

‘Wasn’t offered one, too poorly to ask for one’ – Reasons why some patients do not receive a psychosocial assessment following self-harm: Qualitative patient and carer survey

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Leah Quinlivan^{1,2,3} , Louise Gorman^{1,2,3}, Donna L Littlewood^{1,2,3}, Elizabeth Monaghan³, Stephen J Barlow³, Stephen Campbell³, Roger T Webb^{1,2,3} and Nav Kapur^{1,2,3,4}

Abstract

Objective: Psychosocial assessment following self-harm presentations to hospital is an important aspect of care. However, many people attending hospital following self-harm do not receive an assessment. We sought to explore reasons why some patients do not receive a psychosocial assessment following self-harm from the perspective of patients and carers.

Methods: Between March and November 2019, we recruited 88 patients and 14 carers aged ≥ 18 years from 16 mental health trusts and community organisations in the United Kingdom, via social media, to a co-designed qualitative survey. Thematic analyses were used to interpret the data.

Results: Patients’ reasons for refusing an assessment included long waiting times, previous problematic interactions with staff and feeling unsafe when in the emergency department. Two people refused an assessment because they wanted to harm themselves again. Participants reported organisational reasons for non-assessment, including clinicians not offering assessments and exclusion due to alcohol intoxication. Other patients felt they did not reach clinically determined thresholds because of misconceptions over perceived heightened fatality risk with certain self-harm methods (e.g. self-poisoning vs self-cutting).

Conclusion: Our results provide important insights into some of the reasons why some people may not receive a psychosocial assessment following self-harm. Parallel assessments, compassionate care and specialist alcohol services in acute hospitals may help reduce the number of people who leave before an assessment. Education may help address erroneous beliefs that self-injury and self-harm repetition are not associated with greatly raised suicide risk.

Keywords

Self-harm, suicidal behaviour, liaison psychiatry, psychosocial assessments, qualitative research

Introduction

Self-harm is a major risk factor for suicide and premature all-cause mortality (Carr et al., 2017; Olfson et al., 2017). Health services have an important opportunity for intervention, given that self-harm is a common reason for hospital presentation in Western countries (e.g. Arensman et al., 2018; Carter et al., 2016; Conner et al., 2003; Finkelstein et al., 2015; Perera et al., 2018; Tsiachristas et al., 2020). Psychosocial assessments on presentation to hospital may help prevent repeat self-harm and improve access to appropriate aftercare (e.g. Carroll et al., 2016; Carter et al., 2016).

¹Division of Psychology and Mental Health, Centre for Mental Health and Safety, The University of Manchester, Manchester, UK

²Manchester Academic Health Science Centre, The University of Manchester, Manchester, UK

³NIHR Greater Manchester Patient Safety Translational Research Centre, The University of Manchester, Manchester Academic Health Science Centre, Manchester, UK

⁴Greater Manchester Mental Health NHS Foundation Trust, Manchester, UK

Corresponding author:

Leah Quinlivan, Centre for Mental Health and Safety, The University of Manchester, Jean McFarlane Building, Oxford Road, Manchester M13 9PL, UK.

Email: leah.quinlivan@manchester.ac.uk

Patients who do not receive a psychosocial assessment are at elevated risk of further non-fatal self-harm and suicide (Bennewith et al., 2005; Hickey et al., 2001). National clinical guidelines in Australia (Carter et al., 2016; Royal Australian New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Deliberate Self-Harm, 2004) and in England (NICE, 2011) recommend that all patients presenting to hospital should receive a psychosocial assessment. While monitoring of self-harm and psychosocial assessment rates vary across services and Western countries (Carter et al., 2016), many patients presenting to hospital following an episode of self-harm do not receive an assessment (Bennewith et al., 2005; Cooper et al., 2013). Although quantitative studies have examined differences in characteristics of people who do and do not receive an assessment (Bennewith et al., 2005; Hickey et al., 2001; Kapur et al., 2008), the phenomenon is poorly understood. One explanation for the continued implementation gap between evidence and practice might be the failure to seek wider perspectives on clinical assessment from patients and their families.

In this study, we aimed to investigate the reasons why some patients may not receive a psychosocial assessment after presenting to an emergency department following self-harm. Our specific objectives were the following:

- To explore reasons for not remaining in the emergency department for psychosocial assessment from the perspective of patients and carers;
- To explore other circumstances that may indicate why an assessment did not occur for some patients.

Methods

Design and sample

We conducted a qualitative survey (Supplemental Appendix 1) (Braun et al., 2020) to explore patients' experiences of psychosocial assessment after presenting to an emergency department following self-harm. Additional methodological details are presented in Supplemental Appendix 2.

Recruitment

We invited patients aged ≥ 18 years with experience of self-harm and subsequent psychosocial assessments, or carers of people with such experiences to participate in a qualitative survey through 16 mental health trusts in England, social media and community organisations between April 2019 and November 2019. The survey was predominantly patient-focused. Carers were invited to provide proxy information for the patients' psychiatric diagnosis, living arrangements, and employment and to share their views of the assessment experience for the person presenting with self-harm. We closed recruitment when we deemed that a sufficient volume of descriptive material had been obtained

from the free-text questions and in line with study deadlines. Self-harm was defined as intentional self-poisoning or self-injury irrespective of the suicidal intent, which is consistent with clinical guidance (NICE, 2011). Children and adolescents were not included because of differential service provision for this population in England (Kapur et al., 2013).

Analysis

Thematic analysis was used to explore patterns in participants' experiences (Braun et al., 2020). We analysed structured questions deductively and captured additional codes and context inductively. Our patient and carer partners coded the data and shared their thoughts and ideas in a project workshop, which helped to generate initial codes and themes. L.G. and L.Q. independently systematically coded the full dataset after immersion and familiarisation with the data. Codes and themes were generated, developed and reviewed via discussion between L.Q., L.G. and the wider team, including patients and carers. Together with our patient and carer panel, we refined, revised and named themes from group discussion to ensure relevance and closeness to the data. We analysed responses from subgroups in the dataset (e.g. sex, age, patients/carers) together because the responses substantially overlapped (e.g. responses from carers corroborated with patient experiences). Final themes and quotes were agreed among discussion with the team.

SPSS version 22 (IBM Corp, 2013) was used for descriptive statistics. NVivo 12 Software (QSR International, 2018) was used for data management.

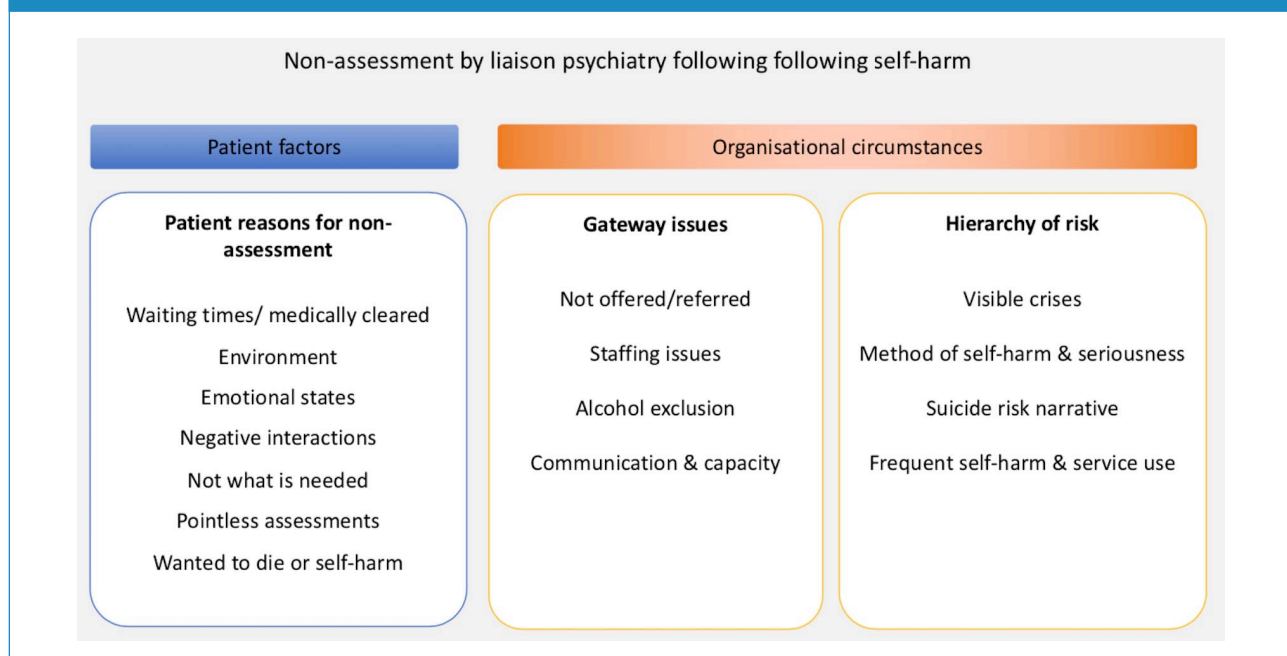
Results

Free-text responses were provided by 102 participants on their experiences of psychosocial assessments (see Supplemental Appendix 3 for the recruitment flow chart). Most participants were patients (88/102, 86.3%), and the remainder were carers (14/102, 13.7%). Patients were aged between 18 and 75 years, and their median age was 34 years. Carers were aged between 41 and 73 years, and their median age was 56 years. Most patient (72/88; 81.8%) and carer (13/14) respondents were women. Most of the sample was of White British or Irish ethnicity (91/102, 91.1%). Further information about patient employment status and self-reported psychiatric diagnosis is presented in Supplemental Appendix 2.

Qualitative results

Three broad themes captured reasons for not receiving a psychosocial assessment from a patient perspective: This first theme focused on the patient, while the second and third themes are focused on organisational reasons

Figure 1. Themes and subthemes developed from the data.



for non-assessment. They were (1) patients' reasons for refusing or leaving before an assessment took place, (2) gateway issues and (3) not fitting into a clinician-determined hierarchy of risk. Figure 1 presents the themes and subthemes developed from the data.

Individual patient/carer reasons for non-receipt of assessment

Waiting times/medically cleared. Most participants who left or refused a psychosocial assessment did so because of long waiting times. Poor communication from some health-care staff over time frames left some people feeling uncertain and anxious. Having to wait until medical staff deemed the person to be medically fit for assessment increased waiting times. This additional delay added to frustrations and led some people to leave the emergency department. Other participants left because of tiredness and waiting so long in the emergency department; they 'wanted to go home' (R05, male, age 18, patient):

You have to be deemed medically fit first before the in-house psych team will even speak to you. You are usually having to wait an additional four hours after you have been treated for the harm, I poison myself, so sometimes I could have been in already for 24hrs, and this means often not sleeping, so I am very cranky, and sometimes I can just tell them to fuck off and just let [allow me to be] back on my way. (R19, female, age 30-34, patient)

I was told the wait was 8 hours to see a MH professional. (R66, male, age 18-24, patient)

Emergency department environment. Having to wait in the main emergency department area intensified some participants' frustration over long waiting times and psychological distress. Lack of privacy in the emergency department exacerbated some participants' feelings of anxiety over talking about their self-harm and other sensitive issues. Other participants felt psychologically unsafe and that their distress was exacerbated in the emergency department because of noise, crowded environments and physically unsafe rooms. The patient or their family members therefore made the difficult decision to leave the emergency department without an assessment because recovery at home was deemed more beneficial to the patient:

I was left waiting for 3 hours to see someone from the RAID team and then I left because I couldn't sit in the waiting room any longer. (R42, female, age 30-34, patient)

Waiting for too long, in a really inappropriate area, distressed, but felt that I would be less distressed if I was at home. (R18, female, age 50-54, patient)

When we have waited hours, my family have decided it's making things worse, so they have taken me home even though they didn't feel it was safe to do so. (R112, female, age 35-39, patient)

Emotional states. Feelings of anxiety, distress and/or feeling trapped in the emergency department were common, leading some participants to leave before an assessment took place. Others left before the assessment because they felt ashamed, guilty or embarrassed after harming themselves.

For some people, feelings of distress were exacerbated by waiting alone for long periods of time in the emergency department, which increased their need to ‘get away’ (R25, female, age 55-59, patient):

The wait was too long and I was anxious, agitated, and in a lot of pain. (R95, female, age 25-29, patient)

Previous experiences and negative interactions in the emergency department. Some participants did not wait for an assessment because of negative past experiences while attending the emergency department following self-harm: ‘I refused a number of times as my past experiences in A&E had been very distressing and done more harm than good to my mental health’ (R41, female, age 25-29, patient). Other participants left the emergency department because of problematic interactions with some healthcare staff: ‘I was in withdrawal for a tramadol addiction and the mental health nurse told me I should be a pharmacist because I knew a lot about tramadol. I got up and left’ (R09, non-binary, age 18-24, patient).

Not what is needed at that time. Some participants left the emergency department because of having to attend other appointments or their workplace (e.g. ‘needed to go to work’ [R116, female, age 35-39, patient]). Other participants refused psychosocial assessments because they did not want to talk about the reasons for their self-harm at that time or discuss triggering issues without adequate follow-up support, which is what they needed at that time: ‘I refused because they would want me to tell them things that I don’t want to talk about and fail to do anything useful’ (R118, female, age 40-44, patient). Sometimes participants refused an assessment because they did not feel distressed after harming themselves: ‘I’m not always psychologically stressed when I self-harm’ (R36, female, age 30-34, patient), or they felt that they had adequate support and were no longer a danger to themselves (R110, male, age 44-49, patient; R34, female, age 50-54, patient).

Pointless assessments. Disillusionment and despondency about receiving any help from mental health staff led many participants to refuse assessments. Some participants considered assessments to be pointless due to previous experiences with the lack of follow-up care: ‘she hasn’t seen the point as she knows that she wouldn’t get the correct help’ (R16, female, age 50-54, carer); ‘I have not opted to see anyone as I see it is pointless’ (male, age 45-49, patient). Some left because they felt they would not receive additional help from the mental health team because they presented in a different catchment area: ‘Was in the wrong city (no point being assessed out of area—this is actually a really big issue)’ (R34, female, age 50-54, patient). Other participants felt they would not receive any further help from an assessment because they were already under the care of secondary mental health services and left for this reason:

There were multiple times that I discharged myself against medical advice following having the physical injuries treated because I decided that getting rest at home would be more beneficial than any benefits from speaking to the mental health team. I knew they could not speed up any referrals for therapy and couldn’t see how it would help at the time. (R41, female, age 25-29, patient)

Wanted to die or self-harm. Two people did not wait or refused an assessment because they wanted to die or harm themselves again: ‘Was too determined to end it’ (R96, female, age 25-29, patient).

Organisational circumstances for non-assessment

Gateway issues

Not offered or referred. For some people, access to a psychosocial assessment depended on the healthcare staff initially treating the person and/or making a referral for further assessment. For example, some participants did not receive medical treatment for their self-harm by acute staff and therefore did not receive a psychosocial assessment. Others reported that they were not offered or referred for a mental health assessment after receiving medical treatment: ‘Wasn’t offered one or knew it was a possibility’ (R12, female, age 50-54, patient) and consequently left the emergency department without an assessment:

I was refused treatment for self-harm and to see psych by an ED doctor because ‘you’re just going to do it again anyway’, so I left the ED department in distress, (only a day out of being discharged from an acute ward very suddenly), and with a wound on my leg that was muscle-deep and eventually required internal suturing. (R34, female, age 50-54, patient)

Staffing. Some participants felt that receiving psychosocial assessments became less of a priority during busy periods. Participants felt that receiving assessments depended on the willingness of some staff to engage with patients who have harmed themselves during these times:

I’ve been told I don’t have to have one and that nurses and doctors are busy. I knew they did not think I had any hope of getting better so there wasn’t any point. They didn’t care about my risks and I didn’t care either. (R38, female, age 30-34, patient)

Alcohol exclusion. Several participants stated that assessments would not occur if the episode of self-harm included alcohol use. One mother described several presentations with her son to the emergency department for self-harm, where the mental health team would not assess him because of his alcohol use:

My son would usually have consumed alcohol prior to self-harming and whilst his overdose / wounds would be

appropriately treated in the A&E department, Mental Health Services (more latterly the Mental Health Liaison Team that was based in A&E 24/7) regularly refused to engage with my son, in any way at all, once they became aware that he had consumed alcohol – they would produce a breath test kit and require him to be under the legal limit for driving prior to having any form of a conversation with him. I am aware of occasions when, despite his records indicating that he was particularly vulnerable and at risk whilst under the influence of alcohol, my son was sent home to an empty flat, in a taxi, in the middle of the night – with no prior attempt being made to ask him as regards contacting a family member or friend to come to the hospital and accompany him home. My son was aged 26 years when he passed away. (R10, [patient, male], carer, female, age 65-69)

Communication and capacity. For some participants, receiving an assessment depended on how they presented and communicated information about their self-harm episode. Some participants felt that receipt of psychosocial assessments was less likely to occur if the person could demonstrate capacity, potentially due to superficial assessments, or if the person appeared ‘well-dressed’, ‘fine and in control’ (R96, female, age 30-34, patient; R20, female, age 55-59, carer). For other participants, having an assessment depended on the person’s ability to articulate their reasons for harming themselves and personal safety. If the person struggled to articulate the reasons behind their distress, or indicated that their self-harm episode was actually unintentional, or said they could keep themselves ‘safe when leaving A&E’ (R102, female, age 18-24, patient), participants reported that they were less likely to see mental health staff:

It very much depends on who is doing the referral. I recently overdosed but described it as ‘fucking up’ and it was therefore seen as a mistake and I didn’t need support without even asking me. (R105, female, age 30-34, patient)

Clinician-determined hierarchy of risk

Visible crises. Some participants felt that assessments occurred more often if the person presented in overt crisis or ‘visibly showed self-harm wounds’ (R97, male, age 18-24, patient). Other participants felt that they were more likely to receive an assessment when their presenting circumstances indicated they were vulnerable and/or at heightened risk. Examples include presenting to the emergency department with a police officer, trying to leave before an assessment took place, or if the person was at imminent risk of self-harm repetition or refusing treatment:

when she has been in crisis, unmanageable in her behaviour, she has also had an assessment, when she was hearing voices in her head telling her to harm herself. (R02, female, age 55-59, carer)

If I continued trying to harm myself within A&E or refused treatment that would further put me at risk, or spoke about

wanting to self-harm again or ending my life. (R102, female, age 18-24, patient)

Method of self-harm and seriousness. Many participants felt the method and perceived seriousness of the self-harm episode determined the provision of a psychosocial assessment. Several participants felt that some staff perceive presentations for self-injury as attention-seeking behaviour and therefore less serious than self-poisoning. However, participants reported that they did receive an assessment when their self-injury required a greater level of medical intervention. Two people stated that the location of the self-injury on their body also affected their likelihood of receiving an assessment:

He eventually did [receive an assessment] after he severed the arteries, tendons and nerves to both wrists and required an emergency stop at one A&E for blood transfusions before being able to be taken to the main trauma unit elsewhere. He DID receive a mental health assessment following this. (R31, female, age 45-49, carer)

Suicide risk narrative. Participants felt that some staff considered self-harm to be more serious if presenting in a suicidal crisis, which was closely linked with the method of self-harm. Some participants felt that staff took patients more seriously when presenting with self-poisoning in line with the pervasive narrative of raised suicide risk following these episodes. Conversely, self-injury was perceived as fitting into a ‘behavioural’ attention-seeking narrative that ignores mental ill-health or raised suicide risk considerations for that group. Participants felt that suicidal plans and intent also determined their access to an assessment and that healthcare professionals perceived their intent was less serious if they contacted emergency services for help:

If I had expressed suicidal thoughts or my injuries had been on certain parts of my body or severe enough to be classed as a suicide attempt. In A&E, unless you’re close to or have tried to kill yourself, you’ll just be sent home. (R09, non-binary, age 18-24, patient)

Making an attempt which could be seen as less serious because you contacted emergency services, you told someone before attempting, you didn’t take a more significant overdose for example or use a more definite method. (R30, female, age 18-24, patient)

Frequent self-harm and service use narratives. Many participants felt that their history of service use and/or attendances for repeat self-harm affected their likelihood of receiving an assessment. One mother reported that her daughter only received an assessment when she presented multiple times with self-poisoning in a short period of time: ‘My daughter took two overdoses within two weeks, and she did have an assessment then’ (R02, female, age 55-59, carer). However,

if the self-harm became frequently repeated and the person became a ‘*frequent attender*’, many participants reported that they would not receive an assessment (R20, female, age 18-24, patient). Other participants felt they did not receive assessments because of their service use history or if they had a diagnosis of personality disorder. Two people reported that their multidisciplinary plans stated that they should not be treated if the person attended the emergency department:

Mental health professionals wrote on my file that I should not receive mental health assessments or treatment from the emergency department. (R35, female, age 30-34, patient)

Many professionals do not consider either self-harm or BPD to be a mental health problem & you are often sent home without any assessment. (R21, female, age 45-49, patient)

My understanding is that the mental health assessment service at this particular hospital is bought into toxic myths around ‘attention-seeking’ and rewarding behaviour’, therefore they refuse to assist people who have been seen before. (R108, male, age 40-44, carer)

Discussion

Main findings

This is the first study to highlight reasons for non-assessment following self-harm from a patient and carer perspective. Patients left the emergency department prematurely or refused assessments for several reasons including long waiting times, previous negative experiences with some healthcare staff and feeling unsafe in emergency departments. Other participants reported leaving because of disillusionment with the lack of follow-up care received via the psychosocial assessment. Two patients refused assessments because they wanted to harm themselves again or die by suicide. Organisational barriers to psychosocial assessment included communication issues during triage and exclusion due to alcohol intoxication. Some patients reported not receiving medical treatment for self-injury and/or not been offered or referred for psychosocial assessment. Other patients felt they did not reach a clinically determined threshold for psychosocial assessment due to the method of self-harm that they used or because they were not perceived to have a heightened suicide risk.

Strengths and limitations

Of course, our study is subject to bias due to the use of a qualitative survey with a non-probability sampling design. We also did not recruit a consecutive sample of patients presenting to emergency departments following self-harm. However, the use of a qualitative survey enabled us to include an often marginalised and stigmatised group of

people in applied healthcare research (Braun et al., 2020). We sought to explore the experiences that may help explain reasons why some of these patients in England do not receive a psychosocial assessment. While our survey was designed to generate qualitative data, we were unable to explore in greater depth or probe issues such as the relationship between historical trauma and engagement with psychosocial assessments.

Monitoring for self-harm attendance and rates of psychosocial assessment may differ internationally. Likelihood of psychosocial assessment has been reported to be as high as 97% in an Australian sentinel monitoring study of patients admitted to hospital for self-poisoning (Carter et al., 2016; Whyte et al., 1997) and 95% in New Zealand (Hatcher et al., 2009). Around 60% of patients presenting to emergency departments in England following an episode of self-poisoning or self-injury receive a psychosocial assessment (Kapur et al., 2008). Service delivery may also differ internationally – for instance, in the use of triage scales to shorten waiting times, and follow-up practices for those who leave without an assessment (Hiles et al., 2015; Kuehl et al., 2020). Even for services with high assessment rates, a proportion of patients may refuse or leave before an assessment has taken place (Carter et al., 2016). Some patients, particularly those who attend services frequently, may also not be assessed psychosocially (Goldney, 2005; Hatcher et al., 2009; Kuehl et al., 2020). Increased awareness of the reasons why some of these patients may refuse assessment may help to improve care quality (Carter et al., 2016).

Our sample included predominantly White British females, which is a recruitment limitation consistent with other studies that were previously conducted in England (e.g. Hunter et al., 2013; MacDonald et al., 2020). However, rates of self-harm are generally higher for women than men in Australia (Carter et al., 2016), New Zealand (Carter et al., 2016; Hatcher et al., 2009), England (Geulayov et al., 2019) and the United States (Finkelstein et al., 2015) and are rapidly increasing in a number of Western countries (Griffin et al., 2018; McManus et al., 2019; Morgan et al., 2017; Perera et al., 2018; Westers, 2019). Rates of self-harm for some methods such as self-poisoning may also be higher for women compared to men. For example, in Australia 71% of patients presenting to the emergency department with an episode of self-poisoning were women (Perera et al., 2018). Our results provide important clinical information on reasons why some of these individuals may not receive a psychosocial assessment following self-harm.

Our sample included a wide age and socio-economic range (see Supplemental Appendix 2), but numbers of students (9/102, 8.8%) and those aged between 18 and 25 years (17/88, 19.3%), >60 years (5/88, 5.7%), male (14/88, 15.9%), and Black and minority ethnic groups (4/88, 4.5%) were disproportionately low. While our results were consistent across subgroups in the data, future studies are needed to explore quality-of-care issues for less represented

populations (e.g. adolescent boys and men, minority ethnic groups, persons of older age) and carers to ensure their views are considered for service development.

This is the only study to have explored experiences of non-assessment following self-harm presentations to the emergency department. Our results provide important information on patients who do not receive an assessment following self-harm and are at greatly elevated risk of harming themselves again. We had comprehensive patient/carer involvement at all stages throughout the research process. Our results were triangulated during the analyses, which was enabled by including a diverse team of people with lived experience, clinicians and researchers with qualitative expertise.

Comparisons with existing research

Consistent with quantitative studies (e.g. Bennewith et al., 2005; Cooper et al., 2013), participants reported that psychosocial assessments were less likely to occur following presentations after self-cutting, alcohol intoxication and repeated self-harm. Our qualitative results corroborate reports that patients presenting to hospital with self-cutting are less likely to receive an assessment (Bennewith et al., 2005). We found that some psychosocial assessments may depend on a clinical evaluation of suicide risk partly determined by the method of self-harm used, with self-cutting representing the lowest level of risk. Similar to Birtwistle et al. (2017) and Bennewith et al. (2005), participants reported that episodes for self-poisoning carried greater weight and urgency for psychosocial assessments. Conversely, self-cutting may be perceived by some staff as being attention-seeking behaviour and therefore taken less seriously, particularly when repeated. While women were preponderant in the study sample, our results also indicate that some clinicians may assume that suicide risk is less likely among some patients presenting with repeated self-harm. Contrary to this view, suicide and deaths by any cause are strongly associated with repeated self-harm compared to single episodes (Bergen et al., 2010; Birtwistle et al., 2017; Haw et al., 2007).

Other studies have highlighted poor patient experiences and frustrations over long waiting times when attending the emergency department following self-harm (e.g. Horrocks et al., 2005; Hunter et al., 2013; MacDonald et al., 2020; Owens et al., 2016). Our results corroborate these views but also highlight that some patients leave before a psychosocial assessment takes place for these reasons. Previous research indicates that presentations to emergency departments may be triggering for people with historical trauma (MacDonald et al., 2020; Molloy et al., 2021; Owens et al., 2016). We were unable to explore the relationship between historical trauma and engagement with psychosocial assessments as we would have done in an interview study.

This is an important area for clinical practice and worthy of a stand-alone co-designed study.

Implications for clinical practice

Our findings suggest that clinical recommendations for all patients presenting to hospital following a self-harm episode to receive a psychosocial assessment (Carter et al., 2016; NICE, 2011) are sometimes not followed in England. While much of our results are based on the responses from a White British sample of women (82%), we provide further evidence of a gap between evidence, practice, and policy in the provision of care to patients who have harmed themselves (Leather et al., 2020). Improvements of care based on clinical guidelines and evidence-based research (e.g. Carter et al., 2016; NICE, 2011; Royal Australian New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Deliberate Self-Harm, 2004) may improve care quality for all patients and potentially reduce suicide rates if they become embedded in routine clinical practice (Shand et al., 2018). However, implementation research is also needed to understand barriers and facilitators in the provision of psychosocial assessments to develop workable and culturally appropriate solutions for underrepresented populations (Leckning et al., 2020).

Our results indicate that many of our participants left the emergency department prematurely due to long waiting times and having to be medically fit for assessment. Consistent with clinical recommendations, psychosocial assessments should not be delayed until after medical treatment has been received (NICE, 2004). Involvement of liaison psychiatry staff at an early point may help to ensure timely access to psychosocial assessments and to foster patient engagement with the process (Carter et al., 2016; Ryan et al., 2015). Our participants preferred the option to wait in safe, suitable environments – ideally separate quiet rooms with check-ins from staff, which is in keeping with clinical guidelines (NICE, 2004).

Evidence-based pathways for patients presenting to hospital following self-harm, with trained triage personnel who are responsive to underlying emotional distress and are effective and empathetic communicators, may help to ensure access to psychosocial assessments (Carter et al., 2016; NICE, 2004; Ryan et al., 2015). Empathic, non-judgemental and validating communication around the person's psychological distress may help to open up conversations or disclosure around self-harm and suicide during initial assessments (Ford et al., 2020; Ryan et al., 2015). Compassionate care could help to humanise the process and encourage some patients to remain in the emergency department to be assessed (Carter et al., 2016; NICE, 2011).

Good-quality mental capacity assessments may help to identify reduced capacity and the presence of mental illness among some patients who refuse assessments (NICE, 2004; Ryan et al., 2015). Capacity to make treatment decisions

may fluctuate rapidly in the context of self-harm and some people may change their minds about accepting treatment and further assessment (Ryan et al., 2015). However, caution is needed when determining priority access to assessments on the basis of communication style or apparent mental capacity. Initial communication over the reasons for self-harm with patients may be affected by internalised stigma and/or from previous negative interactions with mental health services (MacDonald et al., 2020).

Suicide and self-harm repetition risk increases with rising levels of alcohol misuse, particularly among women (Ness et al., 2015). Given the rising prevalence of clinically significant alcohol misuse and the increased risks of further self-harm and suicide for this population, specialist alcohol treatment staff and training of acute staff in hospitals may help to prevent adverse outcomes (Griffin et al., 2018; Ness et al., 2015). Psychosocial assessments and collaborative working between services may help to engage this vulnerable group and facilitate access to appropriate aftercare (Ness et al., 2015).

More dangerous methods of self-harm are strongly associated with suicide, and these patients require careful assessment and follow-up (Bergen et al., 2012; Carter et al., 2016; Geulayov et al., 2019; Miller et al., 2013). However, suicide risk cannot be determined by method of self-harm alone (Miller et al., 2013), and widespread misconceptions over the lower risk for self-cutting compared to self-poisoning are common (Birtwistle et al., 2017). Some evidence indicates an increased suicide risk for self-cutting compared to self-poisoning (Bergen et al., 2012), especially when combined with other methods (Birtwistle et al., 2017). Patients may also switch methods of self-harm over time, often escalating to a more lethal method for their fatal episode (Miller et al., 2013).

Erroneous assumptions over the association between repeat self-harm and attention-seeking behaviour need to be challenged. Repeat self-harm and prior mental health service use are strongly associated with self-harm repetition and suicide risk (Geulayov et al., 2019; Olfson et al., 2017). Suicide risk is particularly raised in the immediate aftermath of hospital presentation for self-harm or discharge from acute services (Fedyszyn et al., 2016; Walter et al., 2019).

Hospital presentations for self-harm represent important opportunities for intervention and follow-up to help prevent repeat self-harm and suicide (Carter et al., 2016;). Psychosocial assessments provide an opportunity to therapeutically engage patients and may ultimately reduce the risk of repeat self-harm and suicide (Fedyszyn et al., 2016). Consistent with clinical guidelines, irrespective of the method, motive or suicide intent, all patients presenting should be offered a psychosocial assessment for each episode of self-harm (NICE, 2011). The forthcoming National Health Service (NHS) Commissioning for Quality and Innovation (CQUIN) target for self-harm in England (Kapur, 2020) will, for the first time, provide a financial incentive to mental health providers to improve the rates of

psychosocial assessment by liaison psychiatry services in England. This may at last help all patients who have self-harmed to get the care that they need.

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Author Contributions

All authors made substantial contributions to the study. S.C., R.T.W. and N.K. were responsible for funding acquisition. We designed and developed the study through discussion at team meetings with L.Q., D.L., R.T.W. and N.K., and at meetings with members of our patient/public involvement (PPI) group. L.Q. coordinated data collection with assistance from D.L.; L.Q. and L.G. did the analyses with input from our wider PPI panel and from E.M., S.J.B., D.L., R.T.W. and N.K.; and L.Q. interpreted the results and with input from L.G., E.M., S.J.B., D.L., R.T.W., N.K., and L.Q. wrote the first draft. All authors contributed to subsequent drafts and approved the final version. All authors take responsibility for the integrity of the data and accuracy of the data analysis. N.K. is the guarantor of the study.

Declaration of Conflicting Interests

The author(s) declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: N.K. is a member of the Department of Health's (England) National Suicide Prevention Advisory Group. He chaired the NICE guideline development group for the long-term management of self-harm and the NICE Topic Expert Group (which developed the quality standards for self-harm services). N.K. is currently chair of the updated NICE guideline for Depression, topic advisor for the current NICE guideline development group for the long-term management of self-harm and is also supported by the Greater Manchester Mental Health NHS Foundation Trust.

Ethical Approval

The study was reviewed and approved by the Greater Manchester Central Research Ethics Committee (REC No: 18/NW/0839) prior to commencement.

Ethics Statement

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

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Patient and Public Involvement

Our patient and carer advisory members were involved in all aspects of the research process. Two panel members (E.M., S.J.B.) with lived experience in this area contributed in depth to the analyses and are co-authors of this paper. This research was also reviewed by a team with experience in mental health problems and their carers who have been specially trained to advise on research proposals and documentation through the Feasibility and Acceptability Support Team for Researchers (FAST-R): a free, confidential service in England provided by the National Institute for Health Research (NIHR)–funded Maudsley Biomedical Research Centre via King's College London and South London and Maudsley NHS Foundation Trust. There was patient and public involvement input into our dissemination plan, which includes communicating key findings to relevant patient groups, carers and mental health services.

ORCID iD

Leah Quinlivan  <https://orcid.org/0000-0002-3944-3613>

Data Sharing Statement

The data that support the findings of this study are not publicly available due to restrictions of the research (consent and information that could compromise the privacy of some research participants).

Supplemental Material

Supplemental material for this article is available online.

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