

# **Self-harm, suicide and risk: a summary**

**Position Statement PS3/2010  
July 2010**

**Royal College of Psychiatrists  
London**

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# **Self-harm, suicide and risk: a summary\***

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\* This Position Statement is a summary of the full College Report 'Self-harm, suicide and risk: helping people who self-harm' CR158 which is available from the Royal College of Psychiatrists' Publications Department and on the College website at [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk). This also contains a full bibliography.

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## OVERVIEW

### Self harm and suicide: A major challenge for all

Self harm and suicide are manifestations of emotional distress and illness which not only cause the individual, their families and friends distress and anxiety but also have a damaging impact on the economy and wider society.

#### The current situation:

- The incidence of self harm in the UK has risen over the last few decades estimated at 400 per 100,000.
- People of all ages and all social groups engage in self harming behaviour or kill themselves, with some groups - such as young people, veterans and prisoners - at particular risk. Many people do not have mental illness but have multiple life problems of a personal, social or economic nature.
- Self harm and suicide need to be tackled through public health strategies and improvements in services.

This College report examines the issues of self-harm, suicide and risk in detail. It was produced by a working group, chaired by Lord John Alderdice. It was compiled with the help of expert evidence from health professionals, third sector providers, policy professionals, service users and carers as well as members of the Royal College of Psychiatrists. It takes the current research picture into consideration, as well as surveys of College members and current government guidelines and initiatives. **This position statement is a summary of some of the key findings and recommendations from the report.**

"Our central theme is that the needs, care, wellbeing and individual human dilemma of the person who harms him or herself should be at the heart of what clinicians do. We must never forget, however, 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. Public health policy also has a vital role to play and psychiatrists should not leave these crucial political and managerial decisions to those who are not professionally equipped to appreciate the complexities of self-harm and suicide."

**Lord John Alderdice, Chair Working Group.**

## THE CHALLENGES: KEY FINDINGS

- **There is a lack of resources for appropriate treatment and a patchy provision of good services for people who self-harm**
- **Surveys of people who self harm have repeatedly made it clear what kind of help they need when they have harmed themselves; however this help is frequently not available**
  - ✿ Evidence also exists of widespread failure by NHS services to comply with the NICE Guideline on Self Harm. As a result some people are discharged from hospital without mental state or needs being assessed, without a care plan, or without follow through to a GP or other service.
  - ✿ Assessments are reportedly carried out using tools that have not been validated.
- **Poor understanding of self harm among those who encounter it as part of their work whether in schools, residential care, community care, prisons or other settings**
- **Instances of unhelpful staff attitudes towards people who self-harm even in health services**
- **Lack of training and support for staff who have to deal with complex and demanding situations with people who present after they have harmed themselves or attempted suicide**
  - ✿ Junior psychiatrists and other inexperienced health professionals are often left to deal with presentations of self-harm without the supervision or guidance of a senior colleague.
  - ✿ The preoccupation within the NHS of managing risk gives risk assessment too dominant a role in clinical care, which is to the detriment of a good therapeutic relationship between healthcare professionals and patients. Clinicians feel frustrated and demoralised that without support from their Trusts, they are unable to carry out the demanding work of attending properly to people who have self harmed and who need their help. The use of locally devised risk assessment tools that lack an evidence base should be abandoned.
  - ✿ Overall, the evidence painted a bleak picture of standards of care for people who self harm in UK hospitals thus leading us to call for better training, more supervision by senior staff members and improved follow up and assessment tools.

## THE OPPORTUNITIES: REPORT RECOMMENDATIONS

This report highlights many examples of excellent best practice across the United Kingdom where dedicated staff are providing innovative and effective self-harm services. These need to be built upon. Our recommendations set out what the government, NHS Trusts and commissioners, professional bodies and the third sector ought to be aiming for to improve the care for people at risk of suicide and self harming behavior. We firmly believe that the changes we propose will be cost effective in the longer term, and furthermore that many do not involve significant expense.

Our recommendations cover a wide range of issues including:

- The need for a proper public health strategy to cover self harm and for the suicide prevention strategy to remain a priority in all nations of the UK
- NHS services, particularly in A & E, to be managed in a way which ensures that people who have self harmed or tried to kill themselves have proper access to care and treatment by fully trained clinical staff and that the NICE Guideline on Self Harm is implemented
- A change to the culture of NHS services to address self harm so that staff who encounter people who self harm are trained and supported in this difficult work.
- Greater recognition by the statutory sector of, and support for, the role of the third sector bodies such as the Samaritans and SANE in assisting those who are involved with self harm or are suicidal
- Psychiatrists, including liaison psychiatrists, need to have a full role in helping people who self harm
- In contrast to suicide, research on self harm has been neglected and overlooked. Funding needs to be allocated to research on the causes and treatments of self harm. Without this people who self harm will continue not to receive the best care, whilst clinicians will still lack guidance as to what works and for whom

## INTRODUCTION

Self-harm is poorly understood in society and people who self-harm are often subject to stigma and hostility. Even working people who regularly encounter cases of self-harm - whether as school teachers, social workers, housing officers, police, prison officers, pastors, and even nurses or doctors - may find the care of people who have harmed themselves particularly challenging. Yet, (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 among the highest in Europe. This is a worrying situation in our society and a particular cause of concern for psychiatrists and other mental health professionals.

The focus of the new College Report on self-harm is to explore why people harm and kill themselves and to consider the role (including the limits of the role) that psychiatrists and other mental health care professionals play in their care and treatment. The experiences and the views of people who harm themselves as well as those of their carers, health professionals and third sector workers are central to this enquiry. Policy and guidance on self-harm and suicide prevention is plentiful and the report does not attempt to retrace the same ground but to examine the evidence of practice on the ground, including the implementation of the NICE Guidelines on Self Harm.

### 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 (for example, where people harm themselves to reduce internal tension, distract themselves from intolerable situations, as a form of inter-personal communication of distress or other difficult feelings, or to punish themselves).

An act of self-harm is not necessarily an attempt or even indicator of intent to commit suicide, indeed it can sometimes be a form of self preservation.

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

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 manifestation of emotional distress; 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), 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 bio-psycho-social 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 on-going problems with whatever help can be made available to them in their context should be the key principles informing the care and treatment of the individual.

## **Part II: The Public Health Agenda**

The suicide prevention strategies in each of the countries of the UK 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 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 frontline 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 our country is experiencing now.

The Third Sector plays a vital role in policy and practice on self-harm and suicide prevention from national charities like the Samaritans to small local organisations and support groups.

'I would like to see more local or an NHS local self help support group. You need to feel you are not alone.'

**'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.'**

National charities and many other local and regional bodies provide support in different ways. They undertake research and campaigns, operate telephone help lines and moderate website forums, do awareness raising and other 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.

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## **RECOMMENDATION**

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**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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## **RECOMMENDATION**

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**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 frontline 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. They should ensure that government websites including NHS Direct and the Departments 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 included in this strategy.**

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

Part II of the Report mentions the important role of other bodies, including professional organisations such as the Royal College of Psychiatrists and the Royal College of General Practitioners. They 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.

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## RECOMMENDATION

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**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

While suicide prevention has been the subject of much research in the UK and elsewhere, self-harm as a distinct issue has 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 to our knowledge. Nevertheless the evidence base remains thin in many areas - 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.

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## RECOMMENDATION

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**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 survey of College members showed that while there is some good, even excellent practice, there are also clear indications of fault lines and failures to meet the standards set by NICE guidelines and professional practice. The College Report chose to focus on areas for improvement together with some examples of good practice. It is not possible for us to appraise the extent of the problems but it is clear that there is at time 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.

'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.' ( NICE Guideline on Self-Harm)

Individual respondents to the College Members' survey expressed considerable concern and frustration about a range of issues regarding the care that vulnerable, sick people could expect to receive.

'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 due to other pressures/lack of training.'

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 was possible to predict the future.

'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.'

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

'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 person who self-harms (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.'

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.

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## **RECOMMENDATION**

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**The Royal College of Psychiatrists should work 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 of psychiatry and with other staff (nurses, doctors, social workers, paediatricians, police and prison staff) in dealing with and in undertaking assessments for people who have harmed themselves (particularly those repeatedly harm themselves) or 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 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 at 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 demoralized. Others reflected on the inadequate assessments that they and others made because of lack of experience and of time.

'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.... 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.'

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.

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## **RECOMMENDATION**

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**The Royal College of Psychiatrists should ensure that training in bio-psycho-social assessment and management of self-harm should be 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 to manage. The lack of practices to support staff reflects the whole culture of some organisations where there is too much emphasis on throughputs and a problem in making space for learning from clinical experience. The College's Psychotherapy Faculty advocates the introduction of reflective therapeutic space in teams to review self-harming behaviour. This would improve psychotherapeutic understanding in case management, enhance staff morale and improve relations between teams and departments.

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## RECOMMENDATION

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**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**

The College Members' survey informed the Working Group on the practice of risk assessments. Risk assessment is a core function of medical practice. However it has come to dominate clinical practice – fuelled by a false view of what future behavior can be predicted and by the culture of blame, that has given rise to a 'tick box' mentality, together with the increased use of junior staff in doing risk assessments. This is despite the acknowledged fact that risk assessment per se has a very limited, and short-term, predictive power.

'... 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.'

College members voiced their dissatisfaction with the continued use of locally developed risk assessment tools that lack validity, absorbed too much clinical time, devalued engagement and impaired empathy. This practice is contrary to recommendations in the NICE Guideline.

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## RECOMMENDATION

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**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 bio-psycho-social assessment not as a separate exercise.**

## **Psychosocial assessments**

NICE recommends that every person should receive a psychosocial assessment after an episode of self-harm. However, this often does not occur particularly for those people who have cut themselves rather than ingested poison. Some people may be discharged with a superficial assessment. 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 clinician's effort and time with less attention to risk assessment and a greater attention to a full bio-psycho-social assessment that reviews holistically their needs of the person and provides a careful future plan.

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## **RECOMMENDATION**

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**People attending hospital after an episode of self-harm should all receive a bio-psycho-social 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**

The pressure to discharge patients from A & E Departments, and the pressures on beds means that sometimes people are discharged too soon after an episode of self-harm or an attempt at suicide. 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 the excessive waiting time involved in A & E attendance. Furthermore, 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 Guideline.

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.

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## RECOMMENDATION

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**The College Report on Assessment for Self-harm (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 CBT, have 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 Guideline.

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## RECOMMENDATION

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**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.

**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 to 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.

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### **RECOMMENDATION**

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**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 under used.

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### **RECOMMENDATION**

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**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.**

#### **Conclusions**

While this Position statement has focused on areas for improvement in practice and policy there were examples of highly motivated multidisciplinary teams and good practice presented to us, giving us a sense of optimism that despite all the challenges there are ways to improve care for 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 a general hospital units, is an effective way to raise standards, reduce bad practice and stigma.'



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