

Better Services for People who Self-Harm
Key Findings and Recommendations from
the Wave 3 Baseline Data

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Key Findings & 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.

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 while 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.

Over 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 not 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 'understanding 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 40 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	<ul style="list-style-type: none"> 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* 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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* 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Audit the number of people who self-harm and receive a psychosocial assessment 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Managers to assess waiting and treatment areas for safety 	<ul style="list-style-type: none"> 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.