



England

# CCG12: Biopsychosocial Assessments by Mental Health Liaison Services

CQUIN Webinar

17 July 2023

# Recap of the CQUIN and results to date

Sam Stringer (NHS England)

# CQUIN Indicator

## CCG12: Biopsychosocial assessments by MH liaison services

Description	Achieving 80% of self-harm <sup>7</sup> referrals receiving a biopsychosocial assessment concordant with NICE guidelines.	
Numerator	Of the denominator, those that had evidence of a comprehensive biopsychosocial assessment concordant with Section 1.3 of CG133 including: <ul style="list-style-type: none"> <li>• Assessment of needs</li> <li>• Risk assessment</li> <li>• Developing an integrated care and risk management plan<sup>8</sup></li> </ul>	
Denominator	The total referrals for self-harm to liaison psychiatry.	
Exclusions	N/A	
Data reporting and performance	Quarterly submission via national CQUIN collection. See the section on <i>Understanding Performance</i> (above) for details about auditing as well as data collection and reporting. Data will be made available approximately six weeks after each quarter. Performance basis: Quarterly.	
Scope	Services: Mental health liaison teams	Period: All quarters
Payment basis	Minimum: 60% Maximum: 80%	Calculation: Quarterly average %

# CQUIN Performance


















Average annual performance – 85%

Region	Submissions	Unique submissions	Q1	Q2	Q3	Q4	Average	>= 60%	>= 80%
East of England	111	99	89%	89%	91%	87%	89%	4	4
London	148	134	84%	92%	89%	89%	89%	6	4
Midlands	197	185	73%	82%	83%	93%	83%	10	8
North East and Yorkshire	205	182	88%	89%	91%	86%	89%	9	8
North West	131	122	86%	89%	93%	92%	90%	4	4
South East	145	135	90%	95%	96%	94%	94%	6	6
South West	114	101	90%	92%	98%	95%	94%	4	2
<b>ENGLAND</b>	<b>1051</b>	<b>958</b>	<b>81%</b>	<b>85%</b>	<b>88%</b>	<b>88%</b>	<b>85%</b>	<b>43</b>	<b>36</b>

# PSRC, MaSH, NCISH

- Dissemination of studies and implementation into regular training to reach front line staff

## Improving biopsychosocial assessments after self-harm

Context	2022/23 CQUIN*			
 Only 50% of people who have self-harmed receive an assessment in emergency departments	Aims to reduce risk of repeat self-harm and prevent suicide 			
A biopsychosocial assessment may reduce the risk of repeat self-harm by 40% 	Target of 80% of self-harm referrals receiving an assessment  <small>*Commissioning for Quality and Innovation</small>			
What did we do?				
 Used the CQUIN audit tool to evaluate performance	 Opted for a target of 90% of referrals receiving an assessment	 Rolled out a biopsychosocial assessment template	 Ongoing auditing - 10 patient audits a month	
What did we achieve in the first six months?				
 84.8% of referrals receiving a biopsychosocial assessment	 Increased quality of assessments	 Increased quality of GP letters	 Increase in copies of GP letters sent to patients	
Next steps				
 2022/2023	 Involve carers	 Improve risk assessments	 Use a trauma-informed approach to assessment	 Roll out template to all psychiatric liaison teams

East Surrey Hospital Liaison Psychiatry Service, SABP



## Psychosocial assessments: evidence and practice

CQUIN for psychosocial assessments event, 17<sup>th</sup> July 2023

**Dr Leah Quinlivan CPsychol**

**Research Fellow, GM PSTRC, University of Manchester**



# Outline

- Background: self-harm
- Psychosocial assessments: evidence and practice
- Engaging with policy and practice
- Summary

What is self-harm?

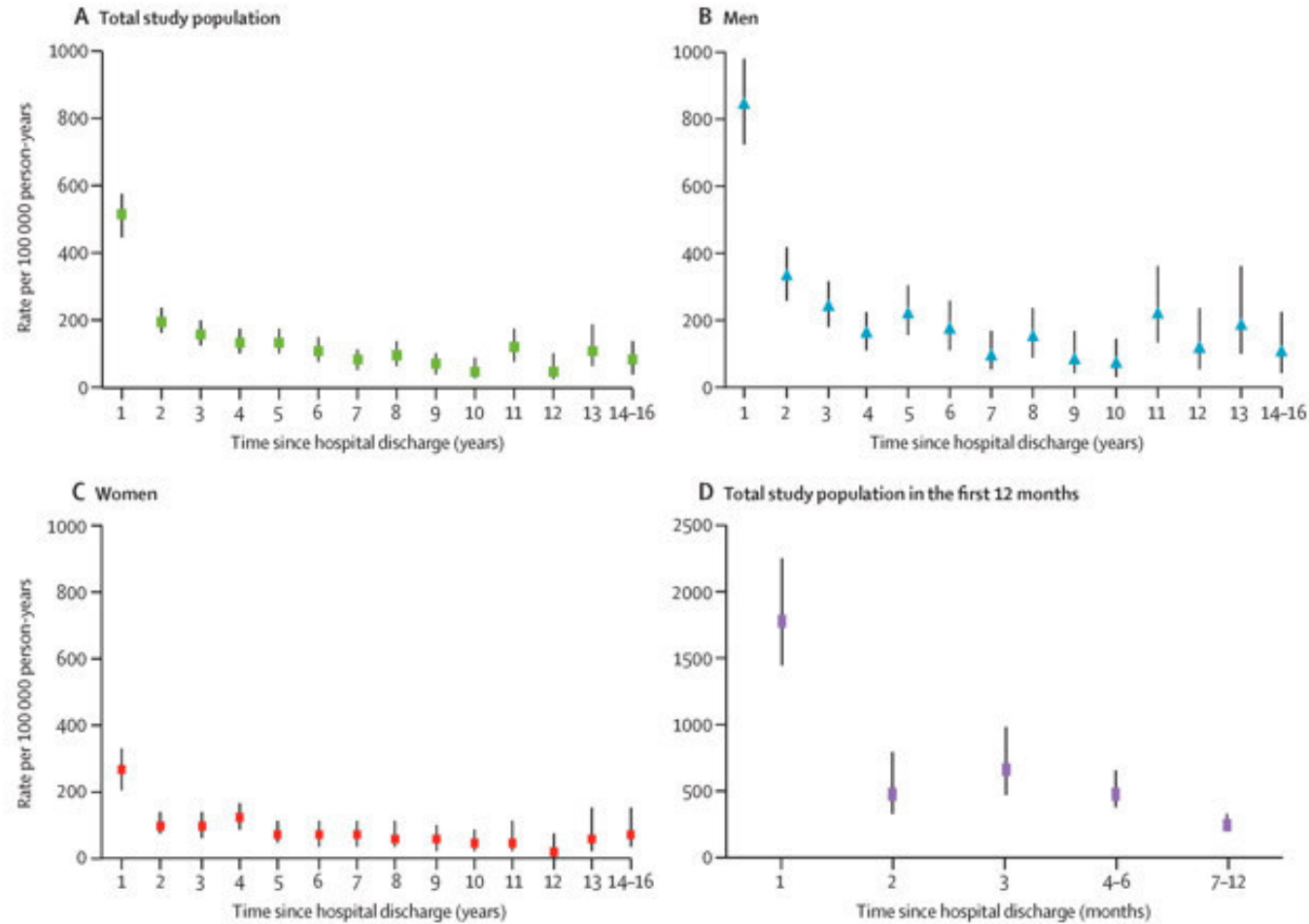


Self-poisoning or self-injury irrespective of  
apparent motivation or medical  
seriousness



# Self-harm and suicide

THE LANCET  
Psychiatry



Geulayov, Galit, et al. "Suicide following presentation to hospital for non-fatal self-harm in the Multicentre Study of Self-harm: a long-term follow-up study." *The Lancet Psychiatry* 6.12 (2019): 1021-1030

# Psychosocial assessments



Sources: Kapur, N et al. (2013). Does clinical management improve outcomes following self-harm? Results from the multicentre study of self-harm in England. [\*PloS one\*, 8\(8\), e70434.](#)

McDaid, D. et al. (2022). Cost-effectiveness of psychosocial assessment for individuals who present to hospital following self-harm in England: a model-based retrospective analysis. *European psychiatry*, 65(1), [e16.](#)

# Psychosocial assessments

OPEN ACCESS Freely available online

PLOS ONE

## Does Clinical Management Improve Outcomes following Self-Harm? Results from the Multicentre Study of Self-Harm in England

Nav Kapur<sup>1\*</sup>, Sarah Steeg<sup>2</sup>, Roger Webb<sup>3</sup>, Matthew Haigh<sup>3</sup>, Helen Bergen<sup>3</sup>, Keith Hawton<sup>3</sup>, Jennifer Ness<sup>3</sup>, Keith Waters<sup>3</sup>, Jayne Cooper<sup>3</sup>

**1** Centre for Mental Health and Risk, Centre for Suicide Prevention, University of Manchester, Manchester, United Kingdom, **2** Centre for Suicide Research, The University of Oxford, Department of Psychiatry, Warneford Hospital, Oxford, United Kingdom, **3** DASH/HSR Healthcare NHS Foundation Trust, Royal Derby Hospital, Derby, United Kingdom

**Abstract**

**Background:** Evidence to guide clinical management of self-harm is sparse, trials have recruited selected samples, and psychological treatments that are suggested in guidelines may not be available in routine practice.

**Aims:** To examine how the management that patients receive in hospital relates to subsequent outcome.

**Methods:** We identified episodes of self-harm presenting to three UK centres (Derby, Manchester, Oxford) over a 10 year period (2000 to 2009). We used established data collection systems to investigate the relationship between four aspects of management (psychosocial assessment, medical admission, psychiatric admission, referral for specialist mental health follow up) and repetition of self-harm within 12 months, adjusted for differences in baseline demographic and clinical characteristics.

**Results:** 35,938 individuals presented with self-harm during the study period. In two of the three centres, receiving a psychosocial assessment was associated with a 40% lower risk of repetition, Hazard Ratios (95% CI): Centre A 0.59 (0.50–0.70); Centre B 0.59 (0.46–0.74); Centre C 0.59 (0.52–0.66). There was little indication that the apparent protective effects were mediated through referral and follow up arrangements. The association between psychosocial assessment and a reduced risk of repetition appeared to be least evident in those from the most deprived areas.

**Conclusion:** These findings add to the growing body of evidence that thorough assessment is central to the management of self-harm, but further work is needed to elucidate the possible mechanisms and explore the effects in different clinical subgroups.

**Citation:** Kapur N, Steeg S, Webb R, Haigh M, Bergen H, et al. (2013) Does Clinical Management Improve Outcomes following Self-Harm? Results from the Multicentre Study of Self-Harm in England. *PLoS ONE* 8(8): e70434. doi:10.1371/journal.pone.0070434

**Editor:** Arnon Libi, Federal University of Rio de Janeiro, Brazil

Received March 25, 2013; Accepted June 18, 2013; Published August 1, 2013

**Copyright:** © 2013 Kapur et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

**Funding:** The authors acknowledge financial support from the Department of Health under the NHS R&D Programme (04/054/2008). NH is a National Institute for Health Research Senior Investigator. The Department of Health and the National Institute for Health Research had no role in study design, collection, analysis and interpretation of data, the writing of the report, and the decision to submit the paper for publication. The views and opinions expressed within this paper are those of the authors and do not necessarily reflect those of the Department of Health. The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

**Competing Interests:** Nav Kapur was Chair of the Guideline Development Group for the MCE self-harm guidelines (long-term management). This does not alter the authors' adherence to all the PLOS ONE policies on sharing data and materials.

\* E-mail: nav.kapur@man.ac.uk

**Introduction**

Self-harm is a major health problem internationally and a common cause of presentation to hospital [1]. Although a number of clinical guidelines have been published [2–6] the evidence-base to guide management is sparse. The most recent systematic review in the field suggested that psychological therapy may be of benefit in preventing repeat episodes of self-harm [7]. However studies to date have been underpowered. Levels of recruitment have been variable and research findings may not therefore be generalizable to the whole population of individuals who come to the attention of services following self-harm. In addition, the treatments which hold some promise – for example, cognitive behavioural therapy, problem solving therapy and dialectic behaviour therapy [8] – are not widely available to individuals in routine healthcare settings [9].

Although observational studies may be prone to bias and do not permit causal inferences to be drawn, they have the advantage that they are carried out in 'real world' settings and can allow investigation of outcomes in the majority of patients. Analysing data collected routinely by health services, a so-called 'outcomes research' approach, may help to inform service provision for self-harm [8]. Much of the work to date has focused on the possible protective effect of psychosocial assessment [7–9], but there are also some findings suggesting that referral to specialist follow up

40% lower risk of self-harm repetition

Sources: Kapur, N et al. (2013). Does clinical management improve outcomes following self-harm? Results from the multicentre study of self-harm in England. *PLoS one*, 8(8), e70434.

McDaid, D. et al. (2022). Cost-effectiveness of psychosocial assessment for individuals who present to hospital following self-harm in England: a model-based retrospective analysis. *European psychiatry*, 65(1), e16.

# Psychosocial assessments: cost effective

European Psychiatry  
www.cambridge.org/eps

Research Article

**Cite this article:** McDaid D, Park A L, Tsachris K, Wood F, Casey D, Clements L, Gidycz S, Kador N, Fook J, Waters K, Manton N (2022). Cost-effectiveness of psychosocial assessment for individuals who present to hospital following self-harm in England: A model-based retrospective analysis. *European Psychiatry*, 65(1), 1–8. <https://doi.org/10.1192/eps.2021.4>

Received: 20 September 2021  
Revised: 20 December 2021  
Accepted: 18 January 2022

**Keywords:** Economic issues, emergency departments, health economics, health services research, suicide

**Author for correspondence:** David McDaid  
E-mail: [d.mcdaid@nhs.uk](mailto:d.mcdaid@nhs.uk)

© The Author(s), 2022. Published by Cambridge University Press on behalf of the European Psychiatric Association. This is an Open Access article, distributed under the terms of the Creative Commons Attribution licence (<http://creativecommons.org/licenses/by/4.0/>), which permits unrestricted re-use, distribution and reproduction in any medium, provided the original article is properly cited.

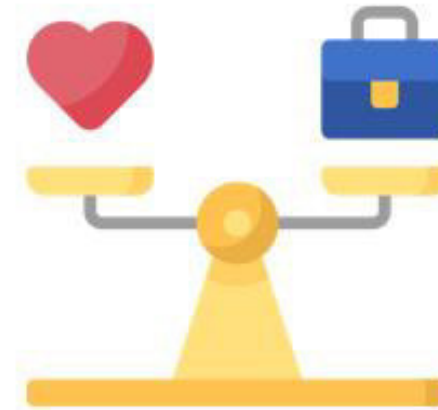
**Cost-effectiveness of psychosocial assessment for individuals who present to hospital following self-harm in England: A model-based retrospective analysis**

David McDaid<sup>1\*</sup>, A-La Park<sup>2</sup>, Apostolos Talachristas<sup>3</sup>, Fiona Brand<sup>4,5</sup>, Deborah Casey<sup>6</sup>, Caroline Clements<sup>7</sup>, Galit Grublayov<sup>8</sup>, Nav Kapur<sup>9,10</sup>, Jennifer Neist<sup>11</sup>, Keith Waters<sup>12</sup> and Keith Hawton<sup>13</sup>


**1** York Policy and Evaluation Centre, Department of Health Policy, London School of Economics and Political Science, London, United Kingdom; **2** Health Economics Research Centre, Nuffield Department of Population Health, University of Oxford, Oxford, United Kingdom; **3** Centre for Suicide Research, Department of Psychiatry, Warneford Hospital, University of Oxford, Oxford, United Kingdom; **4** Oxford Health NHS Foundation Trust, Oxford, United Kingdom; **5** Centre for Mental Health and Safety, University of Manchester, Manchester, United Kingdom; **6** Greater Manchester Mental Health NHS Foundation Trust, Manchester, United Kingdom; **7** NHS Greater Manchester Patient Safety Transformation Research Centre, University of Manchester, Manchester, United Kingdom and **8** Centre for Self-Harm and Suicide Prevention Research, Deakin Healthcare NHS Foundation Trust, Derby, United Kingdom

**Abstract**  
**Background.** Guidance in England recommends psychosocial assessment when presenting to hospital following self-harm but adherence is variable. There is some evidence suggesting that psychosocial assessment is associated with lower risk of subsequent presentation to hospital for self-harm, but the potential cost-effectiveness of psychosocial assessment for hospital presenting self-harm is unknown.  
**Methods.** A three-state four-cycle Markov model was used to assess cost-effectiveness of psychosocial assessment after self-harm compared with no assessment over 2 years. Data on risk of subsequent self-harm and hospital costs of treating self-harm were drawn from the Multicentre Study of Self-Harm in England, while estimates of effectiveness of psychosocial assessment on risk of self-harm, quality of life, and other costs were drawn from literature. Incremental cost-effectiveness ratios (ICERs) for cost per Quality Adjusted Life Year (QALY) gained were estimated. Parameter uncertainty was addressed in univariate and probabilistic sensitivity analysis.  
**Results.** Cost per QALY gained from psychosocial assessment was £10,962 (95% uncertainty interval (UI) £15,538–£6,930) from the National Health Service (NHS) perspective and £8,980 (95% UI £14,538–£6,930) from the societal perspective. Results were generally robust to changes in model assumptions. The probability of the ICER being below £20,000 per QALY gained was 70%, rising to 91% with a £6,000 threshold.  
**Conclusions.** Psychosocial assessment as implemented in the English NHS is likely to be cost-effective. This evidence could support adherence to NICE guidelines. However, further evidence is needed about the precise impacts of psychosocial assessment on self-harm repetition and costs to individuals and their families beyond immediate hospital stay.

**Introduction**  
Self-harm, defined as suicidal intentional self-poisoning or self-injury, irrespective of degree of suicidal intent or other motives [1,2], is a major health care problem globally. In England, it involves over 200,000 hospital presentations at a cost of £128 million annually [3,4]. In addition to these immediate hospital costs, there will be other substantial costs both to health systems and wider society [5]. Risk of completed suicide is more than 50 times greater in people who present to hospital for self-harm than the general population and especially high in the months following hospital discharge [6]. Past studies highlight very high lifetime costs of premature mortality [7,8]. Policymakers have also examined the economic case as part of the development of English national guidelines on suicide prevention [9,10]. There is therefore an economic, as well as moral imperative, to understand not only what works in preventing self-harm and suicide, but also the cost-effectiveness of interventions.  
One potential intervention is psychosocial assessment, which is recommended for all hospital presenting self-harm in England [11]. On average, around 50–60% of people presenting to accident and emergency (A&E) departments for self-harm receive a psychosocial assessment, although this proportion varies across sites [11,12]. Typically carried out by psychiatric liaison



# Recommended by clinical guidelines



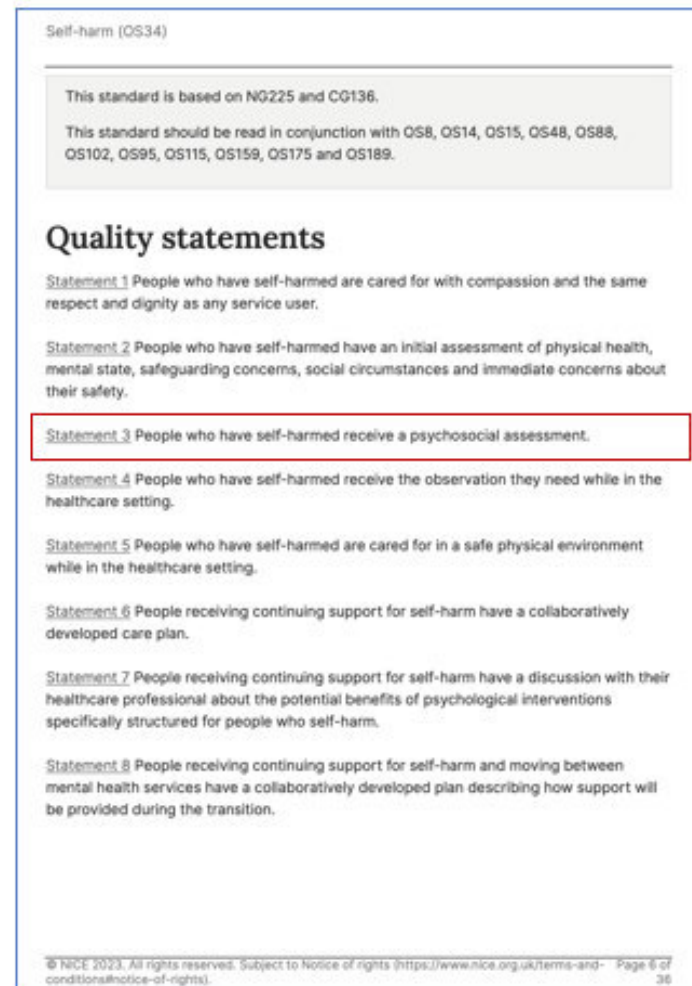
**NICE** National Institute for Health and Care Excellence

**NICE**  
guideline

## Self-harm: assessment, management and preventing recurrence

NICE guideline  
Published: 7 September 2022  
[www.nice.org.uk/guidance/ng225](http://www.nice.org.uk/guidance/ng225)

© NICE 2022. All rights reserved. Subject to Notice of rights (<https://www.nice.org.uk/terms-and-conditions#notice-of-rights>).



Self-harm (OS34)

This standard is based on NG225 and CG136.

This standard should be read in conjunction with QS8, OS14, OS15, OS48, OS88, OS102, OS95, OS115, OS159, OS175 and OS189.

### Quality statements

**Statement 1** People who have self-harmed are cared for with compassion and the same respect and dignity as any service user.

**Statement 2** People who have self-harmed have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and immediate concerns about their safety.

**Statement 3** People who have self-harmed receive a psychosocial assessment.

**Statement 4** People who have self-harmed receive the observation they need while in the healthcare setting.

**Statement 5** People who have self-harmed are cared for in a safe physical environment while in the healthcare setting.

**Statement 6** People receiving continuing support for self-harm have a collaboratively developed care plan.

**Statement 7** People receiving continuing support for self-harm have a discussion with their healthcare professional about the potential benefits of psychological interventions specifically structured for people who self-harm.

**Statement 8** People receiving continuing support for self-harm and moving between mental health services have a collaboratively developed plan describing how support will be provided during the transition.

© NICE 2022. All rights reserved. Subject to Notice of rights (<https://www.nice.org.uk/terms-and-conditions#notice-of-rights>). Page 6 of 38

<https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#psychosocial-assessment-and-care-by-mental-health-professionals>

## BMJ Open Are hospital services for self-harm getting better? An observational study examining management, service provision and temporal trends in England

J Cooper,<sup>1</sup> S Steeg,<sup>1</sup> O Bennewith,<sup>2</sup> M Lowe,<sup>1</sup> D Gunnell,<sup>2</sup> A House,<sup>3</sup> K Hawton,<sup>4</sup> N Kapur<sup>1</sup>

**To cite:** Cooper J, Steeg S, Bennewith O, et al. Are hospital services for self-harm getting better? An observational study examining management, service provision and temporal trends in England. *BMJ Open* 2013;3:e003444. doi:10.1136/bmjopen-2013-003444

Publication history and additional material for this paper is available online. To view this file please visit the journal online (<http://dx.doi.org/10.1136/bmjopen-2013-003444>).

Received 19 June 2013  
Revised 4 September 2013  
Accepted 9 October 2013



<sup>1</sup>Centre for Suicide Prevention, University of Manchester, Manchester, UK  
<sup>2</sup>School of Social and Community Medicine, University of Bristol, UK  
<sup>3</sup>Academic Unit of Psychiatry and Behavioural Sciences, Leeds, UK  
<sup>4</sup>Centre for Suicide Research, Department of Psychiatry, University of Oxford, UK

Correspondence to: Dr Jane Cooper; [jane.cooper@manchester.ac.uk](mailto:jane.cooper@manchester.ac.uk)

Cooper J, Steeg S, Bennewith O, et al. *BMJ Open* 2013;3:e003444. doi:10.1136

### ABSTRACT

**Objectives:** To describe the characteristic management of individuals attending hospital self-harm and assess changes in managed service quality since an earlier study in 2001 in which national guidance has been available in England, UK.

**Design:** Observational study.

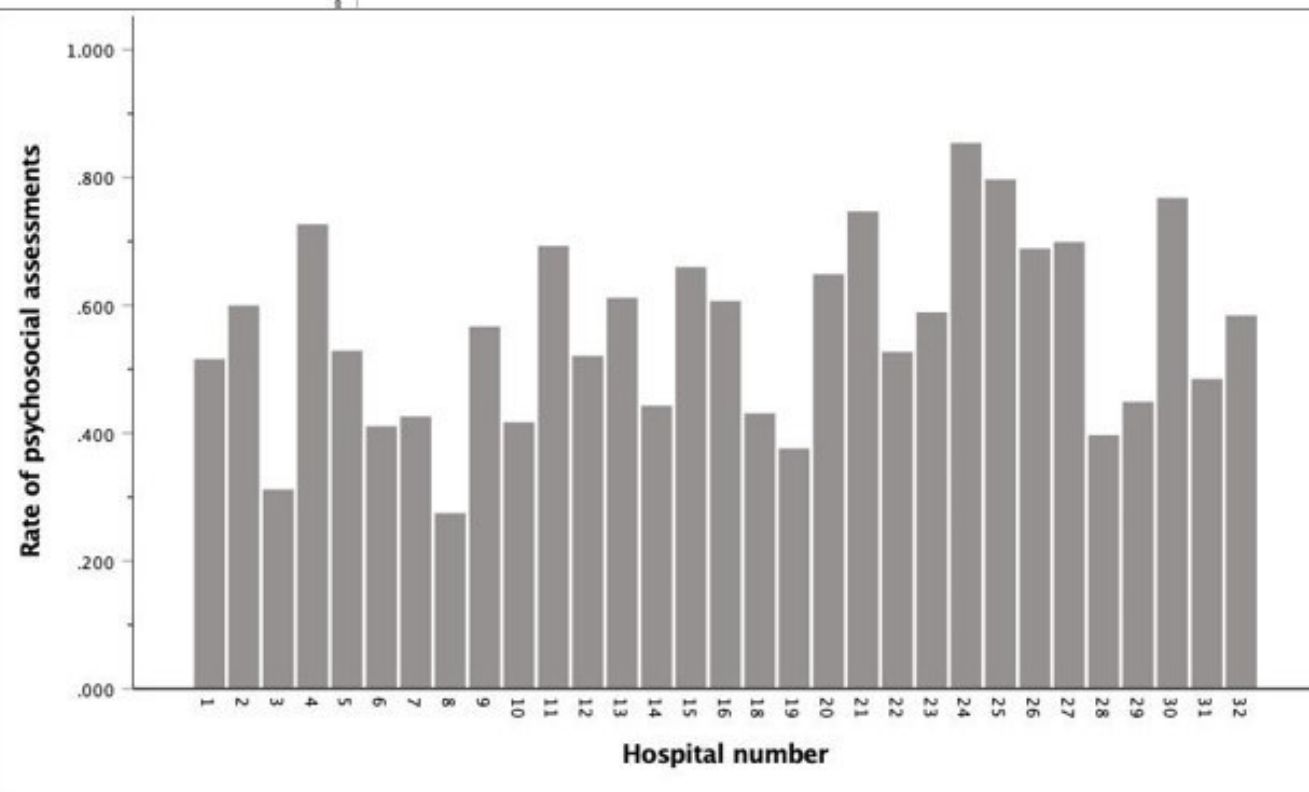
**Setting:** A stratified random sample of 30 hospitals, UK.

**Participants:** 6442 individuals presenting episodes of self-harm during a 9-month period between 2010 and 2011.

**Outcome:** Self-harm episodes, key aspects of individual management relating to psychosocial assessment and follow-up, and a 21-item of service quality.

**Results:** Overall, 58% (3583/6442) of individuals were women and 51% (3274/6442) were < 35 years. Hospitals varied markedly in their management. The proportion of episodes with a psychosocial assessment by a mental health professional ranged from 22% to 88% (median 54%, IQR 41–63%); the proportion of episodes with a referral to general hospital varied from 85% (median 54%, IQR 41–63%); a referral to specialist mental health follow-up was made in 11–64% of episodes (median 28%, IQR 20–36%); referral to non-statutory services was made in 10–45% of episodes (median 15%, IQR 8–23%); 6 episodes resulted in psychiatric admission (7%, OR 4–12%). The special assessment by method of harm, the median rate for self-poisoning was 45% (IQR 28–63%) vs 58% (IQR 48–70%) for self-cutting. Compared with the 2001 study, there was a significant increase in the proportion of episodes receiving specialist assessment, there was an increase in general hospital admission but not in referrals for specialist mental health follow-up. However, scores on the service quality scale increased from a median of 11.5–14.5 (a 2-point increase).

**Conclusions:** Services for the hospital management of self-harm remain variable despite national and policy initiatives. We found no evidence of increasing levels of assessment over time of service quality may have improved.



# Healthcare services following self-harm

Mental health assessments and psychological therapies following self-harm (MhAPT).



## Study background

Good quality mental health assessments (interviews with a doctor or clinician about what led to the hospital visit for self-harm) – are an important part of patient care when a person goes to hospital with self-harm.

All people who present to hospital with self-harm should receive an assessment of their individual needs.

Evidence suggests that the psychological treatments and mental health assessments recommended by the national clinical guidelines can be beneficial in reducing repeat self-harm.

However, there are wide differences in the quality of care when people who self-harm. Not everyone receives an assessment or mental health psychological services.

150 patients/carers

32 hospitals

51 clinician interviews



# Non-assessed patients

Research

**ANZJP**

Australian & New Zealand Journal of Psychiatry  
1-48  
DOI: 10.1177/09638239211011243  
© The Author(s) 2021  
Article reuse guidelines:  
sagepub.com/journalsPermissions  
journals.sagepub.com/home/anj  
SAGE

**'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**

Leah Quinlivan<sup>1,2,3</sup>, Louise Gorman<sup>1,2,3</sup>, Donna L Littlewood<sup>1,2,3</sup>, Elizabeth Monaghan<sup>1</sup>, Stephen J Barlow<sup>1</sup>, Stephen Campbell<sup>1</sup>, Roger T Webb<sup>1,2,3</sup> and Nav Kapur<sup>1,2,3,4</sup>

**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 analysis was 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; Offens 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. Aronsson et al., 2018; Carter et al., 2016; Cooner et al., 2003; Finkelstein et al., 2015; Peres et al., 2018; Teasdale et al., 2020). Psychosocial assessments on presentation to hospital may help prevent repeat self-harm and improve access to appropriate aftercare (e.g. Carrill et al., 2016; Carter et al., 2016).

<sup>1</sup>Division of Psychology and Mental Health, Centre for Mental Health and Safety, The University of Manchester, Manchester, UK  
<sup>2</sup>Manchester Academic Health Sciences Centre, The University of Manchester, Manchester, UK  
<sup>3</sup>NHS Greater Manchester Patient Safety Translational Research Centre, The University of Manchester, Manchester Academic Health Sciences Centre, Manchester, UK  
<sup>4</sup>Greater 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

Australian & New Zealand Journal of Psychiatry, 00(0)





# Falling through the statistical net



Patient reasons



Gateway issues



Hierarchy of risk

# Received psychosocial assessment

Open access Original research

## BMJ Open 'Relieved to be seen' – patient and carer experiences of psychosocial assessment in the emergency department following self-harm: qualitative analysis of 102 free-text survey responses

Leah M Quinlivan<sup>1,2</sup>, Louise Gorman,<sup>1,2</sup> Donna L Littlewood,<sup>3</sup> Elizabeth Monaghan,<sup>3</sup> Steven J Barlow,<sup>2</sup> Stephen M Campbell,<sup>3</sup> Roger T Webb,<sup>1,2</sup> Navneet Kapur<sup>1,2,3</sup>

**ABSTRACT**  
**Objectives** We sought to explore patient and carer experiences of psychosocial assessments following presentations to hospital after self-harm.  
**Design** Thematic analysis of free-text responses to an open-ended online survey.  
**Setting** Between March and November 2019, we recruited 86 patients (82% women) and 14 carers aged ≥18 years from 16 English mental health trusts, community organisations, and via social media.  
**Results** Psychosocial assessments were experienced as helpful on some occasions but harmful on others. Participants felt better, less suicidal and less likely to repeat self-harm after good quality compassionate and supportive assessments. However, negative experiences during the assessment pathway were common and, in some cases, contributed to greater distress, less engagement and further self-harm. Participants reported receiving negative and stigmatising comments about their injuries. Others reported that they were refused medical care or an assessment. Disproportionate attention among some mental health staff centred on pronounced issues over self-harm as a 'behavioural issue', inappropriate use of services and psychiatric diagnosis.  
**Conclusions** Our findings highlight important patient experiences that can inform service provision and they demonstrate the value of involving patients' carers throughout the research process. Psychosocial assessments can be beneficial when empathetic and collaborative but less helpful when overly standardised, lacking in compassion and waiting times are unduly long. Patient views are essential to inform practice, particularly given the rapidly changing service context during and after the COVID-19 emergency.

**INTRODUCTION**  
Self-harm is a common antecedent and strong risk factor for suicide.<sup>1,2</sup> Repeat self-harm occurs frequently, and people who harm themselves more than once have an even higher risk of suicide.<sup>3</sup> Although

hospital presentations represent the 'tip of the iceberg' for self-harm,<sup>4</sup> they provide an important opportunity for intervention via the provision of good-quality care.<sup>5</sup> Liaison psychiatry services are an integral part of the self-harm care pathway.<sup>6</sup> Specialist teams are typically situated in acute hospitals and provide liaison care for patients on wards and in the emergency department.<sup>7</sup> Psychosocial assessments are a core component of care and are recommended for all patients presenting to hospital services having harmed themselves.<sup>8</sup> Good-quality assessments may help to prevent repeat self-harm.<sup>9,10</sup>  
Liaison psychiatry has rapidly transformed to manage the consequences of the COVID-19 pandemic on service provision.<sup>6</sup>

**Strengths and limitations of this study**

- Understanding what works and does not work for patients when receiving psychosocial assessments following self-harm is key to improving practice; however, such evidence is limited.
- This is the largest qualitative study on psychosocial assessments following self-harm and the only study to have also included carer perspectives.
- Our extensive patient and carer involvement and use of a qualitative survey enabled us to access a marginalised and stigmatised group of patients and carers with substantive unmet healthcare needs.
- A limitation of this study is the use of a non-probability survey design; however, our aim was to provide qualitative experiential data and not to generalise to the broader population.
- Most of the respondents in the study were white British women from England (72/86, 81.8%), and their experiences may differ in important ways from other patients who have limited literacy skills or did not complete the survey.

**Check for updates**

© Author(s) 2021. Re-use permitted under CC BY. Published by BMJ.

**Centre for Mental Health and Safety**, University of Manchester, Manchester, UK.  
**Mental Health Research Centre**, The University of Manchester, Manchester Academic Health Science Centre, Manchester, UK.  
**Greater Manchester Mental Health NHS Foundation Trust**, Manchester, UK.

Correspondence to: Dr Leah M Quinlivan; leah.quinlivan@man.ac.uk

BMJ | <https://doi.org/10.1136/bmjopen-2020-024424> 1

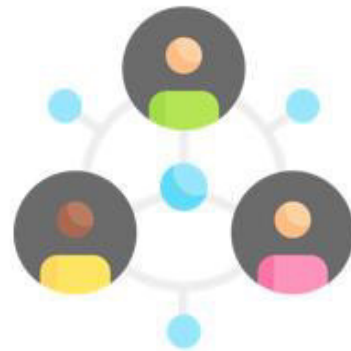
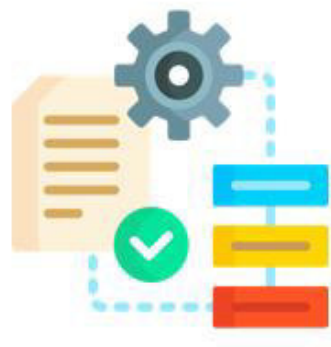


## Psychosocial assessments: What helps?



Source: Quinlivan [LM](#), Gorman L, Littlewood DL, *et al* 'Relieved to be seen'—patient and carer experiences of psychosocial assessment in the emergency department following self-harm: qualitative analysis of 102 free-text survey responses *BMJ Open* 2021;**11** :e044434. doi: [10.1136/bmjopen-2020-044434](https://doi.org/10.1136/bmjopen-2020-044434)

# Engaging with policy & practice



## Indicator Specification

### CCG12: Biopsychosocial assessments by MH liaison services

Description	Achieving 80% of self-harm <sup>1</sup> referrals receiving a biopsychosocial assessment concordant with NICE guidelines.	
Numerator	Of the denominator, those that had evidence of a comprehensive biopsychosocial assessment concordant with NICE guideline Section 1.3 of CG133 including: <ul style="list-style-type: none"> <li>• Assessment of needs</li> <li>• Risk assessment</li> <li>• Developing an integrated care and risk management plan<sup>2</sup></li> </ul>	
Denominator	The total referrals for self-harm to liaison psychiatry.	
Exclusions	N/A	
Data reporting and performance	Quarterly submission via national CQUIN collection. See the section on <i>Understanding Performance</i> in the <a href="#">CQUIN 2022/23 guidance</a> for details about auditing as well as data collection and reporting. Data will be made available approximately six weeks after each quarter. Performance basis: Quarterly.	
Scope	Services: Mental health liaison teams	Period: All quarters
Payment basis	Minimum: 60% Maximum: 80%	Calculation: Quarterly average %

# CQUIN implementation support



Launch event



Quarterly interactive clinics



Regular email and support



NHSE/I ongoing support



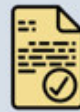
FutureNHS Collaboration Platform

<https://future.nhs.uk/MHCQUIN/groupHome>

## What did we achieve in the first six months?



84.8% of referrals receiving a biopsychosocial assessment



Increased quality of assessments



Increased quality of GP letters



Increase in copies of GP letters sent to patients

## Next steps

2022/2023



Involve carers



Improve risk assessments



Use a trauma-informed approach to assessment



Roll out template to all psychiatric liaison teams

# Summary

- Psychosocial assessments recommended for all patients who have self-harmed
- But wide variability in practice
- Research & lived experience: importance of process: compassion, reassurance, understanding
- Psychosocial assessments core area for policy and QI



## Thank-you

Email: [leah.quinlivan@manchester.ac.uk](mailto:leah.quinlivan@manchester.ac.uk)

Twitter: [@drLeahQuinlivan](https://twitter.com/drLeahQuinlivan)

**NIHR GM PSTRC Team:** Dr Leah Quinlivan, Dr Louise Gorman, Dr Donna Littlewood, Elizabeth Monaghan, Stephen Barlow, Professor Roger Webb, Professor Nav Kapur

& thanks to the [MS4MH-R](#) PPI group





**Humber Teaching**  
NHS Foundation Trust

# Improving the Psychosocial Assessment Experience and Pathway

Emma Thompson, Team Lead  
Emma Hooley, Clinical Lead

# The Mental Health Liaison Service

Hull Royal Infirmary



Humber Teaching  
NHS Foundation Trust



- 24/7 Core 24 Model
- Hull Royal Infirmary and Castle Hill Hospitals
- Population served 600,000
- 1085 Bedded hospital
- Our average per month 375 referrals.
- 78% of the referrals come from ED at source.
- June 2023 introduced 'ED Streaming' into our model of care.



Caring, Learning  
& Growing Together

# The Vision



**Humber Teaching**  
NHS Foundation Trust

- Initially introduced as a concept in 2019 and we used some 'Winter Pressures' money to adopt a 'loose' version.
- Adopted a streaming model throughout the pandemic
- Many lessons learnt
- ICB funding- supported by the mental health investment standard.
- Prime space identified within HRI adjacent to the Emergency Department (Central Location Key).
- Collaborative approach between HUTH, HTFT, MHLS staff and our co production group.



**Caring, Learning  
& Growing Together**



# Why?

- Improving the patient journey
- Improving patient flow through ED and removing time pressures.
- Reduce over crowding in the ED waiting area.
- Providing a calm, relaxing area for patients which allows us to deliver 24/7 specialist mental health support and assessment.
- Supports mental health assessment and confidence rating in risk assessment.



# The 'Humber Suite'



Humber Teaching  
NHS Foundation Trust





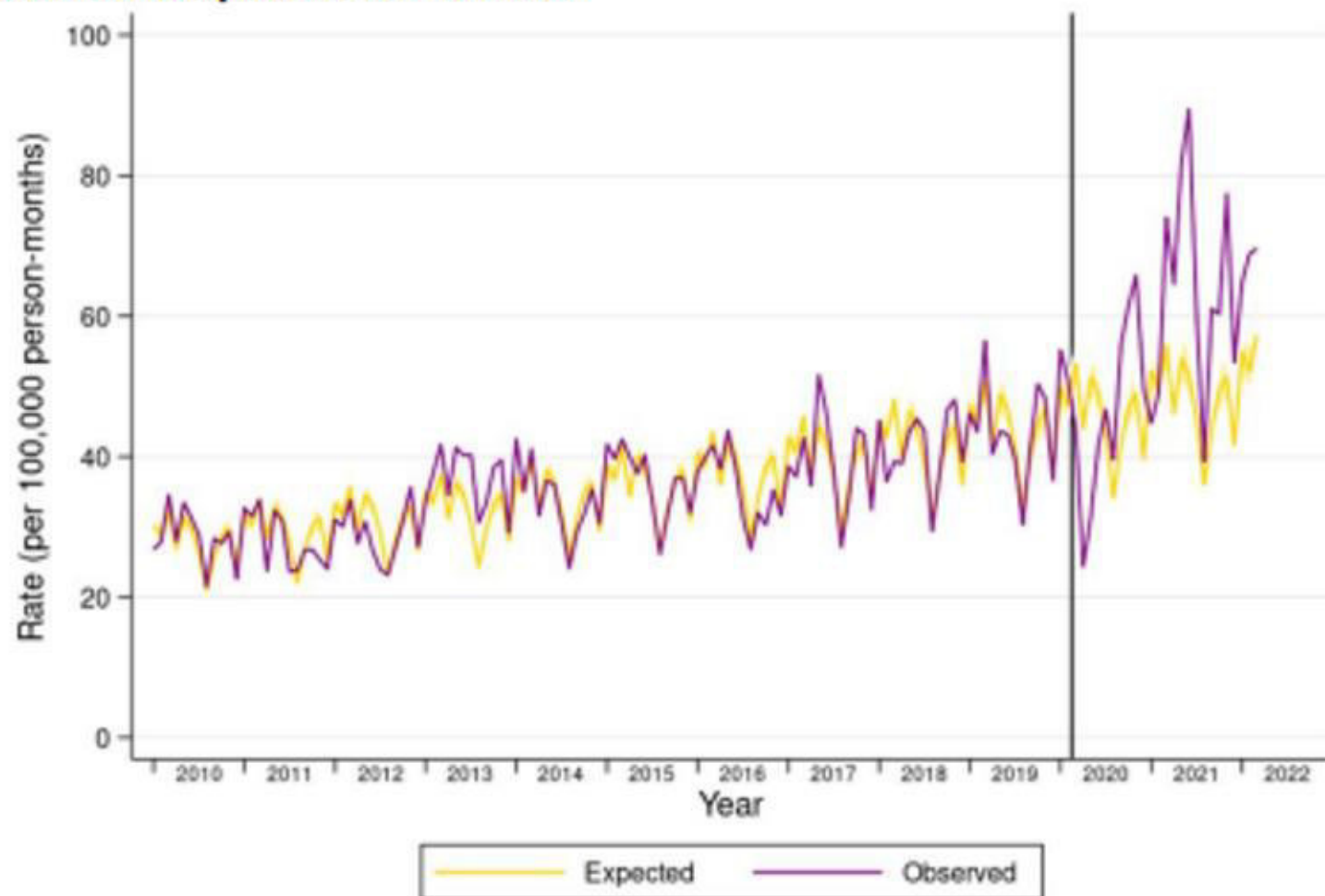
# Self-harm: what next after the CQUIN?

Webinar July 2023

Professor Nav Kapur



## Self-harm episodes for females



**NICE** National Institute for  
Health and Care Excellence

Sign in

- Guidance ▾
- Standards and indicators ▾
- Life sciences ▾
- British National Formulary (BNF) ▾
- British National Formulary for Children (BNFC) ▾
- Clinical Knowledge Summaries (CKS) ▾
- About ▾

Read about [our approach to COVID-19](#)

[Home](#) > [NICE Guidance](#) > [Conditions and diseases](#) > [Mental health and behavioural conditions](#) > [Self-harm](#)

## Self-harm: assessment, management and preventing recurrence

NICE guideline [NG225] Published: 07 September 2022

<https://www.nice.org.uk/guidance/NG225>

- 1.5.1 At the earliest opportunity after an episode of self-harm, a mental health professional should carry out a [psychosocial assessment](#) to:
- develop a collaborative therapeutic relationship with the person
  - begin to develop a shared understanding of why the person has self-harmed
  - ensure that the person receives the care they need
  - give the person and their family members or carers (as appropriate) information about their condition and diagnosis.

- Don't delay
- Take into account needs and preferences
- Private designated area



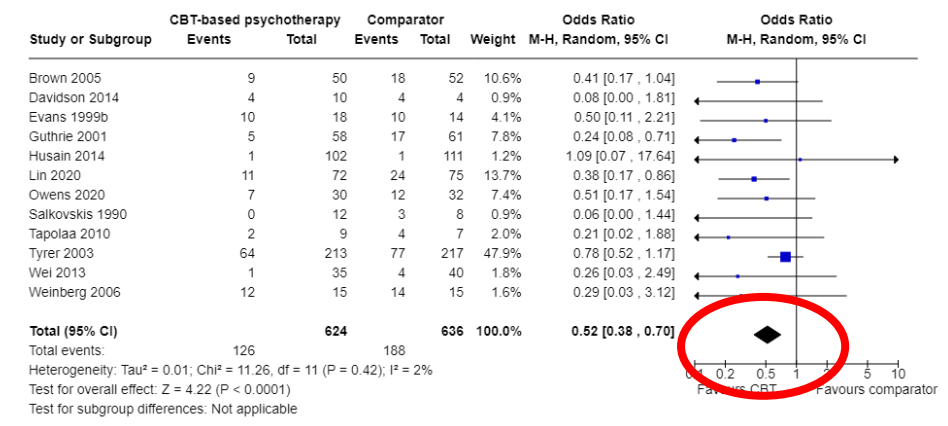
Psychosocial  
assessment may  
reduce the risk of  
repeat self-harm by  
**40%**

1.11.3 Offer a structured, person-centred, [cognitive behavioural therapy \(CBT\)-informed psychological intervention](#) (for example, CBT or problem-solving therapy) that is specifically tailored for adults who self-harm. Ensure that the intervention:

- starts as soon as possible
- is typically between 4 and 10 sessions; more sessions may be needed depending on individual needs
- is tailored to the person's needs and preferences.

1.11.4 For children and young people with significant emotional dysregulation difficulties who have frequent episodes of self-harm, consider [dialectical behaviour therapy adapted for adolescents \(DBT-A\)](#). Take into account the age of the child or young person and any planned transition between services.

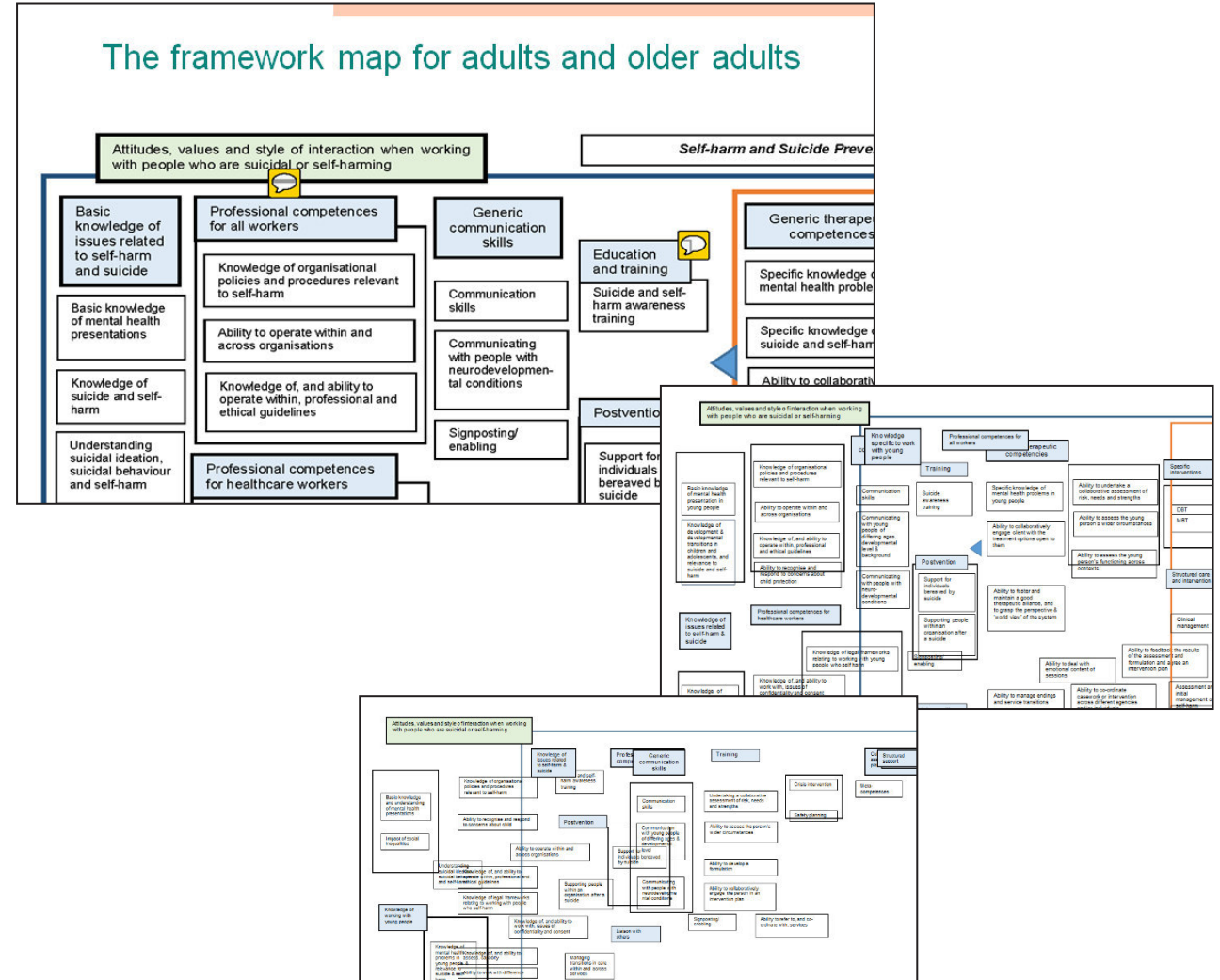
1.11.5 Healthcare staff should be appropriately trained and supervised in the therapy they are offering to people who self-harm.



<https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD013668.pub2/references#dataAndAnalyses>

## Self-harm and Suicide Prevention Competence Framework Adults and older adults

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH



### Brief psychological intervention




Photo by [Gemma Schreyer](#) on Unsplash

#### Why are we taking action?

- Improve access to support in timely manner
- Offer targeted interventions for reducing self-harm
- Encourage GPs to support people who self-harm
- Enhance service users understanding of how to manage emotions

#### What are we planning to do?

- Referral to Mental Health Integrated Community Services (MHICS) by GP
- Offer brief psychological intervention
- 4 sessions by Mental Health practitioner

#### How will we measure impact?

- 2020/2021: Number of patients referred and engaging
- Number of patients signposted
- Feedback (pre and post) wellbeing, satisfaction
- Staff confidence to deliver intervention

**Frimley Health and Care Integrated Care System**

### Digital resources



#### Why are we taking action?

- Improve the digital offer for people who self-harm
- Increase awareness of support and advice
- Give people hope through videos, poems, art
- Encourage engagement with online resource in the community

#### What are we planning to do?

- Webpage
- Information & local services
- Self-harm resources
- Stories of hope
- Poster with QR code to webpage

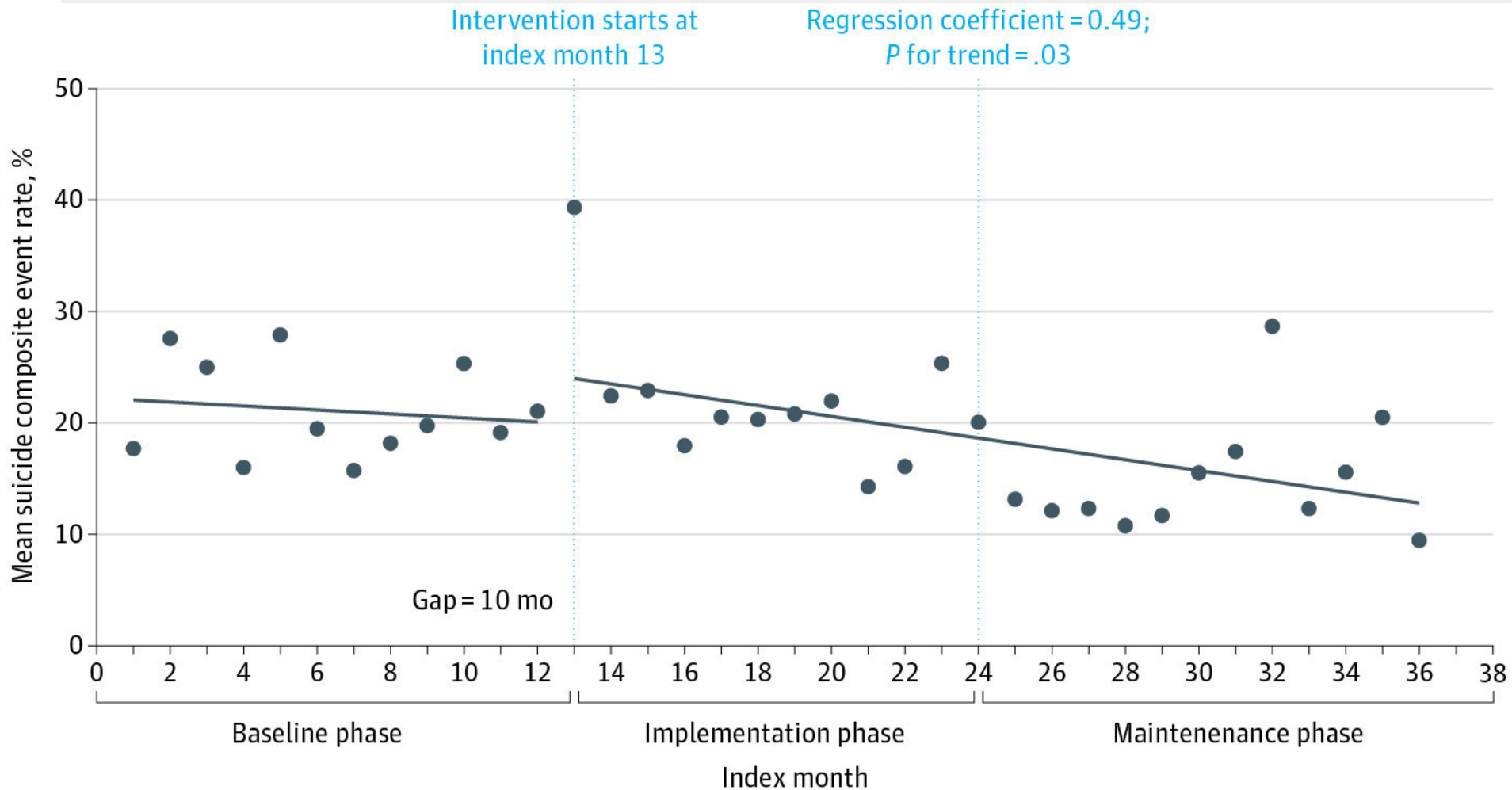
#### How will we measure impact?

- 2020/2021: Website visits
- Stories of hope video views
- User feedback
- QR clicks
- Posters distributed

**Somerset STP**

From: Effect of an Emergency Department Process Improvement Package on Suicide Prevention: The ED-SAFE 2 Cluster Randomized Clinical Trial

JAMA Psychiatry. Published online May 17, 2023. doi:10.1001/jamapsychiatry.2023.1304



# New settings - Primary Care

## Editorials

### Improving the management of self-harm in primary care

Self-harm is sometimes seen by health professionals as a minor problem, yet the risk of suicide is increased fifty-fold in the year after a self-harm episode compared to the general population.<sup>1</sup> Reducing rates of self-harm is a national policy priority but research suggests that self-harm presentations to general practice are increasing.<sup>2</sup> Self-harm is defined as intentional self-injury or poisoning regardless of suicidal intent and can occur at any age.<sup>3</sup> In young females, around one in four have a lifetime history of self-harm.<sup>4</sup> In older adults who have self-harmed the risk of suicide is particularly high.<sup>5</sup> Reliable data about self-harm are relatively sparse because self-harm may be hidden, and even when people do present to clinical services self-harm may be poorly recorded.

It is estimated that there are around 228 000 self-harm hospital presentations each year in England that result in NHS treatment costs of ~£128 million.<sup>6</sup> Even though some people have a single episode of self-harm, around one in five repeat self-harm within 1 year of hospital presentation.<sup>7</sup> Self-harm is also a global health issue. A few approaches have been tested internationally to reduce repeat self-harm in primary care: neither an educational intervention for GPs targeting older adults or structured GP follow-up

#### HOW SHOULD GPs ASSESS PEOPLE AFTER SELF-HARM?

The guideline outlines how a patient who has self-harmed should be treated with *respect, dignity and compassion, with an awareness of cultural sensitivity.*<sup>3</sup> Clinicians should *'establish the means of self-harm and, if accessible to the person, discuss removing this with therapeutic collaboration or negotiation, to keep the person safe.'*<sup>3</sup> GPs should establish the severity of any injury, mental state, and need for further specialist input.

The guideline states that for patients managed in primary care the assessing GP should ensure the person receives regular GP appointments for review of self-harm, information about available support, care for coexisting mental health problems, and a medicines review. Patients who self-harm value continuity of GP care.<sup>12</sup>

It is recommended that GPs consider referring patients who have self-harmed to mental health services for a comprehensive psychosocial assessment. Box 1 outlines when a referral to mental health professionals is recommended as a priority.

The guideline does not recommend the use of risk assessment tools or scales and risk stratification into low, medium, or high for future self-harm or death by suicide, after an episode of self-harm. The pooled estimate of positive predictive values (patients who were scored at 'high' risk of suicide and went on to die by suicide) of all risk scales/tools on future death by suicide is 6%.<sup>13</sup> Instead, GPs should focus on the person's needs and how

#### Box 1. Recommendations for when to make an urgent referral to a mental health specialist

- The person's levels of concern or distress are rising, high, or sustained.
- The frequency or degree of self-harm or suicidal intent is increasing.
- The person providing assessment in primary care is concerned.
- The person asks for further support from mental health services.
- Levels of distress in family members or carers of children, young people, and adults are rising, high, or sustained, despite attempts to help.

concerns for the person, because repeat self-harm is most likely to occur 2–3 days after the last episode.<sup>3</sup>

The guideline recommends that adults who self-harm are offered a structured and tailored cognitive behavioural therapy-informed psychological intervention (at least four sessions) because there is evidence of positive effects on repetition of self-harm and on hopelessness and depression at post-intervention assessment.<sup>3,14</sup> For children and young people with significant emotional dysregulation difficulties who have frequent episodes of self-harm, dialectical behavioural therapy for adolescents should be considered.

Accessing appropriate aftercare for patients following self-harm can be challenging. Waiting times are often long and exclusion from mental health services is unfortunately

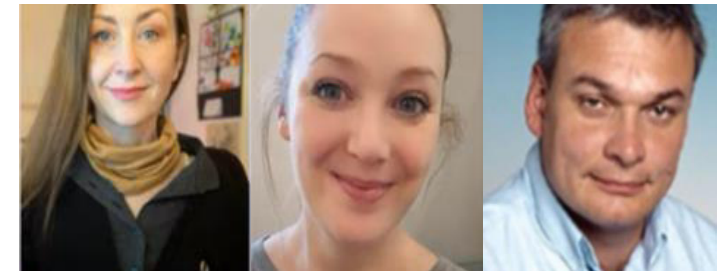
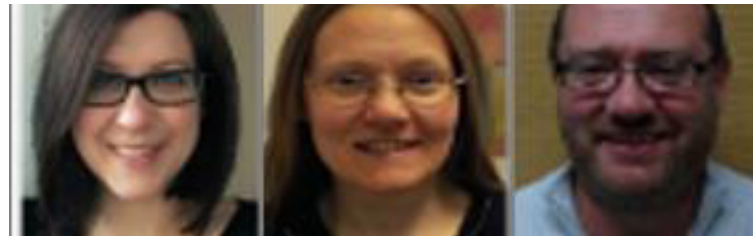
- An opportunity to intervene
- GPs should be able to know how to assess and when to refer
- Continuity and shared decision making
- Safer prescribing
- Accessible aftercare







- Focus on number and quality of **assessments**
- Access to **treatment** - underlying conditions and psychological interventions
- A workforce who are properly **trained and supervised**
- The importance of **implementation**
- Harness the potential of **primary care**
- Be responsive to **new developments** (guidelines and strategies)



 @NCISH\_UK



 @mashproject



 @PSTRC\_GM

# Q&A

Dr Leah Quinlivan (University of Manchester)

---

# Thank You

[Mental Health CQUIN - FutureNHS Collaboration Platform](#)

[england.mhcquin@nhs.net](mailto:england.mhcquin@nhs.net)