Self-harm, suicide and risk: helping people who self-harm

Final report of a working group

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Contents

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Executive summary

Self-harm is poorly understood in society even among those who in their working lives as school teachers, pastors, social workers, housing officers, police, prison officers and even nurses and doctors encounter people who harm themselves. People who harm themselves are subject to stigma and hostility. In contrast to the trends in completed suicide, the incidence of self-harm has continued to rise in the UK over the past 20 years and, for young people at least, is said to be among the highest in Europe. This high level of self-harm among different age and social groups is a worrying feature of our society.

The focus of this report is to enquire into and report on why people harm and kill themselves and to consider the role (including the limits of the role) that psychiatrists and other mental healthcare professionals play in their care and treatment. The experiences and views of people who harm themselves as well as those of their carers, health professionals and third-sector workers are central to this enquiry. As there is much policy and guidance on self-harm and suicide prevention, the report does not attempt to retrace this same ground but rather examines the evidence of practice on the ground, including the implementation of the National Institute for Health and Clinical Excellence (NICE) guidelines on self-harm (National Collaborating Centre for Mental Health, 2004).

This report is the second in the Royal College of Psychiatrists' programme of work on the broad issue of risk. The College report *Rethinking Risk to Others* was published in July 2008 (Royal College of Psychiatrists, 2008*a*) and a new Working Group was set up under the chairmanship of John, Lord Alderdice, to examine risk, self-harm and suicide. This clinical issue is an integral part of the role of the psychiatrist in ensuring the good care and treatment of patients.

Our central theme is that the needs, care, well-being and individual human dilemma of the person who harms themselves should be at the heart of what we as clinicians do. Public health policy has a vital role to play and psychiatrists must be involved and not leave these crucial political and managerial decisions to those who are not professionally equipped to appreciate the complexities of self-harm and suicide. But we must never forget that we are not just dealing with social phenomena but with people who are often at, and beyond the limit of what they can emotionally endure. Their aggressive acts towards themselves can be difficult to understand and frustrating to address, but this is precisely why psychiatrists need to be involved to bring clarity to the differing causes for the self-destructive ways in which people act and to assist in managing the problems for the people concerned, including family, friends and professional carers, who sometimes find themselves at the end of their tether in the face of such puzzling and destructive behaviour.

The report is divided into three parts. In Part I, we give some background information on self-harm in the UK and on understanding why people harm themselves. In Part II, we examine some of the public health policy issues, and in Part III we concentrate on the practice of healthcare professionals and others who work with people who have harmed themselves and are at risk of harming themselves, as evidenced particularly by a survey and consultations with College Members and Faculties. The important role of the third sector is also examined.

PART I: UNDERSTANDING THE PROBLEMS AND THE PEOPLE

For the purpose of this report we define self-harm as an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent. Thus it includes suicide attempts as well as acts where little or no suicidal intent is involved (e.g. where people harm themselves to reduce internal tension, distract themselves from intolerable situations, as a form of interpersonal communication of distress or other difficult feelings, or to punish themselves.)

An act of self-harm is a not necessarily an attempt or even indicator of suicide, indeed it can sometimes be a bizarre form of self-preservation. Nevertheless it covers a wide spectrum of behaviour, with harmful physical effects, and a person who repeatedly self-harms is at a higher risk of suicide.

Self-harm is a behaviour, a manifestation of emotional distress. It is an indication that something is wrong rather than a primary disorder. For each person the contributing circumstances are individual. However, commonly they include difficult personal circumstances, past trauma (including abuse, neglect or loss), or social or economic deprivation together with some level of mental disorder. A person's self–harming behaviour may often be associated with the misuse of drugs or alcohol. The rate of self-harm is higher among women and girls than among men and boys, although completed suicide is more prevalent among men and boys.

People of all ages and from all social and cultural backgrounds may harm themselves but some groups are especially vulnerable because of life experiences, personal or social circumstances, physical factors or a combination of these elements. There is a higher incidence of self-harm among prisoners, asylum seekers, veterans from the armed forces, people bereaved by suicide, some cultural minority groups and people from sexual minorities.

The assessment and management of a person who has harmed themselves therefore requires a biopsychosocial approach which assesses their problems, needs and in so far as is possible understands the risks of further harm to this individual and provides a person-centred management plan. Helping this person address their current and ongoing problems with whatever help can be made available to them in their context should be the key principle informing the care and treatment of the individual.

Finally, we consider some of the interventions that have been found effective for people who self-harm. This is brief, bearing in mind that the findings of the new Cochrane review of interventions into self-harm are about to be published but not available at the time of writing.

Part II: The public health agenda

In Part II we first consider the implications of the evidence about the nature and causes of self-harm for public health strategies. Second, we look briefly at the role of wider bodies than the health sector in dealing with self-harm and suicide prevention.

The suicide prevention strategies in each of the countries of the UK, including that first established in England, have been successful and influential and should be continued, and improved. However, greater priority needs to be given to self-harm whether as part of suicide prevention or as a separate strategy, particularly in the English context. There is also an opportunity for pooling of knowledge and expertise among those involved in each of the suicide prevention strategies throughout the UK.

Given the social context of self-harm and the different populations at risk, a self-harm strategy needs to be cross-departmental. It needs to include the training of front-line staff in a range of sectors, and to ensure appropriate and accessible public information and education. It should involve research into the different aspects of self-harm and it should address emerging issues relating to the internet. In particular, it should focus on drug and alcohol strategies and social exclusion, especially at a time of economic crisis such as the UK is experiencing now.

The third sector plays a vital role in policy and practice on self-harm and suicide prevention from national charities such as the Samaritans to small local organisations and interventions. National charities and many other local and regional bodies provide support in different ways. They undertake research and campaigns, operate telephone helplines and moderate website forums, raise awareness and offer staff training, and provide practical services for people who harm themselves, together with help and advice for carers. Their links with service users and local networks are invaluable and their role in any suicide prevention or self-harm strategies should be fostered.

Recommendations

- Suicide prevention should remain a priority of public health policy in all countries in the UK. There should be structures at national, regional and local level and mechanisms for the flow of information, evaluation and best practice to ensure effective implementation. A partnership approach to implementation should be adopted wherever feasible.
- The needs of those at particular risk (including asylum seekers, minority ethnic groups, people in institutional care or custody such as prisoners, people of sexual minorities, veterans and those bereaved by suicide) should be actively addressed as part of this strategy.
- A UK-wide forum should be established to bring together agencies from the four nations who are involved in suicide prevention policy, research and practice.
- The government department responsible for public health in each of the jurisdictions should lead a cross-departmental strategy to raise awareness of self-harm, ensure appropriate training for front-line staff in education, social work, prisons, police and other relevant agencies in dealing with self-harm, and to help fund and promote research into suicide and self-harm. A partnership approach to implementation should be adopted wherever feasible. The government department responsible for public health should ensure that government websites including NHS Direct and the Department of Health include authoritative, accurate, accessible and user-friendly information on self-harm for service users, carers, family members and friends.
- The monitoring of harmful internet websites should be included in this strategy.
- Suicide prevention strategies and self-harm strategies should explore and strengthen the relationships between third sector and statutory sector providers.

In Part II of the report we also mention the important role of other bodies, including the professional bodies and the third sector. Professional bodies such as the Royal College of Psychiatrists can play a useful role as part of their public education function in providing authoritative and accessible information for those who harm themselves, their carers, families and friends, as well as basic information and toolkits for their staff and colleagues.

RECOMMENDATION

- The Royal College of Psychiatrists should collaborate with other mental health organisations and professional bodies to ensure that helpful and user-friendly information is available for diverse audiences and purposes.

RESEARCH

Finally, Part II addresses the need for research into self-harm. Although suicide prevention has been the subject of much research in the UK and elsewhere, self-harm as a distinct issue received much less attention until recent years. As a result, people who harm themselves often do not get the best care. Services and clinicians lack guidance as to what works, and for whom, and commissioners lack evidence on outcomes to assist their commissioning.

In England, research into self-harm undertaken as part of the suicide prevention strategy and through the Oxford University Centre for Suicide Research and other research organisations has added significantly to the evidence base. Nevertheless, research is still much needed into all aspects of the issue – epidemiological studies, investigations of the full range of causes of self-harm, and, most importantly, effective interventions to treat and in so far as it is possible to help prevent self-harm.

RECOMMENDATION

- A combination of national government funding streams, medical research council/economic and social research council, and charitable funds should consider research into self-harm as a funding priority.

PART III: WORKING WITH INDIVIDUAL PEOPLE

The third part of the report examines the reported experiences of service users who are in contact with health services; what they want and where these services fall short. We then consider, from staff surveys, research and from a survey and consultations with the College Members, Faculties and Sections, what can be learned from the staff experience. Although there is some good, even excellent practice reported to us, there are also clear indications of fault lines and failures to meet the standards set by NICE guidelines and professional practice. It is not possible for us to appraise

the extent of the problems, but it is clear that there is at times a significant mismatch of what service users need, clinicians want and NICE recommends on one hand, and what too frequently occurs in practice – even if though it may be in a minority of cases.

Individual respondents to the College Members' survey expressed considerable concern and frustration about a range of issues concerning the care that vulnerable people who are ill could expect to receive. This was frequently linked to a lack of resources and pressures of busy work places. Major themes included the lack of the necessary resources to allow staff to undertake detailed assessments, or for the implementation and follow-through of management plans, and the tendency to focus on risk assessment whether to provide legal cover in the case of misadventure or from a misguided notion that it is possible to predict the future.

This all has immediate implications for patients' recovery and for long-term costs in the health and social care systems. Although most evidence relates to emergency care, similar pressures apply to acute in-patient wards and community mental health teams (CMHTs).

Presentation at hospital will often be the first time that the person who is harming themselves will have had contact with the health service. Failure to deal effectively with a person at this stage will have major repercussions. It may discourage them from returning in a later crisis. It may mean they become disengaged and lack the care and treatment they need. Such failures are reported to be a major cause of hospital in-patient admissions. The seriousness of this is often overlooked by hospital management.

STAFF TRAINING

Families and friends may be frustrated and distressed by the actions of the person who self-harms, but there is strong consistent evidence that professionals can have similar responses. When the person needs humane care and understanding they may also encounter hostility, disengagement or bewilderment. Evaluations of staff training demonstrate its role in improving their interactions with service users.

RECOMMENDATION

- The Royal College of Psychiatrists works with colleagues in other health disciplines and other relevant partners to develop a common curriculum on self-harm for front-line health professionals and that Trusts and Health Boards provide time for staff regularly to receive this training and professional support.

Respondents to the College survey expressed dissatisfaction with the expertise of some members of their own profession and with other staff (nurses, doctors, social workers, pediatricians, police and prison staff) in dealing with and in undertaking assessments for people who have harmed themselves (particularly those repeatedly harming themselves) or who are suicidal. Many staff considered that they were not trained, or not adequately trained or supported and supervised on psychosocial assessments.

The position is particularly acute in accident and emergency (A&E) departments. It appears common for junior staff, especially junior doctors and psychiatry trainees, to have responsibility – often at night and without

supervision – for assessing and managing the complex and potentially life-threatening situations of people who have harmed themselves or attempted suicide. The person may be under the influence of drugs or alcohol and the question of their mental health as well as their physical and social needs may be an issue. Work schedules, consequent on the European Working Time Directive, were also said to be partly responsible for this development, and young psychiatrists reported that they felt ill equipped for this work, as well as overburdened and demoralised. Others reflected on the inadequate assessments that they and others made because of lack of experience and of time.

This situation is unacceptable by any reasonable standard. Experienced clinicians need to be involved from the outset in these complex and challenging cases to supervise and ideally to assess these patients. Lives may be at stake and well-being certainly is. The Working Group agrees with the views put to us that senior clinicians need to be enabled to provide a greater involvement with patients who harm themselves, and this has significant resource implications. Either more must be provided or it has to be redirected from its current focus. Liaison psychiatrists with expertise with the different groups of people, including adolescents and older people, should be available both for A&E and general hospital wards. They should also be available to provide supervision and training of junior and less experienced staff.

RECOMMENDATIONS

- The Royal College of Psychiatrists should ensure that training in biopsychosocial assessment and management of self-harm is a core competency for all junior psychiatrists. It should be an essential (mandatory) component of prequalification training.
- Trust and Health Board management should ensure that as part of their in-service training junior doctors are exposed to people who harm themselves but with access to supervision on an immediate and regular basis with senior staff. Staffing schedules should ensure that senior clinicians are involved in supervising or managing cases of self-harm from the outset.
- Commissioners of mental health services and Trust managements should make liaison psychiatrists available for A&E and general hospital wards at all times, and they should be there to provide training and support for colleagues dealing with self-harm.

SUPPORT FOR STAFF

Staff needs extend beyond regular supervision to proper ongoing support for cases that can be personally distressing and professionally challenging for staff to manage. It was put to us that the lack of support for staff reflects the whole culture of some organisations where there is too little emphasis on support, supervision and time for reflection. Introduction of reflective practice would improve staff morale and knowledge and improve relations between teams and departments.

RECOMMENDATION

- For there be an improvement in the culture of practice to ensure that organisations support mental health professionals and promote good patient outcomes for those who have harmed themselves. Clinical staff should have sufficient support from colleagues who are available to them. Reflective practice should be embedded into supervision and into organisational practice.

RISK ASSESSMENTS

Biopsychosocial assessments should be done with all patients who self-harm (as per NICE guidelines; National Collaborating Centre for Mental Health, 2004). A central purpose of psychosocial assessment is to identify a patient's needs and the risks to them and to devise a management plan to address these issues. The management plan lays the foundation for future long-term care, which in the case of people who harm themselves requires long-term thinking and should often involve multiple partners.

The College Members' survey informed the enquiry on the practice of assessments, including the important issue of the role of risk assessments. Risk assessment is a core function of medical practice. However, sustained by an overvalued view of predicting the future and a perceived culture of blame, Trusts need to protect against an overdue cloud of litigation threat, which together with the increased role of junior staff tends at present to dominate practice. This is despite the acknowledged fact that risk assessment *per se* has a very limited, and short-term, predictive power of a person's future risk. As they had done for the previous College Report on risk (Royal College of Psychiatrists, 2004), respondents voiced their dissatisfaction with current practice, in particular the continued use of long locally developed risk assessment tools that lacked validity, encouraged a tick-box mentality, distracted staff from their work with vulnerable people, devalued engagement and impaired empathy. This practice is contrary to recommendations in the NICE guidelines.

RECOMMENDATION

- Locally developed risk assessment tools should be abandoned. All risk assessment tools should be evidence-based and widely validated. Where risk assessment tools are used they should be seen as part of routine biopsychosocial assessment and not as a separate exercise.

PSYCHOSOCIAL ASSESSMENTS

There are problems too with psychosocial assessments. People may be discharged with either a superficial assessment or none at all after an episode of self-harm; most critically that means they are discharged without an opportunity to be listened to and to listen, for their personal and medical situation to be understood and the need for future management considered.

There needs to be a rebalancing of a clinician's effort and time, with less attention to risk assessment and greater attention given to ensuring a full biopsychosocial assessment that reviews holistically the needs of the person and provides a carefully thought-out future plan.

RECOMMENDATIONS

- People attending hospital after an episode of self-harm should all receive a biopsychosocial assessment, done in accordance with the NICE guideline, by a clinician with adequate skill and experience.
- Psychiatrists assessing people who have harmed themselves should undertake a comprehensive psychiatric history and mental state examination together with an assessment of risk. In that way risk and needs assessments should be more closely tethered.

Discharge and continuity of care

Pressure to discharge patients from A&E departments and pressures on beds means that sometimes people are discharged too soon after an episode of self-harm or a suicide attempt. Furthermore, contrary to NICE guidelines, patients are often discharged from the A&E department with no or minimal communication to primary care. Some vulnerable people also discharge themselves because of excessive waiting time involved in A&E attendance.

Care pathways are not always in place. Individual management plans may simply respond to the immediate concerns rather than embrace a longer-term perspective. The longer-term management of self-harm appears to vary in quality with the problems of fragmentation of services, duplication of assessments and people being lost to the system being cited to us as of great concern. Lack of follow-through also arises because of communication problems between different teams and staffing shortages, especially over the summer period. There is no clear pathway for self-harm in some Trusts or Health Boards. All of these factors mean that the requisite standard of care was not being provided. These issues must be taken up in developing the new NICE guidelines.

At a time of changes in service design, heightened pressures on resources and new evidence about what works for people who harm themselves, there is clearly a need for new practice-based guidance for clinicians of all professional backgrounds. Clinical care pathways need to be reassessed and recommendations made that reflect these new factors, identify efficiencies, duplication and waste but also ensure that long-term care of people who need it is at the heart of what is done.

Recommendation

- The College Report *Assessment Following Self-harm in Adults* (Royal College of Psychiatrists, 2004) should be updated, reflecting findings in this report, relevant NICE Guidelines and other policy and practice-based developments.

Psychological therapies

Evidence-based therapies, including problem-solving therapy and cognitive–behavioural therapy (CBT), have been proved beneficial for some people who harm themselves. Many respondents to the College Members' survey expressed frustration that appropriate psychological therapies were not available, despite being recommended by the NICE guidelines.

Recommendation

- Mental health commissioners should take more account of the needs of people who harm themselves and ensure that evidence-based psychological therapies are available for individuals who need them. Research needs to be funded into relevant therapies to improve the evidence base.

Particular groups of people

We also report on three particular issues that were raised most frequently to the Working Group by College Members and others as part of this enquiry.

A perceived neglect for people who repeatedly harm themselves and for those with a diagnosed personality disorder was a common theme. It is important that these issues be fully considered as part of the development of a new NICE guideline. We also considered the merits of dedicated self-harm services and urge this to be a subject for future research.

RECOMMENDATION

• As part of our recommendations on research, we highlight the need for an examination of different models of care for people who repeatedly harm themselves with the effectiveness of dedicated self-harm services as part of such an enquiry.

Given the ageing population and the previous comparative neglect of services for older people, and given also that self-harm is a growing phenomenon with older people and the risk of completed suicide is higher in this age group, the Working Group insisted that special consideration needs to be made of the needs of older people.

The College Faculty of Old Age Psychiatry also said that there needed to be a recognition by services that they should: actively treat depression in later life; have a low threshold for referral to specialist services for older people; end the discrimination in their access to services in general; and not underestimate the seriousness of self-harm and suicidal behaviour in later life.

The Working Group strongly endorses these views.

Prisoners and those in forensic facilities are particularly vulnerable to self-harm and suicide. We welcome the work that is being taken forward to improve their situation in England.

RECOMMENDATION

• The four approaches – diversion from the criminal justice system for those with mental illness; equivalent 'in-reach' care for prisoners as for those in the general population; timely and speedy prison transfer for those with severe mental illness; and effective training for prison staff – be energetically pursued in future work throughout all the countries of the UK.

The third sector

The third sector plays a constructive and at times crucial part in the well-being, care and treatment of those who harm themselves. For many people they are the first or only point of call. Their experience, knowledge and skills are immense. Relations with the third sector have not always been fostered by those who work in statutory services and are still underused.

RECOMMENDATION

• Psychiatrists and other mental health professionals should acknowledge the crucial contribution of the third sector in dealing with self-harm and suicide. The Royal College of Psychiatrists and mental health professionals in the statutory sector should collaborate with them, explore ways of partnership working and each should have the opportunity to learn from the experience of the other sector.

Appendix I gives a summarised account of the findings of the College Members' survey. A full version is available on the College website (www. rcpsych.ac.uk/risktoself).

Part I
Understanding the problems and the people

1. Background

Over the past decade the assessment and management of risks posed by people with mental illness to others and to themselves have preoccupied policy makers and services in mental health. This originally stemmed largely from public concern about some high-profile cases where harm had resulted from homicidal actions by people with a mental illness. This resulted in mandatory homicide inquiries focusing on risk to others. The Royal College of Psychiatrists decided to embark on a programme of work on the broad issue of 'risk', but to include risk to self as well as risk to others. The College report *Rethinking Risk to Others* was published in July 2008 (Royal College of Psychiatrists, 2008*a*), and a new Working Group was set up under the Chairmanship of John, Lord Alderdice, to examine risk, self-harm and suicide.

Our approach

In contrast to the trends in completed suicide, the incidence of self-harm has risen in the UK over the past 20 years and, for some groups, is said to be among the highest in Europe. This high level of self-harm among different age and social groups is a worrying feature of our society.

The phenomenon of self-harm is not well understood within the community or even among some professionals who encounter it in their work. People who do harm to themselves are more likely to be subject to stigma and hostility than to be helped to understand why they are harming themselves. Self-harm is of immediate concern to consultant psychiatrists who regularly see people in severe distress who have done or are at risk of doing harm to themselves or even taking their lives. The focus of this report is to give an account of why people harm and kill themselves and to consider the role (including the limits of the role) of psychiatrists and other mental healthcare professionals in engaging with people who find themselves behaving in these self-destructive ways. The experiences and views of people who harm themselves are a very important element of this enquiry.

The Working Group were mindful of the excellent academic research work, government policy development, and health and social care practice that is already taking place. This includes the suicide prevention strategies across the UK and the existing NICE guidelines on self-harm (National Collaborating Centre for Mental Health, 2004) together with the new NICE guidelines under development (http://guidance.nice.org.uk/CG/WaveR/82). The Group therefore decided to concentrate on the barriers to implementation of the policies that are already in place, and to highlight any important gaps or problems of understanding that emerged in our study.

We were able to take into account research being done within the College and by external UK research bodies, including the Oxford University Centre for Suicide Research, as well as the work of mental health charities, service user groups and the findings of our College reports on risk to others. We have not attempted to cover international research.

We decided that although this report should take account of all this evidence, we should not try ourselves to propose clinical standards and assess the effectiveness of clinical interventions, but would concentrate on understanding the experience of the person who had harmed themselves, as well as their carers and those who were charged with trying to help them, and how services might better help them.

The Working Group settled on the following terms of reference.

- To assess what contribution psychiatrists can make to understanding why people harm themselves, and when and how we might contribute to the prevention and treatment of those who harm themselves, and the prevention of suicide.

- To investigate the barriers facing psychiatrists and other mental healthcare professionals in the implementation of relevant policies, services and treatments.

- To investigate the interaction of psychiatrists with other healthcare professionals, service users and families, and to give due care and attention to the experience of service users and carers.

- To investigate the role current models of risk assessment and risk management play in the prevention and treatment of self-harm and the prevention of suicide, and whether and how they might be improved.

In doing this work the Working Group directed itself to pay attention to the importance of the differences between individuals, population groups and contexts. Over the course of our deliberations certain areas of interest emerged from these broad themes and they have formed the basis of the report. We have concentrated on self-harm as a subject in its own right as well as when it may be a precursor to suicide.

PROCESS

The Working Group met throughout 2009 and early 2010 and took evidence in person and in writing from selected experts. (A list of their names appears in Appendix II). Other experts were interviewed individually. The Group was also most grateful for the written submissions provided by College Faculties and the Scottish, Northern Irish and Welsh Divisions, and also for the comments on drafts of the report from College Faculties, Divisions and Special Interest Groups. The College Service Users' Recovery Forum and the Carers' Forum contributed their valuable views and were consulted in the preparation of the report.

COLLEGE MEMBERS' SURVEY

A survey was sent to 9750 College Members with a working email address (in the UK and overseas). It is reproduced in Appendix I. A total of 1540

College Members completed the survey. The results form a key part of this report. Although the results are not statistically representative of the wider College membership, the results provide important insights into the views and opinions of a comparatively large number of College Members. The survey concentrated on risk assessments and on other issues covered by NICE guidelines (National Collaborating Centre for Mental Health, 2004). Responses cover different aspects of, and provide different angles on, the quality of patient care, particularly in acute services.

STRUCTURE OF THE REPORT

In Part I of the report we give some background information on self-harm in the UK and on understanding why people harm themselves. In Part II, we examine some of the public health policy general issues, and in Part III we concentrate on the practice of healthcare professionals and others who work with people who have harmed themselves and are at risk of harming themselves, as evidenced particularly by the Members survey'. We conclude with making recommendations for improvements.

We have included many quotations from patients, carers and healthcare professionals in order to ground the report as much as possible in the experience of the people concerned. These are generally given in italics and quotation marks for ease and clarity of identification. Some of the quotations are from other published research or reports.

We have kept references to a minimum, for ease of reading and have included a bibliography of works consulted. The authors of this report are Rowena Daw and Lord Alderdice, with contributions from other members of the Working Group. The Working Group is deeply grateful to Dr Daw in particular for the enormous amount of work that she did in drawing the material together and writing the text. We are also grateful to Dr Martin Skipper who contributed to the research and provided secretarial support and to Mr Chris Fitch, Research Fellow in the College Policy Unit, who undertook and analysed the College Members' survey and compiled the report in Appendix I.

PREVIOUS RELATED COLLEGE REPORTS

The College has been engaged in previous years with the issues of harm to self and others and the assessment of risk. This report is intended to complement and build upon, but not to replicate, these previous College Reports and the quality standards as described below.

■ *Assessment Following Self-harm in Adults*, Council Report CR122 (Royal College of Psychiatrists, 2004). This report identifies consensus standards for assessment following self-harm. It identifies the competencies expected of both generalist and specialist staff in all hospital and community settings.

■ *Better Services for People who Self-Harm: Quality Standards for Healthcare Professionals* (Royal College of Psychiatrists, 2006). This best practice guideline incorporates the NICE guidance and includes other standards and current legislation from the Royal College of

Psychiatrists, the Faculty of Accident and Emergency Medicine, and the Department of Health. It lists principles for all staff regardless of their profession and describes best practice along a common care pathway, allowing professionals to apply these standards directly to patient care.

■ *Rethinking Risk to Others in Mental Health Services*, College Report CR150 (Royal College of Psychiatrists, 2008*a*). This report examines the concepts and practice of risk assessments for risk to others and makes recommendations for future policy and practice.

2. What is self-harm?

PROBLEMS OF DEFINITION

Given the varying types of self-harm, the different contexts in which it occurs and the different motives and meaning for the individual concerned, defining self-harm is not straightforward. The NICE guidelines (National Collaborating Centre for Mental Health, 2004) use the short and broad definition:

> 'Self-poisoning or self-injury, irrespective of the apparent purpose of the act.'

The service users' National Self-Harm Network (NSHN; 1998) presented an alternative description:

> 'Self-injury is frequently the least possible amount of damage and represents extreme self-restraint.'

Some of the people consulted as part of this report expressed their wish for a single definition that would be clear and acceptable for everyone – service users, carers, health and social care professionals and the public alike; however, self-harm is not a particular disorder or even a particular type of behaviour. Indeed there is a real danger that we lose sight of the fact that this is about people in distress. Worst of all, these people, who are already in distress (no one harms themselves because they are happy), are diminished further by being referred to as 'self-harmers' or 'cutters'. Such terminology prevents those who use it from trying to understand the complexity of what is going on for those with whom they are working. We have avoided such terms in this report, except where we are quoting directly from other work when for the sake of accuracy we use the terms in the original published documents.

In this report we address under the term 'self-harm' intentional acts of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent, a definition that is used widely within Europe and elsewhere (Hawton *et al*, 2007*a*). Thus it includes suicide attempts as well as acts where little or no suicidal intent at all is involved, for example when people harm themselves as a form of interpersonal communication of distress or other difficult feelings to reduce internal tension or to punish themselves.

Self-harm can take many forms. The most common form of self–injury is cutting (with a variety of implements and degrees of severity). There is some evidence that cutting is more repetitive than other forms of self-harm, and that it may not be as predominantly a female activity as is commonly thought (Lilley *et al*, 2008). Other forms include burning, hanging, strangulation, scratching, banging or hitting body parts, and mutilation of parts of the body or interfering with wound healing. A relative increase in the

incidence of hanging over the past few decades has been reported (Hawton *et al*, 2008).

Self-poisoning is the intentional use of more than prescribed or recommended doses of any drug and includes poisoning by non-ingestible substances, overdoses of recreational drugs and severe alcohol intoxication where this seems to be intended as an act of self-harm. People may switch methods of harming themselves over time. Although it is likely that the incidence of self-poisoning is lower in the population that does not seek medical care, it is more frequently encountered in the health services than self-injury.

Substance misuse through excessive alcohol or drug consumption, eating disorders, physical risk-taking, sexual risk-taking, self-neglect and misuse of prescribed medication are sometimes labelled 'indirect self-harm' and one could consider self-neglect as another form of self-harm. Indeed, when people who repeatedly harm themselves through cutting or taking overdoses are helped to overcome these behaviours, eating disorders or other self-damaging problems may emerge. For the purposes of this report we limit our discussion to self-injury and self-poisoning as discussed above.

Incidence in different age groups and gender issues

Suicide is a significant cause of death. In Britain, suicide is the third largest contributor to premature mortality (after heart disease and cancer) (World Health Organization, 2000). Although the suicide rate is now the lowest it has ever been in the UK (National Mental Health Development Unit, 2009), in 2007 there were still 7.9 suicides per 100000 people, which translates into about 4000 incidents per year.

Younger people are more likely to die by suicide than older people. Statistics show that in 16- to 24-year-olds, 5% have attempted suicide, compared with 2% of 65- to 74-year-olds. However, the rate among people over 85 rises again. There are not only age-group differences in suicide rates, but also differences between males and females. According to the World Health Organization (WHO) *Global Burden of Disease: 2004 Update* report (World Health Organization, 2008), men are five times as likely to die by suicide as women. Of people in the UK who die by suicide, only about 25% were in contact with mental health services in the 12 months before the suicide, although it is generally acknowledged that most had a diagnosis of a mental disorder at the time of their death (Bertolote & Fleischmann, 2002). In some studies, the rate of a diagnosed mental illness of those who have killed themselves has been found to be more than 80% (Arsenault-Lapierre *et al*, 2004; Fleischmann *et al*, 2005; McManus *et al*, 2009).

The UK has one of the highest self-harm rates in Europe, reported at about 400 per 100000 people (Horrocks *et al*, 2002). It has been estimated that there are 170000 self-harm presentations at hospitals each year in England (Kapur *et al*, 1998) and self-harm has been quoted as one of the five top causes of acute hospital admissions, but this greatly underestimates the problem since many people do not attend hospital. As with suicide, younger people are more likely to self-harm than older individuals. Of those who present at hospitals, two-thirds of patients who self-harm are under the age of 35 years and two-thirds of people in this age group are female. Overall, women are more likely to self-harm than men; one study recorded

that females are in fact up to five times as likely as males to display such behavior (Fox & Hawton, 2004).

People who self-harm repeatedly are at a high and persistent risk of suicide (Owens *et al*, 2002; Hawton *et al*, 2003). One recent study found an approximately 30-fold increase in risk of suicide, compared with the general population, among those they studied; the rate was substantially higher for female patients than for male patients. Suicide rates were highest within the first 6 months after the index self-harm episode (Cooper *et al*, 2005).

MOTIVES AND CAUSES

People are individuals. People who harm themselves not only do so in varying ways, but the background to their behaviour and their motivations differ as well. Self-harm is a manifestation of emotional distress. It is not necessarily the case that an act of self-harm is an attempt or even indicator of intent to die by suicide (Swales, 2005); indeed, it can be seen as a form of self-preservation. An individual may be strongly motivated to end their life or may be ambivalent. Having taken what they see as a lethal overdose, the person may have informed someone of what they have done.

> 'I don't see it as a prelude to suicide; I see it as a survival thing.'

An act of self-harm is often described by service users as a coping mechanism or as a distraction that brings relief, in most cases accompanied by a complex set of feelings, self-disgust and shame also being among them (Klegg, 2005; Chapman *et al*, 2006). Studies interviewing people who have harmed themselves show remarkable consistency, at least for repeated self-harm, with the desire being to manage unbearable pain or unbearable situations, including the wish to die (Hjelmeland *et al*, 2002; Mental Health Foundation, 2006; O'Connor et al, 2009*a*).

> 'In some ways it gave me control over the pain I felt, rather than having it inflicted on me by someone else, somehow inflicting harm on myself as I say, got me through the other afflictions […] it was just helping me through life in general.'

In a study of people who self-injure and have a diagnosis of borderline personality disorder, about 90% indicated that they felt less angry and anxious and more peaceful after self-injury (Klonsky, 2007). Similarly, adolescents who self-harm, with no history of a psychiatric disorder, have reported mental states such as angry, depressed, lonely and frustrated before self-harm and these were said to be diminished afterwards (Klonsky, 2007). Participants in one study also reported that self-harm helped them to function better, helping them to stay connected with reality and 'afloat in the ebb and flow of day-to-day life' (Csipke & Horne, 2008).

For many people self-harm, especially self–injury, remains a secret activity that persists for a period until circumstances change or 'I grew out of it'. Sometimes with the help of medication or therapy the urge diminishes, is better controlled or alternative means are found to channel distress. Young people may have particular difficulties with disclosure of self-harm. In particular, they fear that by disclosing their self-harm they will lose control to others – family members, the school and other professionals. Their lack of control can exacerbate their self-harm (Mental Health Foundation, 2006). Trusting others to keep their problems confidential is a cause of great anxiety.

It follows that many such people do not come to the attention of any services. This has important implications for public health strategies and is discussed below. Self-harming is a key health problem among adolescents. It may not always indicate 'severe pathology' but rather a period of 'transient distress' (Hawton *et al*, 2006). In a recent small community study, the authors compiled a comparison of motives chosen by young people who either injured themselves or overdosed/poisoned themselves to explain their acts (Hawton *et al*, 2006) (Table 2.1).

Table 2.1 Motives chosen by young people to explain reason for self-injury

Motive	Self-cutting, % (*n/N*)	Self-poisoning, % (*n/N*)
Escape from a terrible state of mind	73.3 (140/191)	72.6 (53/73)
Punishment	45.0 (85/189)	38.5 (25/65)
Death	40.2 (74/184)	66.7 (50/75)
Demonstration of desperation	37.6 (71/189)	43.9 (29/66)
Wanted to find out if someone loved them	27.8 (52/188)	41.2 (28/66)
Attention seeking	21.7 (39/180)	28.8 (19/66)
Wanted to frighten someone	18.6 (35/188)	24.6 (16/65)
Wanted to get back at someone	12.5 (23/184)	17.2 (11/64)

Similar motivation has been expressed in studies across different age groups, including a study involving 1000 people (88% females) aged between 12 and 59 years (Csipke & Horne, 2008). By contrast, self-harm among older people has a distinct and different profile. Interviews with older people consistently show a suicidal intent behind an act of self-harm (Dennis *et al*, 2007).

A person who regularly harms themselves may have different reasons on different occasions when they engage in these actions; indeed their motives can evolve over time. At times, a person's intentions may be confused or may be unknown by them or by others.

Much self-harm is repeated and can become habitual or even addictive (Csipke & Horne, 2008).

'After a while it just feels like routine and a way to keep your mind in check.'

Self-harm can also have a contagious effect, particularly with young people (Hawton *et al*, 2002). Young people in residential care have been reported to be at greater risk of self-harm than those living in the community (Mental Health Foundation, 2006). We consider in the following chapter the particular issues of prisoners and people with intellectual disabilities in care.

3. Self-harm and mental or physical disorders

Mental illness

> 'Self-harm is not an illness, but is more or less dangerous behaviour that should alert us to an underlying problem, difficulty or disorder.' (National Collaborating Centre for Mental Health, 2004: p. 16)

As yet we have not mentioned formal psychiatric illness regarding self-harm. This is not because it is not an important cause in some people, but because it is likely that the majority of those who harm themselves do not have a formal psychiatric illnesses. One of the difficulties in assessment is that unless the assessor is appropriately trained and has the opportunity to conduct a proper psychiatric history with its inherent biopsychosocial enquiry and diagnostic assessment, there will be no differentiation between people who have harmed themselves as a way of dealing with unhappiness and other emotional disturbances, which are directly related to and to some extent an understandable reaction to external circumstances, and those whose self-damaging behaviour is attributable to a psychiatric disorder and a resultant disturbed mental state.

Making such a differentiation is important not only in assessing risk but also in deciding a future management plan. For example, where someone is harming themselves in reaction to unhappy life circumstances it would seem reasonable to assist them to address their problems in a less self-destructive way. In this context, cognitive–behavioural therapy (CBT), may be helpful as a kind of protocol for how to address problems of difficult feelings (e.g. anxiety or depression/unhappiness). It can function as a form of coaching or guidance towards natural healthy problem-solving. Indeed, many people could use the techniques of CBT to assist them in addressing problems of ordinary living.

For those who have more fundamental disorders of personality or who have a formal psychiatric illness, the management or treatment approach may or may not require CBT and/or its elements but will most likely require other biopsychosocial interventions – medication, other psychotherapies, assistance with arrangements for living, containment and protection from harm, etc. In other words, if the self-harming behaviour is attributable to a psychiatric illness then that illness needs to be identified and treated.

There are strong links between self-harm and borderline personality disorder (Klonsky, 2007), but individuals with other diagnoses such as major depression, anxiety disorders, substance misuse, eating disorders, post-traumatic stress disorder (PTSD), schizophrenia and other personality

disorders are also at a high level of risk. The rates of a diagnosed mental disorder are higher among those who persistently self-harm. (One study of patients who repeatedly self-harmed found the prevalence of mental illness and personality disorder to be 90% and 46% respectively (Haw *et al*, 2001).)

In one study of people presenting at general hospitals involving 1108 individuals (a third of whom were assessed by mental health specialists), probable depression was identified in 29%; alcohol or drug misuse in 32% (a further 9% were alcohol dependent); anxiety/stress-related disorders in 13%; a severe mental illness in 7%; and a further 4% were diagnosed with personality disorders (Dickson *et al*, 2009). Four per cent were identified as having no psychiatric disorder evident at time of assessment.

Across all age groups and for both men and women, mental illness, including depression, bipolar disorder, schizophrenia, personality disorders and childhood disorders, has been established as a risk factor for suicide (McLean *et al*, 2008). Suicide is a major cause of death for women who die during pregnancy and after giving birth; this is strongly associated with mental disorder (National Collaborating Centre for Mental Health, 2007*a*).

Given the high rate of psychiatric disorder among people harming themselves and especially in those taking their lives, it is a very important responsibility of anyone assessing the needs of a person who has harmed themselves that they can and do identify whether or not the person is suffering from an identifiable psychiatric illness.

PEOPLE WITH INTELLECTUAL DISABILITIES

The nature and extent of self-harm among people with intellectual disabilities is not well understood, although it is believed to be not uncommon (Lovell, 2008). A recent review of the views of people with intellectual disabilities and their families has stressed the importance of acknowledging self-injury as an issue in its own right, and for it to be taken seriously. They report that too often self-harm is dismissed as 'challenging behaviour' and the specific personal distress underlying it not addressed (Heslop & Macaulay, 2009). Estimates of self-harming behaviour in different populations of people using learning disability services vary (range 1.7–24% across studies) (Deb, 1998; Duperouzel, 2004; Allen *et al*, 2007; Cooper *et al*, 2008*a*). Self-injury has, however, been found to be more serious in people with severe intellectual disabilities. Research has identified a narrower range of contributing factors than in the general population, including genetically determined syndromes and other physiological factors as well as autism.

The fact that the person may be living in an institution that is an impoverished, abusive or neglectful environment has been found, unsurprisingly, to contribute directly to their self-harming behaviour. As with young people in care, people with intellectual disabilities have also cited their disempowering circumstances and having little control over their environment.

'They treat us like kids…and its very horrible.' (Heslop & Macaulay, 2009)

They indicated the circumstances leading to their self-harm. These included being bullied and remembering past traumas but also being irritated

by other residents, having a lack of personal space, too little autonomy, too much noise and not being free to go out when they wished.

DRUG AND ALCOHOL ISSUES AND DUAL DIAGNOSIS

The relationship between drug and alcohol misuse and self-harm is a growing trend that should be a matter of concern for its impact at all levels – on the individuals and their family and friends, on the care services and on the cost to public finances. People who harm themselves while under the influence of alcohol pose distinct problems for services.

People who have – or are recovering from – drug and alcohol problems are at a significantly greater risk of self-harm and suicide than the general population (National Mental Health Development Unit, 2009). (The primary focus of research is the use of illicit drugs, particularly dependence on heroin and/or crack cocaine, but there is also evidence of links between self-harm and suicide and other forms of drug use, including stimulants, and prescription drugs.) The National Confidential Inquiry into suicide and homicide by people with mental illness (Appleby *et al*, 2008) found that the majority of the suicide cases it investigated (58%) were alcohol dependent, 39% were drug dependent and 29% heavily misused both.

In people who have a pre-existing tendency to self-harm or suicide the risk of self-harm can be increased if they have alcohol and drug problems, both as a result of intoxication and in the psychological withdrawal phase. In some circumstances, the use of alcohol or drugs acts as a form of self-medication, and the risk of suicide and self-harm can increase in the short-term when people begin to address their substance problem. These issues are acknowledged in clinical guidelines (Department of Health (England) and the devolved administrations, 2007; National Collaborating Centre for Mental Health, 2007*b*). This has implications for assessment, treatment planning and the management of the withdrawal process. Drug misuse and the pains of untreated withdrawal are also significant factors in the heightened risk of suicide for people in prison. Ruth Wyner, a former drug services worker who spent time in prison, has written:

> 'Sending addicts to prison re-ignites old traumas, and adds to the terror, the despair; the fragile self disintegrates further. … In fact, the trauma of prison can open up those old buried traumas and bring them back to consciousness. … Alienated and angry, depressed and despairing; however offenders deal with their problems, being in prison tends to make them worse.' (Wyner, 2004)

There has been an increase in drug and alcohol misuse in the general population over the past few decades. The per capita consumption of alcohol has, for example, risen by 50% since 1970. The UK also has the highest prevalence of drug misuse in Europe. The UK death rate from acute poisoning with illicit drugs has more than doubled since 1993. According to some evidence (Harris & Barraclough, 1997; Weaver *et al*, 2002), problem drug use is more common in men than in women, among young people, among the socially disadvantaged and in those with alcohol problems.

There is also evidence of self-harming behaviour being more regularly associated with alcohol in women. Drug misuse related to self-harm has also risen for women, and this has been particularly related to a suicide attempts (Haw *et al*, 2005).

'I used to get just stressed out and think "right, hit the bottle"…at first I'd feel a bit better, more relaxed and then…I'd end up feeling like a volcano where I'd explode and I'd either go and hit out at somebody or hit back on myself because I can't cope with this and that's when I'd hit myself hard.' (Sinclair & Green, 2005)

Most people who misuse drugs and alcohol have a mental health problem. According to recent research (Wagner *et al*, 2000), 74.5% of users of drug services and 85.5% of users of alcohol services had mental health problems and, conversely, 44% of mental health service users reported drug use and/or were assessed to have used alcohol at hazardous or harmful levels in the past year. People in drug and alcohol services with comorbid mental health problems have a poorer prognosis, higher rates of relapse, increased hospitalisation and higher suicide rates. These factors have implications for public health, for treatment of the individual patient and for inter-agency working, which will be considered later in this report.

Self-harm and physical health

Aside from the obvious danger of death, self-harm and suicide attempts can be seriously detrimental to an individual's long-term physical health, if they survive. Paracetamol poisoning is a major cause of acute liver failure (Haw *et al*, 2005). Self-cutting can result in permanent damage to tendons and nerves, not to mention scarring and other disfigurements. The NICE guidelines on self-harm note that people who have survived a medically serious suicide attempt are more likely to have poorer outcomes in terms of life expectancy (National Collaborating Centre for Mental Health, 2004). There is evidence of an independent association between a person's physical ill health and their self-harm but it is not clear whether this is associated with pain or personality factors (Goodwin *et al*, 2003).

4. Wider social concerns

Social context

Multiple factors

Although there is a high level of mental disorder among people who self-harm or take their own lives, there are also many who do not have a diagnosed mental illness, and for those who do, their actions are a result of other causes.

This fact has an important bearing on the role and the limits of the role and responsibilities of mental health professionals. It is not surprising that for that reason 30% of the respondents to the College survey considered that it was not primarily an issue for psychiatrists.

> 'The main triggers for self-harm are usually social, particularly family, issues, relationship break-up. Social workers should have more of a role rather than mental health services…Life coaches, youth workers (e.g. Connexions), would be better people to offer this service as they often need housing/training/change of peer group.'

There is, as one respondent put it, a danger of 'overmedicalising the expressions of ordinary human distress'. The reasons people give for precipitating their self-harming behaviour and the knowledge gleaned from research for both self-harm and suicide include a wide range of sociodemographic and personal factors. The Choose Life suicide prevention strategy (Scottish Executive, 2002) lists them under the headings of risks and pressures within society, within communities, for individuals and the quality of the response from services. A diagram is reproduced in Appendix III.

Individual elements include personality traits, family experiences, life events, exposure to trauma, cultural beliefs, social isolation and income. Other factors such as education, housing and wider macro-socioeconomic trends such as unemployment rates may also contribute directly, or by influencing a person's susceptibility to mental health problems. Socially deprived people living in urban areas have been shown to have a higher risk of self-harm (Corcoran *et al*, 2007; Royal College of Psychiatrists, 2008*b*).

As Mr Joe Ferns from the Samaritans told us (personal communication, 2009),

> 'There are multiple factors and multiple different pathways that lead to suicidal behaviours; and suicide is a multi-determined event, meaning that it is generally not the consequence of a single issue but the combination of several issues in a person's life.'

Dr Roberts from DrugScope described the complex issues that may underlie a person's behaviour to the Working Group as follows:

'Where someone is, for example, homeless, with a history of mental health problems and, say, opiate dependent all these factors will be relevant to the issues of self-harm and suicide…Self-harm and suicide are not simply medical problems, amenable to therapeutic solutions, they need to be understood in context. For example, loss of housing or work could lead someone to relapse into problematic alcohol or drug use, which in turn could be linked to self-harm or suicide'. (Dr Roberts, personal communication, 2009)

Self-harm occurs in people of all ages but unsurprisingly rates of self-harm are higher among those who are unemployed, single, live alone, are in debt and have problems with alcohol (National Collaborating Centre for Mental Health, 2004). Social isolation and breakdown in family and other personal relationships are regularly cited as causing self-harming behaviour (Haw & Hawton, 2008).

A Scottish study of those who repeatedly self-harm (Appleby *et al*, 2008) highlighted poor parenting, alcohol-related problems in childhood, adult patterns of alcohol or drug use and violence together with the community environment as some of the factors for self-harm and called for a mixture of public policy and practice (including health service) targeted 'upstream', especially at causes of social exclusion.

Another very important issue is a history of past sexual abuse. The impact of the experience of childhood abuse on adult self-harm is now well established and its link with suicidal behaviour, particularly among women, has been recorded (Bebbington *et al*, 2009). A Canadian study found that where abuse was repeated, and where there was sexual abuse by a member of the immediate family, there was a stronger association with suicide attempts (Brezo *et al*, 2008).

Self-harm in adolescents is associated with many social problems (O'Connor et al, 2009*b*), confusion over sexual orientation and sexuality (Rehkopf & Buka, 2006), problems with boy-/girlfriends, and the occurrence of physical or sexual abuse. Personal characteristics such as perfectionism, pessimism, self-criticism and impulsivity also play a role (Fliege *et al*, 2009). Whether there is a link between a person's self-harming behaviour and what is currently taking place among family members and friends is less clearly established (Corcoran *et al*, 2007). Another study of adolescents aged 15–16 also cited isolation, problems with school and arguments with family or friends (Samaritans & Centre for Suicide Research, University of Oxford, 2003).

SOME PRECIPITATING AND PROTECTIVE FACTORS FOR SUICIDE

People who are unemployed are two to three times more likely to die by suicide than people in employment (Platt, 2003; Rehkopf & Buka, 2006; O'Reilly *et al*, 2008), with unemployed men particularly at risk (Hawton *et al*, 2001). In addition, unemployment can itself contribute to poorer mental health, induce anxiety and depression, lower self-esteem and increase feelings of hopelessness – all of which increase the likelihood that someone will think that life is not worth living. People in debt and those who are homeless are particularly vulnerable (Shelter, 2004).

The context of a person's life and their character may protect them from suicide and give them resilience to deal with adverse circumstances. Problem-solving and social adjustment skills, high levels of reasons for living, optimism, participation in sporting activity, positive family and other personal relationships, and engaging with their community may modify the risks for

people who are also despairing of their life. The atmosphere, organisation and practices of a person's environment (McLean *et al*, 2008), such as in schools, universities, workplaces, hospitals and prisons, may influence the extent to which exposure to risk is translated into suicidal behaviours. The role that a person's culture may have in increasing self-harm or protecting individuals against it has not been widely researched although factors such as religion are clearly relevant. For example, Islam and Christianity both strongly condemn suicide-making religious people, and their family, deeply upset and potentially ashamed by a suicide attempt (or suicide) (World Health Organization, 2000).

DIFFERENT AGE GROUPS

Self-harm does not just appear in adolescence and with young people. Children as young as eight have been found to have harmed themselves. Although adolescent girls are more likely than boys to harm themselves and overall women are more prone to harm themselves than men (Hawton & Harriss, 2008), the rate in young men aged 15–24 years is rising more quickly than in any other group. There are also significant differences in incidence and methods of self-harm between men and women. Older people who harm themselves are more likely to do so in an attempt to end their life (National Collaborating Centre for Mental Health, 2004). Following an older person's self-harm the risk of completed suicide is also higher in their first year (60–100 times), which increases with age (Fox & Hawton, 2004; Hawton *et al*, 2007*a*). The only age group in England and Wales who are not showing a reduction in suicide rates are those over 85 years of age and the numbers in this age group with depression are projected to increase by 80% by 2026 (McCrone *et al*, 2008).

Studies in older people have not found a correlation between suicide attempts and socioeconomic status, levels of education, or childhood sexual or physical abuse (McLean *et al*, 2008). However, isolation and being divorced or widowed has been a contributing factor (Hawton & Harriss, 2006). There is some evidence that physical ill health is associated with self-harm (O'Connell *et al*, 2004), particularly that chronic or terminal physical illness increases the risk of suicide. Overall, among older people, in contrast to younger people, the main factor associated with self-harm and completed suicide is an underlying mental illness, most often depression (Dennis, 2009).

In this area, perhaps more than any other, there are strongly differing views about whether an increased rate of suicide in old age is or is not because of a legitimate wish that some people have to bring their lives to an end because of illness and pain, isolation and loneliness, or a loss of capacity and purpose, or is always properly assumed to be pathological. The clear ethical dilemmas should not stop us from undertaking research to see how far some of the self-harm among older people should be considered voluntary acts as distinct from those undertaken as a result of depressive disorders that represent pathological mental states and are indicative of mental illness. What is certain is that at least a significant number are suffering from illnesses that are treatable and therefore it is important to focus on how best to assess and address their needs. There are multiple factors and many different paths that lead to suicide whatever the age of the person. Understanding why someone chose to die may not always be straightforward or indeed easily fully investigated (Mann *et al*, 2005; Hawton & Van Heeringen, 2009*a*).

Ethnicity

Studies in Britain have found that women of South-Asian ethnicity have a higher than average rate of self-harm compared with White men and women (Bhugra & Desai, 2002). Those under 35 years are at a higher risk than older women. There are inconsistent findings for self-harm rates among teenage girls.

The reasons identified for this difference include isolation and family pressure from husbands demanding a less Westernised form of behaviour; interference from parents-in-law; arranged marriages or the rejection of an arranged marriage; isolation even within the wider community; cultural conflict, and problems at school, including racist bullying. South Asian women who engage in self-harm have also been found to be less likely than their White counterparts to have a psychiatric disorder (Husain *et al*, 2006).

Studies of other ethnic groups are characterised by different definitions, making comparisons difficult (Bagley & Greer, 1972). There is some evidence of an increasing risk for people of Caribbean origin aged less than 35 years.

In a Manchester study (2005–2007) (Dickson *et al*, 2009), 60 Black women had higher rates of self-harm than any other group; rates in Black women were 24% higher than in White women aged 16 years and over. South Asian women also had slightly higher self-harm rates than White women. These findings are in contrast to rates in males. White men had the highest incidence of self-harm, followed by Black men and South Asian men. People from other ethnic groups (including Chinese and mixed race) had the lowest self-harm rates overall. Chinese men in particular had very low rates of self-harm at 44 per 100 000 population. Rates in Chinese women, however, were over three times as high, at 154 per 100 000. In Oxfordshire, in the 16–35 age group, Black females were significantly more likely to self-harm than their White counterparts (Hawton *et al*, 2007*a*). However, the same report showed that in the 35–65 age group the trend was reversed (Hawton *et al*, 2007*a*).

Groups of people at particular risk of self-harm

There are other groups who are specifically vulnerable because of life experiences, personal or social circumstances or a combination of these factors, underscoring the diverse kinds of suffering leading to self-harming behaviour, and the complex relationship between mental illness and self-harm. We do not claim to be comprehensive and do not cover those professions that bring greater risk at particular times (e.g. farmers). However, we highlight some disadvantaged groups: prisoners, asylum seekers, veterans from the armed forces, people bereaved by suicide, people of sexual minority groups and suicide bombers.

Prisoners

People in prison are unusually susceptible to self-harm and suicide. Male prisoners are five times more likely than men in the general public to die by suicide, while the rate among young offenders is 18 times higher (Fazel *et al*, 2005). Self-harming behaviour is also widespread in prisons, the rates for both genders being higher than in the general population (Her Majesty's Chief Inspector of Prisons for England and Wales, 2007; Cabinet Office *et*

al, 2009). Young people are overrepresented in these figures (Mental Health Foundation, 2006.

The nature of the prison environment is likely to exacerbate a person's previous self-harming behaviour and their vulnerability to starting it. The Joint Committee on Human Rights reached the conclusion that:

> 'The evidence we have gathered suggests that prison actually leads to an acute worsening of mental health problems. By sending people with a history of attempted suicide and mental health problems to prison for minor offences the state is placing them in an environment that is proven to be dangerous to their health and well-being.' (Great Britain Parliament Joint Committee on Human Rights, 2004: p. 32)

The WHO's Health in Prisons project listed negative factors in prisons that are likely for the majority of prisoners and which are also associated with self-harm (Gatherer *et al*, 2005).

Suicides are more likely to occur in the first few months of custody (Prison Reform Trust, 2009). The risk can be reduced by sensitive treatment by prison staff, and by the capacity of the prison to respond to the prisoner's concerns. A Prison Reform Trust report (Jacobson & Edgar, 2007) highlighted the need for prisons to find ways of dealing with outside problems that concern new prisoners the most. One prisoner told the Prison Reform Trust:

> 'All these things – like wife, mortgage, kid – they're all hitting your head at once. These sort of things need to be looked at: outside things, and how you're feeling inside. Or things like thinking I'm going to kill myself come out of the blue…If you get help, you don't have to go through these things.' (Jacobson & Edgar, 2007)

Other environmental factors that have been linked to an increased risk of suicide include uncertainty about legal status (Her Majesty's Chief Inspector of Prisons for England and Wales, 2009) and prison overcrowding (Great Britain Parliament Joint Committee on Human Rights, 2004).

Women prisoners and self-harm

Women prisoners account for about half of all self-harm incidents in prison, even though they comprise only 6% of the total prison population (Ministry of Justice & National Offender Management Service, 2008). Women recently released from custody are 36 times more likely than the general population to die by suicide (Pratt *et al*, 2006). Women in prison are more prone to self-harm repeatedly than men.

The higher risk of self-harm and suicide among women prisoners suggests that women prisoners face particular risk factors. These are highlighted in the Corston Report, an inquiry into the particular vulnerabilities of women offenders (Corston, 2008). Women have significant unmet needs that relate to their offending. These cover education, training and employment, housing and income. Their offending is more directly related to poverty and financial difficulties than male offenders. Prison is also said to be harsher for women because prisons and the practices within them have been designed for men.

Women prisoners are more likely than men to be primary carers of young children, which affects their experience of prison. Because there are fewer women's prisons, women are more likely to be located further from

their home than male prisoners to the detriment of maintaining family ties, receiving visits and resettlement into the community. These factors, which increase women's vulnerability, are likely to be associated with high rates of self-harm both before and during prison life.

> 'I entered prison as a person of sound mental health. During my incarceration, I experienced many mental health problems such as medical dependency, self-harm and suicidal thoughts and severe weight loss, due to the unbearable pain of separation from my daughter and being in prison.' (Rickford, 2005)

ASYLUM SEEKERS

Asylum seekers have often experienced traumatic events in their home country; indeed a well-founded fear of persecution on specific grounds is the sole basis of a claim for refugee status. Studies have consistently revealed high levels of mental health problems, especially anxiety, depression and PTSD in detained asylum seekers. They have higher rates of self-harm and suicide compared with the UK prison population (Cohen, 2008). The length of time in detention and the nature of the process itself particularly intensify their distress (Hawton & Harriss 2009*b*). The practice of detention is controversial and the conflicting priorities of clinicians and government in this regard complicate any attempt at solutions that do not involve detention.

VETERANS

A study of 233803 personnel leaving the UK military forces between 1996 and 2005 reported that young men aged 24 and younger have been found to be at a particular, and persistent, risk of suicide – two to three times higher than for the same age groups in the general population and those still serving in the forces (Kapur *et al*, 2009). The risk was greater among males, those with a short service and those of lower rank. The next phase of the Suicide Prevention Strategy for England will develop strategies targeted at this group of people. They include practical and psychological preparation for discharge and encouraging people to seek help after leaving the services. The sad truth is that as a country we pay less attention to the post-discharge needs of our veterans than, for example, the USA, which has substantial veteran health and support facilities. It is clear that many veterans suffer adverse psychological sequelae of their service careers. For many ex-servicemen and women, the full tragic outcome only becomes overwhelming many years after their return to civilian life, and because there has been little follow-up of ex-service personnel the evidence has only recently begun emerging from research work.

LESBIAN, GAY AND BISEXUAL PEOPLE

Lesbian, gay and bisexual people are subject to prejudice, discrimination and social exclusion (including within families). They may experience anti-homosexual hostility and violence, and they may internalise a sense of shame about their sexuality. Misuse of alcohol and drugs may also increase their vulnerabilities to mental disorder and self-harm. A systematic review of mental disorder suicide and self-harm among lesbian, gay and bisexual

people found a higher risk of self-harm, mental disorder and substance misuse than in heterosexual people (King *et al*, 2008). In general, the hidden nature of sexual orientation makes evidence on vulnerability to suicide hard to obtain and thus it was not clear whether or not this resulted also in higher rates of suicide. Nevertheless, the close association between rates of self-harm and subsequent suicide makes it likely that this group are at higher risk for suicide. The authors concluded that their findings were at least partly attributable to the social and psychological circumstances mentioned above. Their findings need to be fed into planning for public health measures and for health services.

SUICIDE BOMBERS

It is impossible to consider the issue of self-harm and suicide in the present international security climate without being aware of so-called 'suicide bombers'. Research work has been done in various parts of the world, including in South Asia and Israel, but the Suicide Terrorism Database in Australia is probably the most comprehensive in the world, holding information on suicide bombings in six countries accounting for 90% of all suicide attacks between 1981 and 2006. As with others, the evidence from this source suggests that:

> 'though religion can play a vital role in recruiting and motivating potential future suicide bombers, the driving force is not religion but a cocktail of motivations including politics, humiliation, revenge, retaliation and altruism.' (Hassan, 2009)

The configuration of these motivations relates to the particular circumstances of the violent political conflict in which there has been the appearance of suicide attacks in different countries. Suicide bombers are not likely to display either personality disorders or mental illness (Hassan, 2010). As Professor Riaz Hassan explains,

> 'The causes of suicide bombings lie not in individual psychopathology but in broader social conditions. Understanding and knowledge of these conditions is vital for developing appropriate public policies and responses to protect the public.' (Hassan, 2010)

These findings are congruent with the work of most serious scholars in the field of terrorism generally and suicide terrorism in particular. The implication seems to be that there is little hope that such people can be identified in advance, especially in the UK. In the Middle East and Chechnya, some individuals have been the bereaved partners of militants killed in other operations, but such personal psychological identification seems to be the exception rather than the rule, as is the case with most terrorists.

Whatever the popular sentiment, scientific research points to terrorism (including terrorism in which the militants sacrifice themselves in the process of carrying out the incident) being more a result of group than of individual psychology (Alderdice, 2007).

Identifying people who might be vulnerable to recruitment into terrorist activity generally is currently being addressed with some energy through the PREVENT component of the UK government's domestic counter-terrorism strategy (CONTEST). The most recent version *Pursue Prevent Protect Prepare* (HM Government, 2010) is available on the Home Office website. How successful it will be remains to be seen.

Carers, friends and family members

Carers and family members of people who self-harm are not themselves a minority group but their closeness to the person who self-harms clearly makes them vulnerable to psychological distress. This is likely to be most acute for parents of young people who self-harm and for those who have been bereaved by suicide (Department of Health, 2008). Mothers and siblings in particular have been shown to suffer episodes of depression after a child's suicide.

Carers may feel isolated, stigmatised and burdened with the anxiety of caring for a family member or friend. They may feel hostile (Griesbach *et al*, 2008). Parents of young people may feel helpless and excluded as their children confide in their peers rather than themselves. (Young people have been found to be more likely to disclose their self-harming behaviour to their friends than to their families (Csipke & Horne, 2008).) Feelings, especially shame or guilt, may be exacerbated by the cultural environment or their religion.

> 'Supporting a friend or relative who self-harms can be distressing, frustrating, confusing and draining as well as rewarding and an opportunity to build a closer relationship. Given these emotions carers should be, where possible, included as part of the team and respected for their knowledge and expertise. Carers can have a profound impact on good recovery outcomes.' (V. Kamerling, personal communication, 2010)

The process of grieving can take longer and involve greater negative emotions when a loved one has been lost by suicide rather than with a natural or accidental death. It can also be accompanied by recurring images, as well as feelings of guilt or abandonment (Department of Health, 2008).

5. Interventions

A Cochrane systematic review of interventions for self-harm will be published late in 2010, and the NICE Guideline Development Group will publish its draft in 2011. These guidelines will provide more up-to-date and comprehensive accounts that we can here. Although an empathic approach is essential in dealing with people who self-harm, it is not clear that any one form of treatment is particularly effective, and in some cases, the most pressing need is to address the underlying social issues or addiction problems.

Service user studies

Most studies on interventions focus on clinical outcomes that use the reduction of self-harming behaviour as the key measure. A small number of studies of service users' views have identified the usefulness of counselling over medication, but the structured research evidence base is weak (Smith & Clarke, 2003).

Evidence from young people to a recent inquiry reported the value of self-support groups and is supported by research into the general effectiveness of these groups (Adamsen & Rasmussen, 2001).

Engaging service users in assessing appropriate interventions has been relatively neglected. One small study (Hume & Platt, 2007) involved service users with varying themes and backgrounds to their self-harm (e.g. psychiatric illness, alcohol dependency, traumatic life events, chronic life problems). These themes affected their experiences of and attitudes to interventions for self-harm. The study found that personal circumstances and life history are major influences on the choice of interventions for self-harm. Nevertheless there was a clear preference for specialist community-based interventions, which focus on the provision of immediate aftercare and acknowledge that the management of self-harm may not necessarily involve its prevention.

Case study 5.1

The Crisis Recovery Unit at the Bethlem Hospital in London is a national specialist residential unit for people of 17 years and above who persistently harm themselves in serious ways. The philosophy of the Unit is that individual young people should retain responsibility for their behaviour, and that – in the short term – self-harm can sometimes be tolerated, although not promoted. This is termed 'therapeutic risk'. The approach is based on the view – supported by practice experience – that if staff remove all potentially damaging items and take full responsibility for the young person's immediate safety, the young person does not make the choice themselves. In the long term, by the time they leave the Unit, they need to have learned their own strategies for coping with the urge to harm themselves. The aim is to help young people start to explore alternative coping strategies, and strategies for dealing with the urge to harm themselves (Mental Health Foundation, 2006).

CASE STUDY 5.2

Selby and York Primary Care Trust has recently developed a self-harm handbook to assist in the engagement, formulation and early stages of intervention with working-age adults (Pengelly & Ford, 2005). Using a cognitive–behavioural model, it aims to address causes and maintenance cycles for repeated self-harm. The handbook is designed to be worked through with the professional(s) involved in the care of someone who has harmed themselves. It is one part of a continuing and comprehensive care plan and should only be used when a service user has given informed consent, is aware of the purpose of the handbook approach, is aware of alternative treatment options, and is not experiencing symptoms of acute mental illness.

CLINICAL INTERVENTIONS

The NICE guidelines (National Collaborating Centre for Mental Health, 2004) examine psychosocial, pharmacological and social service interventions for self-harm, in each case finding little evidence of what works and for whom, and very little evidence of what does not work. Since then, a Scottish systematic review has been published (Leitner *et al*, 2008), and a new Cochrane review on psychosocial and pharmacological treatments for self-harm is due to be published in 2010. Systematic reviews of interventions have evaluated the effectiveness of various types of interventions after incidents of self-harm (Hawton *et al*, 1998; NHS Centre for Reviews and Dissemination, 1998; Fox & Hawton, 2004; Van der Sande *et al*, 2007). The evidence is largely based on studies of people attending hospital accident and emergency services. Most of the literature focuses on self-poisoning, while there is remarkably little on effective therapeutic interventions for people who intentionally cut themselves. Indeed, Fox & Hawton (2004) found no UK-based controlled intervention studies of people who engaged solely in cutting themselves.

In addition, the majority concentrated on reductions in incidents of self-harm rather than mood or quality of life, or what the people involved themselves wanted to achieve. It is difficult therefore to reach conclusions about effective interventions from these studies. Given the size of the population that is at risk from self-harm, and the relation of repeated self-harm to suicide, this is a matter of great concern.

One review of 18 randomised controlled trials noted that some trials of psychosocial treatments have demonstrated statistically significant reductions in the likelihood of repetition of non-fatal self-harm (Crawford *et al*, 2007). However, as the review cautions, 'such findings do not necessarily mean that these treatments would reduce the likelihood of subsequent suicide'. A Cochrane review (Hawton *et al*, 1999) concluded that there were promising results for problem-solving therapy, provision of a card to allow patients to make emergency contact with services, depot flupenthixol for recurrent self-harm, and long-term psychological therapy for female patients with borderline personality disorder and recurrent self-harm. They also reported that assertive outreach can help to keep patients in treatment.

WHAT KINDS OF THERAPEUTIC INTERVENTIONS?

There is a good deal of evidence to suggest that CBT is effective in improving future thinking, decreasing levels of depression and reducing incidents of

self-harm (Slee *et al*, 2008). Evidence also suggests that CBT is effective for patients with recurrent and chronic self-harm.

Problem-solving therapy is a related brief treatment aimed at assisting a person to develop the psychological resources to resolve their own problems. It teaches basic problem-solving skills, and has been found effective in reducing depressed mood, hopelessness and poor problem-solving in other settings (Hawton *et al*, 2009). In self-harm studies it has led to improvements in mood and social adjustment (House *et al*, 1992). It is unclear from the existing evidence how widely it could be applied, and further work is needed to build up an evidence base. Research has been done into different types of problem-solving ability (McAuliffe *et al*, 2006) and its relation to repetition of self-harm, with conclusions for future practice.

> 'Problem-solving therapy is a pragmatic approach which may be suitable for a sizeable proportion of deliberate self-harm patients. It has the advantage of being relatively easily taught, usable by a range of clinicians, brief and comparatively cheap. It has been demonstrated to be of value in the treatment of patients with emotional problems in general practice.' (Townsend *et al*, 2001)

As with other interventions for young people, family therapy may be useful in some circumstances; however, this has yet to be rigorously assessed (Harrington *et al*, 2000).

Although dialectic behaviour therapy has been gaining currency in some places, evidence of its clinical effectiveness is lacking. The Scottish systematic review reports that there is some indication of effectiveness with people with personality disorder (Leitner *et al*, 2008).

Evidence from one study (and referred to in the Cochrane review as noted earlier) suggested that crisis cards may be effective for people who have harmed themselves for the first time (Morgan *et al*, 1993). However, a later and much larger randomised controlled trial found to the contrary, so although there may be a 'self-evident' benefit of people being discharged from hospital receiving cards to remind them and assist follow-up, there is at present no clear evidence of a beneficial impact (Evans *et al*, 2005).

The Scottish systematic review (Leitner *et al*, 2008) addressed suicide, suicidality and self-harm. It found limited evidence of the effectiveness of available interventions to reduce completed suicide but reported that the most promising interventions for attempted suicide included the provision of informal social support (e.g. the Samaritans and the restriction of access to means) (Gunnell *et al*, 2000; Morgan *et al*, 2007; Hawton *et al*, 2009). In relation to self-harm, there was also some 'less-convincing' support for the efficacy of ongoing contact. It found some limited evidence in the context of hospital presentations that referral for specialist support may be of value.

Where self-harm is attributable to a psychiatric illness, pharmacological intervention may be markedly helpful in managing the underlying problem and therefore the danger of repeated or more dangerous self-harm. However, the evidence for the usefulness of pharmacological interventions specifically to address self-harming behaviour beyond definite psychiatric illness is limited.

> 'Clinicians wanting to use pharmaceutical therapies would currently be justified in using lithium to prevent attempted suicide in people with bipolar disorder (but should exercise caution given reports of adverse outcomes) and either fluvoxamine or sertraline to prevent suicidal ideation in people with depression, but beyond these rather limited options the available evidence becomes decidedly equivocal.' (Leitner *et al*, 2008)

Individual studies have shown benefits of clozapine for patients with schizophrenia (Alphs *et al*, 2004; Ernst & Goldberg, 2004).

Harm minimisation

Harm minimisation is a strategy, recommended by NICE (National Collaborating Centre for Mental Health, 2004), only to be used in specialist and dedicated services that allow people to harm themselves in a controlled environment and with sterile instruments in order to ensure that any harm done is as clean and well managed as possible. It could be unhelpful in settings such as in-patient psychiatric wards, where the contagious spread of self-harm may be an issue.

The theory underlying this approach is that self-harm is a coping mechanism, and if it is immediately halted and no replacement offered a more damaging activity may replace it. Ms Sue Waterhouse gave evidence to the Working Group to the effect that in her experience, harm-minimisation techniques, together with psychological support and talking therapies, can be very effective in reducing self-harm activity. The majority of views expressed in the College Members' survey were also positive (www.rcpsych.ac.uk/risktoself).

The view, similar to that expressed directly by some service users, is that the forcible restriction of the ability to harm can have negative consequences and can forestall the efficacy of a talking therapy. Although allowing someone to harm themselves does contain an element of risk, it is said that this risk is outweighed by the potential benefit.

There is considerable controversy surrounding the use of harm minimisation and concern that the guidance can be taken out of context – guidance on harm minimisation is said to be not readily available and therefore misunderstood (Pengelly *et al*, 2008). The use of harm minimisation in prisons is currently under review. Given the controversy around this treatment, guidance needs to be much clearer that harm minimisation must at all times be in a contained environment, be supported by talking therapy and that it is unacceptable and bordering on malpractice if it is not. To reinforce this point, it was suggested that a less provocative name should be employed.

Specific local interventions

In particular localities there may be a place that has become a regular site for people who wish to harm themselves or take their lives – a bridge over a river or a bridge that is particularly high or dramatic. In response to a high incidence of deaths or harm at such places professionals and voluntary organisations have sometimes set up local initiatives to enable them to intervene and provide help (Case study 5.3).

Case study 5.3

At the Robert Gordon University in Aberdeen, Professor David Alexander has worked closely with local police to provide early professional, psychological intervention and negotiation in hundreds of 'critical incidents' where threat of suicide or self-harm had been drawn to police attention, and in Londonderry (Northern Ireland) local taxi drivers were provided with basic training and life-saving equipment to respond to sightings of people who were threatening to or had actually jumped into the river Foyle. In both examples these interventions have been demonstrated to save lives (D. Alexander, personal communication, 2010).

It is important that psychiatrists and other mental health professionals do not restrict their thinking about prevention and intervention to those things that can be done in the clinic, but engage with and in the local community in addressing self-harm and suicide.

Part II
The public health agenda

6. The cost of self-harm

Aside from the physical and mental impact on the person who harms themselves and the impact on the people who work with them, there are economic costs incurred by the act of self-harming. The economic cost of self-harm on a national level has not been calculated, although the direct cost to the National Health Service (NHS) has been estimated at £5.1 million per year from self-poisoning with tricyclic antidepressants alone (National Collaborating Centre for Mental Health, 2004: pp. 25–26). The indirect economic costs of self-harming behaviour to an individual and their family are unknown but are likely to be substantial, especially in terms of days lost from work and other activities, including family responsibility.

The lack of systematic collection of data around self-harm impedes research in this area. However, a recent study (Sinclair *et al*, 2010) found that patients who engage in self-harm have significantly higher overall health service costs in the 6-month period around an episode. There was a cumulative effect on resource costs with increasing episodes of self-harm, particularly for patients with five or more episodes. The highest costs were attributable to in-patient psychiatric care.

The costs of suicide to society include direct economic costs, such as services used (e.g. coroners, police), indirect economic costs such as the value of potential work and earnings lost, and intangible costs, including the human costs of suffering, grief and loss, and the associated morbidity, as well as non-market outputs such as voluntary work, and caring for the family. Although there is debate about how to put a monetary value on intangible costs, the government in Northern Ireland in 2004 estimated that the total cost per suicide, including economic and intangible costs, was £1.4 million (Department of Health & Social Services and Public Safety, 2006). Whether or not this can be replicated elsewhere, the cost to society makes this a significant public policy issue.

Given the widespread incidence of self-harm within society, the fact it affects all age groups, that its causes are social and economic as well as health based and that there are high-risk groups who are least likely to have access to good healthcare, it is clear that the issues should be addressed by government health policy and public health strategies (Platt *et al*, 2007).

GENERAL MENTAL HEALTH POLICY

In 2009, the Scottish government launched *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009–2011*. This document included the reduction of the incidence of suicide, self-harm and common mental health problems as a strategic priority.

In 2009, the UK government introduced New Horizons as its new mental health policy for England and Wales (Department of Health 2009*a*). It was based on the major themes in current government health policies – recovery, personalisation and person-centred care. Recovery involves engagement with the patient/service user as an equal partner in the process of treatment and care, their empowerment, a focus on their strengths and assets, and assiduous attempts at fostering optimism and hope for the future. In principle these approaches might be expected to decrease the occurrence or severity of self-harming behaviour and the likelihood of completed suicide, and individual service users and professionals have reported better outcomes from such approaches. New Horizons promotes the development of measures for services and tools to ensure that care is planned around user-defined goals and quality of life outcomes. It promotes the involvement of service users in the planning and delivery of care.

7. Strategies for the prevention of self-harm and suicide

Suicide prevention strategies have now been established in Scotland, Wales, Northern Ireland, Ireland and England. They cover broadly the same areas, although with somewhat different approaches and different strengths. The suicide prevention strategy for England, for example, deals less with wider prevention measures such as public information and involvement of front-line staff beyond mental health.

The *National Suicide Prevention Strategy for England* (Department of Health, 2002*a*) included targets for reducing the death rate from suicide and undetermined injury by at least 20% by 2010. This target was reflected in key policy documents, including public service agreement targets, NHS operating frameworks, health and social care standards and, until recently, the National Service Framework for Mental Health (Department of Health, 1999).

The government's new programme of action for mental health, New Horizons, has committed to updating England's suicide prevention strategy, taking into account 'changing demography, the current economic climate and special at-risk groups, for example young men leaving the forces, older men and rural communities' (Department of Health, 2009*a*). However, the targets have been abandoned.

Scotland's Choose Life suicide prevention strategy (Scottish Executive, 2002) is a 10-year plan aimed at reducing suicides in Scotland by 20% by 2013. This was reinforced in *Better Health, Better Care* (Scottish Government, 2007). The Choose Life strategy recognised that effective strategies to reduce suicide need to be mindful of the overlap between suicidal behaviour and self-harm. However, the strategy included only those aspects of self-harm that may be considered as an indication of risk of suicide. In 2006, the Scottish Executive recommended that more consideration should be given to self-harm, including guidance about how incidence of self-harm is to be measured and what target for its reduction is to be set (Scottish Executive, 2002).

Towards a Mentally Flourishing Scotland included the reduction of the prevalence of suicide, self-harm and common mental health problems as one of its six priorities (Scottish Government, 2009). To meet these priorities, the Scottish government committed to working with partners to improve the knowledge and understanding of self-harm by:

■ agreeing a definition of self-harm and developing a non-stigmatising language and description of self–harm;

■ increasing awareness of self-harm and its determinants;

- mapping and assessing existing training provision and projects across Scotland;

- increasing understanding of effective methods of prevention and offering guidance to those delivering both general and specific services;

- developing local and national information.

In 2006, Northern Ireland launched a 5-year strategy, *Protect Life: A Shared Vision, Northern Ireland Suicide Prevention Strategy and Action Plan 2006–2011* (Department of Health & Social Services and Public Safety, 2006). The overarching aim is to reduce the suicide rate in Northern Ireland, incorporating targets of a 10% reduction in overall suicide rate by 2008, and by a further 5% by 2011. The strategy contains 62 cross-departmental objectives with specific, targeted actions incorporated within 13 objectives.

In 2008, Wales launched a 5-year strategy called *Talk to Me: A National Action Plan to Reduce Suicide and Self-harm in Wales 2008–2013* (Welsh Assembly Government, 2008). It has seven strategic objectives, including a specific objective to manage the consequences of suicide and self-harm. Each objective is supported by a set of actions with a timetable for implementation over the 5-year period.

According to the *National Suicide Prevention Strategy for England Annual Report on Progress* (National Mental Health Development Unit, 2009), the suicide rate for the year 2007 was the lowest recorded. There was a rise in the past year; nevertheless, the strategy has achieved a result close to the target set for the decade, demonstrating some success for this strategy (National Mental Health Development Unit, 2009). In Scotland there was a 10% fall in suicide rates between 2000 and 2002 and between 2006 and 2008, although rates in men have increased marginally in the latest 3-year period.

Despite these welcome downward trends, suicide remains a significant cause of death and its prevention a major public health issue. The sudden and traumatic nature of a death by suicide can have a devastating effect on the close relatives and friends of the individual and the impact may even be felt throughout a local community.

In England and Scotland, a target for suicide prevention has been discontinued. Targets have had drawbacks and perverse incentives in various aspects of healthcare; however, their entrenchment in various public sector agreements and operating frameworks did require regional and local bodies to take action. Given that structures and mechanisms for implementation are vital to the successful outcome of national strategies, there will need to be adequate capacity and monitoring at regional and local levels of outcome, and effective mechanisms for 'joined-up working' across government departments and agencies as well as between the government and the third sector. There is some anxiety about implementation with changes in the structures in the UK as well as the effects on public finances in the aftermath of the economic crisis – these anxieties have been expressed particularly in regard to the implementation of New Horizons in England.

In England and Scotland, the coordination of suicide prevention by specific post-holders has been replaced by responsibility within the NHS, usually given to someone as part of a larger role. One fear is that the visibility of suicide prevention and the ability to coordinate cross-agency and sector working for suicide prevention could be undermined. The newly launched suicide prevention strategy for Wales, by contrast, has placed the

responsibility for implementing suicide prevention in local service boards, which bring together leaders of local public and third-sector organisations that may be well placed to enable cross-agency and sector delivery of suicide prevention, as opposed to the health services.

A large number of the people who end their lives by suicide are not in contact with mental health services. For example, in 2009 'around 75% of the 4000 people who take their own life each year in England were not in contact with mental health services' (Department of Health, 2009*a*), and this proportion is unchanged since 2002 (Appleby *et al*, 2001). Similarly, with self-harm, the majority are not in touch with services (Meltzer *et al*, 2002).

For this reason alone, national and local policies and strategies need to proactively target and include the statutory and voluntary services. These services notably may include primary care and acute care, general healthcare (including palliative and terminal care), the education sector, prisons and the criminal justice system, youth services, substance misuse services, housing associations, Black and minority ethnic communities, and third-sector organisations.

There is now almost a decade of potential learning from the implementation of different practices of suicide prevention across the UK but no clear mechanism for comparison of outcomes and coherent learning across the nations. There should be more coordinated sharing of knowledge across the nations. Indeed, New Horizons acknowledges that the UK-wide framework for suicide prevention needs to be strengthened.

RECOMMENDATIONS

- Suicide prevention should remain a priority of public health policy in all countries in the UK. There should be structures at national, regional and local level and mechanisms for the flow of information, evaluation and best practice to ensure effective implementation. A partnership approach to implementation should be adopted wherever feasible.
- The needs of those at particular risk (including asylum seekers, minority ethnic groups, people in institutional care or custody such as prisoners, people of sexual minorities, veterans, and those bereaved by suicide) should be actively addressed as part of this strategy.
- A UK-wide forum should be established to bring together agencies from the four nations who are involved in suicide prevention policy, research and practice.

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8. A public health approach specifically to address self-harm

The New Horizons policy (Department of Health, 2009*a*) and *Towards a Mentally Flourishing Scotland* (Scottish Government, 2009) both put public mental health firmly on the public health agenda, and self-harm should be tackled explicitly in any general public health strategy to improve mental resilience.

Self-harm is not necessarily an attempt at suicide or the prelude to a later attempt, but given the rise in self-harm and the rising impact of alcohol on rates of self-harm, it should feature strongly and in its own right either as major part of a suicide prevention strategy, as it does in Wales and Scotland, or as a separate public health strategy. The context of self-harm includes significant damaging social problems.

> 'I do not believe we should be pretending that we can, or be trying to, provide a panacea for this significant problem. Pressure should be brought by us for the government to focus on strategies seeking to promote: unity in families; better services for the unemployed; greater availability, and higher quality, of social housing; and higher-quality secondary education with sport for all. Perhaps (optimistically, I concede) if we take responsibility for those people for whom mental disorder is a significant contributor, then others (housing, education, Department for Work and Pensions, etc.) will take some responsibility for the part they have to play!' (Respondent to Working Group College Members' Survey)

The range of family, social and economic factors that underlie self-harm and the fact that it appears in all age groups, further underscores its relevance to many different government departments apart from the Department of Health. The need for intervention in schools has been powerfully made in research (Hawton *et al*, 2006) and, as we have identified already, there are high-risk populations such as prisoners, veterans, those in care and asylum seekers, as well as issues of gender, sexuality and race to consider. Addressing the problem is therefore a matter of relevance for Department for Education, Department for Business, Innovation and Skills, Ministry of Justice, Home Office (immigration), local government, families and communities, and Ministry of Defence.

In light of this, there ought to be a cross-departmental strategy on self-harm led by the Department of Health. *Truth Hurts* (Mental Health Foundation, 2006) called for such a strategy in relation to children and young people, but we consider that there must be one for adults of all ages. The ageing population makes self-harm in that group particularly ripe for serious consideration.

A cross-departmental approach – drugs and alcohol

We have in Part I discussed the evidence of the relationship between drug and alcohol misuse and self-harming behaviour or suicide. For this reason, strategies to combat these addictions are central to reducing self-harm. The Working Group supports the College policy positions on these issues, including the call for minimum pricing of alcohol (Royal College of Psychiatrists, 2009*a*). The risks of self-harm among people with alcohol and/or drug problems – and the particular high risks for those with 'dual diagnosis' – should also be key issues within a strategy.

DrugScope reported to the Working Group that in their view self-harm and suicide remain marginal issues in drug and alcohol strategies. The two most recent government directives on drugs and alcohol make no reference to self-harm or suicide (Department of Health, 2007; HM Government, 2008). The National Treatment Agency's major report on risk also made no mention of self-harm and suicide (National Treatment Agency for Substance Misuse, 2008). This reflects treatment on the ground, and is indicative of the policy split between alcohol/drug misuse and mental health.

The issues of self-harm and suicide are also marginal in the development of policy on dual diagnosis. The English Department of Health's Dual Diagnosis Good Practice guidance (Department of Health, 2002*b*) recognises self-harm and suicide as key issues for services working with people with severe mental health problems and problematic substance misuse, but other policy documents (Care Services Improvement Partnership, 2007) pay little attention to it.

A significant number of people in the drug misuse treatment field lack a background, experience or even training in mental health issues. This is made more difficult by the high rate of staff turnover. The moves to place drug and alcohol services in the voluntary sector places at risk the link with the expertise of psychiatrists and other mental health professionals. It could well be lost. There is already a lack of research and monitoring in this field.

> 'We were able to find little information about how mental health or drug services address the links between substance misuse (or use) and self-harm or suicide (for example, good practice in assessment and treatment planning). We need more research on practice, identification of good practice and investment in appropriate resources, including training and guidance. We would welcome work from the National Treatment Agency in this area.' (DrugScope, personal communication, 2009)

RECOMMENDATION

- Those who deal with people who are suicidal or have been or wish to harm themselves should have some level of training to assist them in understanding about the differences between mental illness and reactions of distress and in knowing how to access expert psychological and psychiatric services.

Particular issues that need to be addressed

Information and public education

As recently reported (Harrison, 2010), people who self-harm do not always understand what is happening to them or why they do it. Furthermore,

because of the stigma of self-harm, they may feel they are on their own. Although excellent self-harm material is available in booklets and on the internet, they may not be readily accessible or on well-known sites.

'Information on how common self-injury is would be helpful. I used to feel abnormal and weird as I thought I was the only person to do this. Information could have helped reduce the shame and isolation this caused me.'

Carers, friends and family members may play a vital role with their loved one's care. They are also likely to be worried and distressed by behaviour they find hard to understand and need to be provided with information they can feel confident is helpful and authoritative. There is a need for public information to be readily available for carers in appropriate and accessible formats.

'There are some websites, but not trusted sites, or don't seem very professional. You need more official or trusted websites with more information, e.g. like the NSHN. Apart from that, the NHS has very little, except the small basic facts on the website. You need more supportive, interactive or online counsellors to whom people can feel they can go to. Maybe a discreet Facebook group would also help, to connect to others who are in the same situation. Again there is very little public information in leaflets, magazines or newspapers, so you feel you are alone. You need more than just facts. You need case studies and stories, human connection, understanding and support to go with the basic facts of self-harm.' (Naheen Ali, Service Users' Recovery Forum)

A coherent public health strategy must not only make good material available but also include addressing the problems of websites that glamorise the problem of self-harm or show images of cuts and scars.

RECOMMENDATION

- The Royal College of Psychiatrists should collaborate with other mental health organisations and professional bodies to ensure that helpful and user-friendly information is available for diverse audiences and purposes.

THE ROLE OF THE INTERNET AND THE MEDIA

The role of the internet has generated much concern, particularly for its effect on young people. There has been an upsurge in websites encouraging self-harm and even promoting suicide, including discussion of methods of suicide. Although some websites are helpful, some of the virtual relationships developed through Facebook and chat rooms far from adult scrutiny or advice can be unhelpful or positively dangerous. Intrinsic factors such as isolation and disaffection may encourage imitation of risk-laden behaviour. Relationships of this nature, sharing a unique private experience, can be intensive and intimate and result in an increase in dangerous behaviour as a result of exposure.

The number of young people admitted to hospital after cutting themselves deliberately is up by more than 50% in 5 years according to new figures (BBC Radio 1 Newsbeat, 2010). One in five schoolchildren with a history of self-harming questioned by researchers said they first learnt about

it after seeing or reading something online, second only to hearing about it from friends.

> 'I think the internet played a major role; I think it started off my self-harm. I was already thinking about it so went to the web to find out more. I just typed 'self-harm' and there were hundreds of videos. Some are good but others can be very damaging. If I see a picture [of cuts], it can encourage me to do it. Sometimes it's a competitive thing.' (Danielle 17, Belfast)

YouTube is quoted as agreeing that it will take down graphic material but only if those videos deliberately tell or encourage other young people to self-harm.

The Royal College of Psychiatrists has said that it is now 'seriously concerned' about the growing number of websites that glamorise self-harm or show gory images of cuts and scars. They are calling for website owners and moderators to remove material that might promote or trigger self-harm and to link directly to sites that offer professional help and support.

Australia has legislated against use of the internet to promote the idea of suicide or provide advice about methods. However, some researchers in Britain suggest that it may be

> 'more fruitful for service providers to pursue website optimisation strategies to maximise the likelihood that suicidal people access helpful rather than potentially harmful sites in times of crisis.' (Biddle *et al*, 2008)

The role of the media in suicide has been the subject of much debate and consideration by the government and third sector. The current guidelines produced by the Samaritans (2008) aimed at those reporting suicides call for caution and sensitivity in order to avoid copycat behaviour as studies suggest that 'media portrayal can influence suicidal behaviour'. The guidelines advise, for example to avoid using 'explicit details of suicide' and labelling places as suicide hotspots and encourage the media to promote an understanding of the complexity of suicide. The UK *Editors's Codebook* introduced a new rule for editors in 2006 that when reporting suicide, care should be taken to avoid excessive detail of the method used. The revised *Codebook* has expanded its section on reporting on suicide with new guidance in the aftermath of the series of deaths of young people in and around Bridgend, South Wales, and complaints against newspapers about 'excessive detail' (Beales, 2009).

RECOMMENDATION

- A public health strategy on self-harm should address the issue of monitoring of harmful websites.

CROSS-SECTOR TRAINING

All relevant studies of service user experiences demonstrate that the essential qualities of empathy, understanding and skills are not always readily available among the staff in various agencies (see pp. 68–70). They cite the lack of understanding of the nature and causes of self-harm and underline the need for effective training on self-harm for all relevant front-line staff. Staff in drug and alcohol services and prison staff were singled out for particular mention in evidence to the Working Group. Prison staff

have particular challenges in balancing their custodial and their welfare roles (Short *et al*, 2009).

In Scotland, Wales and in some regions of England, awareness-raising programmes are in place as part of suicide prevention strategies together with training for front-line staff in a range of services, including teachers, police and social workers. The ASIST (Applied Suicide Intervention Skills Training), STORM (Skills-based Training On Risk Management) and similar short-training schemes (Box 8.1) have been evaluated (Appleby *et al*, 2000; Gask *et al*, 2006; Griesbach *et al*, 2008; Hayes *et al*, 2008; Harrison, 2010) and show high levels of satisfaction from attendees.

Box 8.1 Awareness-raising programmes

- ASIST (Applied Suicide Intervention Skills Training) is intended as 'suicide first-aid' training. ASIST aims to enable helpers (anyone in a position of trust) to become more willing, ready and able to recognise and intervene effectively to help individuals at risk of suicide. ASIST is said to be by far the most widely used suicide intervention skills training in the world.

- STORM is Skills-based Training On Risk Management for suicide prevention. The training is intended for front-line workers in health, social and criminal justice services. It focuses on developing through rehearsal the skills needed to assess and manage a person at risk of suicide. The STORM package is designed to be flexible and adaptable to the needs of a service.

- Other training resources and approaches are available. For example, Connecting People in Wales is designed to raise awareness and act as a 'feed' into more in-depth training for front-line services. The short introductory session aims to build relationships with the family and to use the term 'suicide mitigation' rather than 'prevention' to move away from the notions of liability and control. Mitigation involves carers and family members and places an emphasis on patient collaboration.

In Scotland, the Choose Life strategy aimed to improve the understanding of all types of front-line staff (Scottish Executive, 2002). The advantage of using a shared training programme across all sectors, not just health, was explained as being the creation of a shared value base that recognised the range of socioeconomic, emotional and psychiatric factors underlying suicide risk and would ensure continuity of approach and inter-agency cooperation. This would be in addition to the specialist training for health professionals.

A concerted programme of training of relevant statutory and related services should be a component of national self-harm strategies. Education providers, prison staff, staff in substance misuse services and those in social work and housing provision are obvious examples.

Recommendations

- The government department responsible for public health in each of the jurisdictions should lead a cross-departmental strategy to raise awareness of self-harm, ensure appropriate training for front-line staff in education, social work, prisons, police and other relevant agencies in dealing with self-harm and to help fund and promote research into suicide and self-harm. A partnership approach to implementation should be adopted wherever feasible and they should ensure that government websites including NHS Direct and the Department of Health include authoritative, accurate, accessible and user-friendly information on self-harm for service users, carers, family members and friends.

- The monitoring of harmful internet websites should be included in this strategy.

9. The role of the third sector

As already noted, people who engage in self-harm often do not come into contact with statutory health or social care services, or at least not on account of that behaviour. Many people who die from suicide have not been in contact with those services prior to their death, and may never have been a patient in respect of self-harming behaviour. This is particularly true for young people and other special groups. In the case of older people, self-harming behaviour may not have been detected by staff, although actually young people are least likely to disclose it. Some people will, however, have used third-sector services. Anecdotal evidence suggests that statutory services can be difficult to navigate, stigmatising and place many 'pre-requisites on people', and that the third sector has had a substantially greater role in dealing with these people as a result.

SELF-HELP GROUPS

There are also national and regional self-help groups throughout the UK, some of which operate online (Box 9.1). Self-help groups have been found valuable, in general and in relation to self-harm in particular (Smith & Clarke, 2003; Mental Health Foundation, 2006). The NSHN (www.nshn. co.uk) has built a network of support groups for individuals who self-harm. It focuses on support and distraction, enabling people to seek alternatives to self-harm. The charity aims to empower individuals to explore reasons for their self-harm and to seek appropriate professional help. It now equally supports friends, families and carers of individuals who harm themselves. The NSHN also aims to raise awareness of self-harm, underlying causes, triggers and the many ways to offer support.

BOX 9.1 EXAMPLE OF A SELF-HELP GROUP IN THE UK

- YouthNet is an online charity that aims to provide young people with a safe environment and a forum to discuss potentially difficult issues, including self-harm, and to exchange information. The internet provides anonymity, reducing barriers to talking about issues, which is reflected in the site's popularity. YouthNet highlights and tries to address issues in the care available to young people, which include mental health services having high thresholds to accessing services, thus forcing patients to increase the severity of their behaviour in order to be seen.

- In evidence to the Working Group, YouthNet indicated that it regards talking about issues as a form of risk reduction for self-harm. It also trains its volunteers and monitors the posted material to assess risk of negative material that may encourage or trigger self-harm. It highlights this as a potential problem of unregulated sites, but generally takes the view that when people want to talk, they want to be helped, which is positive.

They provide training to professional organisations, schools, universities, charities and user groups. The charity runs an online support forum serving over 2000 members.

'I would like to see more local or an NHS local self-help support group. You need to feel you are not alone. Online forums can be a bit uncomfortable and you do not get to see anyone face to face. As they are physical injuries, a support group face to face will help. You can then understand and support others who do it, and it may help you understand yourself and your reasons for self-harming. Such local groups do not exist anywhere in the country it seems'. (N. Ali, personal communication, 2008)

The Working Group heard evidence from the Samaritans and SANE about their services. We give a brief account of their work to exemplify the contribution of theirs (Box 9.2) and other organisations in the third sector.

Box 9.2 Voluntary organisations

- The Samaritans operate throughout the UK and are one of the most widely known and regarded voluntary mental healthcare providers. They provide 24-hour emotional support for callers and respond to contacts by email and short message service (SMS). In their branches they have face-to-face contact with clients. They carry out substantial outreach work in schools, prisons and at festivals. In 2007, they had dialogue with individuals 2 700 000 times. They receive more contacts identified to be from men (49%) than women (45%). They provide information, skills development, and confidential and non-judgemental emotional support.
- SANE's national telephone helpline, SANEline, currently handles an average of over 2000 calls every month from men, women and children affected by mental health problems as well as their carers and health professionals. They undertake research and campaigns, making use of their experience from the helpline and surveys.

Many other third-sector organisations provide services for people who harm themselves. Evidence was provided to us by Rethink, Turning Point and Mind, which all operate services of this kind. Turning Point, for example, provides services particularly for people with dual diagnosis at 200 locations in England and Wales. Their telephone service operates 365 days a year. They provide solution-focused therapy for people who self-harm, most of whom have substance misuse/use issues, and they assist people with medical and other social needs. In evidence to the Working Group they said that they offer long-term support to avert the need for crisis behaviour.

There is clearly a role for engagement between the national third-sector providers and government in policy and implementation, and there is some evidence that this is not occurring in a widespread or systematic fashion.

The Samaritans in their evidence to the Working Group said:

'An approach of partnership implementation, where particular organisations are given responsibility for implementation in different areas could be adopted. This approach was used in Scotland and is being used in Wales, and resulted in key agencies, including from the third sector, being given the resources and remit to drive forward action in specific areas. For Mental Health professionals this approach is helpful because it provides clarity on who is leading on key areas of work, reduces confusion and increased the chances of engagement between voluntary and statutory sector services. It also maximises the use of services and resources that already exist rather than creating duplicate services.'

RECOMMENDATION

- Suicide prevention strategies and self-harm strategies should explore and strengthen the relationships between third-sector and statutory-sector providers.

10. Research

Although suicide prevention has been the subject of much research in the UK and overseas, self-harm as a distinct issue has received much less attention until recent years. As a result, people who self-harm often do not get the best care. Services and clinicians lack guidance as to what works, and for whom, and commissioners lack evidence of outcomes to assist their commissioning.

In England, research into self-harm, undertaken as part of the National Suicide Prevention Strategy (Department of Health, 2002*a*) and through the Oxford University Centre for Suicide Research and other research organisations, has added significantly to the evidence base. Nevertheless, research is still much needed into all aspects of the issue; epidemiological studies, investigations of the full range of causes of self-harm, and, most importantly, effective interventions to treat and to prevent self-harm.

It is evident from our discussion of interventions that a robust evidence base is lacking for pharmacological interventions and for most therapies, in particular family therapy, dialectical behaviour therapy, and psychodynamic therapy, and for interventions such as harm minimisation. More research is needed into the effectiveness of these and other interventions, such as CBT, for particular groups.

The Scottish review (Leitner *et al*, 2008) also identified a need for research into 'interventions which may be effective for the general population or for specific populations other than people with depression or borderline personality disorder'. They also state that given some evidence for the effectiveness of 'relatively simple interventions' such as providing a person with ongoing contact and support, 'future research would benefit from going "back to basics" and exploring in greater depth this type of minimalist approach'. This is currently being investigated by researchers in Manchester, Bristol and Oxford.

There needs to be more research into issues of service provision, for example whether dedicated self-harm services deliver better outcomes. The specific correlations and relationship between self-harm and suicide and drug or alcohol addiction, together with interventions and services for this group of people, is an area that has been neglected.

There is also a lack of knowledge of longer-term outcomes from service-user perspectives. Their lived experience of pathways into and out of self-harming behaviour focusing on what they say has worked for them should be researched. The experience of carers has also been neglected. They should be studied, both in their own right and regarding the insights into self-harm they have gained from the experience and knowledge of people they have cared for. Other priorities for research were identified by members of the Working Group and include the following.

- Prospective and case–control research studies of self-harm in the community would help to address the many gaps in our knowledge.

- Effectiveness and economic evaluation of mandatory training for front-line health workers, taking into account direct costs of repeat self-harm and indirect costs.

- How self-harm is dealt with in primary care, including issues of attitudes and training.

- The role of nurses, the tools they use and the problems they encounter with patients who self-harm.

- Cost–benefit analyses of assessments and interventions for self-harm.

- Research into causes of self-harm, including biological, psychological and social causes and their interactions.

- Better evidence base for treatment of those with an intellectual disability or autism-spectrum disorder.

- Development of triage tools and their evaluation.

- Interventions for those bereaved by suicide.

- Studies of the role and experiences of carers.

There is no point in government and others calling for evidence-based practice unless the research is in place to develop and evaluate the evidence.

RECOMMENDATION

- A combination of national government funding streams, medical research council/economic and social research council funds, and charitable funds should consider research into self-harm as a funding priority.

Part III
Working with individual people

11. Introduction

The NICE guidelines on self-harm (National Collaborating Centre for Mental Health, 2004) address the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care, providing guidance, not only on services but on good practice in dealing with individual patients. A second NICE guideline is under development. It will cover the medium- and longer-term care management of people who self-harm, as well as their ongoing psychosocial assessment, psychosocial and pharmacological interventions for the specific treatment of self-harm, safe prescribing, treatment of people with specific care needs and special techniques (e.g. harm minimisation), and training for healthcare professionals treating people who self-harm. Other relevant NICE guidelines include those for borderline personality disorder (National Collaborating Centre for Mental Health, 2009*a*) and depression (National Collaborating Centre for Mental Health, 2009*b*).

The College document, *Assessment Following Self-harm in Adults* (Royal College of Psychiatrists, 2004) identifies consensus standards for assessment following self-harm. Competencies expected of both generalist and specialist staff are identified. Standards are described for the organisation and planning of deliberate self-harm services, procedures and facilities, training and supervision. These are specifically described for A&E, the general hospital, the community setting and the psychiatric in-patient unit. More detailed advice is given regarding particular patient groups: the patient who is intoxicated, the patient who repeatedly harms themselves and the patient who is reluctant or appearing to refuse intervention. The specific risks associated with older adults are also highlighted. Managerial standards are suggested for a self-harm planning group or coordinator.

The Working Group was keen to gain an insight into how policies and standards were actually implemented, not just at the macro-level but in the experience of psychiatrists and others who deal directly with individuals in need, as well as the service users themselves and their carers. A Members' survey was conducted and this provided useful data (Appendix I). Selections from this survey are quoted in the report.

12. Overarching themes

THE ROLE OF PSYCHIATRISTS AND OTHER HEALTHCARE PROFESSIONALS

Psychiatrists and other colleagues in health services are not only involved in policy and service development but in working directly with individual people who have harmed themselves, or are at risk of doing so. However, given the wide spectrum of behaviour and the multiple causes for it, the extent of their role varies (Box 12.1).

Box 12.1 A LIAISON PSYCHIATRIST'S RESPONSE TO THE COLLEGE MEMBERS' SURVEY

The groups we see across our three acute [A&E] sites in North London are roughly as follows.

- Essentially one-off self-harm in response to stress; usually a small overdose, no evidence of mental illness, often embarrassed by what they've done, unlikely to attend follow-up appointment (we tried it >85% DNA rate) and not really suitable for home treatment team or CMHT, therefore the majority are referred back to general practitioners (GPs).
- Repeat self-harm, usually in response to something/somebody destabilising their mental state, established diagnosis of emotionally unstable personality disorder, usually already linked in with CMHT, psychology or personality disorders service.
- Repeat self-harm or suicidal threats when intoxicated, sometimes under Section 136, often presenting dramatically, usually no fixed abode or out of area, rarely other psychiatric comorbidity apart from dissocial personality, usually discharged when sober with no follow-up.

Most clinicians working in general hospital practice will primarily see patients who have taken overdoses, while in community practice and mental hospital in-patient facilities there will, in addition, be a substantial number, especially young people and those with disturbances of personality, with a history of cutting or mutilating themselves. There is evidence that most general practitioners treat patients in their own homes following self-harm, provided there is no risk to life (Dennis *et al*, 1990). In many cases seen in general practice, self-harm could best be regarded as an episode in the long-term treatment of a patient who requires support services and interventions configured from within general practice (Poustie & Neville, 2004).

There is evidence that hospital services offer less to people who have cut themselves, although these individuals are far more likely to repeat their actions than are those who have taken overdoses of drugs. They are less likely to receive a psychosocial assessment or to be admitted to

general hospital. This appears to reflect a mistaken view that this behaviour necessarily reflects a low level of suicidal intent, with a lack of understanding that people may switch from cutting themselves to poisoning themselves (Lilley *et al*, 2008).

In the College Members' survey, most respondents (71%) agreed that they had a role in managing people who harm themselves, with higher numbers of those in forensic and addiction services (85%) and lower numbers of those in A&E departments, where they are more likely to see patients with a lower rate of mental illness.

Participants stressed the important role of experienced psychiatrists to deal with the complex nature of self-harm. It was emphasised that they were needed to assure appropriate screening and signposting to treatments when they are needed (see below).

> 'I have seen several completed suicides (can provide details) in medical negligence cases where social workers and the like have performed (incorrectly completed) liaison risk assessments and discharged patients to kill themselves. Also seen people who self-harm (including one man who had tried to gas himself) inappropriately managed by CMHT by deferring discussion of the case until a multidisciplinary team meeting the next week…or another male self-harmer admitted to an experimental unit with no nursing staff or observations, who hung himself within hours. There is a real crisis in getting these patients properly and swiftly assessed by the most competent members of the team and then getting them the appropriate management, e.g. admission if necessary…The College MUST highlight these problems more…or else it will be seen as a complacent accessory to these tragedies.'

On the other hand there was concern that their role in ongoing management should not be overstated. People who have harmed themselves, but without an indication of underlying significant mental illness, should generally be discharged to primary care, where they should be assisted to address their life and relationship problems and not be encouraged to see their problems as evidence of illness. Sometimes psychiatrists took on too much of the burden when the person should rather have been referred to social, psychotherapeutic or other services. Members also emphasised that psychiatry should also be clinically driven rather than risk driven.

> 'I don't think it helpful to regard all self-harm as due to mental illness. Some of these patients would not reach the threshold for any diagnostic category of illness, yet they are usually very angry, and often chronically deprived and miserable too with few other methods of dealing with their lives. This is not about 'labelling' but about recognising the nature of the problem, which is always psychosocial, which leads to a more helpful clinical approach.'

Some participants even felt that the intervention of psychiatrists could make the situation worse.

> 'We clearly have a role in helping people to understand why they self-harm and, if a treatable mental disorder is present, to ensure that the patient is receiving appropriate treatment. However, inappropriately labelling someone's behaviour as stemming from an 'illness' can undermine the person's autonomy in managing their behaviour.'

The perception that self-harm is not necessarily the province of psychiatrists may also reflect changes in practice, the emphasis on risk

included, that appear to have narrowed the focus of psychiatric practice and devalued the therapeutic relationship.

On the other hand, *Good Psychiatric Practice* (Royal College of Psychiatrists, 2009*b*) makes clear that where the psychiatrist is involved, their role includes establishing and maintaining a therapeutic alliance with the need for the psychiatrist to be competent in obtaining a full and relevant history that incorporates developmental, psychological, social, cultural and physical factors, and to be knowledgeable about the social and life experiences of their patients.

THE COLLEGE MEMBERS' SURVEY

The survey of College members was not able to give a full account of the extent of the problems that they encountered, their settings or geographical spread. However, the survey provides a snapshot with common themes and issues that are consistent with other surveys, academic research and service users' reported experience. Respondents' accounts chime with these other accounts, although overall they rate their services more positively than service users do.

Individual respondents expressed considerable concern and frustration about a range of issues concerning the care that vulnerable, sick people could expect to receive.[1] This was frequently linked to a lack of resources and pressures of busy work places.

> 'How many patients get admitted to general medical wards following self-harm, and then self-discharge – sometimes with tragic results – following a brief (if any) conversation with a very junior psychiatrist. It is alarming how easily someone with very severe, but possibly as yet undiagnosed, mental health problems, following a very serious suicide attempt, can leave the medical wards with no clear management plan – and everyone turning a blind eye owing to other pressures/lack of training.'

Another respondent to the survey made a pithy statement of what they thought was needed.

> 'The public affirmation of the extreme importance of self-harm as a signal of likely impending suicide and the prevention of suicide as a national goal. The statement of self-harm as vital an indicator as chest pain or stroke or a 4-hour breech as a presentation at A&E settings and the requirement of primary care trusts to commission for self-harm as they do for acute stroke and chest pain.'

In their detailed comments, psychiatrists raise problems they particularly face in dealing with self-harm, including:

- insufficient appropriate training for staff, including psychiatrists
- inexperienced staff put in charge, especially out of hours
- lack of attention to self-harm by senior clinicians
- a culture that puts too much emphasis on risk assessment
- insufficient evidence for what treatments work
- lack of available psychological therapies.

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1. See qualitative data in Appendix I.

This all has immediate implications for patients' recovery and for long-term costs in the healthcare system. Although most evidence relates to emergency care, similar pressures apply to acute in-patient wards and CMHTs. However, presentation at hospital will often be the first time that the person who is harming themselves will have had contact with psychiatric services. Failure to deal effectively with people who harm themselves or attempt suicide is a major cause of hospital in-patient admissions and the seriousness of this is often overlooked by hospital management.

The question of resources

The problem of resources underlies some of the shortcomings the College Members identified.

> 'In my Trust there is a block on further development for financial reasons and services are underdeveloped, so there is an incomplete self-harm pathway. There is therefore a gap between aspirational strategy and resources available. This leads to problems with training and for staff trying to help distressed people without appropriate resources. Hence staff, particularly those working from a narrow biomedical model, will dismiss patients, which may at least be honest, rather than offering an inadequate service, which can make things worse.

There is an urgent need for an improvement in the NHS standards of care for people who have harmed themselves and who receive care in A&E departments and in hospitals; there is less information about how well people are managed and treated in the community. In a period of austerity in the NHS there is an evident danger that substandard care will become more widespread, thereby creating, for the long term, more expense and strain on services because of untreated illness.

Compliance with NICE guidelines

Having regard to NICE guidelines is now a legal duty on the NHS under the NHS Constitution (Department of Health, 2010):

> 'Nationally approved treatments, drugs and programmes: You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you.'

Two-thirds of respondents reported having read the NICE guideline on self-harm, with the lowest number being those working in addictions (50%) and the highest in child and adolescent settings (86.6%).

Psychiatrists rated the performance of the service settings in which they work in accordance with six aspects of service provision as specified by NICE (National Collaborating Centre for Mental Health, 2004). Across all six items, most considered that performance was good or very good; the lowest rated performance was information provision, where 67% rated it this way. Across the main psychiatric specialties, greater dissatisfaction was, on balance, voiced by those in liaison, learning disability and old age services. Furthermore, trainees rated services less highly than consultants. Those working in child and adolescent services had the highest level of satisfaction.

13. What do service users and carers want from services?

Evidence from service users

The first contact that a person who harms themselves makes with NHS services will occur in a variety of contexts and settings – through ambulance services, an A&E department, a GP surgery, at a general hospital, as an in-patient in a psychiatric facility, at a community-based mental health service, in prison, in residential care or in a children's home. The person's actions may bring them to the attention of the police and to a place of safety. How they fare in this first contact is vital. The attention they get at this contact may determine the quality and continuity of care they receive from then on, and it may well determine their response in a later crisis. Good care at this stage may also encourage further willingness to seek help when needed, improve quality of life and may contribute to their overcoming the problem behaviour. It may reduce the need for hospital admissions.

There are numbers of studies of service users' views and experiences of contact with health services after self-harm (Horrocks *et al*, 2005; Platt *et al*, 2005; Mental Health Foundation, 2006; Broadhurst & Gill, 2007; Royal College of Psychiatrists, 2008*b*; Heslop & Macaulay, 2009). They emphasise that above all, people need an empathic non-judgemental approach to their self-harming behaviour, based on understanding the issues involved and the functions self-harm may fulfil for the individual. What is most helpful is a relationship in which they are 'listened to and supported not judged, where the boundaries are clear and where those relationships can support them over a long period of time' (Burke *et al*, 2008).

> 'I think the main thing that's helped me reduce my self-harming is the ability to talk about my feelings; I've never been able to talk to anyone before about my feelings. I've had help through psychiatric services but they don't seem to understand and [they] judge and label you, and there is always the fear that if you say the wrong thing they're going to lock you up.'

Service users can find it difficult and distressing to talk openly to someone they do not know. The stigma of self-harm may inhibit them. They may fear that discussing their problems will intensify their distress by bringing back repressed memories. Service users need to trust and also to feel safe in disclosing painful personal issues. Cultural expectations and negative previous experiences can also be inhibiting.

Rather than being expected simply to stop harming themselves (which is seen as very unhelpful) people who self-harm value assistance with successful distraction techniques and alternative coping mechanisms. They seek help to acquire skills and information that give them greater choices and control. They also need support to improve their mental resilience. Providing reasonable hope for recovery from their distress should be a routine part of their care.

A person who attends hospital will need their distress acknowledged as well as prompt attention to their physical care, but for busy healthcare staff having to switch from physical care to mental health needs can be challenging. Timely provision of information about their treatment and good communication are helpful. However, having their views taken seriously, participating in decisions about their care and treatment, and having clear explanations for decisions are highly rated (Taylor *et al*, 2009). A willingness or ability to accede to cultural requests, including preferences as to the gender of staff, makes a big difference, as does a sensitivity to, and understanding of, the social context that has contributed to the behaviour.

It would appear, however, that although service users give some reports of good care, these basic needs are not being routinely met.

Problems experienced

The NICE guideline reports many service user concerns over the services that they receive, including the attitudes of staff (National Collaborating Centre for Mental Health, 2004). Those who present at A&E are often put low on the triage scale and have to wait while 'more important' patients are dealt with first (Taylor *et al*, 2009).

> 'The result of this is that 43% of service users said that they had avoided emergency services in the past because of previous negative experiences and the same number had avoided services for fear of being detained under the Mental Health Act.' (National Collaborating Centre for Mental Health, 2004: p. 112)

A systematic review of the international literature on service users' experiences at A&E departments concludes that poor communication between patients and staff and a perceived lack of staff knowledge with regard to self-harm are common (Taylor *et al*, 2009; see also Broadhurst & Gill, 2007). The College project Better Services for People Who Self-harm, a survey of 509 service users' experience of emergency services following self-harm, had similar findings (Royal College of Psychiatrists, 2008*b*). The attitudes and behaviour of staff were the most significant factors affecting experience of care and their ability to cope once leaving the emergency service. Some respondents to the survey recalled being told that they were wasting time and resources. This compounded their distress and led them to discharge themselves prematurely.

Some service users felt that the initial and psychosocial assessment placed insufficient emphasis on their own views and needs. Some also considered their physical care was inadequate, especially that pain relief was not provided. A previous negative experience had deterred 35% from seeking appropriate help and for some this meant that they were less able to access an assessment and potentially helpful interventions.

Two contrasting observations were:

'The doctors and many of the nurses and other staff in this department seem well informed and are obviously trying to provide a non-judgemental professional caring service for people who have self-harmed.'

'It was an awful experience I would rather die than go back there.' (Royal College of Psychiatrists, 2008*b*)

These findings are consistent with those from other service user surveys. Truth Hurts, reporting on the experiences of adolescents states that many young people complained that A&E staff ignored their mental state, concentrating entirely on their physical problems.

'On the occasions I have been admitted to an A&E department they have concentrated on medically patching me up and getting me out. Never have I been asked any questions regarding whether this is the first time I have self-harmed or if I was to do it again or how I intend to deal with it.' (Mental health Foundation, 2006)

It is likely that in respect of other matters such as lack of privacy, long waiting times and superficial contact with busy staff, the experiences of people who self-harm are not different from others who attend in an emergency (Horrocks *et al*, 2005).

CARERS

There is a lack of information about the views and needs of carers of people who self-harm. Carers may feel isolated, stigmatised and burdened with the anxiety of caring for a family member or friend who repeatedly harms themselves. Their own feelings, especially feelings of shame, may be exacerbated by their cultural environment or their religion.

Friends and relatives can play a crucial role in the care and treatment of people who self-harm. They can provide emotional, practical and financial support and encourage people to seek appropriate support and treatment. They can become involved in treatment plans and, above all, make the person feel wanted, needed and loved. In surveys of people who self-harm, carers are seen as more helpful than professionals and by many as the main source of support.

It is important to recognise that friends and family are not always helpful or healthy in their relationships with service users; however, where carers have been identified and service users are willing to involve them, they should be part of the process from the outset. They should also be offered a carer's assessment at the first point of contact if the service user agrees.

Professionals should regard it as automatic to enquire about the service user's carer and the level of involvement that they would like to see from them. If there is a joint agreement that the carer be involved, they should be kept informed on situations that concern them, especially when it directly relates to their care giving. Important issues of confidentiality will apply but aspects of care that will involve the carer should be openly discussed. Carers bear a lot of responsibility and when the relationships are positive can have a profound impact on good recovery outcomes. As far as possible

and appropriate they should be included as part of the team and respected for their expertise and knowledge.

The NICE guidelines on self-harm (National Collaborating Centre for Mental Health, 2004) make recommendations for professionals to work with carers of people who have self-harmed (Box 13.1). These envisage that carers will play a direct role in the care of the service user.

Box 13.1 Recommendations for professionals working with carers

- Key objectives in treatment of self-harm should include effective engagement of service user and carer where appropriate (p. 29).
- Healthcare professionals should provide emotional support and help to carers and relatives as they may also be experiencing high levels of stress and anxiety (p. 51).
- Carers may need advice on risks of self-poisoning (p. 63).
- Carers might be part of harm minimisation techniques and alternative coping strategies (p. 64).
- Initial management of people who repeatedly self-harm should include advising carers of the need to remove all medication and objects that could be used for self-harm (p. 68).
- Carers and relatives of service users should be enabled to accompany them to appointments and treatment (p. 83).

Page references within National Collaborating Centre for Mental Health, 2004

Although respondents to the College Members' survey reported positively about the level of involvement of carers in their service there is little direct information about the views of carers themselves. A College Report from the College Centre of Quality Improvement on the performance of 112 acute in-patient mental health wards for working-age adults (Cresswell & Lelliott, 2009) reported that a substantial minority of carers (about 40%) had not been offered an interview with staff or a carer's assessment and a third had not been able to engage meaningfully with the process or the patient's discharge. We recommend above (p. 59) that research into the role and experiences of carers is needed.

14. The College Members' survey: skills and services needed

The evidence of healthcare professionals and service users' and carers' experience of the service has been referred to in the previous chapter. In this chapter we consider it in more depth, looking specifically at what the College Members' survey told us about the skills and services that College Members believe are required for professionals engaging with and undertaking assessments and management of patients who self-harm and patients who are suicidal.

Staffing issues

Staff attitudes and training

Staff views on this issue have complemented those of service users. For example, the College project Better Services for People Who Self-harm found that 26% of staff felt that they did not know enough about self-harm to communicate effectively (59% of staff in the A&E department), and 35% of staff felt that those who self-harm regularly were not treated as well as those who have done so only once (Royal College of Psychiatrists, 2008*b*). The project concluded that increasing staff understanding can be achieved relatively easily by giving staff more information on why people harm themselves and suggestions as to the best response. Involving service users at an early stage of planning and training is hugely beneficial in improving services.

The problem of staff attitudes to self-harm has been the subject of many studies in the UK and overseas. Overall, they show that large numbers of healthcare staff have a profoundly negative reaction to patients who harm themselves (Patel, 1975; O'Brien & Stoll, 1977; Creed & Pfeffer 1981; Crawford *et al*, 2003), compared with those with physical illness, and that this is likely to be reflected in the quality of clinical care. The attitudes were most pronounced in general medical settings, where patients were often seen as time-wasting. There appears to be a more sympathetic attitude to those who have a mental illness and those who were clearly suicidal at the time. Those who repeatedly self-harm are less well regarded (Mackay & Barrowclough, 2005).

A study of school nurses within one UK primary care trust reported that nurses felt frustrated and inadequate when working with young people who self-harm despite the training many of them had received (Patterson *et al*, 2007*a*; Cooke & James, 2009). This study concluded that self-harm

training for school nurses needed to incorporate both practical approaches and theoretical knowledge. Another study linked negative perceptions to their lack of knowledge, their qualifications and their general level of experience (Wheatley & Austin-Payne, 2009).

Respondents to the College Members' survey noted that staff consider self-harm challenging to manage because they have a limited understanding of it. As a result some people who need the most help are in danger of being excluded. We were also told in evidence from Choose Life (Scottish Executive, 2002) that psychiatrists also often feel uncomfortable with patients who have attempted suicide, and they hesitate to ask simple questions about the patient's motivation. One respondent to the College Members' survey gave the view that:

> 'although suicidal intention is not commonly reported, very many of the young people we see agree that they were suicidal for a moment at the time of the overdose (we are not talking about cutting here). It is a good idea to ask about this, because it is a relief to the patient to have his or her despair acknowledged even if it has to some extent lifted.'

Two contributors[2] said that the difficulties that a suicidal or self-harming patient may present to staff were due partly to the person's complex motivation (e.g. an ambivalence about dying) and partly to the aggression and anger they may display towards staff who are trying to assist them. Outlining a psychoanalytic understanding of the issue, they emphasised the central importance of the therapeutic alliance with the clinician and the need for the clinician to go beyond a 'medicalised and sanitised' interpretation to one that recognises the nature of the destructive forces underlying the patient's behaviour. Only in that way can the clinician achieve some understanding of what the behaviour means for that person. In their view, training must also address these deeper issues to provide staff with the confidence and competence they need.

The NICE guideline (National Collaborating Centre for Mental Health, 2004) states that:

> 'clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed.'

The impact of staff training on attitudes has been evaluated and both general hospital and psychiatric staff have reported significant improvements in attitudes and confidence (Turnbull & Chalder 1997; Samuelsson & Asberg, 2002; Patterson *et al*, 2007*b*; McAllister *et al*, 2009) after their training. Given that there is a rise in the incidence of self-harm and that in-patient beds in psychiatric wards have declined, given also that more mental health issues are dealt with by GPs, primary care training programmes need to be targeted at doctors. ASIST and similar programmes are a useful introduction to self-harm, but a more sophisticated training programme is essential for health and mental health professionals. This needs to address knowledge of self-harm, attitudes, communication and clinical issues such as assessment and management. A standard national programme would provide greater consistency.

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2. Dr Robert Hale and Dr Don Campbell the Portman Clinic, London, UK.

RECOMMENDATION

- The Royal College of Psychiatrists works with colleagues in other health disciplines and other relevant partners to develop a common curriculum on self-harm for front-line health professionals and that Trusts and Health Boards provide time for staff regularly to receive this training.

TRAINING ON PSYCHOSOCIAL ASSESSMENTS

Fewer than 50% of respondents to the College Members' survey considered that they (or their team) had the training to undertake psychosocial assessments of risk and need with people who had harmed themselves.[3] The highest percentage of those who have been trained were in liaison settings (62.7%). Over two-thirds of the 85 psychiatric trainees and doctors working in A&E departments rated their training in conducting psychosocial assessments as 'insufficient' (Royal College of Psychiatrists, 2008*b*). Respondents expressed dissatisfaction with the expertise of their own profession of psychiatry and with other staff – nurses, doctors, social workers, pediatricians, police and prison staff. Dissatisfaction was also frequently voiced about the fact that junior staff were undertaking assessments without the requisite skills or experience.

> 'I also think that in some services junior psychiatrists do not get much training, during normal working hours, of the assessment of self-harm and are expected to undertake this work out of hours or in some cases not at all. It should be a requirement of psychiatric training and not just left to nursing staff.'

When asked if they had received a psychosocial assessment, 62% of service users replying to the College survey said yes (Royal College of Psychiatrists, 2008*b*), although a third were dissatisfied with the quality of assessment they had received. In some cases, service users felt that the assessment was something that was 'done to me, rather than with me'. Fully involving the person who harms themselves in discussions about their problems and future care is essential.

JUNIOR STAFF

Some participants in the College Members' survey questioned whether junior psychiatrists and trainees should be entrusted with the assessment and management of self-harm. Such responsibility, including whether to discharge the patient, sometimes rested with them. This is partly due to the fact that most incidents occur after hours, when junior staff are the only ones on hand.

> 'In terms of our service, weekends and nights there is one psychiatry trainee covering apparently the largest A&E in the UK and the rest of the teaching hospital. We hardly ever do joint assessments with crisis

3. In total, 25% of those in learning disability, 44% in rehabilitation, 47% in old age and 48% in general adult reported this. However, the large majority of psychiatrists reported agreeing or strongly agreeing that they had been provided with the training to explore with the patient the underlying causes of their self-harm (82.4%). Unsurprisingly this was most evident in those working in academic settings (73%) or where their main psychiatric specialty was psychotherapy (92.1%). Only learning disability reported a lower proportion (67.3%).

resolution team owing to their unavailability...As a trainee it can feel quite overwhelming at times…a patient has waited 8 hours and there are then two or three phone calls interrupting the assessment.'

'Junior doctors see more self-harm than all the other cases put together when on call. I would estimate that 90% of the patients I saw out of hours were self-harm. This is strenuous, repetitive and puts people off doing psychiatry.'

'As a junior doctor I was often left with the responsibility to deal with deliberate self-harm on my own when on call outside hours. This certainly helped to burst my confidence in assessing such behaviour but the risks became diluted with the crises and home treatment team input...The issue is often how to provide a safe plan with significant scarce resources.'

The European Working Time Directive appears to have created particular staffing problems at night.

'Junior doctors' shift work patterns now rely heavily on high standards of hand-over to ensure that the necessary after-care arrangements are made for any patients seen in emergency care following an episode of self- harm. This standard tends to diminish where there are high rates of locums or junior doctors from dispersed sites.' (Pitman & Tyrer, 2008)

Others believed that trainee psychiatrists are being deprived of the training opportunities they need. It was suggested that senior psychiatrists were not taking enough of a role and the implications for the quality of care were obvious.

'Self-harm appears to me to be an area of psychiatry that is neglected by senior medical staff. Generally, nurses or very junior psychiatrists carry out assessments, often alone. This has implications for the physical safety of the assessor and influences the quality of the assessment. It is unclear why people who self-harm seem to be screened out from senior psychiatric input in this way.'

'Often pressure is put upon psychiatric juniors/liaison teams to see and discharge patients quickly rather than giving the patient the respect of giving them some time (where appropriate) to be psychologically ready to discuss their reasons for self-harm.'

A recent review of an A&E department in North Wales makes similar findings (Jones & Avis-Jones, 2007).

Other views underlined the value, as we stated above, in having experienced clinicians, including psychiatrists, directly involved in assessing and treating patients who self-harm from the outset, given the complex nature of these cases.

LIAISON PSYCHIATRY SERVICES

Respondents to the College Members' survey and other evidence received from the College Faculties emphasised the need for better access to liaison psychiatrists and higher levels of funding. The lack of paediatric liaison services and those specialising in the care of older people was also raised. The decline and closure of comprehensive liaison psychiatry services and poor commissioning of liaison psychiatry services was cited as a pressing problem, as it had been in the Academy of Medical Royal Colleges (2008) report. The report recommended that:

'Patients in the acute hospital should have the same level of access to a consultant psychiatrist as they would have from a consultant specialising in physical health problems. Ideally liaison services across the country should be developed so that a consultant liaison psychiatrist is available.

Acute trusts should be commissioned to ensure provision of Acute Care Liaison Psychiatrists.'

Department of Health guidance provides that the A&E response should be delivered by liaison psychiatrists, not crisis teams (Crompton & Daniel, 2007). Liaison psychiatry services are in an ideal position to: educate and support other mental health colleagues in self-harm; ensure a more effective and efficient service to patients who self-harm; and save duplication of work by other staff. The involvement of liaison psychiatrists in training also needs to be supported by Trusts.

Roles in multidisciplinary teams

The opportunities and challenges of multidisciplinary teams were also raised. On the one hand it was agreed that psychiatrists should certainly not be seen as the only people who can assess and help people who harm themselves, but on the other hand practice in these teams could give rise to concern if there was not senior psychiatric supervision. Some questioned whether all mental health staff had received the right professional training to acquire the skills that were needed.

'Increasingly with New Ways Of Working…the multidisciplinary team are expected to manage many such complex cases relatively independently, referring to consultants only for "supervision or support" as they see fit. I have been concerned to discover cases when in my view the risks of harm to patients have not been recognised by team members…'

It is clear that a greater attention to the issue of self-harm is required overall. Training and management practices need to be re-examined and changed to ensure that regular training of staff, especially junior psychiatrists, occurs and that appropriately trained staff are available.

The Working Group believes it is vital that these issues are addressed by Trust management and commissioners. In essence, although service users are calling for more empathic consideration of their case, the healthcare system is operating in a way that makes this almost impossible for staff to provide. Some respondents questioned whether this level of care would be deemed acceptable in relation to physical crises.

RECOMMENDATIONS

- The Royal College of Psychiatrists should ensure that training in psychosocial assessment and management of self-harm should be a core competency for all junior psychiatrists. It should be an essential component of prequalification training.
- Trust management should ensure that junior doctors are exposed to people who harm themselves but with access to supervision on a regular basis with senior staff. Staffing schedules should ensure that senior clinicians are involved in supervising or managing cases of self-harm from the outset.
- Commissioners of mental health services and Trust managements should make liaison psychiatrists available for A&E and general hospital wards at all times and they should be there to provide training and support for colleagues dealing with self-harm.

Staff supervision, support and management

The burden placed upon junior staff, including psychiatrists and trainees, to assess and deal with the majority of self-harm presentations raised the issues of supervision and support for staff. Evidence to the Working Group called for more support to be given to staff who work in an environment where they are more likely to encounter this behaviour as it can be detrimental to their mental well-being. Staff cited the negative feelings associated with treating a person who has repeatedly self-harmed. They reported that they felt frustrated and had a sense of failure with such patients because of their perceived inability to treat the causes of self-harm – only the results (National Collaborating Centre for Mental Health, 2004). The need for support for staff has featured in other studies (Thompson *et al*, 2008). It was noted that patients with intellectual disabilities are often a particular challenge for front-line A&E staff owing to difficulties in communication and errors of attribution.

One participant noted that other agencies, including social care and even child psychology, refer patients as soon as possible to child and adolescent mental health services (CAHMS) to reduce their own anxieties about the patient.

> 'I see CAHMS as often being put in a position of handling/soaking in the anxiety of other agencies/professionals. I think that there is a burning need to train professionals about the mechanisms/theory of self-harm and suicide and the difference between the two. We provide a consultation service for professionals to try and contain their anxieties about self-harm and therefore enable them to continue working with the patients.'

The NICE guideline states:

> 'Providing treatment and care for people who have self-harmed is emotionally demanding and requires a high level of communication skills and support. All staff undertaking this work should have regular clinical supervision in which the emotional impact upon staff members can be discussed and understood.' (National Collaborating Centre for Mental Health, 2004)

The important role of reflective practice in supervision and support was raised by the College Psychotherapy Faculty. This is considered below.

RECOMMENDATION

- There must be an improvement in the culture of practice to ensure that organisations support mental health professionals and promote good patient outcomes for those who have harmed themselves. Clinical staff should have sufficient support from colleagues available to them. Reflective practice should be embedded into supervision and into organisational practice.

Assessments

Risk assessment

The NICE guidance requires risk assessments to be undertaken (National Collaborating Centre for Mental Health, 2004).

'All people who have self-harmed should be assessed for risk: this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.'

Participants raised similar concerns about risk assessment as those voiced in a previous College (Royal College of Psychiatrists, 2008*a*). That report had discussed the impact of the blame culture on mental healthcare that had led to an overemphasis on risk assessment, with the underlying fallacious assumption that, properly undertaken, risk assessment could predict future events such as homicide or suicide, or repeat self-harm. Academic research provides evidence for the limited role that risk assessment can play in predictions of risk (Shergill & Szmukler, 1998; Powell *et al*, 2000; Coryell & Schlesser, 2001; Szmukler, 2003; Undrill, 2007).

Professor George Szmukler presented to the group research on the effectiveness of risk assessment tools. The conclusion was that the prediction of suicide and the assessment of suicide risk in respect of any individual patient is virtually impossible. The rates of suicide on a national scale are predictable; however, this does not translate into being able to predict who is likely to die by suicide, only that someone is. Any useful assessment, in his view, is better done without the complexities arising from elaborate tools but should instead be based on more efficient and smaller tools or on psychosocial assessments (G. Szmukler, personal communication, 2009).[4] Another expert said that, in her experience of working in a dedicated self-harm service, the prediction of self-harm or suicide was only accurate for up to one week ahead (L. Gask, personal communication, 2009).

The College Report states (Royal College of Psychiatrists, 2008*a*):

'Risk management is a core function of all medical practitioners and some negative outcomes, including violence, can be avoided or reduced in frequency by sensible contingency planning. Risk, however, cannot be eliminated. Accurate prediction is never possible for individual patients…because of the multiplicity of, and complex interrelation of, factors underlying a person's behaviour.

This concern with risk, instead of stimulating better and safer practice, appears to have had a negative impact on mental health professionals, professional practice, service users and the public.'

Respondents to the College Members' survey voiced similar views, believing that positive risk taking and overall patient well-being were both jeopardised by defensive practice arising from the preoccupation with risk assessment. Use of separate risk assessment tools is dangerous as overreliance on them too easily leads to complacency and can misdirect people into thinking that there is a short-cut to assessment that ignores detailed history and mental state assessment and the need to synthesise a detailed clinical formulation based upon these.

The majority of respondents were critical of risk assessment instruments premised on 'tick box' assessments. These were seen as bureaucratic or defensive tools employed by their organisation. This was

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4. Part of a PowerPoint presentation to the Working Group, 'Predicting suicide – a rare event', given at The Royal College of Psychiatrists, September 2009.

also sometimes associated with the move towards junior and non-medical staff undertaking assessments. It appears to apply to community as well as in-patient settings. A key concern was that clinical skill and nuance was being overlooked.

'In our service, the junior doctors must complete vast amounts of paperwork for each person they see in A&E with self-harm. There was also talk recently of introducing a further 'tick-box' questionnaire for patients about their intentions and suicidal behaviours.'

'…in our wish to minimise risk we can veer towards introducing more and more forms and questionnaires to document risk, which may help us to feel better, but which actually take time away from talking with the patients and helping them.'

'I do not agree with the actuarial 'paper-pushing' way that risk assessments seem to be taken out by CMHTs – in my experience they give little clinical information of relevance. I have seen several near misses by multidisciplinary team members overconfident in these blunt 'tools'; they feel that if they are trained to tick some boxes, this means they are trained to undertake sometimes complex assessments which require a full psychiatric understanding of the patient and their situation.'

The Working Group concluded with a concern that the endemic tick-box mentality removed staff from people, devalued engagement and impaired empathy. Empathic listening and talking have key therapeutic benefits. The best risk assessment is done not by filling out a pro forma but by understanding the individual needs of the patient and recognising patients as individuals who will be affected in ways that can only be predicted by a personal evaluation and not through a generic risk approach. It was also noted that in any case the lack of a standardised approach meant that assessments could often be unnerving for service users who may be used to one system and are then subjected to a different one.

Furthermore, the aversion to risk-taking or allowing patients to take more control for fear that the professional caregiver would be held responsible for any negative outcome was contrary to the recovery approach that government policy upholds. The freedom to take risks would be helped if there was more of a shift from risk factors to protective factors and from risk assessment to needs assessment.

We took note of the NICE guidelines (National Collaborating Centre for Mental Health, 2004):

'Risk assessment therefore appears to be a useful means of identifying a small group of very high risk people – that is, people who have unusually high relative risks of further self-harm or suicide – while being too inaccurate to be used as a screening measure to allow services to be targeted on those whose risk is above a certain threshold.

An alternative approach is to accept that risk lies on a continuum. Risk assessment serves to place an individual on that continuum, at the time of the assessment. Its main value is to influence the decision about urgency and intensity of intervention, rather than to determine the contents of (or even the offer of) intervention.

Additionally, it can serve as a focus for discussing the person's current attitude to their problems, and since risk may change it can be monitored to inform changes in the intensity of intervention. Thus most of the items that might appear in a risk assessment scale could

be enquired about and dealt with accordingly by a needs assessment approach. A clear advantage in assessing risk in the context of a needs assessment approach is that the risks identified can be used to tailor further assessment of need, and the subsequent interventions to the individual in their particular circumstance, taking account of their past history.'

The guidelines also state that:

'Integrating risk assessment into a needs assessment framework represents a possible solution to the problems identified, although this remains to be evaluated (National Collaborating Centre for Mental Health, 2004: p. 158).'

The Working Group views with some concern the continued reliance on locally developed risk assessment tools. Where risk assessment tools are used they should be seen as part of routine psychosocial assessment, not a separate exercise.

RECOMMENDATION

- Locally developed risk assessment tools should be abandoned. All risk assessment tools should be evidence based. Where risk assessment tools are used they should be seen as part of routine psychosocial assessment, not as a separate exercise.

PSYCHOSOCIAL NEEDS ASSESSMENT

The NICE guidance states:

'All people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment.' (National Collaborating Centre for Mental Health, 2004)

However, there is evidence that this is not in place (Hughes & Kosky, 2007), particularly for those who have cut themselves and who drank alcohol before or during the episode (Horrocks *et al*, 2002).The introduction of a self-harm pathway and protocol can substantially increase the proportion of psychosocial assessments requested and completed (Horrocks & House, 2002). Recent research found that a substantial proportion of patients who harmed themselves were discharged from A&E departments without a psychiatric assessment and that they may be at greater risk of further self-harm and suicide than those who are assessed. The authors concluded that hospital services need to be organised so that these patients receive a psychosocial assessment (Hickey *et al*, 2001). There is some controversy as to the usefulness of this form of assessment for those who have attempted self-poisoning (Owens, 2006).

Between 40 and 50% of all participants in the College Members' survey reported personally undertaking psychosocial assessments with all patients who had self-harmed; 64–71% reported that the teams in which they worked undertook these assessments with all patients. Unsurprisingly, those reporting liaison as a specialty were more likely to undertake assessments of all types with all patients reporting self-harm (between 78 and 82%).[5]

Compliance with the NICE guidelines in relation to psychosocial assessment was examined also in a large study of over 10 000 episodes of self-harm at six hospitals in three cities – Leeds, Manchester and Oxford – the authors concluding that the guidelines were far from being followed. A person was more likely to have an assessment if they were admitted to the general hospital, and admission practices varied between centres (Hawton *et al*, 2007*b*).

The NICE guidelines underline the importance of a full psychosocial assessment.

> Health services aim to minimise harm and therefore try to reduce or prevent self-harm as a priority. Many healthcare professionals view self-harm as attempted suicide, and few healthcare professionals consider or discuss the meaning, function or intention of acts of self-harm, instead assuming that suicide was intended and should be prevented as far as possible.' (National Collaborating Centre for Mental Health, 2004: p. 73)

Although the majority of those responding to the survey reported that either they or a member of the team routinely undertook an assessment, some questioned the quality of this work owing to pressures mentioned above, with a lack of time and inadequate funding.

> 'Assessment is often superficial and dismissive. The act of self-harm tends to limit the evaluation of underlying longer-term issues, whether or not there is a diagnosable mental illness. However, the diagnosis of depressive illness is too often assumed to be a sufficient explanation for self-harming behaviour and suicidal ideation. Expressed suicidal ideation, or self-harming behaviour, can lead to unthinking referral to crisis resolution teams, rather than an attempt to understand and contain what is happening within an existing therapeutic relationship.

> The single most useful factor that might prevent these problems is a comprehensive psychiatric assessment, including psychosocial assessment and psychodynamic formulation. This does not necessarily have to be done by a psychiatrist, but every psychiatrist should know how to carry out such assessments, and as self-harm assessments are increasingly carried out by mental health workers from other professional backgrounds, psychiatrists have less and less opportunity to acquire and maintain such skills.'

In addition to the patient's psychological and social needs, it is important that their physical needs are also properly assessed. These are people who have tried to harm themselves physically, through ingesting toxic substances or damaging their bodies. One has a sense that sometimes if the psychosocial is addressed, this physical component is forgotten despite it also being a central feature. It is one of the reasons why psychiatrists should fulfil a key role – they are as individuals fully medically and psychosocially trained and able to carry out a biopsychosocial assessment.

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5. Participants reporting rehabilitation, addictions and psychotherapy as their main specialty were least likely to undertake assessments with all patients who had self-harmed. Conversely, those still in training were more likely to undertake assessments of all types with all such patients (between 55 and 75%). Overall, 40–43% of all participants indicated undertaking psychosocial assessments with specific patients.

> CASE STUDY 14.1
>
> The Bradford and Airedale Teaching Primary Care Trust have piloted a novel service for patients who self-harm in which specially trained district nurses, practice nurses and nurse practitioners provide medical treatment in the local GP surgery or from a local crisis team out-of-office hours (Nursing Standard, 2006). The service provides physical treatments such as wound or burns management, but the aim is also to provide private and more lengthy assessments in which staff are able to understand the meaning behind the act of self-harm. Delivered in a setting outside A&E the scheme is expected to improve the quality of psychosocial assessment and of patients' experiences, and full implementation depends on the response of service users. Clearly, this represents an example of efforts to match NICE guidelines over standards of psychosocial assessments (see Training on psychosocial assessments, National Collaborating Centre for Mental Health, 2004: p. 64), using a process of trial and evaluation.

RECOMMENDATIONS

- People attending hospital after an episode of self-harm should all receive a biopsychosocial assessment done in accordance with the NICE guidelines by a clinician with adequate skill and experience.
- Psychiatrists assessing people who have harmed themselves should undertake a comprehensive psychiatric history and mental state examination of which the assessment of risk is an important part. Assessments of risk and need should be more closely tethered.

CHANGES IN THE CULTURE OF CARE

Investment in training together with better support and supervision for staff, with input from senior clinical staff, including liaison psychiatrists, should bring about a cultural change to benefit patients who self-harm.

REFLECTIVE PRACTICE

The College Psychotherapy Faculty put more fundamental points to us about the need for a change in the culture of services that would also be likely to yield better quality outcomes overall. There is, in their view, a cultural problem of making space for thinking in many organisations, with a performance management approach adopted in critical incident reviews that inhibits learning from clinical experience after a suicide or other untoward incident relating to self-harm.

> 'We recommend regular reflective therapeutic space in teams to review the self-harming behaviour. The aim of the routine reflective space would be to learn about the emotional and psychological aspects of self-harm and suicidal patients so that professionals would become more able to use psychotherapeutic understanding in assessment and risk management. A key development in the routine introduction of reflective practice would be to improve staff morale throughout their increasing capacity to take safely informed risks as a component of therapeutic management which is containing in the psychotherapeutic sense of the word.'

Reflective practice applies equally to organisations. Some psychiatrists still perceive a blame culture in which individuals are scape-goated for the failings of systems. Organisations may unintentionally contribute to this, and therefore fail to learn systemic lessons. The blame culture

creates defensive practice that ill serves patient need. The practice of reflective thinking about self-harm and suicide is especially needed across the organisation in relation to the pressures exerted by patients whose vulnerability collides with the vulnerability of staff and when the latter feel they lack senior organisational support for taking risky decisions, which could leave them exposed.

Reflective practice was also cited as a vehicle for education, team development and to aid organisational integration. The survey repeatedly raised important themes surrounding these issues. Reflective practice groups can help to address service limitations already raised by the College Members' survey and can be a vehicle to bring members of the multidisciplinary team together, including senior and junior medical staff, link different parts of the organisation and reduce discontinuity of care and duplication.

RECOVERY-ORIENTATED PRACTICE

The value of recovery-orientated practice in giving hope is central to helping to deal with the complex situations that the service user needs to negotiate in order then to address self-harming behaviour.

Dr Fiona Mason, a senior psychiatrist who leads a service for female patients in a medium secure unit, gave evidence of her practice, underlining the role that instilling hope had for the recovery of her patients.

'Many patients never seem to have been told that recovery is an option. Distress is increased, and effectiveness of treatment curtailed, when individuals' views are not taken into account; they may not have been invited to attend their care meetings and may not have had their needs listened to.

Service user experience, the expectation of safety, the prioritisation of needs and beginning with the end in mind are all positive factors in treatment for those who have self-harmed. Trust between the service user and staff is essential. Once this is achieved then real change can begin. Trust is built through validation of an individual's distress while pushing for change – making the service user feel valued and taking into account their experiences of treatment and desire for more effective treatment. There has to be a belief in change, hope for the service user, who can then work towards helping themselves.'

DISCHARGE, ONWARD REFERRAL AND CONTINUITY OF CARE

A central purpose of psychosocial assessment is to identify a patient's needs and risks and to devise a management plan to address them. Here, we consider some issues arising immediately after an assessment and initial treatment before then looking more generally at the care pathway.

Over a third of respondents to the College Members' survey stated that discharge decisions about patients were being made by junior staff with little training or experience.[6] They deprecated the fact that there was overriding

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6. Sixty per cent of those reporting that rehabilitation was their main psychiatric specialty agreed or strongly agreed with this statement, as did about 43% of those from forensic, psychotherapy, liaison, and addictions settings.

pressure on front-line professionals to discharge individuals quickly from A&E or in-patient care, often giving little time for the individual or professional to take stock of the situation and provide appropriate care. A common experience for the patient was a limited (out-of-hours) assessment and no time to begin to recover from the physical and psychological effects of their self-harm before they are discharged.

> 'Often pressure is put upon psychiatric juniors/liaison teams to see and discharge patients quickly rather than giving the patient the respect of giving them some time (where appropriate) to be psychologically ready to discuss their reasons for self-harm.' (Respondent to College survey)

Some respondents reported that hospital admission was a problem because of a lack of beds. Research also demonstrates that in some services all patients referred to the general hospital following self-harm are admitted to a medical bed, and thus are kept in hospital to allow referral to the mental health team. In other hospitals, patients are not admitted and may be discharged before the metal health team can assess them.

> 'I always have concerns that those individuals seen in A&E and sent home are often assessed by the most junior staff. Often there are protocols that all admissions must be discussed with senior staff, but perhaps those at highest risk are those being sent home and should be discussed with senior staff.'

A significant issue raised was the importance of admitting children and young people under 16 years of age to the paediatric ward after self-harm. Respondents wrote:

> 'It gives a very powerful window of opportunity to assess the situation in the cold light of day and away from home circumstances.'

> 'It reduces the pressure on junior staff to make decisions in the night.'

However, with limited resources the threshold for admission of young people will be higher, with the consequence that they will have a limited out-of-hours assessment and little or no time to recover from the physical and psychological ill effects of their self-harm. Participants also observed that admission of those aged over 16 years required consideration because of the different policies on adult wards. Adult psychiatrists have a different system by which those who self-harm are assessed immediately and discharged without an overnight stay.

S<small>ELF</small>-<small>DISCHARGES</small>

People who have self-harmed are particularly likely to self discharge or abscond (Barr *et al*, 2004). The problems and pressures in A&E departments can impact on the number of people who self-discharge prematurely and who are in a vulnerable state. As one respondent to the College Members' survey put it:

> '...the group of deliberate self-harm individuals who can get missed is that of the self-discharges from the emergency department – in our centre we have developed a weekly review of such missed cases, and action is then taken to follow them up or alert their GP or others involved in their care.'

Patients who self-harm and who leave the acute hospital environment before an assessment takes place have an increased risk of subsequent self-harm (Crowder *et al*, 2004).

In its evidence to the Working Group Committee, the charity SANE gave two examples (Case studies 14.2 and 14.3).

CASE STUDY 14.2

A man diagnosed with schizophrenia who had absconded from a psychiatric hospital earlier in the day was found trying to jump off Tower Bridge. He was taken to an A&E department and left without constant supervision to wait for an assessment. Sadly, the wait, it appeared, was too long. Unnoticed, he left the hospital, then jumped off Westminster Bridge into the Thames and drowned. SANE would like to see a speedier response in A&E departments, and specialist input from psychiatric teams, to people who have attempted suicide or may be at risk of taking their lives.

CASE STUDY 14.3

A talented artist in his forties who had had schizophrenia and bipolar disorder since the age of 17 had learned, when suffering his frequent relapses when he would become suicidal, to admit himself to a particular hospital where he could find the space, nursing care and protection he knew he needed. When the hospital was demolished, the only bed available was on the third floor of a unit on a main road, where there was no space or activities, which he found oppressive. Nevertheless, it was the only place where he could feel safe. When his wife begged for him to be admitted to the unit just before Christmas, he was told that he would be visited instead by a community team and a psychiatrist left a message on his phone offering him an appointment a month ahead. No one responded to his and his wife's repeated messages about how desperate he was becoming. He hanged himself.

REFERRAL TO GENERAL PRACTITIONERS

There needs to be effective communication between GPs and secondary care for people who have harmed themselves and need further attention. The NICE guidelines recommend that the information following a psychosocial assessment should be passed on to the patient's GP. Mental capacity and evidence of mental illness should be communicated to GPs if patients leave before a specialist assessment. College guidance recommends that for people admitted to medical wards, information should also be passed to GPs (as well as a referral to a specialist) within 3 days (Royal College of Psychiatrists, 2004). In one study (Cooper *et al*, 2008*b*), of the 93 cases seen in the A&E department at a teaching hospital over a month, only 62% of cases were referred. Clinicians in A&E provided few communications, and they were of limited content. Communication from psychiatric staff was the most detailed. The authors conclude that reliance on communication by A&E staff would leave a substantial proportion of patients discharged from A&E with no or minimal communication to primary care. Psychiatric services also need to improve the rate of communication to the patient's GP following assessment.

More than 6% of patients discharged from psychiatric in-patient care are readmitted for an episode of self-harm within 12 months, with a third of these episodes occurring in the month after discharge. Self-harm after discharge from hospital shares many of the features of suicide after discharge. Gunnell *et al* (2008) conclude that interventions should be developed to reduce risk during this period.

Marjorie Wallace from SANE expressed her view to the Working Group:

'…the first 48 hours after discharge are when people are at their most vulnerable. Many are simply left to get home alone and are then not seen or contacted by a team until up to 7 days later. The transfer from a safe, secure and monitored environment back into society can be very traumatic for people, and there needs to be a greater recognition of the added stress this brings. SANE has offered to work with psychiatric teams via its telephone helpline service, to call service users when they have got back home after discharge and then again at regular intervals, at times such as evenings and weekends when other help might be difficult to reach, alerting them to potential crisis. However, monies were not forthcoming from primary care trusts to fund this preventative service.'

Care pathways

The management plan lays the foundation for future long-term care, which in the case of self-harm requires long-term thinking and often involves multiple partners. Management plans should embrace a long-term strategic perspective and not merely respond to the immediate concerns.

The longer-term management of self-harm appears to vary in quality. Of great concern is the fragmentation of services, duplication of assessments and people being lost to the system. Lack of follow through also arises because of communication between different teams and staffing shortages, especially over the summer.

More than half of all respondents (55%) to the College Members' survey consider that services are available outside the immediate crisis. However in relation to the ability to provide short-term follow-up there was a difference between the main psychiatric specialties and those working in liaison, who reported that performance was neither good nor very good in a third of all cases. There was a particular problem with limited follow-up services for 16- to 18-year-olds.

'In CAMHS we do not have an outreach crisis service, which makes follow-up of non-attenders very hard. Child and adolescent mental health services are underresourced to cover recurrent individuals with self-harming behaviour. Also when patients present from a non-local area to our area we cannot be sure of the kind of follow-up they get.'

Another group of patients for whom long-term care is essential but often lacking are the patients whose self-harming behaviour is entrenched and repetitive. Some have a diagnosed personality disorder. In commenting on the lack of services for these 'most stigmatised patients', one respondent to the survey stated:

'Some of them need to be seen as long-term patients, with proper management and treatment plans, something that goes against the current climate of cutting the provisions and the recovery model. They might recover from a particular episode of self-harm, but unless they are taken on seriously and treated, another crisis is just around the corner, draining the resources in a continuous manner.'

Less than a half of respondents (48%) reported that a self-harm care pathway or policy existed or was being developed; almost a quarter (23%) reported that no pathway document existed; and 29% did not know. It

appears that pathways are best developed in child and adolescent settings. Pathways are least well developed for those attending addiction services. This is most concerning. We trust that these defects will be fully considered by NICE and should be taken up by the College in future work on assessment of people who harm themselves.

There were several examples of positive experiences. One psychiatrist noted:

> 'I have found that focusing training on well-motivated teams of people with strong links to the voluntary sector, crisis teams, and an ability to communicate quickly and effectively with primary care, available to say A&E departments and related general hospital units, is an effective way to raise standards, and reduce bad practice and stigma. They can educate general hospital colleagues. Such teams should have a psychiatrist providing leadership and support around audit, research and clinical decision-making over prescribing, etc.'

In the view of one participant commenting on A&E, a multi-agency pathway should replace the existing model:

> '…of a line of professionals carrying out their individual assessments without a care planning meeting or even having a robust mechanism to liaise with each other to ensure safe management/discharge.'

The College Faculty of General and Community Psychiatrists said that the process and practice of the care programme approach (CPA) needed to be strengthened for patients under secondary mental healthcare. The National Suicide Prevention Strategy for England (Department of Health, 2002*a*) as well as confidential inquiries into the causes of suicide and undetermined deaths have frequently relied on appropriate implementation of CPA policies for patients admitted to the psychiatric hospitals, as well as for patients being managed by CMHT as an important standard of safe practice.

> 'Even where good liaison psychiatry services exist there still appears to be a barrier integrating with A&E. Having separate general and mental health trusts exacerbates the problem. I would like to see the mental health staff actually based (not visiting from separate building or office) alongside A&E staff. At present there remains a culture of "mental health" problem, we'll do our bit, stitch them up/parvolex, then refer them to mental health, nothing more to do with us. Mental health staff come as outsiders, often completing two sets of records. This is OK, but the separation of mind and body is completely outdated and I would like to see true holistic practice."

Different models of service delivery for mental health patients are being discussed and practiced (Royal College of Psyciatrists, 2010), driven by the economic downturn and a shortage of financial and staff resources. This is also an opportunity to do things better and maybe get back to the basics of good patient care. We note these developments, which will impact on people who self-harm and should be used to improve care pathways, reduce duplication and lead to better collaboration between services.

It is beyond the scope of this report to consider these issues in detail, given also more in-depth work that can be achieved by NICE. However, the top-line messages are clear – the need for an agreed multi-agency pathway that provides for long-term care that is clinically appropriate and fosters a therapeutic alliance with person and clinician. Plans of treatment and care

need to embrace a long-term, strategic perspective and not merely respond to immediate concerns.

In the light of new developments in service delivery and of these problems it would be timely for the College to review and update its existing guidance on a pathway for self-harm.

RECOMMENDATION

- The College Report *Assessment Following Self-harm in Adults* (2004) should be updated, reflecting findings in this Report, relevant NICE guidelines and other policy and practice-based developments, including the results of service redesign initiatives.

PSYCHOLOGICAL THERAPIES

The range of interventions for self-harm is discussed elsewhere. Many respondents to the survey commented on the need for training in these therapies and for further research to be funded so that they may improve the evidence base. It was noted that self-harm is considered to be challenging to manage owing to limited understanding and therefore avoidance by professionals, thus becoming an exclusion for such individuals who need the most help. Proper training is needed to improve the skills of all professionals.

> '...making sure that staff using psychological therapies in this area are properly trained and not just deployed having had 'taster' experiences in various therapies, as I think this could be very harmful to patients particularly in the long term.'

The answers to the survey questions on the availability of psychological therapies were revealing. In liaison, general adult, addictions, and learning disabilities about 50–55% of respondents agreed that such therapies were widely available in their organisation for people who self-harmed. This contrasts with 73–78% of those respondents practicing in child and adolescent, psychotherapy and forensic settings.

The impact of the improving access to psychological therapies (IAPT) programme on other therapy services was regretted, but it was also noted that in Scotland, where there is no IAPT programme, the lack of services is greater.

> 'Still there are people who find it difficult to access psychological input. I would recommend all people who present with self-harm irrespective of comorbid mental illness or not should have mandatory psychological input, as most of the patients use self-harm as a maladaptive coping strategy and it should start from the first attempt of self-harm – doesn't matter if the self-harm was significant or not. We should not wait for multiple self-harm episodes to justify the psychological input.'

> 'Locally, the lack of psychological interventions for young people who self-harm is a matter of significant concern. We are fairly confident that we assess adequately but are often not able to offer appropriate intervention owing to lack of resources, having poor accommodation and a severe lack of psychologists or other specialists who might provide these.'

There is a duty on services to provide those interventions for self-harm that are recommended by NICE.

RECOMMENDATION

• Mental health commissioners take more account of the needs of people who harm themselves and ensure that evidence based psychological therapies are available for individuals who need them. Research needs to be funded into relevant therapies to improve the evidence base.

DEDICATED SELF-HARM SERVICES

GENERAL VIEWS

Respondents to the College Members' survey were divided as to the role of dedicated self-harm services. The advantage of specific self-harm services is that members of staff can help train their colleagues more effectively; however, it does mean some fragmentation of services. It was also said that in most cases a holistic approach that treats self-harming behaviour as one part of the person will be most effective. For these reasons we do not take a position on a separate stand-alone self-harm service as the preferred structure for delivering care, given that there is such individual variation between patients presenting with it. A well-resourced (especially for psychotherapies) and trained CMHT and primary care service may well provide a more joined-up and coordinated service than a separate one.

However, even though dedicated self-harm services were not seen as necessarily a model for widespread adoption, there were some good examples dealing with the most severe, entrenched and repeated cases of self-harm (see below). One respondent wrote:

'I run one of the few specialist psychiatric treatment and training services for people who repeatedly self-harm. We are based in South London. We have excellent clinical results (backed up by robust outcome data) and yet perpetually struggle to obtain primary care trust funding for referred patients and are in a constant battle over funding.'

REPEATED SELF-HARM

People who repeatedly self-harm over a long period of time are a distinct group who are at a particularly high risk of suicide (Hawton *et al*, 2003). Negative feelings associated with treating these people was cited as a major cause of poor service provision. Staff reported that they felt frustrated and had a sense of failure in regard to individuals who repeatedly harm themselves because they feel unable to understand or treat the causes of self-harm (National Collaborating Centre for Mental Health, 2004). Individuals who repeatedly self-harm were said to be considered a drain on acute services, absorbing much clinical time, often exhibiting challenging behaviour, and there was too little training on how to manage their behaviour and too few therapies to care for their needs.

The Royal College of Psychiatrists (2006) surveyed professionals working in general hospitals and came to the same conclusions. There need to be improved services for people who repeatedly harm themselves. Many of these people have long-standing personality-related and multiple life

problems, may be misusing drugs or alcohol, and those with a diagnosed personality disorder are also highly represented. One respondent opined:

'There is much that can be done to assist them but there is no investment or money available to create a specialist service... If an age-inclusive service could be developed with the aim of early education and support could be developed (i.e. like the early intervention service), then the significant costs to the service overall would be reduced.'

Another respondent stated that continued investment in specialist services for people with personality disorder that offer evidence-based treatments could play an important part in reducing the incidence of repeated self-harm.

'There needs to be comprehensive and "systemic" training of adult in-patient ward staff in the management of the person who repeatedly self-harms...complemented by more availability of psychology/psychotherapy support or, arguably, more consultant "time" available on the wards to oversee/supervise staff in the management of these more challenging cases.'

Evidence was received from a dedicated self-harm service in England (Case study 14.4).

CASE STUDY 14.4

There are about 1300 presentations to the Emergency Department of the Manchester Royal Infirmary each year with a repetition rate of 27% over 2 years. The median time to repetition is 12 weeks but 10% of repeaters do so within the first week of the index episode. Overall, 60–90% of people have some form of major psychosocial problem – depressive disorders, anxiety states, alcohol or substance misuse and related problems, abusive relationships, complex family difficulties or other difficult social circumstances. About 50% of patients are found to be illiterate or to have very low levels of literacy (15% illiterate and most have an average reading age of 7–8 years) and the level of social deprivation is high.

The specialist team (Self-Harm, Assessment, Follow-up and Engagement, SAFE) run weekly sessions in GP surgeries in self-harm hot spots and also see people at home. There is a low level of support and care from patients' families, who are often not in a mental state to provide it.

There are three nurse therapists who assess and treat self-harm. The SAFE team provides a specific treatment service for people who self-harm, with four sessions of psychodynamic interpersonal therapy. They link up with other services if necessary and work closely with GPs. An integrated continuous training system is headed by a liaison psychiatrist. Ease of access is the key to ensuring that people remain in treatment. Rather than forcing them to come to a hospital, which they may find difficult, services are offered at a GP's surgery or at home, with a higher uptake rate than with hospital appointments. These home visits or treatments in local general practice is more effective.

RECOMMENDATION

- That there is more research into different models of care for people who repeatedly self-harm with the effectiveness of dedicated self-harm services as part of such an enquiry. We trust that this will be considered as part of the work on the forthcoming NICE Guideline on Self-harm.

Issues for some particular groups

Three groups of service users were particularly singled out for mention by respondents to the Working Group survey: people with personality disorder, older people, and prisoners and forensic patients. Some of the issues have been considered earlier but here we mention some particular points.

People with diagnosed personality disorder

People with a diagnosed personality disorder are traditionally a stigmatised group. They are highly represented among prisoners and among those who repeatedly self-harm. Attitudes to and service provision for people with personality disorder was seen as particularly poor. Mainstream services are sometimes reluctant to take them on partly because they absorb much time and resources. Some psychiatrists do not see personality disorder as part of their remit and are uncomfortable treating them or simply untrained to do so. The problems were summarised by one respondent.

> 'These are the most stigmatised group among our patients, seen as particularly demanding of services and emotionally draining. Their care is often from crisis to crisis, with very little understanding except from psychological services, where I work.
>
> I would like to see clarity regarding the role of the Mental Health Act in psychiatrically managing personality disordered patients who repeatedly self-harm (i.e. as a preventive intervention). At times it appears services may make the personality disorder worse by detaining patients in a countertherapeutic manner, solely to reduce the risk of suicide.'

Older people

Older people have been seriously disadvantaged by the current organisation of mental health services. They have been unable to access crisis resolution, assertive outreach, home treatment and early intervention teams in England. The Audit Scotland report found a similar trend in Scotland, with older people having difficulties accessing care. There are only 0.6 health psychologists per 100 000 people for the over 65s in Scotland, whereas for 20- to 64-year-olds the ratio is 6.7 to 100 000 (Audit Scotland, 2009).

Liaison psychiatry services covering general hospitals and A&E departments are also lacking. At the same time the limited number of specialist services has been unable to manage the growing body of people who need care. Older people have substantially less access to psychological therapies than younger adults, although the IAPT programme in England applies equally to older people.

This overall discrimination, which is now acknowledged by governments, has had an impact on those who self-harm. The number of people over the age of 74 with depression is projected to increase by 80% by 2026 (McCrone *et al*, 2008). Therefore, there is likely to be a significant increase in the number of older people presenting with self-harm and suicidal behaviour, and in the number of those who complete suicide.

> 'It may be no coincidence that only one in six older people with depression receive treatment of any sort and while 50% of younger

people with depression are referred to specialist services it is only 6% of older people.' (Lee, 2007)

General adult psychiatrists lack the specialist skills to treat these patients, indicating that specialist old age psychiatrists' services are called for.

'Psychiatrists for adults of working age often seem out of their depth when dealing with deliberate self-harm patients who have multiple physical pathologies and take multiple medications and who already have a poor prognosis because of physical illness.'

'Self-harm in the elderly is sometimes assessed by crisis teams that mainly work with working-age adults. They lack skills in assessing older adults. Specialised crisis teams/liaison psychiatry teams are needed for the elderly.'

It was stated that there is little or no provision of self-harm care pathways for older adults. Developing pathways with adult services was in its infancy and guidance particularly related to older people was lacking and should be developed.

'Whether through lack of training, confidence, etc., the [adult] staff teams often feel deskilled with older people and tend to admit where a younger person may have access to specialist day services or crisis team.'

The Chief Executive of the National Benevolent Fund for the Elderly, Julia Robertson, pointedly characterised the importance of isolation as follows:

'Nearly 600 000 older people leave their house only once a week or even less.

In the UK, 300 000 older people often go an entire month without speaking to friends or family.

An estimated 200 000 older people in the UK do not receive the help they need to leave their house or flat.

A third of UK suicides committed by over-55-year-olds.'

The College Faculty of Old Age Psychiatry told the Working Group that: health services need to recognise that they should actively treat depression in later life; have a low threshold for referral to specialist services for older people; end the discrimination in their access to services in general; and not to underestimate the seriousness of self-harm and suicidal behaviour in later life. The Working Group strongly endorses their views.

Prisoners and forensic patients

The Corston Report explicitly raises concern about the risk of self-harm in prisons for women.

'It is clear to me that prison cannot be the right place for managing these types of behaviours [self-harm], which stem from deep-rooted long-term complex life experiences such as violent and/or sexual abuse, lack of care and/or post-traumatic stress disorder, in addition to a personality disorder. These are problems created within the community, which is where they should be addressed. The Prison Service cannot and

should not be expected to solve social problems. Low-level offending women who self-harm should be diverted out of the route to prison into appropriate NHS services.' (Corston, 2008: p. 76)

Baroness Corston also expressed concern at the gaps in training prison officers to work with people who present a high risk of self-harm.

'Equally shocking is…the expectation that prison staff will take on the management of these women, insufficiently trained and sometimes uncomprehending of the motivation that drives women to injure themselves, as part of their normal daily (and nightly) routine.' (Corstom, 2008: p. 12)

As reported in Part I, recent initiatives have brought improvements in England. A new strategy for England, *Improving Health, Supporting Justice* (Department of Health, 2009*b*), takes account of both the Corston Report and Lord Bradley's review of people with mental health problems and intellectual disabilities in the criminal justice system (Bradley, 2009).

Respondents to the College survey gave examples of where a multi-agency response to the risk of self-inflicted death in prison works well (Case study 14.5)

CASE STUDY 14.5

A consultant psychiatrist who works with the Mental Health In-Reach Team at HMP Leeds and HMP Wealstun offers rapid psychiatric assessment and treatment of inmates with severe mental health problems and offers consultation with primary care and secondary care services within the prison. This will include inmates with thoughts and acts of self-harm, which enables healthcare and the prison to manage these persons effectively as well as to be able to identify early any treatable mental illness.

Some of the people with the most severe mental illness are located in secure hospitals. A successful programme for women who have been transferred from prison to hospital was outlined to the Working Group (Case study 14.6).

CASE STUDY 14.6

St Andrews is a medium secure service for women, most of whom have personality disorder as a primary or secondary diagnosis, have highly disrupted backgrounds, a high level of previous substance misuse and almost all of whom self-harm (93%). A graded phased multidisciplinary treatment plan is devised and implemented over time. The programme is based firmly on recovery principles and aims to enable women to take control of their lives, to find alternative coping mechanisms to self-harm and to consider their future in a more positive way. The programme contains a range of therapies and some use of clozapine has proved beneficial.

However, respondents to the College Members' survey also cited the lack of equivalent standards of care for prisoners, including psychological therapies, the need for joint working of prison and NHS staff and the urgent need for training of prison staff in self-harm. These issues apply in all parts of the UK.

'Self-harm in prison has a huge association with untoward childhood experiences, particularly sexual abuse, and is associated with the general

mental health consequences of such abuse. The women would often benefit from CBT directed at the experience itself, and at depression, anxiety and PTSD. Sometimes they get it. In my view, the College have a duty in this review to reserve a special place for prisoners.'

Prisoners and those in forensic facilities are particularly vulnerable to self-harm and suicide. We welcome the work that is being taken forward to improve their situation in England.

RECOMMENDATIONS

We recommend that the following four approaches be energetically pursued in future work throughout all the countries of the UK.

- Diversion from the criminal justice system for those with mental illness.
- Equivalent care for prisoners as for those in the general population.
- Timely and speedy prison transfer for those with severe mental illness.
- Effective training for prison staff.

15. Third-sector providers

The important role of the third sector in dealing with the problems of self-harm was emphasised by individual College Members. It is already clear from the College Members' survey that psychiatrists frequently refer patients to voluntary services. A total of 81% respondents stated that they refer to their mental health services 'often' or 'sometimes' and 82% to their other services, but the nature of these referrals has not been established.

We also heard from the Samaritans that they are seeking to establish protocols with statutory services and have some service agreements with a range of statutory health providers, including GP practices, A&E departments and Social Services. They said that they are sometimes hampered by barriers to a closer relationship. Some professionals are reluctant to make referrals to them because of their uncertainty as to the medico-legal transfer of duty of care and different attitudes to risk. There is no particular General Medical Council policy that prevents referrals, but a psychiatrist must in all cases ensure that the person or organisation to whom the referral is made has the requisite skills and attributes for the patient.

Greater dialogue and collaboration could be expected to resolve some of these uncertainties, and we believe that this issue needs to be urgently explored further. The Royal College of Psychiatrists should work with the major third-sector providers to provide appropriate advice and information on the issue of collaborative working. It is clear that psychiatrists and other mental health professionals can learn from the experience and expertise of third-sector providers, who can in turn be informed by collaboration with these professionals.

RECOMMENDATION

- The Royal College of Psychiatrists, other mental health professionals and UK Departments of Health should acknowledge the crucial contribution of the third sector in dealing with self-harm and suicide, explore ways of partnership working that obviate anxieties about competence and medico-legal concerns and each should have the opportunity to learn from the experience of the other sector.

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16. Conclusions

It is likely that there is much variation across the country in the standard of care for people who harm themselves. That much practice is humane and effective is borne out by the fact that there is a reasonable level of staff and service user satisfaction in the results of this and other surveys.

Nevertheless there is enough evidence to demonstrate that we are far from achieving the level of care that service users need or the standards set out in policies and guidelines. Poor assessments, relying too much on risk issues, staff unskilled in dealing with patients who harm themselves, inappropriate discharge arrangements, lack of follow-up of patients, lack of care pathways, insufficient access to psychological treatments and poor access to services for particular groups amount to inadequate standards of care that impact on the lives of service users and their families. There is a serious problem relating to the deployment and availability of senior staff, with adequate psychotherapy and psychiatry training. It is likely that because of these services and staffing defects, the majority of self-harm remains invisible until a crisis occurs, adding to human misery and to the stress on hospital services.

Although some might consider that a time of economic austerity is an inauspicious time to propose improvements in care, we believe that it also provides opportunities to improve practice. This is a coherent set of proposals which taken together could improve service users' experience and care as well as the morale and the skills of those who work with them.

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Appendix I:
Online survey of College Members*

Section 1

What was the aim of the survey?

The survey aimed to gauge the opinions and experiences of Members of the Royal College of Psychiatrists on the issue of self-harm.

Self-harm was defined as 'self-poisoning or self-injury, irrespective of the purpose of the act. This includes acts with and without suicidal intent'. This included any person for whom self-harm was a relevant clinical concern.

What questions did it ask?

The survey was comprised of ten questions. Eight questions required at least one quantitative response, while two asked for qualitative data.

In Section 2 of this report, we present quantitative data based on responses from 1540 participants.

In Section 3, we present qualitative data based on responses from the 540 participants (35% of the total sample) who answered the question 'The College is currently undertaking a comprehensive review of policy and practice on self-harm. This will report back later in 2009. Do you have any other issues that you would like to see addressed by that review?'.

How was it conducted?

An invitation to participate in the survey was sent to 9750 College Members in the UK with a working email address. This constitutes 78% of the UK College membership ($n = 12554$).

Who responded?

1540 College Members completed the survey (16% response rate).

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*Carried out by the Policy Unit, Royal College of Psychiatrists, 29 June–23 July 2009. Sample size $n = 1540$.

Psychiatric specialty

Of the sample, 46% gave their main specialty as general adult psychiatry (Table 1). Other groups included child and adolescent psychiatry (16%), old age psychiatry (11%), and forensic psychiatry (5.2%). Just under 7% of all participants were not decided/still in training (6.9%).

It is not currently possible to compare the main psychiatric specialty reported by consultation participants with the wider profile of all UK College Members. This is because this data is not collected in a comparable format.

Regional breakdown

Approximately 85% of all participants belonged to the English Division of the College, followed by 9.2% within the Scottish Division, 4.2% in the Welsh Division, and 1.8% in the Northern Ireland Division (Table 2).

In comparison to the regional profile of the total UK College membership, there were some differences between the numbers of participants from the South-East, South-West, London, and Northern and Yorkshire Divisions.

Membership status

About 64% of participants were College Members, followed by pre-membership trainees (16.8%), and Fellows (14.7%) (Table 3). In comparison to the profile of the total UK College membership, there were some differences between the numbers of participants who were College Fellows and Members.

Which data are not presented in this report?

Additional quantitative tables are available at www.rcpsych.ac.uk/risktoself. These provide quantitative data for each survey question broken down by reported main psychiatric specialty.

Qualitative data on the type of service in which participants primarily encountered people who had self-harmed are not presented in this report, owing to issues with data quality and specificity.

What are the limitations of the survey?

The survey invited all UK College Members with a working email address to participate.

The resulting responses therefore represent a non-probability sample with a sampling bias towards members with email addresses. They are not statistically representative of the wider College membership. The results, however, do provide important insights into the views and opinions of a comparatively large number of the College membership.

Section 2: Quantitative results

In this section we present quantitative data based on responses from 1540 participants.

Table 1 Main psychiatric specialty reported by participants (*n* = 1540)

Specialty	*n* (%)
General adult	711 (46.2)
Old age	170 (11)
Psychotherapy	52 (3.4)
Academic	13 (0.8)
Liaison	52 (3.4)
Child and adolescent	246 (16.0)
Learning disability	52 (3.4)
Forensic	80 (5.2)
Addiction	33 (2.1)
Rehabilitation	25 (1.6)
Not decided /still training	106 (6.9)

It is not possible to accurately determine the main psychiatric specialty of all individuals registered as Members with the College. Members can register with one or more of the ten different Faculties within the College, but the ability to register with multiple Faculties does not make for a meaningful comparison.

Table 2 Geographic division of participants

Division	All participants, *n* (%)	Total UK College membership,[a] *n* (%)
England (total)	1302 (84.5)	10456 (83.6)
Eastern	110 (7.1)	875 (7.0)
South East	140 (9.1)	1533 (12.3)
South West	128 (8.3)	890 (7.1)
London	335 (21.8)	2886 (9.6)
Northern and Yorkshire	191 (12.4)	1202 (9.6)
Trent	114 (7.4)	901 (7.2)
West Midlands	135 (8.8)	956 (7.6)
North West	149 (9.7)	1213 (9.7)
Scottish	141 (9.2)	1199 (9.6)
Welsh	65 (4.2)	507 (4.1)
Northern Ireland	27 (1.8)	342 (2.7)

a. Total UK membership is based on the number of individuals registering at a College Division as of 31 January 2010.

Table 3 Membership status of participants

	All participants, *n* (%)	Total UK College membership,[a] *n* (%)
Fellow	226 (14.7)	2053 (16.4)
Member	562 (63.5)	7803 (62.2.)
Affiliate	56 (3.6)	515 (4.1)
Pre-membership Psychiatric Trainee	258 (16.8)	1997 (15.9)
Honorary Fellow	2 (0.1)	65 (0.5)
Specialist Associate	16 (1)	104 (0.8)
Other	11 (0.7)	17 (0.1)

a. Total UK membership is based on the number of individuals registering at a College Division as of 31 January 2010.

Which type of assessments are undertaken by psychiatrists?

Between 40 and 50% of all participants reported personally undertaking psychosocial, risk or mental state assessments with all patients who self-harmed (Table 4).

A total of 40–43% of all participants indicated undertaking risk, mental state or psychosocial assessments with specific patients.

Approximately 10% of all participants indicated undertaking such assessments with specific patient groups (10%).

Between 1 and 7% didn't undertake any form of risk or psychosocial assessment. This may be because such work was undertaken by other members of the mental health team in which they worked.

Table 4 (www.rcpsych.ac.uk/risktoself) provides data on assessments personally undertaken by psychiatrists broken down by self-reported psychiatric specialty. It indicates that participants reporting rehabilitation, addictions, and psychotherapy as their main specialty were least likely to undertake mental state or risk assessments with all patients who self-harmed.

Conversely, those still in training are more likely to undertake assessments of all types with all patients reporting self-harm (between 55 and 75%).

Which type of assessments are undertaken by teams?

A larger proportion of respondents reported that the teams in which they worked undertook risk or psychosocial assessments with all patients who had self-harmed (Table 5). This was reported by 64–71% of respondents.

Overall, 14–16% of respondents reported their teams undertook assessments with specific patients.

Table 4 Thinking about the setting where you primarily work with people who have self-harmed (%)

	(a) Do you personally undertake mental state assessments	(b) Do you personally undertake risk assessments	(c) Do you personally undertake psychosocial assessments
With ALL people who have self-harmed	48.2	48.5	39.5
With SPECIFIED GROUPS of people who have self-harmed	9.5	10.4	9.8
When necessary for SPECIFIC PATIENTS who have self-harmed	41.5	39.6	43.2
I DO NOT undertake this assessment	0.7	1.5	6.7
Don't know	0.1	0.1	0.8
Base	1531	1522	1503

In total, 13–15% of respondents indicated they undertook assessments with specific patient groups.

Only 1–3% reported that their team did not undertake any form of assessment.

This raises questions about the circumstances in which it is appropriate for psychiatrists to decide when to undertake a risk or psychosocial assessment with patients who have self-harmed.

PSYCHIATRIC SPECIALTIES

Table 5 (www.rcpsych.ac.uk/risktoself) provides data on assessments undertaken by the teams in which psychiatrists work, categorised by psychiatrists' self-reported psychiatric specialty. The table indicates that participants reporting learning disability and academic as their main specialty were least likely to undertake mental state, risk or psychosocial assessments with all patients who had self-harmed. Conversely, those reporting liaison as a specialty were more likely to undertake assessments of all types with all patients who had reported self-harm (between 78 and 82%).

PERCEIVED QUALITY OF SERVICES FOR PEOPLE WHO SELF-HARM

The consultation asked participants to rate the performance of the service settings in which they worked. This evaluation related to six aspects of service provision to people who had self-harmed (Table 6):

- item (a) – equality and parity of provision
- item (b) – safe and supportive environment
- item (c) – treatment for physical consequences

Table 5 Thinking about the setting where you primarily work with people who have self-harmed (%)

	(a) Does your team undertake mental state assessments?	(b) Does your team undertake risk assessments?	(c) Does your team undertake psychosocial assessments?
With ALL people who have self-harmed	67.2	70.6	64.3
With SPECIFIED GROUPS of people who have self-harmed	13.5	12.8	14.6
When necessary for SPECIFIC PATIENTS who have self-harmed	14.7	13.7	15.8
The team DO NOT undertake this assessment	2.8	1.1	2.3
Don't know	1.9	1.7	3.0
Base	1490	1488	1477

- item (d) – information provision
- item (e) – communication with carers
- item (f) – short-term follow-up

TOTAL SAMPLE

Across all six items, the lowest proportion of all participants reporting that the service performance was good or very good was 67% (item (d)), and the highest was 82% (items (a) and (e)).

Across all six items, the proportion of all participants reporting that service performance was poor or very poor ranged from 3.2% (item (c)) to just over 7% (items (b) and (d)).

The working relationship with carers was rated good or very good by 82% overall, although trainees were less positive (66%).

PSYCHIATRIC SPECIALTIES

Across the main psychiatric specialities, there were differences in ratings (Table 6; www.rcpsych.ac.uk/risktoself).

Greater dissatisfaction was, on balance, voiced by those in liaison, learning disability and old age services. Furthermore, trainees rated services less highly compared with consultants.

Those working in child and adolescent services had the highest level of satisfaction.

In relation to the ability to provide short-term follow-up, there was a difference between the main psychiatric specialties reported and participants working in liaison psychiatry, with reports that performance was neither good nor very good in a third of all cases (33.3%).

CARE PATHWAYS FOR SELF-HARM

In answer to the question, 'In the setting where you work, is there a policy or published "care pathway" for people who self-harm?', 40% of respondents reported that a self-harm care pathway or policy existed.

In the overall sample, 8% indicated that although there was currently no care pathway, one was being developed; 23% reported that no pathway document existed; and 29% did not know.

The term 'care pathway' is defined as planned, coordinated and multidisciplinary practice. This can span across different health and social care sectors, as well as the statutory, voluntary and private sectors.

PSYCHIATRIC SPECIALTIES

Differences occurred between main reported psychiatric specialty: 77% of respondents working in child and adolescent settings indicated that there was a pathway or that one was being developed, compared with 48% in liaison psychiatry and 27% of those in addictions.

REFERRALS

In terms of referrals made to other services, approximately 40% of all respondents answering this question indicated that they made a referral often and sometimes to a dedicated self-harm service (Table 7).

Table 6 Continuing to think about the setting where you primarily work with people who self-harm, we'd like you to rate this setting's performance in relation to self-harm (%)

	(a) People who have self-harmed are treated with the same care, respect and privacy as any patient	(b) People who have self-harmed are offered an assessment environment that is safe, supportive and minimises any distress	(c) People who have self-harmed are offered treatment for the physical consequences of self-harm	(d) Staff provide full information about the treatment options to patients	(e) With appropriate patient consent, staff effectively communicate and work with carers	(f) It is possible to offer short-term follow-up for people who have presented with self-harm where this is indicated
Very poor performance	0.2	0.5	1.0	0.7	0.2	1.5
Poor performance	6.3	6.9	2.2	6.6	6.3	4.7
Neither poor nor good	10.5	17.4	13.4	19.2	10.5	10.2
Good performance	43.7	45.0	43.9	44.7	43.7	40.4
Very good performance	38.4	29.3	35.2	22.3	38.4	40.2
Base	1530	1528	1513	1523	1523	1517

Table 7 How frequently do you (or your team) refer people who have self-harmed to the following services? (%)

	Housing	Employment	Education	Dedicated self-harm services	Voluntary sector: mental health service	Voluntary sector: other
Often	14.7	7.8	12.8	14.4	20.6	25.9
Sometimes	64.0	51.1	50.7	26.0	60.5	56.5
Never	12.9	26.2	22.1	12.5	9.7	10.5
No service exists	1.9	5.0	4.9	30.8	3.7	1.6
Don't know	6.5	9.8	9.4	16.3	5.5	5.5
Base	1497	1486	1472	1482	1491	1493

Table 7 How frequently do you (or your team) refer people who have self-harmed to the following services? (%)

	Primary care	Acute hospital: general ward	Acute hospital: A&E	Specialist mental health services	Private or independent sector	Other
Often	37.9	12.2	23.4	28.1	2.1	7.4
Sometimes	50.7	66.4	68.4	59.8	30.5	11.3
Never	8.3	17.3	5.6	7.4	52.3	22.6
No service exists	0.9	0.5	0.4	1.5	3.5	3.9
Don't know	2.2	3.6	2.3	3.2	11.5	54.8
Base	1479	1488	1482	1483	1474	557

Continued

Thirty per cent of respondents, however, indicated that no dedicated self-harm service' existed that they could refer to. In relation to housing, 79% of respondents often or sometimes made referrals to such services. This was particularly the case among those working in addictions (100%). Across the sample, there were lower rates of referral to work or to education.

Breakdowns by main reported psychiatric specialty are contained in Table 7 (www.rcpsych.ac.uk/risktoself).

NICE GUIDELINES

Seventy-four per cent of respondents reported having read the NICE guidelines on self-harm; 24% had not read the Guidelines and 1.9% did not know.

The proportion of respondents reading the NICE guidelines on self-harm were lowest in those working in addictions (50%), and highest in those in child and adolescent settings (86.6%) (Table 7; www.rcpsych.ac.uk/risktoself).

TRAINING

Forty-six per cent of the total sample replied that they had received specific training in relation to repeated self-harm.

Thirty-six per cent of those reporting old age as their main psychiatric specialty, 42% of those from addictions and 43% of those in general and adult settings reported that they had had this training. The highest percentage of those who have been trained were in liaison settings (62.7%)

ATTITUDINAL QUESTIONS

TRAINING: PSYCHOSOCIAL ASSESSMENTS

Table 8 required participants to state their level of agreement with a range of statements. Less than 50% of respondents, for example, agreed or strongly agreed that they (or their team) had the training to undertake psychosocial assessments of risk and need of people who had self-harmed (item (a)). Overall, 25% of those in learning disability, 44% in rehabilitation, 47% in old age, and 48% in general adult reported agreeing or strongly agreeing with the statement (Table 8(a); www.rcpsych.ac.uk/risktoself).

TRAINING: UNDERLYING CAUSES OF SELF-HARM

In Table 8(b), the large majority of psychiatrists reported agreeing or strongly agreeing that they had been provided with the training to explore with the patient the underlying causes of their self-harm (82.4%). This was most evident in those working in academic settings (73%) or where their psychiatric specialty was psychotherapy (92.1%). Only learning disability reported a lower proportion (67.3%) (Table 8(b)).

ROLE OF PSYCHIATRISTS

Table 8(c) indicates that the majority of respondents agreed or strongly agreed that psychiatrists have a key role to play in the prevention of self-harm (71%). More interesting perhaps is the number who disagree with this view, including 11.3% of adult psychiatrists (67% thought otherwise) compared with forensic and addiction psychiatrists, of whom 6% disagreed but 85% agreed. This may reflect the different patient groups typically seen by these consultants (www.rcpsych.ac.uk/risktoself).

EXPRESSION OF MENTAL ILLNESS

In Table 8(d), 25% of respondents agreed or strongly agreed, 27% disagreed or strongly disagreed, and 48% neither agreed nor disagreed with a statement on whether self-harm was an expression of an underlying mental illness.

DISCHARGE

In Table 8(e), over a third of all participants agreed or strongly agreed that discharge decisions about patients were being made by junior staff with little training or experience. Sixty percent of those reporting that rehabilitation was their main psychiatric specialty agreed or strongly agreed

Table 8 Listed below are a number of statements. Please indicate the strength with which you agree/disagree with each statement by ticking the appropriate box (%)

	(a) All health professionals in my team, including junior psychiatrists, social workers and psychiatric nurses, are properly trained in undertaking psychosocial assessments of risk and need for people who have self-harmed	(b) I have been provided with the training and knowledge to explore with the patient the underlying causes of their self-harm	(c) Psychiatrists have a key role to play in the prevention of self-harm	(d) Self-harm is an expression of an underlying mental illness
Strongly disagree	3.9	1.8	1.5	3.9
Disagree	25.8	7.3	7.8	23.2
Neither disagree/agree	21.2	8.5	19.9	47.9
Agree	38.6	48.8	48.8	21.1
Strongly agree	10.4	33.6	22.0	3.9
Base	1523	1530	1520	1523

Table 8 Listed below are a number of statements. Please indicate the strength with which you agree/disagree with each statement by ticking the appropriate box (%)

	(e) In terms of discharge of people who have self-harmed, decisions are often made by junior staff with little training or experience	(f) In my organisation, psychological therapies are available for people who self-harm when this is appropriate	(g) Services for management of repeated self-harm are lacking outside of the immediate crisis	(h) Harm minimisation strategies for self-harm (excluding attempted suicide) are a useful tool
Strongly disagree	9.1	5.9	4.3	1.4
Disagree	25.6	19.8	21.8	3.6
Neither disagree/agree	20.6	15.6	19.2	23.5
Agree	29.1	46.2	39.3	60.2
Strongly agree	5.7	12.6	15.4	11.3
Base	1522	1521	1521	1527

Continued

with this statement, as did approximately forty-three per cent of those from forensic, psychotherapy, liaison, and addictions settings (www.rcpsych.ac.uk/risktoself).

Psychological therapies

In Table 8(f), the availability of psychological therapies gave a revealing picture. In liaison, general adult, addictions, and learning disabilities 50–55% of respondents agreed or strongly agreed with the statement that such therapies were widely available in their organisation for people who self-harmed. This compares with 73–78% of those respondents practising in child and adolescent, psychotherapy and forensic settings (www.rcpsych.ac.uk/risktoself).

Service provision

In Table 8(g) (whether services were available outside the immediate crisis), more than half of all respondents (55%) agreed or strongly agreed that they were.

Harm minimisation

Finally, over 70% of all respondents indicated that harm minimisation was a useful strategy. Respondents in all main psychiatric settings except academic settings had over 60% of participants agreeing or strongly agreeing with this statement (Table 8(h); www.rcpsych.ac.uk/risktoself).

Section 3: Qualitative results

In this section, we present data based on responses from the 540 participants (35% of the total sample of 1540 respondents) who answered the qualitative question:

> 'The College is currently undertaking a comprehensive review of policy and practice on self-harm. This will report back later in 2009. Do you have any other issues would you like to see addressed by that review? These can be general issues, or issues relating to your main psychiatric specialty.'

Overview

In this report, we consider the ten most commonly cited themes by respondents (Table 9).

For each of these themes we develop a typology to quantitatively depict the range of opinion among participants. We also present extracts of qualitative data to illustrate respondents' opinions and views. However, we open this report with a brief review of participants' understandings and conceptions of the term 'self-harm'. This provides an insight into what the term 'self-harm' means to those working in the field.

Table 9 Commonly cited themes

	Citations, *n*	Total sample, %
1. Roles and responsibilities	161	30
2. Training and education	128	24
3. Risk assessment tools	64	12
4. Age groups: children, adolescents and youth	62	11
5. Diagnostic groups: personality disorder	59	11
6. Services: A&E	58	11
7. Evidence and guidelines	58	11
8. Psychological therapies	54	10
9. Repeated self-harm	50	9
10. Services: liaison/general hospital	45	8

RESULTS

PARTICIPANTS' DEFINITIONS AND CONCEPTS OF SELF-HARM (CITATIONS: 98; CITED BY 18% OF SAMPLE)

Participants' understandings and conceptions of the term 'self-harm' could be broken down into four categories: underlying factors; mental disorder; spectrum of conceptions; and negative conceptions.

UNDERLYING FACTORS

The majority of participants (in this category) raised concerns about the potential medicalisation of self-harm, and the danger of overlooking underlying social problems:

> 'The problem is that self-harm is (very often) a "medical" end-point to a social problem. Excluding those for whom major mental illness is the cause of the self-harm, trying to find a medical solution to a predominantly social problem will always be difficult.' (ID 1494)

Participants in this category felt self-harm was not exclusively a health problem. Although requiring psychiatrists' professional input, it was seen as requiring far greater involvement with agencies in the social care sector:

> 'Self-harm should not be seen a being an exclusive mental health problem, but part of a wider societal problem. Most patients who self-harm do not have a serious mental illness, but often have poor coping skills and poor social support.' (ID 1409)

MENTAL DISORDER

A smaller number of participants, however, went further. Contending that self-harm wasn't a mental disorder, these participants observed it was beyond the remit of psychiatric and mental health services:

> 'Psychiatric services are NOT responsible for addressing or preventing self-harm in general but for identifying and treating...any MENTAL DISORDER which is associated with self-harm. This may seem a pedantic distinction but I believe that it is an honest and important one. Self-harm is not a psychiatric disorder in its own right.' (ID 1070)

SPECTRUM OF CONCEPTIONS

Other participants noted that conceptions and understandings of self-harm used in everyday practice were broad, often resulting in difficulties or inappropriate action. These participants called for a greater specificity in the definition and use of the term.

> 'The definition of self-harm was difficult. We get many referrals of supposed self-harm that we do not consider as such, e.g. children who poke themselves with pencils. By your definition, children and young people who take risks could be included – alcohol, staying out overnight…overeating, food avoidance, unprotected sex, etc.' (ID 1135)

> 'Your definition of self-harm is rather too broad to be…useful in elderly psychiatry, when there are so many ways people with dementia can cause themselves harm.' (ID 1165)

NEGATIVE CONCEPTIONS

Some participants observed that self-harm was either perceived negatively by health and social care professionals, or treated as synonymous with personality disorder.

> 'The main reason for "dislike" of self-harm patients is the impression that they are a drain on scarce mental health resources and the realisation [by the] professional that little is being achieved in terms of improvement of their clinical condition.' (ID 1102)

> 'Self-harm is considered synonymous with 'personality disorder', often with the term used in a derogatory and judgemental meaning.' (ID 1390)

ROLES AND RESPONSIBILITIES (CITATIONS: 161; CITED BY 30% OF SAMPLE)

The roles and responsibilities of different professionals involved in working with people who had self-harmed raised numerous concerns among participants.

SELF-HARM: DO PSYCHIATRISTS HAVE A ROLE?

> 'Yes – there is a central role.'

Participants in this category believed that psychiatrists had an important role to play in relation to self-harm. As one participant noted, this was a core part of their job:

> '…every patient I see gets a mental state exam, risk assessment, and appropriate psychiatric history. I do not agree with the actuarial 'paper-pushing' way that risk assessments seem to be taken out by CMHTs – in my experience they give little clinical information of relevance.' (ID 1200)

Others observed that the assessment of self-harm was part of their role owing to the absence of skills among other professionals in the multidisciplinary team:

> 'As a psychiatrist I am often asked to do mental state examinations on young people who display minor self-harm and am told "they are suicidal" when they are clearly not but no one seems able other than doctors to assess risk and consider safety.' (ID 1372)

A small minority of psychiatrists, however, felt they should not have a central role in dealing with self-harm. Some believed that self-harm was not a mental disorder and therefore outside of the psychiatric remit (p. 118, ID 1070). Others pointed to psychiatric work being driven by risk rather than clinical factors.

A small number of participants went even further, observing that the intervention of psychiatrists in self-harm cases could make the situation worse, rather than better.

'Self-harm is a symptom not a disorder itself. Where self-harm exists as part of a mental illness, then the illness should be treated. Where there is no mental illness then this is not any business of psychiatry or psychiatrists. We do harm by medicalising the stress of everyday life and holding out a utopian view of happiness for all.' (ID 821)

However, other participants took a more balanced approach, concluding that work on self-harm was a role better led by other professional groups.

'Psychiatrists should certainly not be seen as the only people who can assess and help people [who self-harm]. I have found that focusing training on well-motivated teams of people with strong links to the voluntary sector, crisis teams, and an ability to communicate quickly and effectively with primary care, available to say A&E departments and related general hospital units is an effective way to raise standards.' (ID 1180)

Risk assessment within the multidisciplinary team

Participants raised concerns about who undertook, and was responsible for, risk assessments.

One group of participants identified assessment as a task for all properly trained members of the multidisciplinary team.

'[Assessment] does not necessarily have to be done by a psychiatrist, but every psychiatrist should know how to carry out such assessments.' (ID 1302)

This group included participants who pointed out that without multidisciplinary team involvement, assessment solely undertaken by psychiatrists would not be possible, and possibly even detrimental to patient care.

'There is pressure to provide urgent risk assessments for child and adolescent patients 24 hours a day, 7 days a week in my NHS trust. However, the most trained staff are psychiatrists, and there are not enough of them to provide this kind of coverage without seriously compromising other work that is more ongoing. This puts focus on crisis rather than preventative work.' (ID 589)

It was, however, noted that if every member of the multidisciplinary team was potentially capable of undertaking assessments, clear guidance was needed on who undertook assessments and in what situations:

'…[we need] guidance on who can carry out assessments of risk/self-harm in the immediate 'aftermath' or if this needs to be done by a psychiatrist (my impression is that it does not in all cases, especially in CAMHS…but this may be warranted).' (ID 1132)

However, there were concerns among a second strand of participants about the potential consequences of the multidisciplinary team undertaking assessments:

'The self-harm team members (who are all non-medical staff) do…short assessments, limit their questions to the self-harm pro formas while assessing the self-harm cases and often overlook some common psychiatric problems.' (ID 1236)

'Although patients who self-harm are well treated by A&E for their physical problems (cuts, overdose, etc), there is almost never ANY attempt to assess the mental state by A&E staff. The most that is written is "self-harm, refer Psychs" or "Depressed, Psychs to see." ALL doctors should be able to do a basic assessment and mental state examination.' (ID 1085)

Critically, this perspective was not a crude broad-brushed critique of colleagues. Instead, it was nuanced in terms of the context in which the service was being delivered:

'There is increasing reliance on nursing staff to undertake risk assessments for all patients (including those who self-harm). The needs of the service often require that staff attend primarily to the "crisis presentation". This means that the emphasis is on the here and now and not on how the person got to where they are and what might be the consequences for them in the future. This means that any intervention is necessarily short term and frequently opportunities to provide long-term solutions are missed. This is partly related to nursing training, but also to the high turnover expectation of acute mental health services (particularly 4-hour waiting time targets in A&E settings).' (ID 1237)

TRAINEE PSYCHIATRISTS AND SELF-HARM

Many participants felt that a substantial burden was being placed upon trainees to assess and deal with the majority of self-harm presentations, and also make decisions about whether to discharge the patient:

'I would estimate that 90% of the patients I saw out of hours were self-harm.' (ID 735)

This included concern that junior staff were not always adequately supervised.

'In my view many members of the multidisciplinary team are unaware of their limitations in risk assessment and all too often such assessments are carried out by my junior staff without ratification by more experienced colleagues.' (ID 1034)

Critically, such a burden on junior psychiatrists (including a lack of appropriate supervision) also carried an accompanying risk for the patient:

'I always have concerns that those individuals seen in A&E and sent home are often assessed by the most junior staff. Often there are protocols that all admissions must be discussed with senior staff, but perhaps those at highest risk are those being sent home without having been discussed with senior staff.' (ID 1233)

There was also a concern that trainees were not being routinely exposed to self-harm cases, and were therefore not obtaining skills to deal with this:

'I doubt that psychiatrists in training are receiving adequate properly supervised clinical experience in assessing or treating such cases as nurses now do much of this work, and their opportunities are reduced by shorter working hours and other NHS cultural change (like 4-hour A&E target).' (ID 1396)

Some participants consequently called for interventions to overcome this, including attention to training rotas to ensure junior doctors received adequate exposure (and supervision) to cases of self-harm.

RISK MANAGEMENT AND THE MULTIDISCIPLINARY TEAM

The issue of assessments conducted by members of the multidisciplinary team has been touched on above. However, many participants held the view that there needs to be close collaboration across different professional groups, particularly in relation to the management of self-harm after a risk assessment had been conducted.

> 'The recognition of self-harm for the illness behaviour that it is and that policy and practice must include close collaborative working with the A&E and surgical departments. In an ideal world, psychiatric nurses work in the A&Es and have access to rapid therapeutic interventions with separate teams within 48 hours of contact with A&E.' (ID 1076)

Again, there were concerns about how much had been done to raise the skills and confidence of professionals outside of psychiatry to undertake such assessments:

> '…who all too often become complacent about actions of self-harm in individuals who regularly repeat such acts. In my view many members of the multidisciplinary team are unaware of their limitations in risk assessment.' (ID 1034)

Views also existed about whether those undertaking an assessment of harm or risk were able to provide care to that patient.

> 'There is an issue in the local service that those who assess self-harm and risk are not necessarily in a position to implement their management plan as there are other teams that determine admission to hospital or choice of intervention. This limits the individual clinician in their ability to manage self-harm.' (ID 1203)

Other participants highlighted the importance of two key professional groups: paediatricians and social workers. These were seen as key to delivering effective care.

> 'The consultation should talk to paediatricians as well as child psychiatrists, as they are the ones responsible for admitting to paediatric wards. Also maybe general physicians responsible for admitting 16- to 18-year-olds. This is often the point of conflict in some hospitals. Also the consultation might want to look into the falling use of hospital social workers. When I was an senior house officer in child psychiatry we did all our ward deliberated self-harm assessments jointly with the hospital social worker. Now we have to beg/pray to get the young people assessed by Social Services before discharge & it only happens in extreme child protection cases.' (ID 1247)

AVOIDING OWNERSHIP OF SELF-HARM

Participants reported that some agencies often appeared to avoid taking responsibility for the care of patients who self-harmed:

> 'Other agencies which include social care and even child psychology seem to worry so much about children self-harming and see it wrongly as a risk of suicide and try and pass the patient as soon as possible

to CAHMS as a way of passing the buck as well as reducing their own anxieties about the patient.' (ID 1422)

Others reflected on similar experiences of agencies trying to avoid ownership:

'Acknowledgement and exploration of the dynamics between mental health services and other services who have contact with people who self-harm, in particular the A&E department. Frequent and ongoing disagreements over who "owns" these patients can lead to a poor service for this complex group.' (ID 1389)

'As a junior, I have found that nursing staff are obstructive to these patients being admitted, particularly those who repeatedly self-harm under the influence of alcohol. It is written in care plans not to admit without discussing with the CMHT/intensive home treatment team. However, these patients tend to present out of hours when there is just a junior on-call with another consultant who doesn't know the patient. Often the nursing staff say "this is all alcohol" or "there isn't a mental illness". As a junior, I feel quite unsupported. The phrase "Yeah well he/she never does it [suicide], does she?" is the nursing staff's justification for being obstructive to admission. The culture in mental health nursing must change, as should pejorative remarks or hints at "personality disorder" because we can't "cure" a patient.' (ID 1110)

Resources

Throughout the consultation, participants repeatedly stated a common problem with a lack of resources for providing services to people who have self-harmed.

'We currently lack the resources to offer follow-up to all who self-harm, this especially is important for the repeaters. Repeated presentations to A&E could also be addressed with sufficient multidisciplinary staffing.' (ID 711)

It also spanned commentary on a lack of specific programmes or professional types:

'I have been trying for several years to point out to the local primary care trusts that there is a strong evidence base for offering problem-solving CBT as secondary prevention of self-harm. Yet there is no implementation of this fairly well-proven treatment locally. This very morning we were making the case to someone from the primary care trust to employ a nurse therapist whose role would be to mobilise primary care counsellors and IAPT to deliver problem-solving CBT for people who have self-harmed once or twice already. No money available for service developments apparently.' (ID 1119)

Voluntary sector

A small number of participants commented on the activities of the voluntary sector, with an underlying concern about the services provided to people who self-harm.

'Locally, third-sector services often offer services to people who repeatedly self-harm, with and without a specific personality disorder, either because they are offered no service in secondary care, or because it is inadequate. The local third-sector services are not

specifically commissioned or trained to offer these services effectively.'
(ID 1122)

Training and education (citations: 128; cited by 24% of sample)

Training and education issues were cited in relation to four key areas.

Risk assessment training

Providing high-quality training in risk assessment was the most frequently cited issue in this category, with most participants calling for further investment in training to assess suicide risk and the assessment and management of self-harm, especially repeat self-harm.

I think training in assessing suicide risk is poor…given that suicide is a major cause of death among out-patients as compared to say the annual training in CPR.' (ID 485)

'Psychiatrists should have compulsory training in learning how to deal with (including the language to use, setting, things that can be helpful to minimise distress in patient, etc) a patient who has self-harmed and people who chronically self-harm.' (ID 666)

Thinking about psychiatrists as a group, participants highlighted the importance of providing training to junior doctors.

Junior doctors in training need more exposure to assessments of patients who self-harm along with the crisis teams. Some trusts are excluding these in order to make rotas European Working Time Directive and New Deal compliant. This also helps to reduce bandings of junior doctors as most of these assessments are done out of hours in A&E settings. This I feel is depriving junior doctors of an important aspect of their training and needs to be addressed on an urgent basis.' (ID 964)

However, this was not just an issue for junior doctors, but also for non-training grade psychiatrists.

'I think it is important that whatever training there is on assessment and management of self-harm it should be rolled out to both trainees and non-training grade psychiatrists – they all see patients in this category.' (ID 599)

There were, however, some who did not believe that training was the central issue.

'My training and that of other staff groups equips me to deal with self-harm and risk assessment. Why are we so obsessed with the post-modern idea of having to have a certificate or specific training module for every aspect of our work. It devalues the wealth of experience that most staff have already and makes people feel unskilled in providing the services already on offer.' (ID 836)

Training for other groups

Other participants drew attention to the need of other members of the multidisciplinary team receiving training.

'The review should address the training and competency of non-psychiatrists who perform assessments – as John Tooke pointed out, nurses in roles such as this frequently do not have any evidence of their competency in this work.' (ID 564)

'Given the high prevalence of self-harm in adolescents I would like to see more training of staff and services available to adolescents in school settings.' (ID 478)

'A&E staff appear to have very little training in dealing with people who self-harm (and 'psychiatric' presentations in general). They can come across as angry/shouting and patronising to the patient, despite having good intentions. It appears to be particularly difficult at times when A&E is busiest.' (ID 879)

Repeated self-harm

Specific observations were made about the need for training in relation to repeated self-harm.

'There needs to be comprehensive and "systemic" training of adult in-patient ward staff in the management of repeated self-harmers … complemented by more availability of psychology/ psychotherapy support or, arguably, more consultant "time" available on the wards to oversee/supervise staff in the management of these more challenging cases.' (ID 1225)

Psychological therapies

Training in the provision of psychological therapies was noted by several participants.

'Making sure that staff using psychological therapies in this area are properly trained and not just deployed having had "taster" experiences in various therapies, as I think this could be very harmful to patients particularly in the long term.' (ID 1027)

'Evidence-based treatments like dialectical behaviour therapy should be available to all. Training for such specialist therapy should be available to professionals who are interested and all professionals should be trained in principles of evidence-based treatments for self-harm. Self-harm is considered to be challenging to manage owing to limited understanding and thus avoidance by professionals, thus becoming an exclusion for such individuals who need the most help.' (ID 1141)

Risk assessment tools (citations: 64; cited by 12% of sample)

Respondents cited 'risk assessment' as a key issue the College should address. This covered the following issues: tools, limitations and resources.

Tools

A number of psychiatrists were interested in the development of a standardised risk assessment tool, but were cautious of 'tick box' instruments. These were often seen as administrative or defensive tools employed by their organisation.

'Use of different risk assessment forms that are not validated and yet exist for mandatory completion, irrespective of the setting or the situation.' (ID 1049)

'I have a concern over the administration of self-harm and the uninformed use of "rating scales". Increasingly the filing of forms by organisations is more important than thought in the management of self-harm.' (ID 1359)

However, some participants – often owing to organisational pressures on time and resources, or simply the task of having to employ the range of locally developed tools available – welcomed the development of such tools.

'If the junior doctor is provided with an easy-to-follow proforma for assessment, e.g. with tick boxes and circles, for the common questions, it will save valuable time for doctors and the patients. At present we cover multiple sites at night, including two A&Es, and are often pressurised by the A&E staff.' (ID 1217)

A small number of participants suggested providing greater support to those who had to undertake assessments in the context of untoward and serious events.

'I think we also need to look at issues of reducing paper work and create a system that is more proactively aiming to genuinely deal with self-harm patients rather than getting drowned in paper work and making it a back covering exercise to staff. There should be some new policy that could provide assessors with some kind of protection in the eventuality of an incident, so it could give them the independence to take decisions in the best interests of the patients rather than them opting for the safer route of admitting the patients who self-harm (as is often seen).' (ID 1434)

LIMITATIONS

The limitations of the current organisation and undertaking of risk assessment were highlighted by participants. These included concerns about the utility of risk assessment tools, and the diminishment of professional skill and judgement.

'I think that the current emphasis of many services on risk assessment is dangerous: an appreciation of the risks associated with an individual can only be achieved by a more comprehensive psychosocial and needs assessment. Unfortunately, many mental health services will only offer a service to someone who is deemed to pose a "risk". Such a policy is discriminatory against people with mental health problems, and would not be tolerated in a physical healthcare setting.' (ID 1035)

Some participants identified the limitations placed on them by the wider system in which they were working, including reduced access to in-patient beds.

RESOURCES

The majority of participants' comments in this subcategory related to the availability of resources to either allow staff to undertake detailed risk assessments, or for the implementation and follow-through of management plans.

AGE GROUPS – CHILDREN, ADOLESCENTS AND YOUTH (CITATIONS 62, 11% OF ALL CITATIONS)

Participants' comments covered admission, paediatrics, access and assessment.

ADMISSION

A number of participants identified issues relating to the admission of children and young people.

'I think it is crucial that young people under 16 are admitted to the paediatric ward after self-harm. It gives a very powerful window of opportunity to assess the situation in the cold light of day and away from home circumstances.' (ID 1099)

However, some participants pointed to the challenge of young people admitted onto adult wards, and looked for the College to provide a clear view.

'According to our protocol, young people who are admitted onto paediatric wards following self-harm have an overnight stay prior to being assessed by CAMHS staff. Things are less clear for young people admitted onto adult medical wards because the physicians want a faster turnover and also adult psychiatrists have a different system and those who self-harm can be seen almost immediately and discharged. This leads to a bit of confusion and sometimes tension between ourselves and physicians.' (ID 1293)

Some participants, however, did not agree with this.

'I go along with the caveat that everyone has to be admitted to allow assessment, but I'm not sure I agree with it. Most people can make rational choices, but this is an area where we don't allow them choice. I personally dislike the risk assessment culture that has been imported from adult services. I think this has contributed to a risk-averse culture. This has resulted in agencies trying to avoid responsibility, which reduces the possibility of containing crises.' (ID 955)

Others, meanwhile, pointed to resource limitations.

Finally, a number of participants wondered whether admission to in-patient wards for young people might also be translated to adults experiencing self-harm.

'Admission to in-patient paediatric and general wards is very helpful to carry out a psychosocial assessment as well as a risk assessment and helps to liaise with the professionals that are most helpful. It reduces the pressure on junior staff to make decisions in the night. Currently it is only offered to young people under 16. I am, however, wondering whether this system would be beneficial to people over 16 too.' (ID 1224)

Paediatrics

The role of paediatric services and professionals was highlighted by eight participants.

'Paediatric staff and A&E staff need SOME mental health training, ability to work with families, training on consent issues, Children Act, Mental Health Act, etc., and to see deliberate self-harm in children as relevant to their role…A great deal is written about the unsuitability of adult mental health wards for children, but paediatric wards can also be unsuitable for mentally ill/behaviourally disturbed children if their stay is prolonged and paediatric staff do not see their presence on the ward as appropriate, or treat them with less respect than their other patients. Difficulties arise when it is unsafe to discharge a teenager to home and social services are unable to accommodate them/offer support.' (ID 1523)

Access

Access to services for children and young people was a commonly raised issue, including specific reference to psychological therapies.

'There are limited resources for 17- to 18-year-olds. We as a CAMHS are underresourced to cover these areas. In CAMHS we do not have an outreach crisis service, which makes follow-up of non-attenders very hard. CAMHS are underresourced to cover recurrent harmers.' (ID 502)

Assessment

The majority of comments made by participants are adequately covered in Section 1 of this report. However, a number of additional observations were made by participants, including:

'...16- to 18-year-olds service is a major issue, for example A&E assessment by the appropriately qualified professionals, e.g. CAMHS staff not available. Mental Health Act assessment for under-16s is not easily available owing to lack of an approved mental health professional. We have a plan and vision for a high-quality service but no extra resources available to deliver it.' (ID 1380)

Diagnostic groups – personality disorder (citations 59, 11% of all citations)

People living with personality disorder were a concern for participants, with participant comments covering services and stigma and exclusion.

Services

Service provision for personality disorder was a key issue.

'I think services are poor generally in thinking about and assessing for personality disorder in repeated self-harm, and thereafter, if say borderline personality disorder was identified, we have limited resources locally for directing those people to get appropriate help.' (ID 1122)

Services were also identified as lacking a long-term perspective to care.

'The necessary coordinated long-term care needed for people with personality disorders is lacking or inadequate in all services in which I have worked. Those with severe personality disorders may get psychotherapy for periods of time but are unlikely to get long-term care-coordination and team support. This often results in their care being managed by a succession of junior doctors, resulting in over-medication.' (ID 1279)

Stigma and exclusion

Discriminatory attitudes, or active discrimination, against people living with personality disorder was highlighted by many participants.

'There is a lack of understanding and training about self-harm; patients are often labelled as "Just a personality disorder", seen as manipulative and not suffering from mental illness. These are the most stigmatised group among our patients, seen as particularly demanding of services and emotionally draining. Their care is often from crisis to crisis, with very little understanding except from psychological services where I work.' (ID 1280)

Such attitudes were perceived by participants to be reflected in services attitudes to taking on people with personality disorder who self-harmed.

'Some psychiatrists do not see personality disorder as part of their remit, resulting in some people not being allocated care coordinators because 'there's no work for them to do.' (ID 794)

'This group of patients take an awful lot of resources from all general adult services and…a significant amount of clinical time…[from] other patients for [whom] we feel more comfortable treating, or rather, have more chances to help in the short-medium term.' (ID 1308)

SERVICES – A&E (CITATIONS 58, 11% OF ALL CITATIONS)

From the range of different service providers who featured in participants' responses, A&E were the most commonly referred to.

STAFF TRAINING

The majority of comments made by participants are adequately covered in Section 2 of this report. However, a number of additional observations were made.

'Training of A&E nurses in self-harm assessment is important – in the same way that psychiatry uses senior nurses to specialise in self-harm assessment, the A&E nurses could train up senior staff to help with liaison in A&E. More crisis services need to be set up that are not immediately linked to doctors and nurses in psychiatry – this will get away from repeatedly pathologising and biologicalising this patient group.' (ID 1128)

'Improved support/ education within A&E services – staff can be anxious, become dispirited, leading to poor and inadequate assessment and management. Support and supervision for junior staff. Attitudes within A&E have improved greatly in past 10 years. Has contributed very much to problems related to stigma.' (ID 1395)

ASSESSMENT

Again, comments made by participants are covered in Section 1 of this report. However, a number of additional observations provide interesting detail.

'It is variable, but often there is minimal information gathered by A&E/ ward staff with regard to risk and psychosocial assessment. Often insufficient for them to make an informed decision about whether the patient has the capacity to decide to leave the department before assessment by a mental health practitioner has taken place. In this particular hospital mental capacity in totality in reduced to a tick box of whether or not they are "competent". If faced with a patient who wants to leave, the nurses often look in the notes and if competent is ticked the patient is permitted to go home, even though no such assessment of their capacity to make that particular decision at that time is assessed. People with overt psychosis have been permitted to leave, without psych assessment.' (ID 1479)

'The old and vexed issue of how to respond when called to A&E to a non-psychotic patient who has taken an overdose and is now refusing help; my own view is that this should be seen as a symptom of mental disorder until proven otherwise through in-depth assessment, but with the increasing profile of capacity issues every year, how hard will it be to persuade A&E colleagues to treat in the patient's best interests rather than let them die?' (ID 737)

Links with other services

The relationship between A&E and other services was pointed to.

> 'The recognition of self-harm for the illness behaviour that it is and that policy and practice must include close collaborative working with the A&E and surgical departments. In an ideal world, psychiatric nurses work in the A&E and have access to rapid therapeutic interventions with separate teams within 48 hours of contact with A&E. So what I would like to ask is: 1. To what extent are psych services responding to immediate assessment in A&E and what skills do these assessors have? 2. What is the patient pathway following assessment in A&E? 3. What lessons can be learnt from the best outcome services? 4. What is the service user/patient perspective and how is that gathered for this review?' (ID 1076)

> 'Even where good liaison psychiatry services exist, there still appears to be a barrier integrating with accident and emergency. Having separate general and mental health trusts exacerbates the problem. I would like to see the mental health staff actually based (not visiting from separate building or office) alongside A&E staff. At present there remains a culture of 'mental health' problem, we'll do our bit, stitch them up/parvolex, then refer mental health, nothing more to do with us. Mental health staff come as outsiders, often completing two sets of records.' (ID 1487)

Discharge and follow-up

Discharge was identified as a particularly challenging period by many participants.

> 'The group of DSH individuals who can get missed is that of the self-discharges from the emergency department – in our centre we have developed a weekly review of such missed cases, and action is then taken to follow them up or alert their GP or other involved in their care.' (ID 1178)

> 'I have lost count of the times I have reviewed a dead person's notes to see that after a suicide attempt they have been reviewed by someone in A&E and 'given a leaflet' or a 'telephone number'. (A recent report into the Northwest crisis team numbers found that a third of patient calls were met with no answer or an answerphone). The College MUST highlight these problems more…or else it will be seen as a complacent accessory to these tragedies.' (ID 1177)

Other participants identified the lack of follow-up to people who had self-harmed as an area that needed to be addressed.

> 'We used to be able to offer 1:1 follow-up to all self-harmers who came to A&E often with the senior nurse who assessed them. This was a good and well-used service and enabled more assessment time to see whether further referral was necessary and also allowed brief focused psychological work. The 4-hour targets in A&E and the need to provide 24-hour A&E nursing cover has now made this impossible and we offer an inferior service with letter to GP to arrange follow-up, knowing that this rarely happens. I feel having self-harm workers (specifically trained) who can ensure links with primary care and also take on a case-load to do short-term work would be very beneficial. Personally I think such workers in a general hospital setting would be ideal to bridge the gap between primary and secondary care. In my experience many GP councillors do not feel they have the skills to take on – self-harmers. I feel saddened at how little we can offer these patients unless they are

actively suicidal. The local CMHTs are not keen to have self-harmers referred unless they are seen to have major underlying mental illness or are very high risk. Local studies have shown GPs receiving a letter to say somebody needs follow up arrange it in about 10% of cases! So most of the people we see end up with nothing!' (ID 1429)

EVIDENCE AND GUIDELINES (CITATIONS 58, 11% OF ALL CITATIONS)

The existence of supporting evidence for policy and practice recommendations was a key concern for many participants. Some, interestingly, also called for clarification of statements made in evidence-based guidelines, such as those produced by NICE.

SUPPORTING EVIDENCE

There was often strong concern about programmes or practice interventions being recommended in the absence of supporting evidence.

'I think the College should do something about stopping people from making recommendations about practice in the absence of proper scientific evidence that the recommendations are effective, or worse, when the evidence shows they are ineffective. I try to treat my patients with kindness and humanity, and to make them feel they matter – and that takes a lot of time – and I'm a bit fed up being told to follow policies that are ill thought out or introduced for political reasons, sometimes by people who either lack training in scientific method, or who should know better.' (ID 1503)

Other participants pointed to specific aspects of NICE and other guidelines lacking supporting evidence. For example, as two participants noted:

'NICE guidelines for the management of self-harm in children and young people recommend an intervention for repeated self-harm for which there is no evidence base (developmental group therapy). This needs to be urgently revised.' (ID 472)

'NICE talks about dialectical behaviour therapy – I think there should be a review of evidence for this therapy and a specific statement made about who would benefit from this approach.' (ID 500)

PSYCHOLOGICAL THERAPIES (CITATIONS 54, 10% OF ALL CITATIONS)

Access to psychological therapies among people who self-harmed was commonly referred to among participants, covering access and staffing and experience.

ACCESS

'I left my previous post…because services we had developed locally for people with self-harm were dismantled by the Trust Executive and psychological services to free up staff to undertake IAPT. A good skill base and success rate was wiped out by stupid managers without any consultation.' (ID 525)

STAFFING AND EXPERIENCE

'Rather than yet another policy we need more senior staff with appropriate time, psychotherapy AND psychiatry or psychology training

as well as sufficient medium-term crisis services. The latter ones are unfortunately far too often staffed with inexperienced colleagues, and these crisis resolution teams rarely provide an extended assessment and if indicated short- to medium-term treatment.' (ID 1485)

Repeated self-harm (citations 50, 9% of all citations)

Individuals who repeatedly self-harmed were identified as a group that needed additional services and intervention and training support.

Services

'There is much that can be done to assist [people who repeatedly self-harm] but there is no investment or money available to create a specialist service for them. If an age-inclusive service with the aim of early education and support could be developed (i.e. like the early intervention service), then the significant costs to the service overall would be reduced. This will not occur in any meaningful way without "priming the pump" with an initial investment, which in this current climate is unlikely to happen.' (ID 1017)

Training

'I feel we need more training on management of repeat serious self-harmers. I do not feel that there is enough support for people who self-harm, often they are excluded from secondary care support as the belief is that we make them worse, and I am not sure where the evidence for this actually comes from to inform this general belief.' (ID 1240)

Services – liaison/general hospital (citations 45, 8% of all citations)

Participants presented a range of views about psychiatric liaison services, and links with the general hospital setting. These were organised around issues of better service provision and addressing poor levels of funding.

Need better commissioning of liaison psychiatry services – and ensure that mental health trusts understand these are not the same as a crisis team (especially if the crisis team function on Department of Health crisis resolution home treatment criteria where SMI is needed). Need to ensure a service limited to self-harm assessment in an acute hospital will also cover acute hospital wards, orthopaedics, intensive care, etc., in addition to A&E.' (ID 1091)

'The decline and closure of comprehensive liaison psychiatry services.' (ID 1206)

Appendix II: People who gave evidence to the Working Group

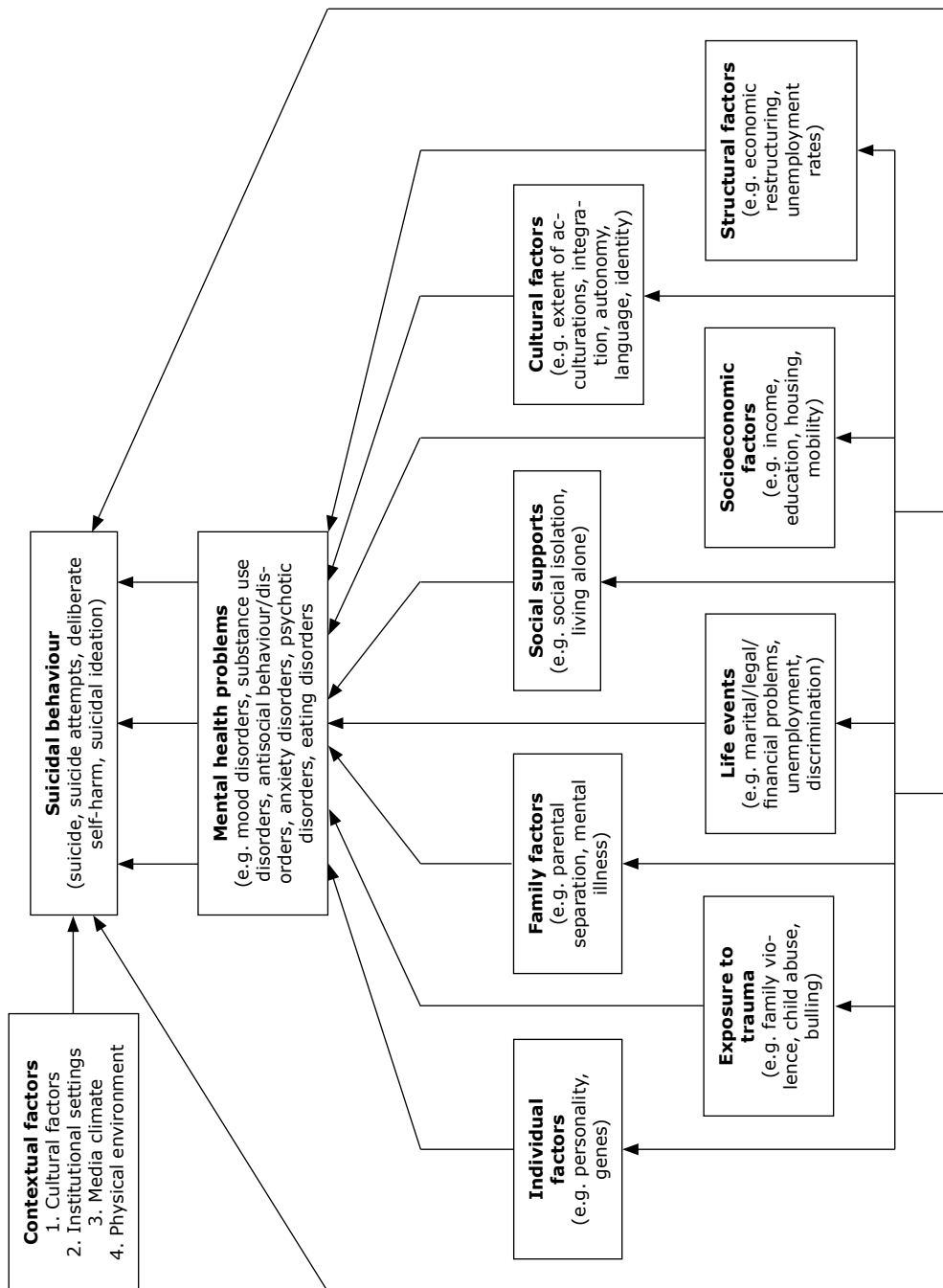|	
Dr Donald Campbell	Senior Honorary Consultant, Portman Clinic
Dr Alys Cole-King	Consultant Liaison Psychiatrist, Wrexham Maelor Hospital
Mr Patrick Daniels	Advice and Volunteering Manager, YouthNet
Ms Margaret Edwards	Head of Strategy, SANE
Mr Joe Ferns	Acting Director of Policy Research and Development, Samaritans
Professor Elspeth Guthrie	Honorary Professor of Psychological Medicine, University of Manchester; Chair of the Liaison Faculty of the Royal College of Psychiatrists
Dr Robert Hale	Consultant Psychotherapist and Psychoanalyst, Portman Clinic
Professor Keith Hawton*	Consultant Psychiatrist, Professor of Psychiatry at Oxford University, Director Oxford Centre for Suicide Research
Dr Fiona Mason	Consultant Forensic Psychiatrist, Associate Medical Director for Services for Women and Consultancy Service
Mr Dougie Paterson*	Programme Manager, Choose Life
Mr Gavin Peake-Jones	Director, Consultancy Services, Open Minds
Professor Stephen Platt*	Professor of Health Policy Research, Director of the Research Unit in Health, Behaviour and Change
Dr Marcus Roberts	Director of Policy, DrugScope

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*Separate meeting with Rowena Daw and Martin Skipper.

Professor George Szmukler	Consultant Psychiatrist, Professor of Psychiatry and Society, Institute of Psychiatry, London
Jim Valentine	Communities Manager, YouthNet
Ms Marjorie Wallace	Chief Executive, SANE
Ms Sue Waterhouse	Leader on Women and Gender, National Gender Equality Lead at National Mental Health Development Unit

CONSULTATIONS AND OTHER EVIDENCE RECEIVED FROM INDIVIDUALS

Miss Naheen Ali	Member of Service User Forum, Royal College of Psychiatrists
Ms Lesley Bell	Turning Point
Professor Kam Bhui	Professor of Cultural Psychiatry and Epidemiology and Honorary Consultant Psychiatrist, Barts and the London School of Medicine & Dentistry
Dr Peter Byrne	Consultant Liaison Psychiatrist, Senior Lecturer in Psychiatry at University College London
Professor Carolyn Chew-Graham	Professor of Primary Care, University of Manchester, Royal College of General Practitioners Clinical Champion for Mental Health
Ms Christine Cartin	Turning Point
Professor Linda Gask	Professor of Primary Care Psychiatry, University of Manchester
Mr Willian Gore	Public Affairs Director, Press Complaints Commission
Professor Riaz Hassan	Emeritus Professor in the Department of Sociology, Flinders University in Adelaide, Australian Research Council Professorial Fellow
Mr Ian Hulatt	Mental Health Adviser, Royal College of Nursing
Dr James Johnston	Consultant Psychiatrist in Psychotherapy, Leeds University
Ms Mary Nettle	Mental health user consultant
DrugScope Samaritans Young Minds	

Appendix III: Pathways to suicide behaviour