurses working on the EAU were fantastic with me; they were caring, respectful and did not judge me. I have never experienced this before in all the years I have been attending A&E. They made a massive difference to me when I was very ill and so I wrote to them to tell them. For people in mental distress a little TLC makes a massive difference and it felt important to tell them.
- Everyone was very good to me. Doctors, nurses, ambulance staff, mental health staff.
- Attitudes have changed in recent years; in general I get treated much better than I did a few years ago.
- The consultant was superb - she calmed me down, explained everything to me, reassured me and was extremely understanding and non-judgemental. I cannot get across how brilliant and caring she was.
- The counsellor was very easy to talk to and made me feel like she understood everything I told her.
- On this occasion the doctor doing the ward round was good, didn't say stupid things or belittle me - makes a change. Also doctors seen on admission to the ward were good and spent time talking to me which was very positive and I am grateful for.
- The receptionist was very sensitive, even offered to take my details in a side room if I didn't feel comfortable talking in front of people in the waiting room. She made my friend feel at ease (he was a bit embarrassed to be with me).

Consideration of needs/wishes (2 comments)

- All staff were excellent they didn't force me to see the psych team when I didn't want to.

Good physical care given (2 comments)

- The staff in A&E in their actual treatment to my physical wounds have always been fantastic.

Good mental health care given (1 comment)

- Several of the nursing staff on the wards were very helpful with my panic attacks.

Speed of response (1 comment)

- The mental health people were very quick to arrive and talk me through my problems.

Q22. Is there anything negative that you would like to say about the staff that you saw? Do you have any suggestions for improvements? Please be clear about which staff group you are referring to.

Negative staff attitude (33 comments)

- At one point I felt that one nurse looked at me in a disapproving way of what I had done. Staff should not judge people like me for what we do. We are not looking for attention or sympathy. What we do is part of a release of our tension or anger. We just need help.
- They can be negative about mental health.
- One specific triage nurse was very judgmental, seemed angry that I was wasting their time, and wanted to give insufficient treatment.
- Some doctors and nurses and ambulance staff are very arrogant, like they begrudge having to treat you, not understanding at all.
- Most staff (both doctors and nurses) involved in my care were very ignorant, if not rude towards me. They openly displayed fear of me even though I have absolutely no history of violence. They made presumptions that I did not work when in fact I am a professional and they made me feel worse about myself by making me feel like I was a time waster and that I was just attention seeking.
- Nursing staff should try and be a little more understanding instead of looking down on you as if you're crap. I try not to go to the hospital anymore when I self harm because of it.
- I wish people wouldn't judge me for what I do. I understand why people think I waste time. I wish I could make them understand.
- Staff nurses (triage staff) - I was dismissed as being one of a group of people they treat who self-harm, e.g. one staff member rolled their eyes when I came in.
- We should be treated by doctors and nurses in exactly the same way as anyone else who has come for treatment and hurt themselves accidentally, not have nurses pretend they are cleaning your wound but are just being rough.

More training/mental health knowledge needed (9 comments)

- Physical health care staff should be provided with greater training regards mental health and deliberate self-harm and suicide.
- Apart from the ambulance service everyone else seemed to need training on how to cope with people who have self harmed.

Lack of information given (6 comments)

- I was left alone in a side room for 5 hours. I was not communicated to and didn't have a clue what was happening.
- Nursing staff were dismissive and patronising, failed to explain what activated charcoal was - I was left with two cups of it, alone in the corridor. I suffer with an eating disorder as well so struggle to drink in front of people.
- No-one told me my blood results or when the doctors were coming etc.

Kept waiting for treatment (4 comments)

- Being kept waiting a long time for treatment, this makes me more likely to self-harm in hospital, while I wait to be seen.

Lack of sufficient discussion/communication (4 comments)

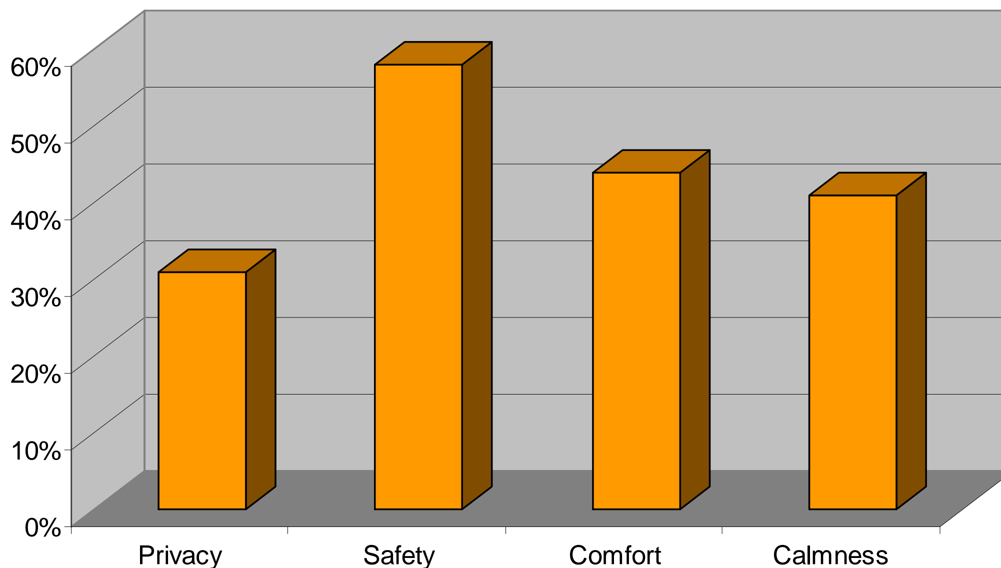
- They should talk to you in more detail and ask more questions. Then they might just get where we are coming from.

Other

- Place the reception in a more confidential area. Train the receptionist to leave the triaging to the triage nurse and not to leave self-harmers to the back of the queue if several people arrive close together.
- I would have really appreciated a quiet room, I felt like a freak show - just wanted to be treated humanely.

Q23	Do you think the environment of this ED offer patients enough:	Yes	No	Don't know Can't remember
	Privacy?	31%	62%	7%
	Safety?	58%	35%	7%
	Comfort?	44%	54%	3%
	Calmness?	41%	54%	6%

Figure 9: Percentage of service users who feel that their local Emergency Department environment provides enough privacy, safety, comfort and calmness.



If you answered 'No' for any of the above, please say which part/s of the environment need to be improved and what needs to be done.

Lack of privacy (18 comments)

- Curtains to bed areas are left open and the staff can be overheard talking about patients.
- Staff awareness of patients' privacy to be increased.
- Privacy - it's really hard when doctors ask questions at your bedside about if you've tried to kill yourself, all the other patients can hear.

Not comfortable (13 comments)

- I had a lot of back pain but was not given any pillows or other form of support for my back.
- Waiting area not comfortable for 4 hours when distressed.

Provision of extra quiet rooms (8 comments)

- It would be better that the person be seen in a more confined room away from the hustle and bustle of staff and patients passing. The patient should be provided with a quiet room away from noise, but not left in the room on his/her own for too long.
- Could do with more than one quiet room as this is often already taken.

Not a calm atmosphere (6 comments)

- Sitting too close to other people. Lots of people moving around and it was noisy. I felt agitated, nervous and anxious.
- Calmness - staff seemed very stressed. The A&E department was hectic, noisy, no privacy, staff had no time to engage.

Being left on own – unsafe (6 comments)

- Safety - I don't believe someone who has just taken an overdose should be left alone for such a long period of time.
- Didn't feel that safety was considered. Was often left alone with trolley containing scalpels, sutures, etc.

Not feeling safe due to staff or other patients (4 comments)

- You are not physically safe from staff, I had a heart monitor on for about two hours then they said it hadn't been working and just to leave it because it wouldn't stick, and they pin you down and cause you pain.
- There were too many people under the influence of alcohol and I felt under threat.

Q24	Have you ever....	Yes	No	Don't know Can't remember
	Used emergency services following self-harm before?	76%	21%	3%
	Had contact with mental health services before this visit?	88%	13%	0%

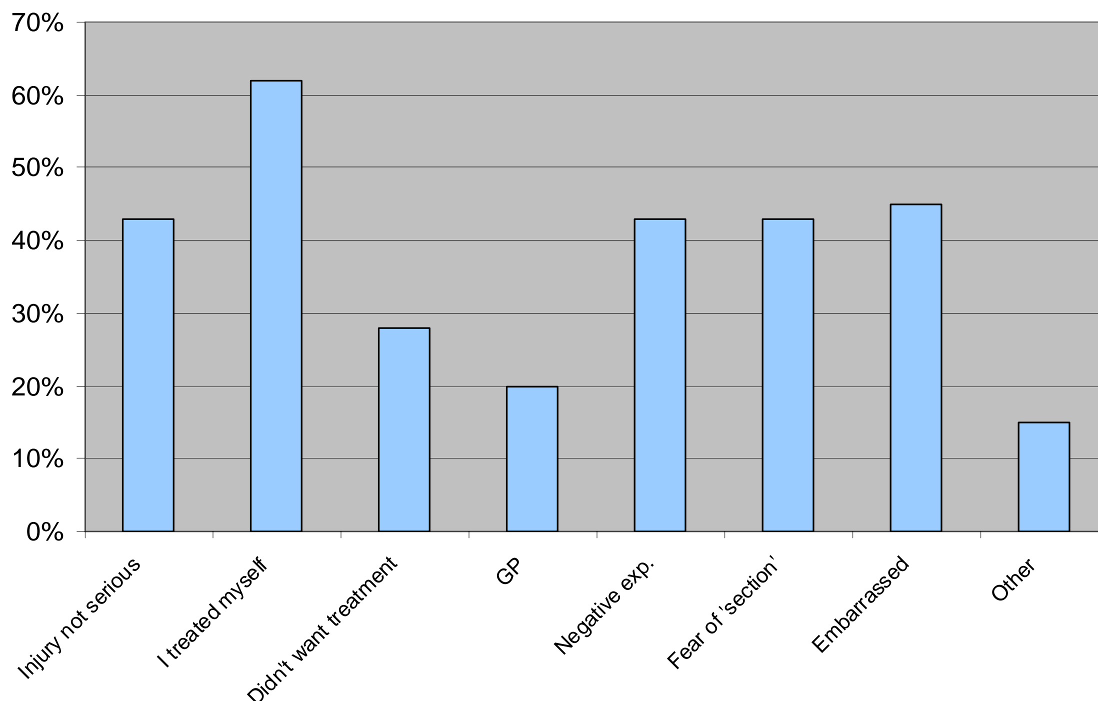
Q25	If you have self-harmed in the past but NOT used emergency services, why was this? Tick as many boxes as you wish	
	The injury wasn't serious enough	43%
	I treated myself	62%
	I didn't want the injury or illness to be treated	28%
	I went to my GP	20%
	I've had a negative experience of services before	43%
	I was worried I might be sectioned	43%
	I was embarrassed	45%
	Not applicable	13%
	Other	15%

If other, please state below:

- Was under 16, didn't want parents to know.
- Sometimes I felt as if I was being treated like a naughty schoolboy and people hadn't time for my problem.

- Having overdosed, physically unable to call ambulance, in and out of consciousness for three days on floor at home, when finally conscious decided it was too late and not to contact services even though I didn't want to die, too ill to contact services, avoiding being given impulsive behaviour label by psychiatrist, didn't want to speak to liaison for personal reasons, overdose included illegal drugs and knew I wouldn't be treated for this, unable to afford taxi, many reasons on different occasions.
- I didn't feel well enough to go through the system.
- Wanted to die.

Figure 10: If you have self-harmed in the past but NOT used emergency services, why was this?



Q26. Is there anything else you would like to say about your experience of using services following self-harm?

Positive comments

Staff were good (3 comments)

- I thought everybody was very kind to me.
- 80% of A&E doctors and nurses treat me with kindness, consideration etc. Staff make the process either bearable or unbearable but things have improved in the last sixteen years.

Physical treatment (2 comments)

- Keep using anaesthetic for self-harmers when stitching is required. It is very thoughtful of the doctors when they use anaesthetic before cleaning the wound, which is otherwise very painful.
- Immediate physical issue taken care of.

Good aftercare (2 comment)

- If you get past the uncaring and hostile receptionist and the nonchalance of A&E staff, the mental health and crisis teams here have been unfailingly supportive. It's a shame the barriers to them are so difficult to get by when you feel at the most need of them and sometimes it becomes impossible to access help.
- I do feel I was supported in my follow up assessment.

Negative comments

Staff attitudes to people who self-harm (10 comments)

- I have had bad experience from hospitals and the way staff treat patients is appalling. I felt unsafe and had no one to turn to for help.
- My initial [visit] to A&E was a negative experience and I was disgusted by staff attitudes. I was very distressed and I did not get the support I felt I needed.
- Positively I have seen changes in the way I've been treated in recent years although I do feel that if healthcare professionals understood the reasons why people self-harm and can be helped to see the bigger picture it might take the stigma away a bit more. Although I am not spoken to badly these days, I still sense that people like me are a pain and wasting time and taking up beds. When I attend A&E I am just another self-harmer that's all people see I guess, seeing the bigger picture and being treated the same way as someone with a broken leg or arm. Treat the person not the label, it's important to understand self-harm is something that keeps people alive, a coping mechanism, and not an attention seeking act.

Need to be taken seriously/have needs considered (3 comments)

- If a person who self-harms and makes an effort to go to ED, it is obvious he/she is seeking help and support. The person should not be just bandaged up and sent home otherwise this could provoke a further incident. It may make the person feel unworthy of help or feel rejected. The person should be seen by a professional psychiatrist and asked if he/she requires hospitalisation and the wishes of the person should be accepted. If the person has done serious self-harm, and cannot answer for him/her self, should that person then be sectioned for his/her own safety.
- Everything that happened seemed to be for the convenience of staff rather than to meet my needs.

More opportunity to talk and better aftercare (2 comments)

- Physical issue taken care of, but not enough talking through...poor aftercare.
- If a promise is made to a person for contact the following day - this must be carried out.

Waiting times for treatment (2 comments)

- I would like to be treated like a human. Not to be pushed down the list of emergencies all the time (regarding the 4 hour wait).

Need more training for staff/ more specialist input (2 comments)

- It would be nice to see the improvement of more integrated specialist staff to work with those patients who have self harmed. Increased basic training for physical health care staff who come into contact with this patient group.
- I think it would be helpful if ED staff were given more information about self harm and some of the reasons why people do it. Perhaps to be made aware of how certain things that staff say can negatively impact patients.

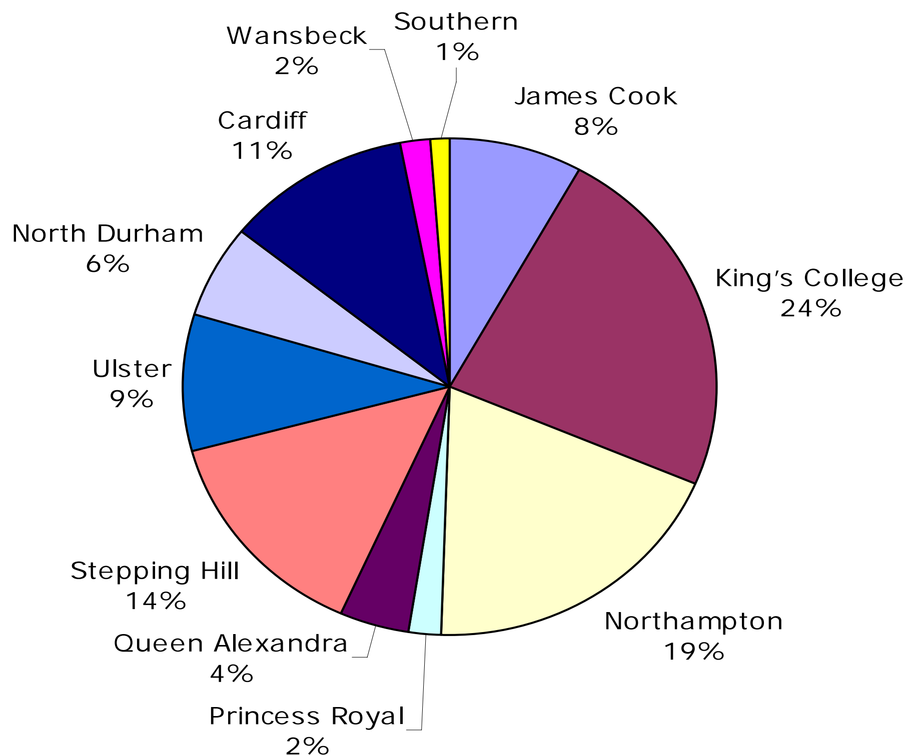
The Staff View

The following questionnaire was available online from August to November 2007. Comments from staff have been counted and categorised according to their content. Examples of common quotes are included below and remain unchanged, apart from a standard spell check.

In total, **395 staff** from the hospitals listed below completed the online questionnaire:

1. James Cook University Hospital
2. King's College Hospital, London
3. Northampton General Hospital, Northamptonshire
4. Princess Royal University Hospital, Bromley, Kent
5. Queen Alexandra Hospital, Portsmouth, Hampshire
6. Southern General Hospital, Glasgow
7. Stepping Hill Hospital, Stockport, Cheshire
8. Ulster Hospital, Belfast
9. University Hospital of North Durham
10. University Hospital of Wales, Cardiff
11. Wansbeck General Hospital, Northumberland

Figure 11: Breakdown of staff responses



Q1. Which service/department do you work for?	
Ambulance Service	7% (27 staff members)
Emergency Department	35% (140 staff members)
Mental Health Service	49% (194 staff members)
Other	9% (34 staff members)

Q2. AMBULANCE: Which of these job titles best describes your role?	
Paramedic	48%
Ambulance Technician	26%
Manager (Area Services or Operations)	15%
Care Assistant	0%
Emergency Care Practitioner	0%
Student	11%
Other	0%
EMERGENCY DEPARTMENT: Which of these job titles best describes your role?	
Qualified Nursing Staff	57%
Unqualified Nursing Staff	3%
Consultant/Associate Specialist	8%
SpR/SHO/F2/Staff Grade	23%
Receptionist/Admin/Clerical	4%
Domestic/Security/Porter	1%
Student	0%
Other	5%
MENTAL HEALTH: Which of these job titles best describes your role?	
Qualified Mental Health Nurse	44%
Unqualified Mental Health Nurse	2%
Consultant Psychiatrist/Staff Grade/Associate Specialist	10%
Training Grade Doctor (SpR/SHO/ST)	11%
Admin/Reception/Clerical/Secretary	2%
Therapist/Psychologist/Psychotherapist	14%
Social Worker	9%
Student	2%
Other	6%
OTHER STAFF: Which of these job titles best describes your role?	
Advocate	6%
CDU Staff	0%
General Practitioner	9%
MAU Staff	12%
Pharmacist	0%
Social Worker	0%
Toxicologist	0%
Voluntary Organisation worker	0%
Service Manager	0%
Other	74%

The training needs of all staff

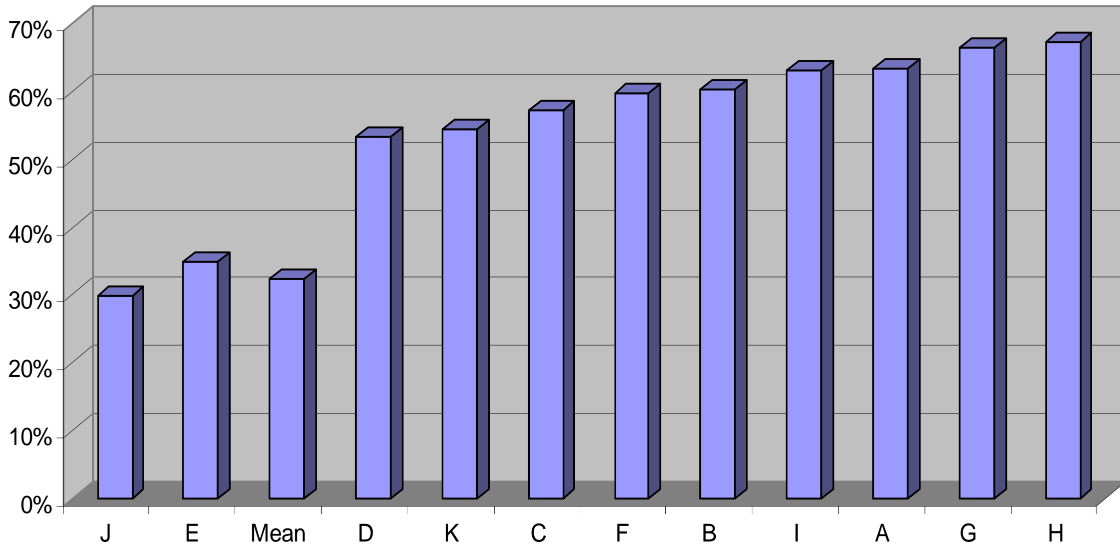
Areas highlighted as insufficient by 50% or more staff are **in bold**

Q3. Training/Education/Awareness Please rate the education/training you have received in the following areas relating to self-harm.	Sufficient	Insufficient	N/A
Basic awareness of mental health problems	82%	16%	2%
Understanding why people self harm	67%	31%	2%
Assessing mental health needs	65%	29%	6%
Basic awareness of risk	83%	15%	2%
Assessing mental capacity	55%	35%	8%
Assessing the social needs of the person	61%	29%	8%
The impact of cultural differences on self-harm	33%	**62%**	4%
The basis of the Care Programme Approach (CPA)	44%	47%	7%
Understanding the role of local services	63%	32%	2%
Basic understanding of the Mental Health Act and relevant common law	71%	25%	3%
Conducting preliminary assessments	60%	26%	12%
Conducting in-depth psychosocial assessments	37%	39%	23%
How to refer/discharge a patient appropriately	67%	20%	12%
Assessing risk, hopelessness and suicidal intent	64%	27%	8%
Understanding the care pathway	47%	45%	6%
Using psychological therapy with people who self-harm	30%	**50%**	19%
Training specific to older aged patients (65 and over)	14%	**57%**	28%
Training specific to young people (16 and under)	21%	**54%**	23%
Working with people who misuse alcohol or drugs	50%	43%	5%
Mental health and self-harm awareness	65%	32%	2%

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

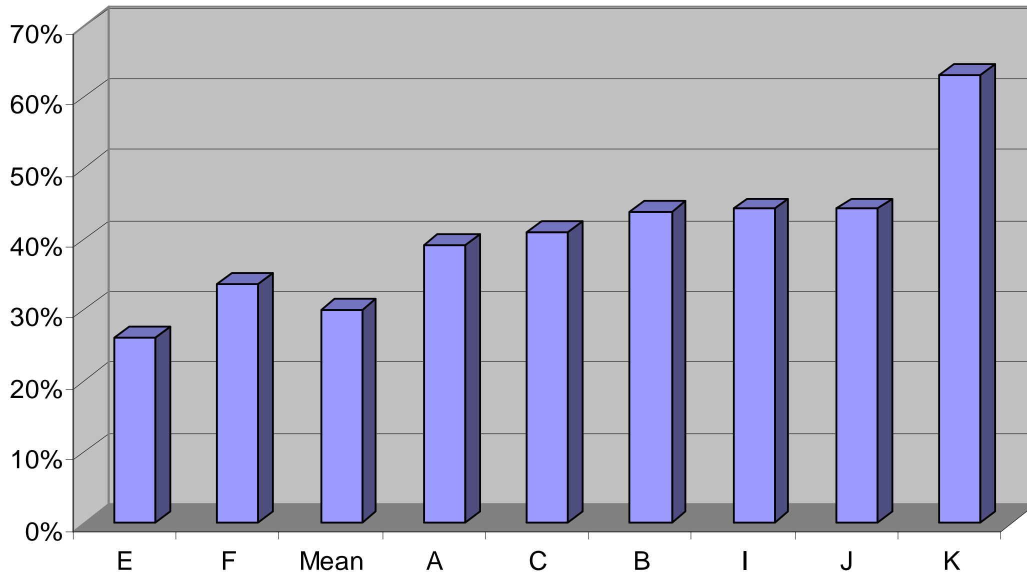
Q4. Would you have liked to have received more education on mental health and/or self-harm during any of the following? Please select as many as applicable	
Your **initial** basic training	49%
Your **induction** with the Trust	37%
Any **refresher** training you have received	66%

Figure 12: Average percentage of <u>all</u> staff groups who have received sufficient training in the areas listed in question 3, above



The letters A-K are the unique codes relating to each participating team. Trusts that cannot locate their unique code should contact the central project team.

Figure 13: Average percentage of <u>non-mental health staff</u> (ambulance and ED) who have received sufficient training in the areas listed in question 3.



N.B. Two teams had very small numbers of responses from non-mental health staff and have therefore been excluded from the above chart.

Ambulance staff

Areas highlighted as insufficient by 50% or more staff are **in bold**

Q5. Training/Education/Awareness Please rate the education/training you have received in the following areas relating to self-harm.	Sufficient	Insufficient	N/A
Basic awareness of mental health problems	59%	41%	0%
Understanding why people self harm	19%	**81%**	0%
Assessing mental health needs	19%	**74%**	7%
Basic awareness of risk	89%	11%	0%
Assessing mental capacity	11%	**78%**	7%
Assessing the social needs of the person	19%	**67%**	15%
The impact of cultural differences on self-harm	4%	**96%**	0%
The basis of the Care Programme Approach (CPA)	0%	**89%**	7%
Understanding the role of local services	48%	**52%**	0%
Basic understanding of the Mental Health Act and relevant common law	70%	30%	0%
Conducting preliminary assessments	26%	**70%**	4%
Conducting in-depth psychosocial assessments	0%	**59%**	41%
How to refer/discharge a patient appropriately	7%	**74%**	19%
Assessing risk, hopelessness and suicidal intent	15%	**81%**	4%
Understanding the care pathway	7%	**85%**	7%
Using psychological therapy with people who self-harm	0%	**63%**	37%
Training specific to older aged patients (65 and over)	4%	**89%**	7%
Training specific to young people (16 and under)	4%	**89%**	7%
Working with people who misuse alcohol or drugs	19%	**81%**	0%
Mental health and self-harm awareness	30%	**70%**	0%

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

Is there any other training not listed above that you feel you need?

- Intervening in a crisis.
- Generally an area that is widely neglected within our training programme other than to give us specific mental health act info.
- Further training with a greater awareness for each of the categories listed.
- Mental health assessment training and awareness of risk.

Ambulance staff

Q6. Would you have liked more education on mental health and/or self-harm during any of the following? Please select as many as applicable	
Your **initial** basic training	74%
Your **induction** with the Trust	7%
Any **refresher** training you have received	85%

Q7. If you would like more training, which of the following methods would suit you best? Tick as many as apply	
A slide set presentation on self-harm*	41%
An information leaflet 'Understanding People Who Self-Harm'*	44%
Online training exercises*	56%
In-house lectures/workshops/seminars	67%
Training delivered (or partly delivered) by service users	56%
Shadowing mental health colleagues	41%
External courses	30%
Study days	37%
Regular updates/feedback on performance	48%
Anything else?	0%

*These will be provided by the national 'Better Services for People who Self-harm' team.

Q8. Please rate **the support and supervision you have received relating to caring for people who self-harm.**	Excellent	Sufficient	Insufficient	N/A
Clinical supervision: to discuss the emotional impact of working with self-harm	0%	22%	70%	4%
Reflective supervision - to get feedback on how a specific situation was managed	0%	33%	59%	4%
De-briefing opportunities: allowing staff to de-brief promptly following a specific incident that has been traumatic for you	0%	22%	74%	0%
General support from colleagues	22%	52%	22%	0%

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?

- Post-traumatic support.

ED staff

Areas highlighted as insufficient by 50% or more staff are **in bold**

Q5. Training/Education/Awareness Please rate the education/training you have received in the following areas relating to self-harm.	Sufficient	Insufficient	N/A
Basic awareness of mental health problems	72%	25%	2%
Understanding why people self harm	54%	43%	1%
Assessing mental health needs	41%	49%	8%
Basic awareness of risk	69%	29%	1%
Assessing mental capacity	41%	47%	9%
Assessing the social needs of the person	46%	43%	8%
The impact of cultural differences on self-harm	19%	**75%**	5%
The basis of the Care Programme Approach (CPA)	9%	**77%**	9%
Understanding the role of local services	46%	47%	2%
Basic understanding of the Mental Health Act and relevant common law	54%	42%	2%
Conducting preliminary assessments	44%	39%	15%
Conducting in-depth psychosocial assessments	7%	**59%**	33%
How to refer/discharge a patient appropriately	61%	24%	13%
Assessing risk, hopelessness and suicidal intent	45%	41%	11%
Understanding the care pathway	24%	**64%**	9%
Using psychological therapy with people who self-harm	10%	**61%**	26%
Training specific to older aged patients (65 and over)	10%	**74%**	15%
Training specific to young people (16 and under)	16%	**71%**	12%
Working with people who misuse alcohol or drugs	39%	**52%**	6%
Mental health and self-harm awareness	51%	46%	2%

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

Is there any other training not listed above that you feel you need?

- The care programme approach and its uses.
- Further training in the management of psychiatric patients.
- Assessing for discharge and or referral.
- Resources for people who would benefit from cognitive behavioural therapy or cognitive analytical therapy.

ED staff

Q6. Would you have liked more education on mental health and/or self-harm during any of the following? Please select as many as applicable	
Your **initial** basic training	47%
Your **induction** with the Trust	41%
Any **refresher** training you have received	76%

Q7. If you would like more training, which of the following methods would suit you best? Tick as many as apply	
A slide set presentation on self-harm*	46%
An information leaflet 'Understanding People Who Self-Harm'*	35%
Online training exercises*	51%
In-house lectures/workshops/seminars	73%
Training delivered (or partly delivered) by service users	36%
Shadowing mental health colleagues	37%
External courses	26%
Study days	51%
Regular updates/feedback on performance	43%
Anything else?	5%

*These will be provided by the national 'Better Services for People who Self-harm' team.

Comments:

- Service user involvement would be the greatest teaching tool by far.
- We are sometimes told ED referrals are inappropriate; this is sometimes done in a negative way, when it would be appreciated if it were seen as an opportunity for teaching.
- Resources available especially at night when psychiatry services do not want to come and assess and it is felt that it is a risk to discharge patient especially when threatened violence.
- Role play.
- Practical training / teaching sessions are better than more pieces of paper.

ED staff

Q8. Please rate **the support and supervision you have received relating to caring for people who self-harm.**	Excellent	Sufficient	Insufficient	N/A
Clinical supervision: to discuss the emotional impact of working with self-harm	2%	32%	56%	7%
Reflective supervision - to get feedback on how a specific situation was managed	6%	28%	59%	6%
De-briefing opportunities: allowing staff to de-brief promptly following a specific incident that has been traumatic for you	3%	25%	66%	6%
General support from colleagues	17%	64%	16%	2%

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?

- The support from ED colleagues is generally very good, however we are often not supported by the psychiatric services who are often not on the shop floor with the patients.
- Feedback about patients that are sectioned and admitted, and support from the mental health team in doing this process, finding bed etc.

Mental health staff

Q5. Training/Education/Awareness Please rate the education/training you have received in the following areas relating to self-harm.	Sufficient	Insufficient	N/A
Basic awareness of mental health problems	96%	2%	2%
Understanding why people self harm	87%	12%	1%
Assessing mental health needs	94%	4%	2%
Basic awareness of risk	95%	3%	2%
Assessing mental capacity	75%	18%	5%
Assessing the social needs of the person	77%	15%	6%
The impact of cultural differences on self-harm	49%	46%	2%
The basis of the Care Programme Approach (CPA)	81%	14%	4%
Understanding the role of local services	78%	17%	1%
Basic understanding of the Mental Health Act and relevant common law	91%	7%	2%
Conducting preliminary assessments	82%	7%	8%
Conducting in-depth psychosocial assessments	69%	21%	10%
How to refer/discharge a patient appropriately	82%	9%	7%
Assessing risk, hopelessness and suicidal intent	90%	6%	3%
Understanding the care pathway	74%	23%	2%
Using psychological therapy with people who self-harm	53%	37%	9%
Training specific to older aged patients (65 and over)	20%	40%	39%
Training specific to young people (16 and under)	30%	33%	34%
Working with people who misuse alcohol or drugs	64%	30%	4%
Mental health and self-harm awareness	84%	13%	2%

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

Is there any other training not listed above that you feel you need?

Self-harm in specific client groups (9 comments)

- Within my role I am often required to conduct risk assessment and discharge packages for service users who self harm and also have some level of learning disability. Whilst my experience with the client group has given me acquired skills to assist in this area and I can of course seek advice - specific training in interventions and needs specific to this client group would be beneficial and is not currently available to me as a practitioner.
- Issues regarding autistic spectrum disorders.
- Training specific to older age patients.
- Personality disorders and self harm.
- Working with acute crisis stress, rape, domestic violence.
- Deaf awareness.

Mental health staff

Types of therapy/intervention (5 comments)

- DBT techniques.
- How to engage with clients who self harm on a one to one basis to explore their psychological account on why they self-harm and appropriate interventions to manage such behaviour.
- Managing persons who self harm within the mental health inpatient setting.

More formal training available (4 comments)

- NB. Most training has been from experience hardly any formal training has been undertaken.
- Consent and Capacity Children Act.
- There is currently a shortage in places for training in personal safety despite it being mandatory.
- I believe I have had adequate training in the past in most of the above, however a great deal of this was self-funded, not provided by my current employer, and in fact most training has been frozen in my trust. I believe my current employer is very poor in relation to training.

Other comments

- Family/carer support for those caring for people who self harm.
- Managing risks.

Q6. Would you have liked 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	35%
Any **refresher** training you have received	55%

Q7. If you would like more training, which of the following methods would suit you best? Tick as many as apply	
A slide set presentation on self-harm*	25%
An information leaflet 'Understanding People Who Self-Harm'*	27%
Online training exercises*	37%
In-house lectures/workshops/seminars	64%
Training delivered (or partly delivered) by service users	45%
Shadowing mental health colleagues	27%
External courses	47%
Study days	41%
Regular updates/feedback on performance	35%
Anything else?	8%

*These will be provided by the national 'Better Services for People who Self-harm' team.

Mental health staff

Any other comments on which methods of training you would prefer?

Specific types of training (5 comments)

- Experiential role play scenarios.
- It would be useful to review basic wound care issues.
- It is imperative to include information on psychodynamic perspectives on self-harm. To properly understand this it is also imperative to have an increase in the training and promotion of psychodynamic thinking and interventions in the clinical workplace.
- I participated in Storm self injurious training which was extremely helpful.
- This mode of training can be supplemented by an online training.

Training for frontline staff (2 comments)

- We provided awareness sessions and training to senior house officers and general hospital staff, further resources would have been useful, as previously stated there is no link to fulfil wider training needs for these issues for frontline staff.
- I do not want these for myself but am keen that any form of training be more available to the medical/ nursing/ ambulance/ reception staff in A&E.

Training related to personality disorders (2 comments)

- Supervision by personality disorder teams.
- Nationally accepted and disseminated practice regularly updated, especially where self-harm is part of a more complex type of presentation like personality disorder.

User-led training (1 comment)

- Training led by people who use self harm services.

Creation of specialist posts (1 comment)

- I believe that each Trust should employ advanced practitioners who have trained at University level specifically to provide a clinical service to emergency departments, lead a team providing specific follow up clinics for those who self-harm and provide cascade/in-service training and awareness to inpatient and community staff. Therefore recognising the importance of this service - this team would also benefit from having service users available for consultation/ involvement where possible. We are seeing the creation of many advanced practitioner posts nationally to pick up medical duties and cover the 'Hospital at Night' Initiative but I feel strongly that there is a need to highlight self harm services as being a speciality in the same way that child and adolescent mental health services are targeted and resourced specifically and not provided for from the pool of adult and old age acute mental health services.

Other comments

- Some induction sessions missed due to on call demands. Better scheduling of induction?
- Lists of referral options/details would be useful.
- Information leaflets from some of the voluntary sector services may be of use.

Mental health staff

Q8. Please rate **the support and supervision you have received relating to caring for people who self-harm.**	Excellent	Sufficient	Insufficient	N/A
Clinical supervision: to discuss the emotional impact of working with self-harm	22%	48%	26%	4%
Reflective supervision - to get feedback on how a specific situation was managed	23%	40%	28%	7%
De-briefing opportunities: allowing staff to de-brief promptly following a specific incident that has been traumatic for you	24%	37%	37%	2%
General support from colleagues	49%	45%	4%	2%

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?

- To discuss every patient being assessed.
- De-briefing is probably a very bad idea. If an event has been traumatic for staff, research shows that debriefing actually increases the incidence of post traumatic stress disorder.
- Clinical supervision available but at a time when I couldn't attend.
- Whilst I have clinical and managerial supervision I feel that teams working with our client group should have regular team supervision perhaps facilitated by manager and consultant lead - looking at any issues/de-briefing - not just waiting for a specific incident and the practitioner finding time to raise this or not.
- Senior manager support and acknowledgement of stress related role.
- Interestingly we used to have a system where every patient was discussed with specialist registrar or consultant - this was changed by team leader to only patients the mental health nurses wanted to discuss - which has led to none being discussed - which I think is a great shame. There are many opportunities 5 times a week for the mental health nurses to discuss/de-brief etc. but none for non-mental health staff.

Other staff

Areas highlighted as insufficient by 50% or more staff are **in bold**

Q9. Training/Education/Awareness Please rate the education/training you have received in the following areas relating to self-harm.	Sufficient	Insufficient	N/A
Basic awareness of mental health problems	59%	38%	3%
Understanding why people self harm	47%	44%	9%
Assessing mental health needs	29%	**56%**	15%
Basic awareness of risk	62%	29%	9%
Assessing mental capacity	35%	**50%**	15%
Assessing the social needs of the person	65%	18%	18%
The impact of cultural differences on self-harm	18%	**71%**	12%
The basis of the Care Programme Approach (CPA)	9%	**76%**	15%
Understanding the role of local services	53%	38%	9%
Basic understanding of the Mental Health Act and relevant common law	32%	**56%**	12%
Conducting preliminary assessments	26%	41%	26%
Conducting in-depth psychosocial assessments	12%	47%	41%
How to refer/discharge a patient appropriately	50%	24%	26%
Assessing risk, hopelessness and suicidal intent	32%	44%	24%
Understanding the care pathway	24%	**62%**	15%
Using psychological therapy with people who self-harm	9%	**62%**	29%
Training specific to older aged patients (65 and over)	3%	**59%**	35%
Training specific to young people (16 and under)	6%	**74%**	21%
Working with people who misuse alcohol or drugs	35%	47%	12%
Mental health and self-harm awareness	44%	44%	9%

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

Is there any other training not listed above that you feel you need?

- Security handling/ baby sitting mental health patients for up to 14 hours with no training?
- The security team are often used as pre-assessment RMN's asked to monitor mental health patients especially those who are intoxicated and who cannot be assessed. We are given NO training to deal with these types of patients and rely on our own customer care abilities but it is difficult when dealing with self harmers. Any training would be of assistance when we have a daily contact with mental health patients.
- Basically: as adult trained nurses we need some kind of training package to help us understand why people self harm and how to look after them appropriately. And what's out there to refer to.

Other staff

Q10. Would you have liked more education on mental health and/or self-harm during any of the following? Please select as many as applicable	
Your **initial** basic training	62%
Your **induction** with the Trust	50%
Any **refresher** training you have received	74%

Q11. If you would like more training, which of the following methods would suit you best? Tick as many as apply	
A slide set presentation on self-harm*	35%
An information leaflet 'Understanding People Who Self-Harm'*	50%
Online training exercises*	62%
In-house lectures/workshops/seminars	82%
Training delivered (or partly delivered) by service users	47%
Shadowing mental health colleagues	50%
External courses	26%
Study days	59%
Regular updates/feedback on performance	44%
Anything else?	9%

*These will be provided by the national 'Better Services for People who Self-harm' team.

Comments:

- All the above would keep knowledge up to date.
- Protective behaviour workshops specific for self-harmers.
- Full qualifications for the role we are expected to carry out on a day to day basis and not just a couple of days/weeks....

Q12. Please rate **the support and supervision you have received relating to caring for people who self-harm.**	Excellent	Sufficient	Insufficient	N/A
Clinical supervision: to discuss the emotional impact of working with self-harm	9%	21%	62%	9%
Reflective supervision - to get feedback on how a specific situation was managed	15%	15%	62%	9%
De-briefing opportunities: allowing staff to de-brief promptly following a specific incident that has been traumatic for you	9%	24%	59%	9%
General support from colleagues	24%	56%	15%	6%

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

Other staff

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

- Someone with a mental health background to be there when WE need them, not when they feel the patient does!
- Mental health child and adolescent mental health services support specific to self-harm.
- Clinical.

Staff Attitudes and Opinions

Q13. 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	8%	67%	12%	12%
Respect and support received from staff	10%	58%	19%	11%

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

Q14. Please read through the following statements and tick the circle that most closely reflects your own thoughts in relation to working with people who self-harm.	Strongly Agree	Agree	DK/NA	Disagree	Strongly Disagree
I can understand why a person might self-harm	31%	60%	5%	1%	2%
People who self-harm do it primarily to seek attention	2%	14%	60%	19%	4%
Staff morale is **not** affected by high numbers of admissions relating to self-harm	3%	21%	44%	21%	11%
When a person repeatedly attends the ED following self-harm, it causes a sense of frustration and failure in staff	10%	53%	23%	3%	10%
People who self-harm regularly are treated as well as 'one-off' self-harm patients	3%	32%	41%	8%	14%
I **do not** know enough about self-harm to communicate effectively with this patient group	5%	21%	46%	23%	4%
There should be multi-disciplinary case reviews of people who attend regularly for self-harm	33%	58%	2%	1%	5%
There are sufficient numbers of staff in my department	2%	22%	37%	28%	9%
The ED is generally an appropriate place for this patient group	2%	19%	46%	19%	12%
I am clear about the roles of - Ambulance, ED, and mental health teams	14%	55%	23%	2%	5%

Any comments?

Staff attitudes and frustrations (7 comments)

- Staff feel frustration but not necessarily failure at repeat attendances.
- It is harrowing to see any patient treated with disrespect in the ED but it happens. Staff get worn down, complacent and sceptical. They do not see the patients who get better and therefore do not have hope for patients who self harm. It is awful to see your colleagues and yourself, especially when tired, judging someone and then go on to treat them with any degree of contempt....I am unhappy that a busy department is full of people who are run down and edgy, there to treat a vulnerable group of patients who need more kindness and compassion than your average patient.
- In 20 years of working in the ED I have seen a shift in the way people who DSH are treated. Generally speaking, I would say that before, people who DSH were disliked as they were seen to distract from what were considered to be 'proper' or 'worthy' ED cases. They were often given a low priority and forced to wait for treatment. I have heard of nursing and medical staff expressing their frustrations directly to the patient, especially if the DSH is repeated. I have heard of cases where the treatment of DSH wounds has been different to other patients attending with similar non-DSH wounds. Over the last few years, education in universities and 'in-house' regarding self harm has increased amongst nursing staff and most people understand that it is an illness. However, this does not take away the natural frustration felt by staff when they perceive that something perceived as preventable has occurred. I think people with self harm are treated better today.

ED not appropriate place for dealing with all needs (7 comments)

- Self harmers are not best treated in emergency departments in my view, as seen as low priority - so long wait to be seen, then invariably lengthy delay if requiring psychiatric input.
- The ED is an appropriate place for patients who need treatment of the physical "injuries." Once medical treatment is not needed, they are more appropriately cared for by staff with mental health training who have much better access to other services and support.
- I agreed that ED should be the first point of call, however I feel that there should be specialist units to facilitate care for this client group.
- A&E is not really a place of safety.

Need for specialists teams or roles/lack of skills in general staff (5 comments)

- I believe that a small specialist team lead by an appropriately qualified Advanced practitioner should be in place to provide and monitor services for those who self harm, rather than assuming that the special care and skills need to provide this service are naturally available within acute and old age services and all staff...Is this about stigma/undervaluing self harm as a difficulty WORTHY of a specialist service?
- I feel that A&E liaison for self harm is a specialised role, I do not feel that NHS managers appreciate this and see it as a role that anyone trained in mental health can undertake.

Lack of staff (3 comments)

- Qualified psychiatric staff required in our A&E to cover care...or at least an "on-call" system to rapid respond.
- When the unit is under pressure, which is most shifts these days, it is difficult to find an appropriate place for these patients to be seen and to find a member of staff to give them the time they need.

Need coordinated approach between services (2 comments)

- There is a lack of a coordinated approach to working with and supporting these clients.

Stigma of self-harm (1 comment)

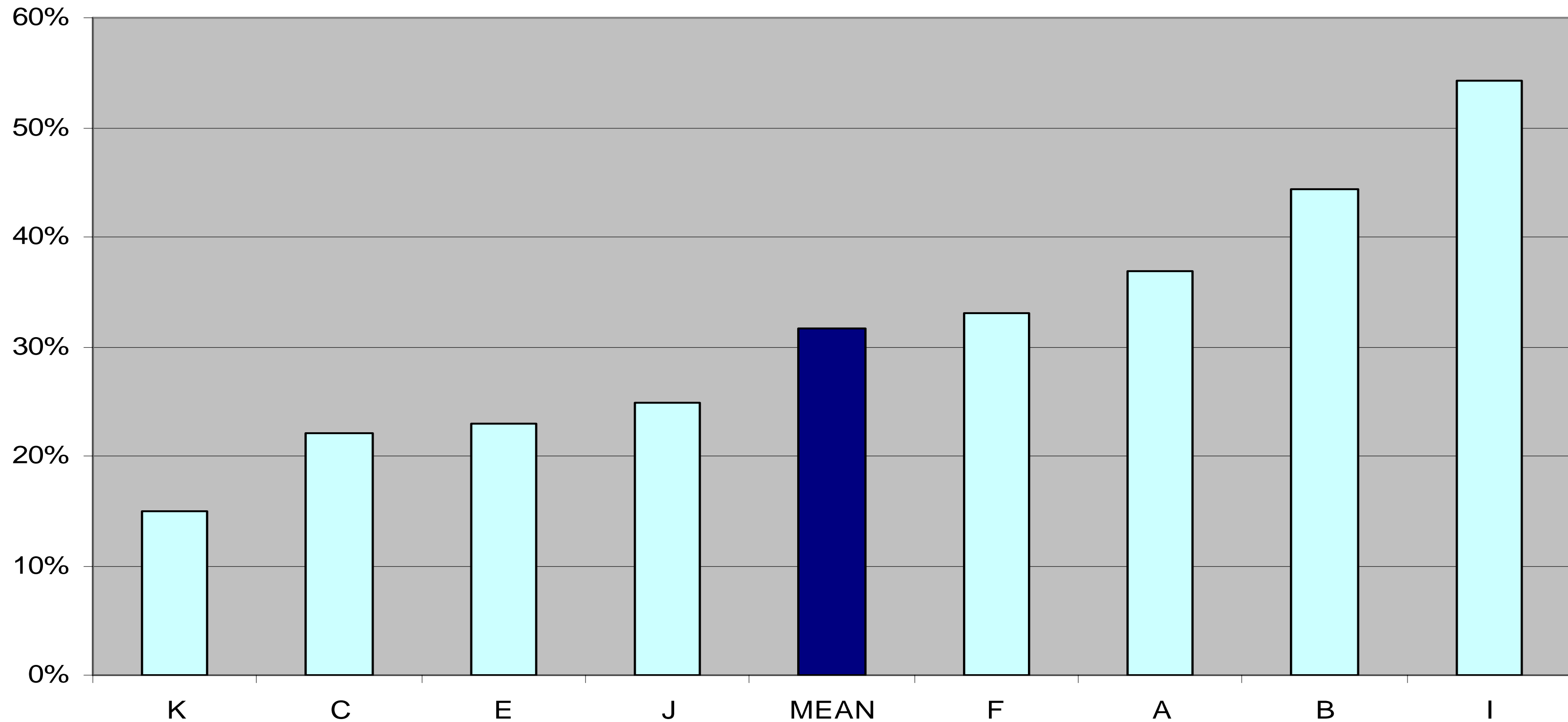
- A&E has always been a stigmatising place for self-harmers, government 4 hour targets have made it worse as such patients often need more time. Not only are the patients but our staff feel stigmatised at times. Mental health patients are referred to as 'your patient' in a way that a medical or surgical patient would not be. There is not ownership of mental health patients by A&E non-psychiatric staff.

Other comments

- Self harm = wait for psych assessment = patient breaches = we get penalised.
- Need better out of hours mental health support, for both ED and ambulance.
- Working for a specialist team within the mental health trust, but not working specifically with mental health clients, we frequently find that the Community Mental Health Teams are unwilling to take on clients unless they are psychotic. Clients who are clearly very distressed but who do not meet diagnostic criteria for a major mental illness are frequently left in a vacuum or we are left to try to patch together some form of treatment on top of what we are already meant to be doing with the client.

Q15. Finally, how do you rate the following, in relation to people who self-harm?	**Excellent**	**Good**	**Average**	**Poor**	**Very Poor**	**Don't know**
The **physical environment** of the ED (privacy, safety, comfort)	1%	12%	40%	26%	7%	13%
Staff **training and education**	1%	15%	35%	28%	4%	14%
Staff **support and supervision**	3%	21%	31%	25%	4%	14%
Staff **attitudes** (respect and support)	4%	23%	42%	17%	1%	11%
Access to mental health services in the ED **within hours**	15%	34%	25%	9%	3%	13%
Access to mental health services in the ED **out of hours**	6%	23%	25%	19%	9%	15%
Communication/handover between **ambulance** and **ED** staff	3%	29%	22%	6%	2%	38%
Communication/handover between **ED** and **mental health staff**	3%	32%	28%	9%	3%	23%
Communication/handover between **ambulance** and **mental health staff**	1%	10%	13%	14%	9%	52%
Quality of **physical treatment**	6%	41%	27%	3%	1%	19%
Verbal information provided to patients (updates on waiting time, physical state)	2%	22%	34%	11%	1%	29%
Written information provided to patients (leaflets, contact details etc)	1%	16%	27%	19%	6%	29%
Quality of **psychosocial assessment**	7%	24%	28%	7%	2%	31%
Aftercare arrangements	4%	25%	25%	12%	4%	28%

Figure 14: teams that rated their overall service for people who self-harm as 'Excellent' or 'Good' (based on the mean scores for all of the areas of service provision detailed in question 15 above).



Staff from team 'I' were most likely to rate the overall service they provide to people who self-harm as 'excellent' or 'good'. Staff from team 'K' were least likely to rate their overall service as 'excellent' or 'good'.

If you are unsure of your team's unique code, please get in touch with the central project team.

Figure 15: Teams that rated their access to mental health services <u>within hours</u> as 'Excellent' or 'Good'

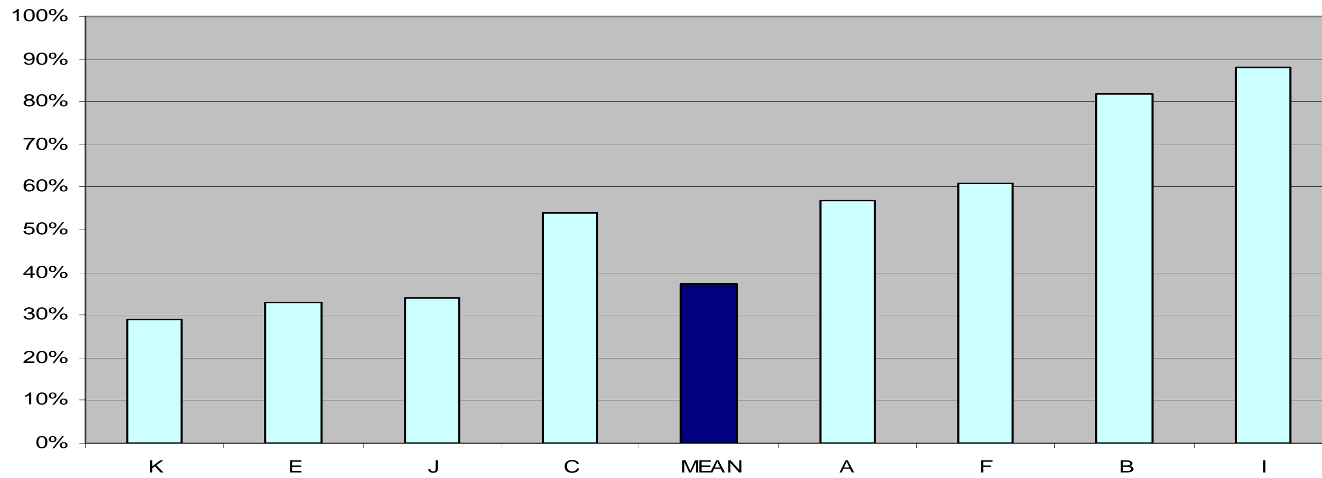


Figure 16: Teams that rated their access to mental health services <u>out of hours</u> as 'Excellent' or 'Good'

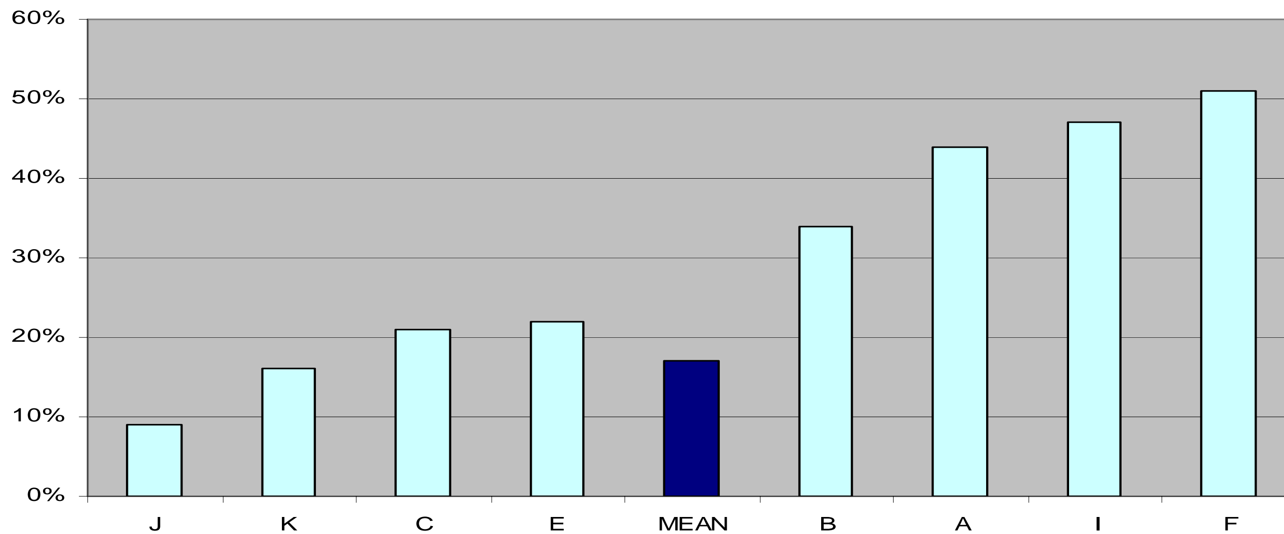


Figure 17: Teams that rated the quality of psychosocial assessment provided to people who self-harm as 'Excellent' or 'Good'

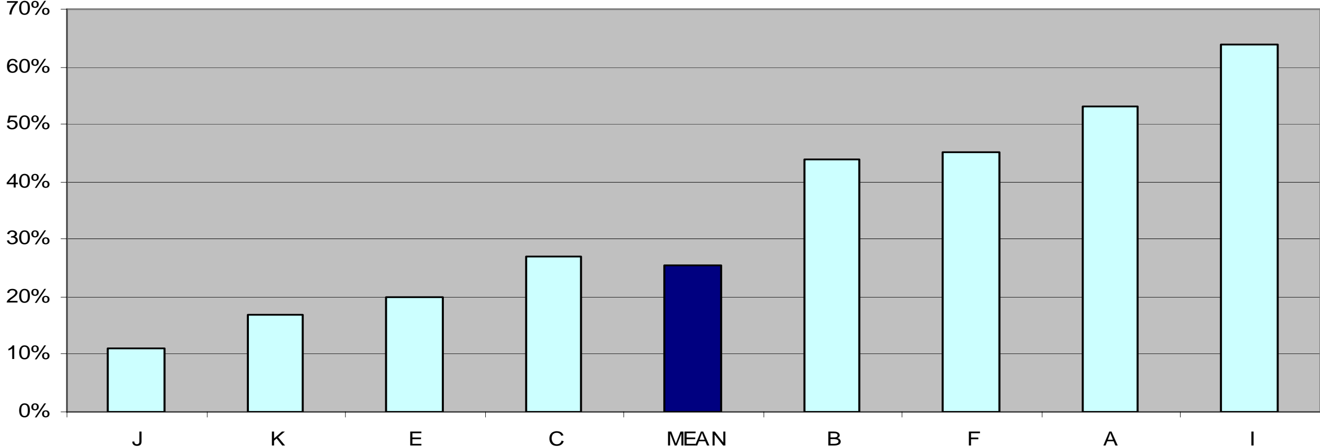
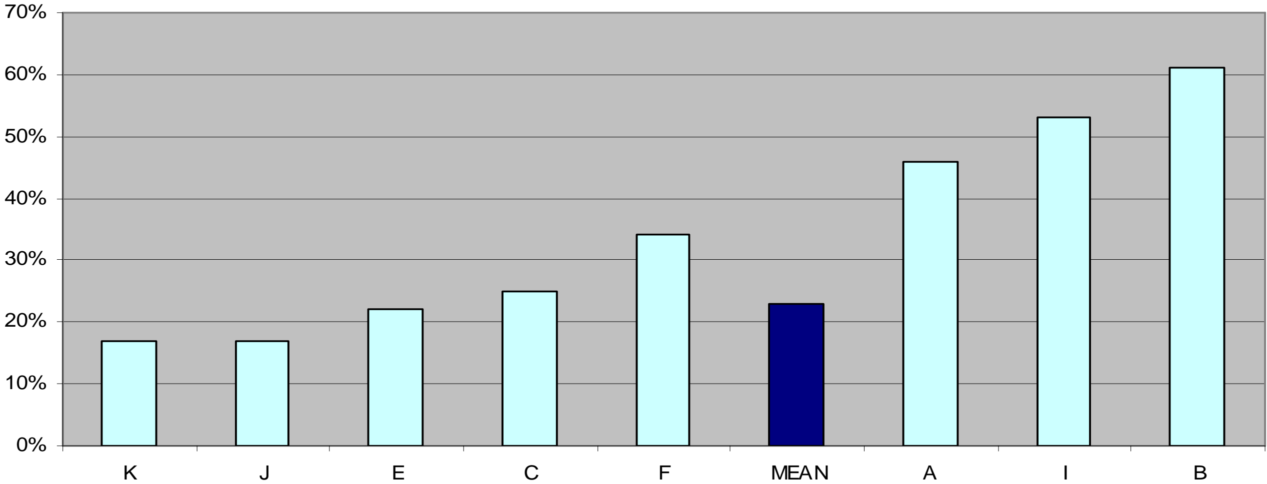


Figure 18: Teams that rated the quality of aftercare provided to people who self-harm as 'Excellent' or 'Good'



Q6. Any comments on what works particularly well? Please be as specific as possible.

Good support/fast response from mental health specialists (20 comments)

- Having psychiatric liaison nurses within the department, patients are seen much quicker. Unfortunately have to share them with rest of trust.
- Psychiatric liaison nurse offers good service and is part of MDT, provides good support to staff.
- Access to regular ED mental health team 24 hours.
- Immediate action of Mental Health Team.
- Having on call rota so young people are seen without too much delay. Good follow up arrangements, seen quickly and being able to be flexible to patient needs.
- Liaison Psychiatry input onto ED works well. They offer good psychosocial assessments and subsequently liaise with Community Mental Health if the patient is then discharged.

Good access to mental health services within hours (10 comments)

- In hours the support from the mental health team on any aspect of mental health is extremely supportive to the ED medical and nursing team. Out of hours support is varied and is not as smooth. This can take up a lot of time on phone calls and accessing support for clients.
- Within hours, access to the mental health nurses is very useful and very beneficial.
- It seems ok in hours, out of hours very difficult to get help from anyone!!!

Good working relationships and communication between services (15 comments)

- The quality of care these patients receive is enhanced when the level of communication between the appropriate multidisciplinary team members is effective.
- Integrated care pathway a smooth transition between services.
- Good liaison between ED and our department (mental health). Good protocols in place for follow-up and care pathways.
- Consistent multidisciplinary approach with shared risk management.
- Close liaison and availability of the community mental health team when self-harmers present.

Good support and supervision (5 comments)

- Good support and supervision, time for discussion in team meetings.

Good patient care (5 comments)

- Staff supportive and generally sympathetic in ED, but sometimes problems due to environment of busy ED.
- Physical care of the patient and maintaining high standards of healthcare despite greater challenges in history taking and examination. I think patients are treated with the same respect and their problems taken as seriously as those with other complaints.

Staff attitudes (3 comments)

- My clients tell me they are treated very well by the staff and are positive about the service. The physical care, e.g. suturing is felt to be done sympathetically also.
- Being treated with dignity and respect however this is variable dependent on staff on duty.

Good communication with service users (3 comment)

- Talking WITH the patient, being direct, not beating about the bush but not harsh.
- When staff take time to listen to patient.

Other comments

- Family involvement if possible with patient in ED.
- We used to have a team of nursing staff trained to assess and treat self-harm patients. This service has been withdrawn now. This service group is waiting longer and longer to receive psychological assessment and treatment. This has led to a high number of these patients not waiting for treatment and therefore not receiving the correct amount of support and follow up.
- Consistent specialist nurses knowing patients well.
- Education to staff not trained in mental health surrounding issues re self-harm.

Q17. Any comments on what works less well, and how this could be improved? Please be as specific as possible.

Follow-up care and access to mental health/other services (13 comments)

- Access to follow up specific to self harm – community mental health teams focus on serious and enduring mental health problems, so it is hard to get self-harm follow up.
- Transfer of patients from emergency departments to mental health units is very poor. This is due to the fact that it is not seen as an emergency for transfers.
- Access to social work services is less good especially out of hours. Access to mental health records is very difficult.
- Follow up arrangements are not able to be made for those who do not require admission or assessment by psych team as there are none in place. Responsibility given to patient to contact own CPN/GP next day for follow up. Direct access to liaison psych clinic for new presentations of self-injury or for those with no psych input would help.
- There does not seem to be much communication/referral route for ambulance service to mental health services. Often the only thing we can do is take them to ED, not appropriate some of the time.
- Having protocols to access other professionals if required for example if young person subject to a care order e.g. social worker.

Poor communication between teams (11 comments)

- Communication between the ED and psychiatric team in terms of referrals, ongoing management and education on mental health issues such as self harm.
- Information systems between mental health and ED departments different and does not enable prompt clear communication channels. Carers/family are often overlooked.
- Poor communication with ambulance staff.
- Once the A&E liaison finish, care in A&E is provided by either the duty senior house officer or the crisis team if they are free, which can sometimes result in long waits and poor communication. As a community psychiatric nurse I am sometimes aware my client has attended A&E during the night but the senior house officer has dictated a clinical entry and gone home, so I have no information about the episode.

Delays in mental health assessment (9 comments)

- High risk patients waiting a very long time for psych team to come and review them. This could be improved by the psychiatric nurse coming to assess each patient briefly just after triage and prioritising who they see first. Also patients being sectioned who end up spending hours and hours waiting for full assessment particularly if they are sedated. Having a specific facility for patients being sectioned would be very helpful.
- Mental health patients generally wait longer to be seen by mental health specialists than patients who need to be seen by any other speciality. I do not know the reasons why this is, but I feel that it has probably been harder for them to attend and they frequently need to be seen by specialists straight away. Many mental health patients do not wait for assessment/treatment as the wait is so long.
- Out of hours patients have to wait for hours to see a psychiatrist as they are usually off site.

Staff attitudes and communication to patients (7 comments)

- Some poor staff attitudes towards mental health issues.
- Stigma from non-mental health team. Huge emphasis on waiting times rather than quality of care.
- Culture and attitude is a real problem throughout adult mental health services, particularly in relation to self-harm. This is made difficult by staff often paying lip service to service user needs, and understanding of self-harm behaviour. Culture and attitude can only be shifted if people want to change, and many staff don't want to.
- I have rated verbal information in ED as poor based on the views my clients have expressed. They have often complained about waiting a long time with no explanation, and I am aware of occasions where clients have left without receiving treatment because of this.

Physical environment (5 comments)

- No designated area available to assess people who present following an act of self harm.
- Lack of admission facilities for children and young people.
- Lack of good rooms to see people in.

Problems with out of hours services and alternative provision (4 comments)

- There doesn't appear to be any out of hours help and advice available to Ambulance Staff and A&E is the only place available to us. I don't feel this is the most appropriate place for them to be.
- Poorer access out of hours, via crisis team, who are often very busy with patients in the community.

Lack of training (4 comments)

- More training and support for A&E staff, and perhaps a designated team to deal with people who self harm.
- I don't know what training ED medical staff have in dealing with self harmers. Some staff I have come across are very good, others get very nervous and some are not particularly understanding.

Lack of clarity about referrals (2 comments)

- Inconsistency about the roles and protocols for referrals and staff on both sides being ill informed about where referrals should go and who should be assessing. We have had multiple changes to who assesses people attending the ED and this causes delays and incidents where people leave the ED without proper assessment.
- As a paediatric nurse, it is difficult to know who to contact in a crisis situation with a child that self harms, and also there is the situation with 16-18 year olds, who may not be appropriate for adult mental care, but do not fit the criteria for CAMHS assessment and care.

Other comments

- Lengthy un-validated form for assessing suicide risk.
- Services for older people insufficient and generally services are not focussed on the needs of older people - not usually seen in ED but usually admitted to wards.
- The new guidelines set up by the government stating that patients should be seen within four hours has put pressure on all members of staff and have put pressure on mental health workers to make decisions about patients and mental health services have not expanded to meet these needs, they have also expected staff to carry out these new recommendations with out putting in any more staff resources.
- By nature of an A&E department, it is busy and noisy and there is no privacy. This cannot be avoided.
- Working in security, we're not part of the main treatment process, however, our frustrations frequently match the patients over waiting time and lack of information. When patients have been waiting a long time and then decide they want to go home and are told they can't and ask us to prevent them leaving…this creates un-necessary animosity. The whole assessment process needs to be quicker, but the hold up normally occurs from having doctors who cannot [conduct an] assessment when patient under the influence and only one social worker covering a large area, so it takes ages. During this time there are no suitable facilities in which the patient can stay.

Policy Checklist

Each team was asked to complete the following survey between August and November 2007. **Eight** teams in total completed the survey.

'HC' = questions that relate to the Healthcare Commission's recommendations about self-harm.

The following questions relate to the care of young people under the age of 16.

Q1. Does the trust have a clear process in place to ensure that:	Yes	No	Unknown
All children and young people's clinicians have been trained in the assessment and early management of mental health problems?	3	2	1
Training includes the assessment and early management of young people who have self-harmed?	3	2	1

Comments

- No specific training at present time. However paediatric nurses have training days and would be happy to invite mental health to deliver training.
- Yes in A&E, unknown if all CAMHS staff have been trained in the assessment and early management of mental health problems. Not all CAMHS staff have training in the assessment and early management of young people who have self-harmed.
- Nurses receive training, everyone receives training during the year working in A&E but this is not necessarily at the beginning of employment.
- This training is for mental health practitioners who assess children and young people within the acute trust. No specialist young people's training has been provided to ED Staff
- Crisis team attends for young people and adults aged 16 and over. Self harm liaison team for young people and over 16s work 7 days per week.

Q2. Are young people <u>assessed</u> in a separate children's area of the Emergency Department	
Yes	4
No	2
Unknown	0
Not-applicable	0

Comments

- 08:00 - midnight only, children's ED shuts then. But there is an adolescent room for use at other times.
- In the pipeline for next year.
- Within the 2 paediatric rooms.
- The site has a specific paediatric area for children and young people.

Q3. Are young people <u>treated</u> in a separate children's area of the Emergency Department	
Yes	4
No	2
Unknown	0
Not-applicable	0

Comments

As above

Unless need specialist care/unstable - such as resus, area.

Q4. Are all young people who self-harm admitted overnight to a paediatric or adolescent ward?	
Yes	3
No	3
Unknown	0
Not-applicable	0

Comments

- Not all - only those under 16. All others seen at the time by on-call children/adolescent SpR out of hours and self harm worker in hours. At this hospital all under 18's classed as young people and not seen by adult services.
- Approximately 2/3 are admitted. Some are admitted if A&E cannot obtain an opinion from CAMHS on the same day. CAMHS service 9am - 5pm, 5 days a week.
- Yes the protocol in ED is to admit all young people. If the young person refuses the ED IT system and quick referral guide for accessing mental health services gives direction on who should be contacted.
- Patient choice plays a part. The admitting ward is in a different hospital but the same trust.

The remaining questions relate to the care and treatment of all people who self-harm, regardless of their age.

Q5. Does the trust have a clear process in place to ensure that all triage nurses working in emergency departments have been trained in the use of mental health triage systems? (HC)	
Yes	5
No	2
Unknown	1

Comments

- Mental health triage systems not used. Ongoing training to triage staff about mental health issues and recognition of such.
- Timing of training may vary after beginning employment
- Manchester Triage system is used however self-harm pathway asks questions about current mental state, previous self harm. Also a fast track triage form is used where triage nurse can refer to liaison psychiatry team.
- Triage staff use the Manchester triage system supplemented by Becks for adult services.

Q6. Is the trust able to provide all people who self-harm with clear and understandable information about the care process, both verbally and as part of written material in a language they understand? (HC)	
Yes	4
No	4
Unknown	0

Comments

- Have written information for overdose and self harm. Also given verbal information by ED staff about process. At this time all written material in English only due to costs of printing in other languages - our borough has over 100 different languages spoken.
- The information is currently only given in English.
- Includes wound care leaflet, mental health service information leaflet which includes collaborative care plan, and self harm leaflet.
- Some leaflets available but they are not as specific as this.

Q7. Are there locally agreed protocols regarding the ambulance service taking the service user to an alternative service rather than the ED, where appropriate? (HC)	
Yes - protocols exists and these are generally adhered to	0
No formal protocols but this is common practice	0
No formal protocols and this does not happen	8
Unknown	0
Not Applicable	0

Comments

- No alternatives at present time. Local Minor Injuries Unit has no mental health input.
- Could access the primary care access centre which is next door to ED?

Q8. 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	6
No formal policy but this is common practice	0
No formal policy and this does not happen	1
Unknown	0
Not Applicable	0

Comments

- The pathway of care to mental health services is through the crisis team.
- 24 hour team of nurses and SHO based in offices above ED.
- There is a good working relationship between services and processes in place for 24hr contact and services to respond for assessments.
- The mental health liaison team is not funded 24/7; however there is access to mental health services 24/7 but this is fragmented
- The Mental Health Trust has a policy for this and is developing a new crisis team operational document. The area does not have a liaison psychiatrist or liaison team. The home treatment team is based in the inpatient psychiatric unit on the same site as the hospital and the nurses and consultant carry out assessment. Nurses are on call from the team in A&E, 8am-10pm. Service has improved dramatically since this team has been put in place. After 10pm, the duty doctor on call from the inpatient psychiatric unit who has difficulty leaving the unit to go to A&E. There is a tri-borough duty service gate keeping role which covers the borough after 10pm until 8am. They do not visit A&E.
- Access is limited for people who have self harmed, but Crisis resolution team does work into ED out of the liaison psychiatry teams hours and will respond to those people who are actively suicidal, those with psychotic symptoms, those with an enduring mental health problem and are in crisis, those who require in patient mental health care.
- Adult services well supported by liaison team 7 days per week. 24/7 available to ED for adult and children.

Q9. Are the response times for psychosocial assessment in the table below generally met?	
Yes - almost always, even during 'out of hours'	1
Yes - except for during 'out of hours'	4
Very rarely or never	2
Unknown	1

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

Comments

- The response time for the crisis team is 1 hour - this can be breached at busy times due to lack of parking for the team they may spend 1/2 an hour or more looking for a parking space/or waiting.
- Liaison team is based on site, with on site Section 12 doctors during office hours and list of local Section 12 doctors who are able to respond quickly out of hours. The only time that targets are not met is when there is a high clinical demand from the ED for psychiatric assessments.
- Response to A&E during hours Monday – Friday 9-5 is set at response within 60 minutes however on most occasions this occurs within 30 minutes.
- 8am - 10pm a) Home treatment team try to see patient within 4 hours b) Home treatment team will give priority to patient in own home if at risk, as the patient in A&E is in a place of safety c) A&E will warn mental health team if patient has been admitted but is not physically fit enough to be assessed d) Home treatment team will provide appropriate care and service when the patient is fit to be assessed, e.g. overdose or alcohol intoxication.
- First line attendance is met during the operational hours of the liaison psychiatry team. Section 12 approved doctor is mostly met within the liaison psychiatry hours. But out of hour response has not been audited.

Q10. Is there a policy on referrals from the emergency department to mental health units?	
No - all referrals go via the crisis team or liaison team	4
Yes - a policy exists and this is generally adhered to	3
No formal policy but this is common practice	1
Unknown	0
Not Applicable	0

Comments

- 24 hour services on site.
- A&E phone details to mental health team. A&E do not use a proforma. Home treatment team has a proforma for referral which is compiled on the Rio system of IT. Home treatment team gathers information about the patient from records of community mental health teams before seeing patient. Assessment is entered onto Rio system.
- Adult referrals go through the crisis and liaison teams. Children and young people are transferred to the local paediatric ward who then provide mental health assessment, or GP/school nurse/health visitor informed if follow up required on qilted, A&E forms.

Q11. Is there a policy regarding the availability of the mental health trust's IT system in the emergency department?	
Yes - a policy exists and this is generally adhered to	1
No formal policy but this is common practice	2
No formal policy and this does not happen	5
Unknown	0
Not Applicable	0

Comments

- Only for use by MH professionals currently, but as liaison team are based in ED then there is easy for ED staff to ask for information from liaison staff.
- No, but we would like to be able to access the mental health IT systems within A&E.
- During the mental health liaison team operational hours there is access to some locality IT information. Out of hours there is no access within the ED.
- It is not possible to access the mental health trust IT system from A&E. The psychiatric unit is on the same site where there is access to the mental health system - manager/nurses/consultant can go back to inpatient unit to input data.
- Currently in discussion as to the possibility of access in the near future
- Access to IT policy for the acute trust to access information form the mental health system is currently being ratified by mental health trust. Education for acute hospital staff will then take place.

Q12. Do you have assessment checklists, risk matrices or a pro-forma for telephone referrals from the emergency department to community mental health teams?	
Yes - these documents exist and are generally adhered to	2
No	5
Unknown	0
Not Applicable	1

Comments

- All referrals to the Community Mental Health Team (CMHT) have to be done by the liaison team on computerised patient record system, and CMHTs will only accept ED referrals that have been seen by liaison team. However we do have GPs in the department and it has been suggested that they should refer to CMHTs if they feel needed as they would from the surgery.
- An integrated care pathway for self harm exists which is an initial assessment and which identifies risks about the individual and prompts referral to the mental health services. Liaison psychiatry follows this process through and supports referral if required into CMHTs.
- Referrals come via MHLT unless urgent/Mental Health Act
- No specific risk assessment tool in A&E. In the past have used SAD PERSONS scale. Mental health team have referral proforma completed from telephone conversation with A&E.
- All referrals to the CMHTs are via the liaison psychiatry team or crisis resolution team
- For over 16's, a referral form is available but the liaison team will take referral with minimum information. Under 16 medical transfers to another hospital, who provide mental health assessment from the doctors who then refer to local CAMHS team if appropriate. Or referral from ED to school nurse/GP direct for ongoing care.

Assessment

Q13. 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	4
No formal policy but this is common practice	1
No formal policy and this does not happen	3
Unknown	0
Not Applicable	0

Comments

- This is seen as the role of the liaison team following referral from ED. On a positive note, this enables quick referral and response. It is felt by staff that this would be too time consuming at triage.
- it is an integrated care pathway for self harm not policy.
- It is not always appropriate to carry out a psychosocial assessment at triage. The patient may not be conscious, lucid or may have a physical injury needing immediate attention.
- As part of the self harm pathway, standard questions. This is currently being ratified - it is proposed an audit will take place.
- Applies for adults and young people aged 16+. Under 16s are assessed by the triage nurses and transferred if medical care required.

Q14. Does triage/meet and treat take into account the person's emotional distress when prioritising patients?	
Yes	6
No	2
Unknown	0

Comments

- Emotionally distressed persons are prioritised and referred immediately from triage.
- To a degree. This may depend on the urgency and severity of other patients in A&E and staffing levels, e.g. patient with myocardial infarction, severe accidents, children with breathing difficulties.
- Triage only dept does not do meet and treat. Emotional distress is taken into account and they can be seated in a quiet area.
- Although this can be a factor it depends upon other demands within the unit.

Q15. When a person first arrives at the ED, is risk instantly established, in terms of: (tick as many as applicable)	
The physical severity of the self-harm	6
Any obvious severe distress	5
Is the person actively suicidal?	5
Is there a risk that the person will leave before assessment and treatment is provided?	6

If a standardised form is used for this, please state which one.

- Manchester triage scale on triage screen. Written triage on ED card with. information about whether person is suicidal and their level of distress.
- Threshold Assessment Grid (TAG) used.
- Not used - have used SAD PERSONS assessment in the past.
- For children and under 16s the A&E form is used completed under 'qilted' for planning care and discharge.
- Manchester triage used all of the above.
- The self harm pathway includes all the above. An audit is required to ensure this is being completed and the quality of the clinical notes.

Q16. How often is there is a difference of opinion between the acute hospital services & the mental health services regarding a patient's fitness for psychosocial assessment?	
Always	0
Often	2
Sometimes	5
Rarely	0
Never	0
Unknown	1

Comments

- This has much improved over time and continues to do so. Much more emphasis on parallel working.
- Due to multiple factors - alcohol is a particular issue.
- The small home treatment team cannot always carry out assessment when the request is made if they have competing requests at the patient's home or if patient is not fit to be assessed at that stage. It is difficult for the duty doctor to leave the psychiatric unit.
- The pathway has just changed for young people who now attend the ward if necessary.
- Out of hours 10pm - 8am there is a strange reluctance to come and see the patient.
- Issues are usually related to medical fitness, alcohol intoxication, and confusion due to organic causes which have not been ruled out. Rarely disagreement with mental health's assessment.

Q17. Who normally conducts psychosocial assessments within hours?

- The crisis team covers ED in hours.
- The Senior House Officers (SHO) and the liaison nurses.
- The A&E staff initially complete the integrated care pathway for self harm which includes a psychosocial assessment which helps to decide admission or home and this is followed up by a psychosocial assessment by mental health services i.e. liaison psychiatry.
- The Mental Health Liaison Team.
- For adults the liaison/crisis team. For young people, transfer to the ward.
- Crisis and home treatment team have a good working relationship with A&E
- emergency department mental health liaison team till 19:30 hrs week days and 9-5 Saturday, Sunday and bank holidays
- Liaison psychiatry team - nursing and medical staff. Older persons liaison nurse On Call Child and Adolescent Mental Health Services

Q18. Who normally conducts psychosocial assessments out-of hours?

- The SHO for mental health covers from 5pm-12 midnight, then the role comes back to Crisis until the following 5pm.
- Liaison Nurses and SHO's.
- A&E staff as above by completing the integrated care pathway. However if immediate input is required by mental health services out of hours, the crisis team will respond to the A&E department.
- MHLT (some unsociable hours covered) unless the Mental Health Act is required, or patients wait to see the MHLT next day.
- Duty doctor for inpatient psychiatric unit 10pm-8am.
- The on-call psychiatry SHO.
- Psychiatric SHO for ED or Acute wards or Crisis resolution team - ED only
- As above for young people.

Q19. Is a standardised form used for psychosocial assessment?	
Yes	7
No	1
Unknown	0

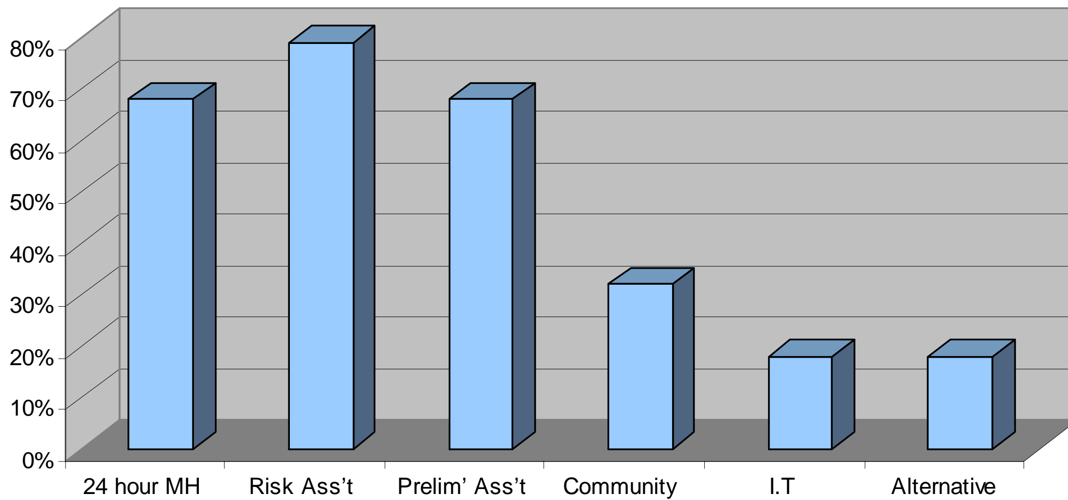
- Information is inputted onto an electronic system which has guidance for what information should be put down, but at the time of assessment no form is used. Some felt that anxiety about filling in all the sections of a form may detract from the appropriate assessment of what the patient feels is important.
- There is an integrated care pathway for self harm.
- The Crisis Team (home treatment team) Core Assessment.
- Recently reviewed and standardised with audit department. Psychiatric SHO also uses standardised tool. Crisis resolution use their generic assessment tool

Q20. During the assessment, are service users generally: (tick as many as applicable):	
Encouraged to describe the self-harm and what led to it, in their own words?	8
Asked to rate their own level of risk and say what might help them feel more safe? Fully informed about all the service and treatment options available, in a spirit of collaboration?	7
Encouraged to express their needs and preferences and be fully involved in deciding what will happen next?	7
Provided with written material about available local services?	5
Encouraged to draw up a realistic and achievable plan for accessing these services?	4
Encouraged to draw up a list of people and resources from whom they will seek support?	6
Provided with an 'aftercare' sheet or something similar, which describes what will happen next?	2
Told what will happen to their assessment notes and who will be notified (GP, mental health team etc)?	8
Asked if they are clear about what has been discussed and if they have any questions or concerns?	8

Comments

- The service user representative expressed the sections not ticked 'sometimes' occur but that there is no consistency.
- Leaflets at the printers are ready to be used when received.
- Basic care plan as part of a process.
- Aftercare sheet is discussed but not written down.
- Confidentiality within a need to know basis explained.
- The mental health team have a small library of leaflets and crisis cards.
- There is no clarity or system for follow-up after initial event. Patient may not attend GP surgery. School nurses cannot speak to children under 16 without parent's permission.
- All of the above. All service users are given liaison psychiatry service leaflet with information on who has completed the assessment, who information will be passed to, full details of their planned appointments for follow up, and telephone details of local groups, crisis lines etc.
- Applies to care provided by crisis/liaison team and to children.

Figure 19: Percentage of the 38 wave 1 & 2 teams with the following working arrangements in place at baseline



- **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? (Some teams commented that this arrangement is informal).
- **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, teams can see how well they 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 (R)	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	R	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	E	NICE

	promote joint clinical decision-making on the basis of understanding and compassion		
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	R	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	R	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	R	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

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, teams can note which of the HC standards they are currently meeting, and which require extra work. This may help teams to prioritise 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: National Themes Emerging from Wave 1 & Wave 2 Members

In 2006 and early 2007, 38 teams across two separate waves of activity have gone through the baseline audit. This summary should be viewed in the context of response rates, and in conjunction with the more detailed data in the full reports, available at www.rcpsych.ac.uk/cru/auditselfharm.htm

1. The service user experience

Of the 682 service user questionnaires received, around 60% related to emergency departments that participated in the 'Better Services' programme; the remainder refer to non-participating hospitals.

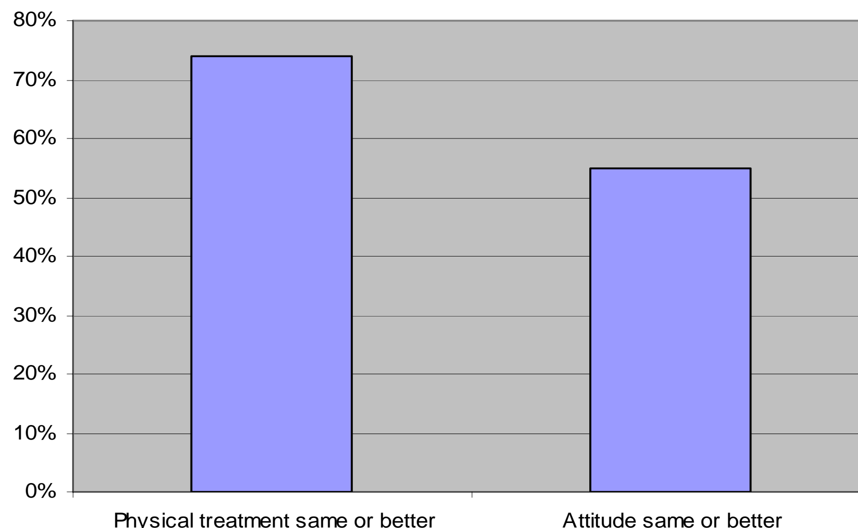
1.1 Staff attitudes

- The attitude of staff was by far the single most important factor affecting service users' quality of care. Ambulance staff were most likely to be rated positively in terms of showing respect, support and understanding. Other staff groups received broadly similar ratings, with over a quarter of staff being rated negatively. Poor staff attitudes can result in patients not engaging with services. In some cases, it can also lead to further self-harm/attempted suicide:

'I don't appreciate being called a nutter… I was treated very negatively by the staff in A&E. This just compounded how I was already feeling and made me feel worse. In consequence I went home and cut again.'

- A significant proportion of staff agreed that people who self-harm are often treated negatively compared to other patients.

Figure 1: Percentage of 1,182 staff who felt that people who self-harm are treated 'the same' or 'better' than other patients, in terms of: i) physical treatment and ii) staff attitudes



1.2 Quality of physical treatment

- A third of service users rated the physical treatment they received as being poor - lack of pain relief and poor quality suturing were common complaints. The importance of staff providing physical care in a professional manner was also a common theme:

'He took great pains to suture very neatly - when I commented on this he said "I don't want to leave any scars" to which I replied that I am covered in them. He said "not on my watch". This impressed me greatly.'

'She told me that since I cut myself I must like pain, so therefore I shouldn't need pain relief'.

- These findings are supported by the fact that one-sixth of the 1,182 ambulance, ED and mental health staff surveyed about physical treatment felt that people who self-harm receive worse quality physical treatment than other patients.

1.3 Communication from staff

- Service users valued regular updates and contact with staff while they were in the ED. Over one-third of service users felt forgotten or ignored. For some, this led to self-discharge before treatment or assessment was completed.

1.4 The Emergency Department environment

- Over one-quarter of service users and one-third of staff rated the environment of the emergency department negatively. The most frequently mentioned issue was a lack of privacy when waiting, being treated, and when receiving psychosocial assessment.
- Concerns about safety were also highlighted by many staff and service users. Over one-half of the staff surveyed (60%) felt that the ED is not an appropriate place for people who self-harm:

'It's very hectic and stressful for patients…staff are usually too busy to give much attention to this client group which surely can't be good if they are feeling suicidal.'

1.5 Mental health input

- Only half of the service users surveyed reported having been asked about their mental distress during triage or initial assessment and many felt that ED staff lacked understanding of mental health issues.
- When asked if they had received a psychosocial assessment, 62% of service users said yes, although a third were dissatisfied with the quality of assessment they had received.
- Over two-thirds of the 85 non-consultant grade doctors working in the ED rated their training in conducting psychosocial assessments as 'insufficient'. Most (82%) said that they do not understand the Care Programme Approach.
- Only half of the service users were satisfied with aftercare. Suggestions for improvement included better follow-up immediately after the ED attendance and

shorter waiting lists for ongoing therapy. A number of service users also commented on the need for an overnight bed.

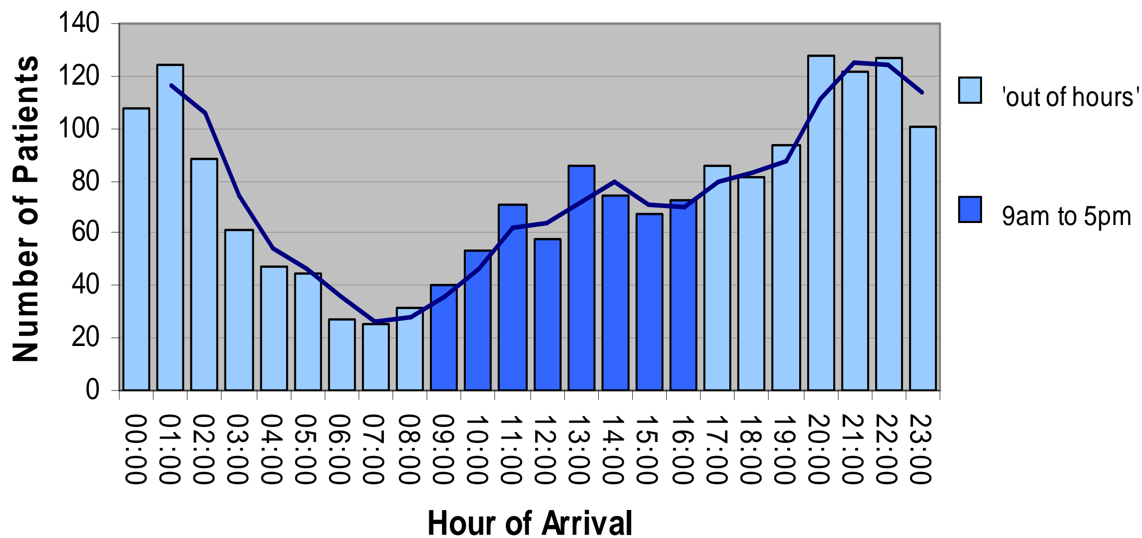
2. Waiting times and outcomes

The following is a summary of data from the case notes of 2,172 admissions for self-harm in 2006, across 37 UK hospitals.

2.1 Hour of arrival at the Emergency Department (ED)

The majority of patients (70%) arrived 'out-of-hours' (between 5pm and 9am).

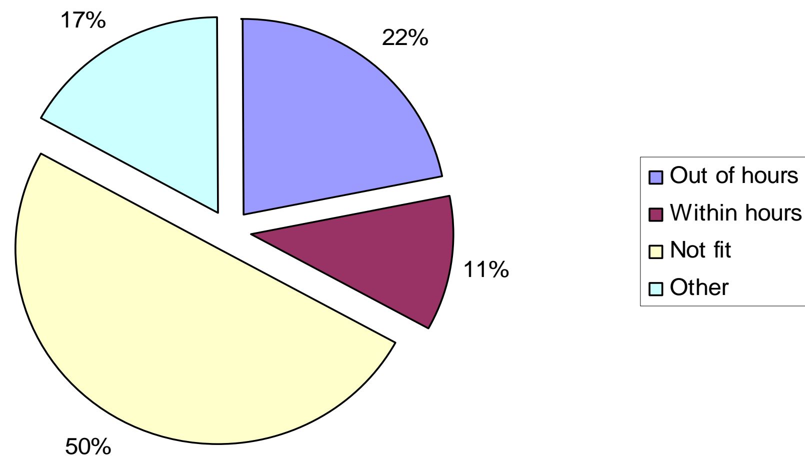
Figure 2: Hour of arrival at the Emergency Department (ED) for 2,172 patients across 37 U.K hospitals



2.2 Reasons for discharge being delayed from the ED

- Data on delayed discharge were available for 7 teams. Of the case notes for 378 patients across these teams, there were 109 (29%) reports of discharge being delayed. The most commonly cited reason for delayed discharge was 'patient not fit for treatment'.

Figure 3: Reasons given for delayed discharge from the ED:



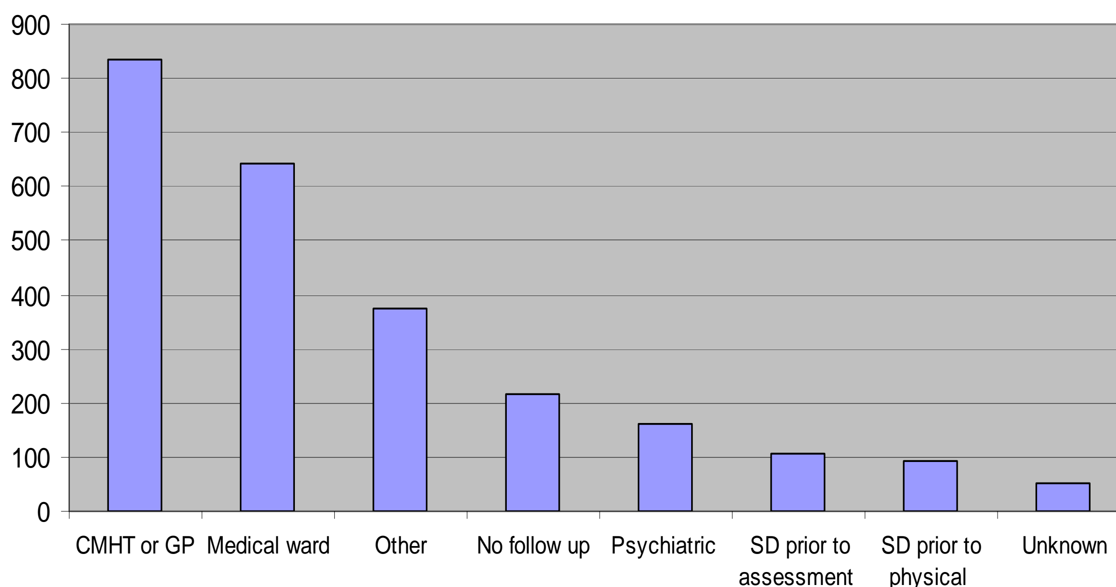
Key

- **Out of hours** – psychosocial assessment delayed, patient arrived out of hours.
- **Within hours** - psychosocial assessment delayed, patient arrived within hours.
- **Not fit** - Patient (physically or psychologically) not fit for assessment.
- **Other** - awaiting blood test results, awaiting transfer to mental health services, needed monitoring bed

2.3 Patient outcome

- The case notes of 2,172 patients recorded a total of 2,481 outcomes (some patients had more than one outcome).
- The most common outcome was 'referral to G.P or community mental health team (CMHT)'.
- A number of patients were referred to a medical or psychiatric ward overnight.
- Others self-discharged (SD) prior to assessment or treatment.

Figure 4: Number of outcomes listed for 2,481 people attending the ED following self-harm



3. Joint working

3.1 Arrangements for liaison mental health services

- Although over two-thirds of teams reported that they had an arrangement in place to ensure effective liaison psychiatric services, available 24 hours a day, many reported problems with this in practice.
- Many teams commented that they struggle to meet the response times recommended (below) by the Royal College of Psychiatrists and the British Association for Accident and Emergency (BAEM). This is particularly problematic when patients arrive out of hours, as most people who self-harm do.

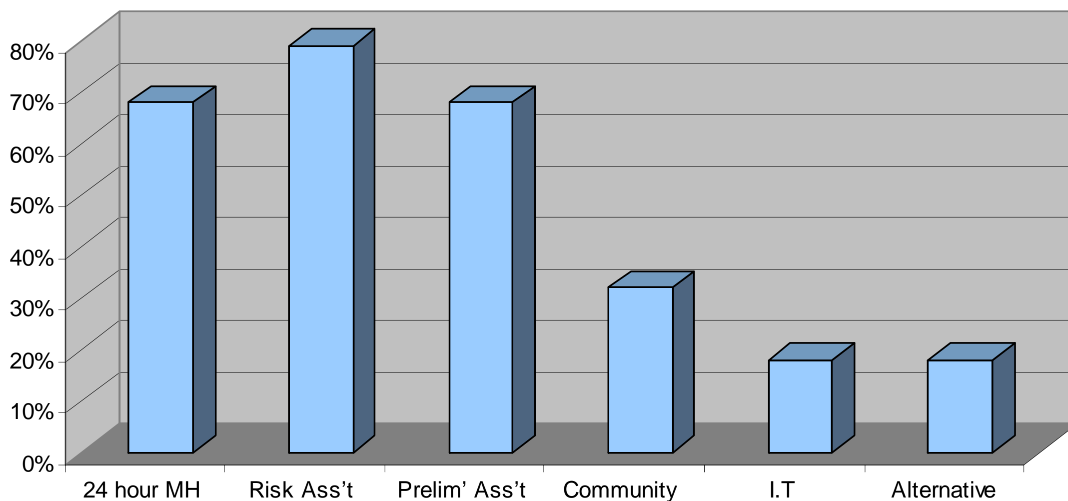
Figure 5: Response times recommended by the Royal College of Psychiatrists and the British Association for Accident and Emergency (BAEM).

	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

3.2 Policies regarding referral to mental health services

- One-third of teams have locally agreed protocols regarding the ambulance service taking the service user to an alternative appropriate service, rather than the ED.
- Two-thirds of services have a policy regarding referrals from the ED to the mental health unit – these tend to be arranged via the liaison service or the crisis team.
- The table below describes the arrangements in place according to the baseline data collected – it is worth noting that many of the teams have since begun improving their local working arrangements.

Figure 6: Percentage of teams (N = 38) with the following arrangements in place during the baseline data collection (2006/2007):



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? (Some teams commented that this arrangement is informal).
- **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?

4. Staff views on training, support and staffing

The following summary relates to staff surveys conducted in 2006 and 2007.

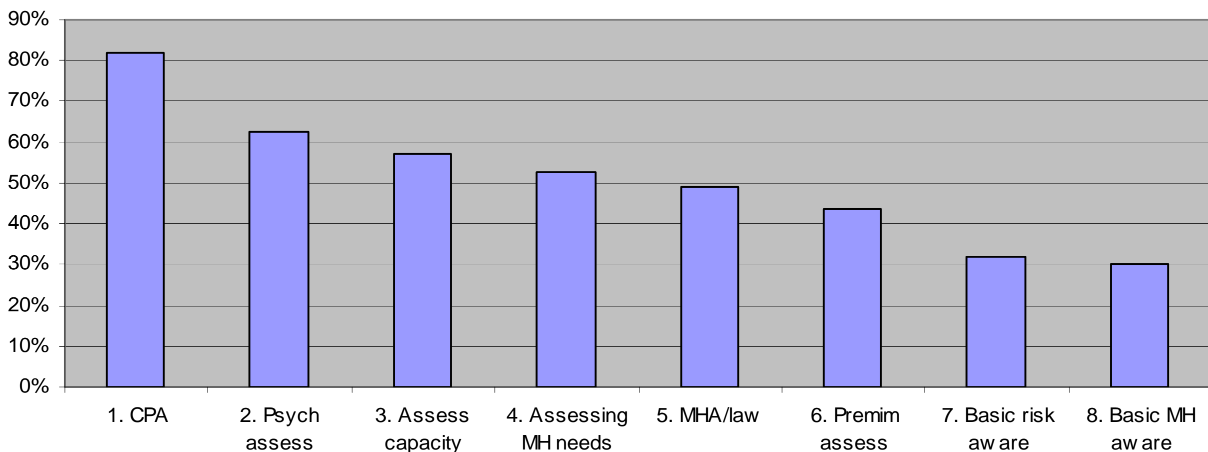
4.1 The training needs of 562 emergency department (ED) staff
Respondents: 55% qualified nursing staff, 30% doctors, 15% others

- Over half 'do not know enough about self-harm' to communicate effectively with this patient group:

'When we encounter the person who has self-harmed we only treat the cut wrist......we have no training to allow us to understand these people and so cannot talk to them or assist in their more major health problems.'

- As stated previously, over two-thirds of the 85 SpR/SHO/F2/Staff Grade doctors working in the ED rated their training in conducting psychosocial assessments as 'insufficient'. Furthermore, 82% reported that they do not fully understand the Care Programme Approach.
- Over two-thirds of ED staff would like better clinical and reflective supervision and debriefing and many felt that this would be best delivered by mental health colleagues.
- Communication between ED and MH staff was rated positively by 43% of staff. Suggestions for improvement centred around better joint working, clearer care pathways, better handovers and more input and training from the MH team.

Figure 7: Training needs reported by ED staff (nurses, doctors and others)



Key

1. The basis of the Care Programme Approach (CPA)
2. Conducting a psychosocial assessment
3. Assessing mental capacity
4. Assessing mental health needs
5. Basic understanding of the Mental Health Act and relevant common law
6. Conducting a preliminary assessment
7. A basic awareness of risk
8. A basic awareness of mental health

4.2 The training, support and supervision needs of 152 ambulance staff
Respondents: 64% paramedics, 26% technicians, 3% managers, 7% others

- Two-thirds of ambulance staff rated the training and education they had received in 'basic mental health' as insufficient.
- The majority of ambulance staff (84%) feel they have not received sufficient training in 'understanding why people self-harm'.
- Despite this, service users consistently rate ambulance staff more positively than ED and mental health staff in terms of being supportive and respectful.
- Three quarters of ambulance staff rated their supervision and de-briefing opportunities as insufficient.

4.3 The training, support and supervision needs of 436 mental health staff
Respondents: 45% qualified mental health nurses, 13% mental health practioners, 9% consultant psychiatrist/staff grade, 9% training grade doctors, 24% others.

- The majority of mental health staff rated the training and education they had received around mental health and self-harm as sufficient.
- Over half (61%) would like more training in 'the impact of cultural differences on self-harm'.
- Of the 110 mental health staff surveyed in wave 2, over 55% would like more training in 'using psychological therapy with people who self-harm'.
- Almost a third of mental health staff would like more training in conducting psychosocial assessments.
- Over two thirds of mental health staff were satisfied with the level of supervision and support provided to them.

4.4 Staff morale

- Over half of the staff surveyed felt that staff morale is adversely affected by high numbers of admissions relating to self-harm. This was particularly high in staff groups who rated their mental health training and understanding as insufficient:

'Morale is affected by dealing with high numbers of people who self-harm because of our lack of training in mental health. It's difficult to know if we are dealing with these patients in the most appropriate manner, or are making a positive contribution to patient care...it feels that we are just patching them up and not solving anything...this can hurt staff emotionally.'

- A third of ambulance and mental health staff, and two-thirds of ED staff felt that there are insufficient numbers of staff in their department.

Summary

The first two audits of the 'Better Services for People who Self-Harm' programme confirm what many have suspected for some time; that service users often experience negative attitudes and that many staff would benefit from greater training, education and support. Increased access to mental health staff in the ED was frequently suggested as a means to improving services.

APPENDIX 3: Plan, Do, Study Act (PDSA) Form
Complete one of these forms for each objective

Organisation Name: ____

Locality/team: ________________________________ **Month(s) of Activity:** __________

Start Date: ___________________________ **End Date:** ___________________________

Objective

Desired Outcome
Description of PLAN (Who, what, where, when, why) - don't forget predictions and measures

Description of DO (How was the plan carried out) - highlight problems/issues/feedback and any early analysis of data

Description of STUDY (How was the analysis undertaken) - summarise your findings. Did they match your initial predictions?

Description of ACT (what changes have been/are being made)

Team Lead: ____ **Date:**______________