Services for assessment, aftercare, and psychological treatment following self-harm

Rachael Lilley
David Owens

Abstract

Effective intervention following self-harm is vital because of the strong link between self-harm and suicide. Unfortunately, services for people who self-harm have been poor in the UK and elsewhere. In 2004, the National Institute for Health and Clinical Excellence issued a guideline setting out clear standards for care following self-harm, many of which are included in this article. Whether this guideline has led to much needed improvements in care is not clear; there are few published experiences concerning implementation of the guidance but some studies suggest that care continues to be unsatisfactory. The barriers to implementation of self-harm guidelines are not clear, but the lack of definitive research evidence for effective treatments is a potential candidate. Several systematic reviews have failed to demonstrate a statistically significant reduction in fatal or non-fatal repetition following intervention after self-harm. Recent studies have, however, shown clear benefits for some psychological therapies – in particular for cognitive behavioural therapy with a problem-solving element. Promising results have also been demonstrated for some brief interventions designed to encourage uptake of aftercare following self-harm. This article sets out a little of the evidence for these potentially beneficial interventions, including recent developments in research evidence and implications for future research.

Keywords aftercare; clinical trials; general hospital; NICE guidelines; psychological treatments; psychosocial assessment; self-harm

Rachael Lilley ***BSc RMN MSc*** *is a researcher at the Leeds Institute of Health Sciences, University of Leeds, UK, and a qualified mental health nurse. She trained and worked as a nurse in Leeds Partnerships Foundation Trust and has spent the past five years working primarily on local and multicentre research projects about general hospital services for people who self-harm. Conflicts of interest: none declared.*

David Owens ***BSc MD MRCPsych*** *is Senior Lecturer and Honorary Consultant Psychiatrist at the University of Leeds' Institute of Health Sciences, and at Leeds Partnerships NHS Foundation Trust, UK. He has a long-standing research interest in services for self-harm. He qualified in Leeds and undertook much of his psychiatric training in Nottingham. He spends much of his time organizing a postgraduate research training programme in the University of Leeds. Conflicts of interest: none declared.*

What's new?

- Since the 2004 NICE guideline for care after self-harm, little has been published on experiences of implementing the guidelines or on whether they have led to badly needed improvements in services for people who harm themselves
- Definitive evidence on effective treatments for people who self-harm is still lacking, but recent trials continue to show clear benefits for cognitive behavioural therapies
- Uptake of interventions following self-harm remains problematic in research and in clinical practice. Interventions that encourage engagement with services have shown promising results and further trials are under way
- The imminent update of the Cochrane review of treatments after self-harm may provide clearer evidence for effective interventions following self-harm

Effective intervention following self-harm offers an ideal opportunity for suicide prevention because self-harm is the most significant risk factor for suicide. Yet the provision of healthcare services for people who self-harm has long been in disarray around the UK, and in many other countries. In recognition of this sorry state of affairs, the most recent national guidelines for the treatment of self-harm in England and Wales[1] were issued along with the acknowledgement that '*170,000 people a year attend emergency departments because they have self-harmed, of those an estimated 80,000 never receive a psychological assessment or follow up even though the risk of committing suicide after self-harming one or more times is 100 times greater than the average risk in the population*' and '*few people providing care in casualty understand why people self-harm and don't know how to help them effectively*'. As we shall see, these high-profile guidelines, together with emerging research evidence, point the way towards better care – but nearly 5 years since their publication we should be asking whether these recent developments have led to badly needed improvements in service provision.

Attending hospital

This article deals only with healthcare services that might be available to those who attend the general hospital, but it is important to bear in mind that many people, especially young people, stay away from the emergency department following self-harm. In a large survey as few as 1 in 8 young people of school age who had undertaken self-harm reported going to hospital; much of the self-harm in this survey was by self-cutting but, even when the harm was poisoning, only 1 in 4 reported hospital attendance.[2] This contribution does not, however, deal with the hospital's response to children and young people who harm themselves, for whose care there are additional and specific recommendations.[1] Little will be said here, either, about episodes in which the primary care team is the first contact. In urban areas, at least, most self-harm episodes that lead to contact with any part of the health service are dealt with in the hospital emergency department; in a study in south London, more than 90% of self-harm

episodes identified through general practice records involved attendance at the emergency department.[3]

Guidelines for hospital care following self-harm

When someone attends hospital after self-harm they generally go to the emergency department where, in England and Wales, there are in place very specific guidelines for their care. The two most recent sets of guidance come from the National Institute for Health and Clinical Excellence (NICE)[1] and the Royal College of Psychiatrists.[4] The high profile of the NICE guidelines, commissioned by the Department of Health and expected to be taken fully into account by health services and professionals, brings about some optimism concerning improvements in service provision. Both guidelines specify the kinds of service that patients should receive following self-harm; many of the steps towards better assessment, aftercare, and psychological treatment suggested below are drawn directly from these guidelines.

Assessment at triage

At triage, staff in the emergency department are expected to combine assessment of physical and mental state in a respectful and understanding way, taking account of any emotional distress. It is expected that doctors and nurses who are not mental health specialists will nevertheless provide sufficient psychosocial assessment to determine mental capacity, the presence of mental illness, and the patient's willingness to remain for more detailed psychosocial assessment. If there is drug or alcohol intoxication, assessment may be quite unreliable or even impossible to carry out, and waiting for adequate assessment or for treatment should be in a safe and supportive environment, if necessary supervised by a member of staff. The NICE guideline clearly states that someone who wishes to leave before he or she has received a psychosocial assessment or treatment should, if their mental capacity is diminished or they have a significant mental illness, be prevented from leaving and referred for urgent mental health assessment.

Achieving quality assessments at triage

It is plainly asking a lot of emergency department staff that they should undertake a preliminary psychosocial assessment that is reasonably thorough, but there has been a clear demonstration in Leicester, UK, of how clinical audit can bring about gratifying improvements.[5] Three years after an initial audit, the emergency department staff were found, at re-audit, to have made substantial progress. Although there were still deficits – especially when it came to asking about substance use, and a basic assessment of the present mental state – the emergency department staff were routinely recording in the case record much of the important information that is required for basic clinical care.[5] For the many patients who leave the emergency department prematurely, collecting such information at this early stage can provide a basis for the mental health service to make arrangements for assessment and follow-up – should the service have in place the capacity for such outreach work.

Psychosocial assessment

Generally speaking, after triage, patients will go on to be dealt with in the main emergency department. For decades, it has been the health service's official policy that all patients who attend hospital should, before discharge, receive a psychosocial assessment carried out by staff specifically trained for the task.[6–8] It is similarly expected, under the most recent guidance, that everyone who attends hospital because of self-harm should have a comprehensive assessment of their needs and risk.

Assessment of mental health and social needs (and risks)

NICE guidance says that everyone's assessment should include evaluation, and recording in the case records, of the environmental, psychological, and motivational factors specific to the act of self-harm, paying attention to current suicidal intent and hopelessness, as well as providing a full assessment of mental health and social needs. So that there is a thorough assessment of risk, there should also be an identification of the main clinical and demographic features known to be associated with the likelihood of further self-harm or suicide.

Reducing reliance on risk assessment

So-called 'risk assessment' as the guiding principle of psychosocial assessment is a flawed notion. It might be useful were it a reasonably accurate business, but it is not. The positive predictive values of key questions, or of repetition scales that have been constructed, are low. Put another way, low specificity of the risk factors means that relatively few of the patients who seem to be at high risk go on to repeat over the months that follow,[9] whereas the low sensitivity of these scales means that those who seem to be at low risk account for most of the cases of subsequent suicidal behaviour.[10,11]

Consequently, as recommended by NICE, the appropriate psychosocial assessment of someone who has attended hospital after self-harm will arrive at a formulation that blends the assessment of the two targets: needs and risk. Of course, the patient needs to be mentally fit if the assessor is to make supportable judgements about the nature of the needs and risk: that is, not too drowsy or intoxicated. Often, even for immediate planning of care, the views and corroborative accounts of key informants will be needed. The patient and the person who has undertaken the assessment should read and agree what has been written about needs, and arrange for this information to be passed on to the general practitioner. The main components of assessment of need after self-harm are set out in Box 1.

Main components of assessment of need after self-harm

- Social situation (including current living arrangements, work, and debt)
- Personal relationships (including recent breakdown of a significant relationship)
- Recent life events and current difficulties
- Psychiatric history, including any history of previous self-harm and alcohol or drug use
- Mental state examination
- Enduring psychological characteristics that are known to be associated with self-harm
- Motivation for the act

Box 1