CCG12: Biopsychosocial Assessments by Mental Health Liaison Services

CQUIN Webinar

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[7] 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: • Assessment of needs • Risk assessment • Developing an integrated care and risk management plan[8]	
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 *Understanding Performance* (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
ENGLAND	**1051**	**958**	**81%**	**85%**	**88%**	**88%**	**85%**	**43**	**36**

PSRC, MaSH, NCISH

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

Improving biopsychosocial assessments after self-harm

Context

Only 50% of people who have self-harmed receive an assessment in emergency departments

A biopsychosocial assessment may reduce the risk of repeat self-harm by 40%

2022/23 CQUIN*

Aims to reduce risk of repeat self-harm and prevent suicide

Target of 80% of self-harm referrals receiving an assessment

**Commissioning for Quality and Innovation*

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

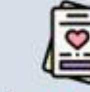
Increased quality of GP letters

Increase in copies of GP letters sent to patients

Next steps

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

NIHR | Greater Manchester Patient Safety Translational Research Centre

Psychosocial assessments: evidence and practice

CQUIN for psychosocial assessments event, 17th July 2023

Dr Leah Quinlivan CPsychol

Research Fellow, GM PSTRC, University of Manchester

Outline

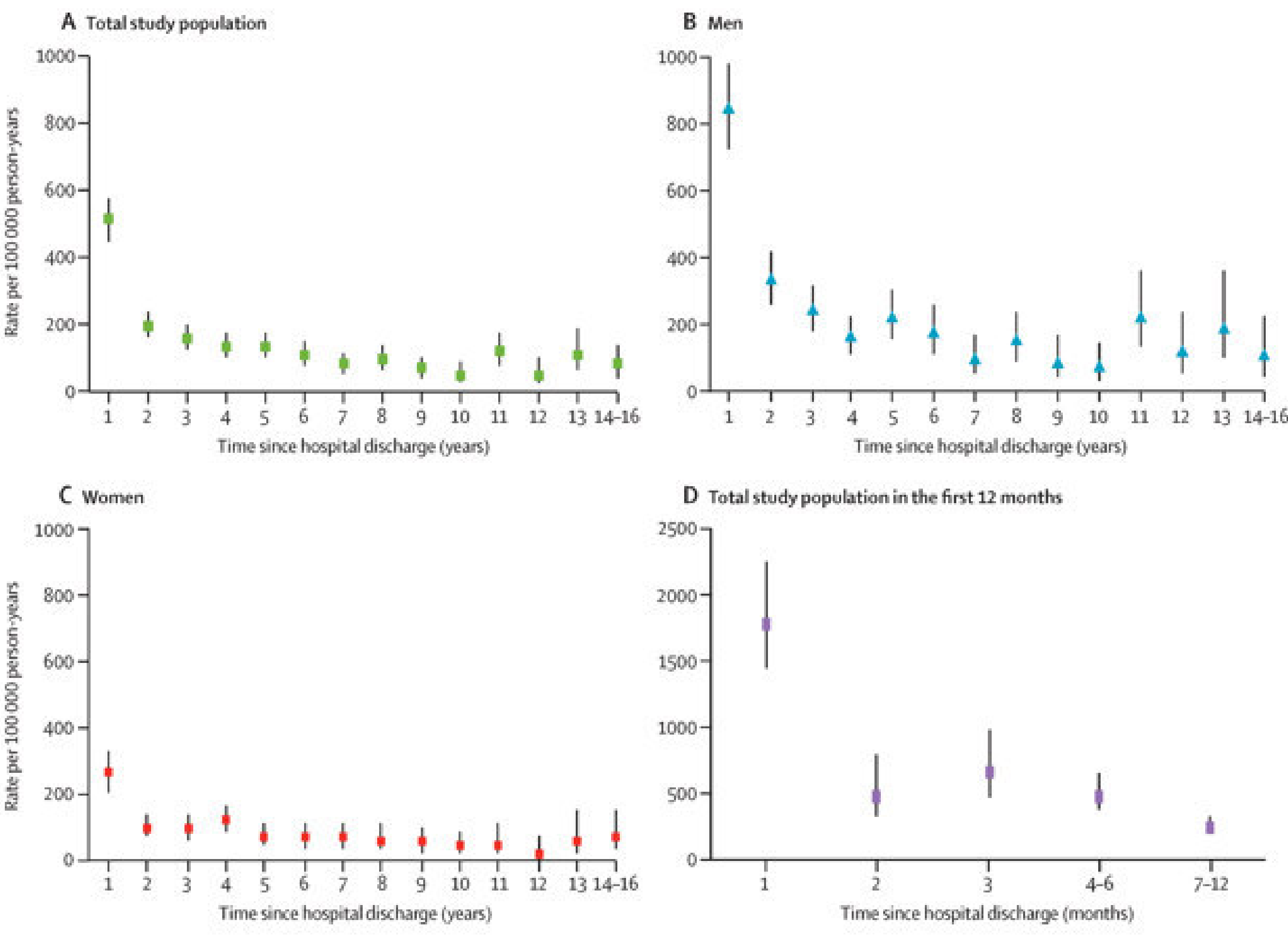
- Background: self-harm
- Psychosocial assessments: evidence and practice
- Engaging with policy and practice
- Summary

What is self-harm?

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

Self-harm and suicide

THE LANCET
Psychiatry



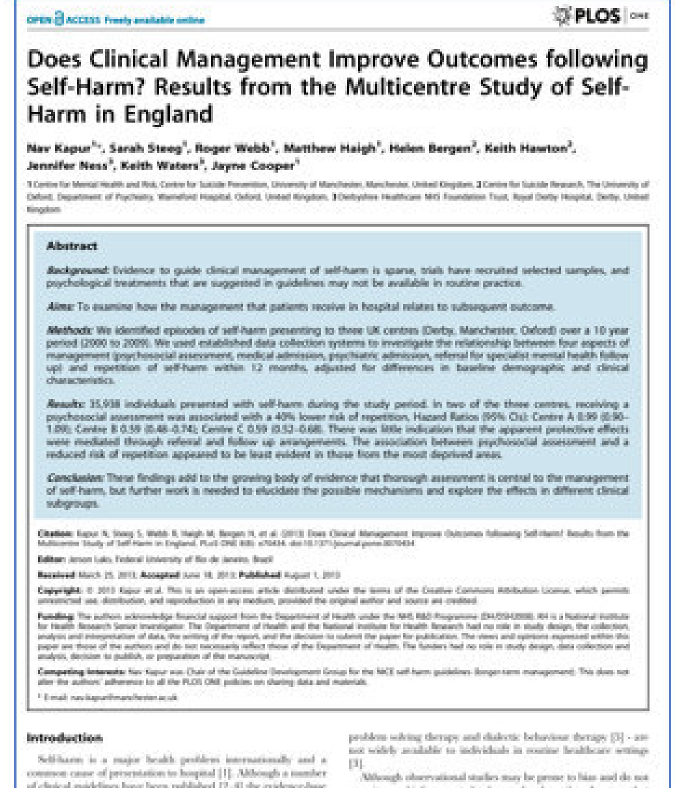
Geulayov, Galit, et al. "Suicide following presentation to hospital for non-fatal self-harm in the Multicentre Study of Self-harm: a long-term follow-up study." The Lancet Psychiatry 6.12 (2019): 1021-1030

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[1,*], Sarah Steeg[1], Roger Webb[1], Matthew Haigh[1], Helen Bergen[2], Keith Hawton[2], Jennifer Ness[3], Keith Waters[3], Jayne Cooper[1]

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 Derbyshire 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% CIs): Centre A 0.99 (0.90–1.09); Centre B 0.59 (0.48–0.74); Centre C 0.59 (0.52–0.68). 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: Jerson Laks, Federal University of Rio de Janeiro, Brazil

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

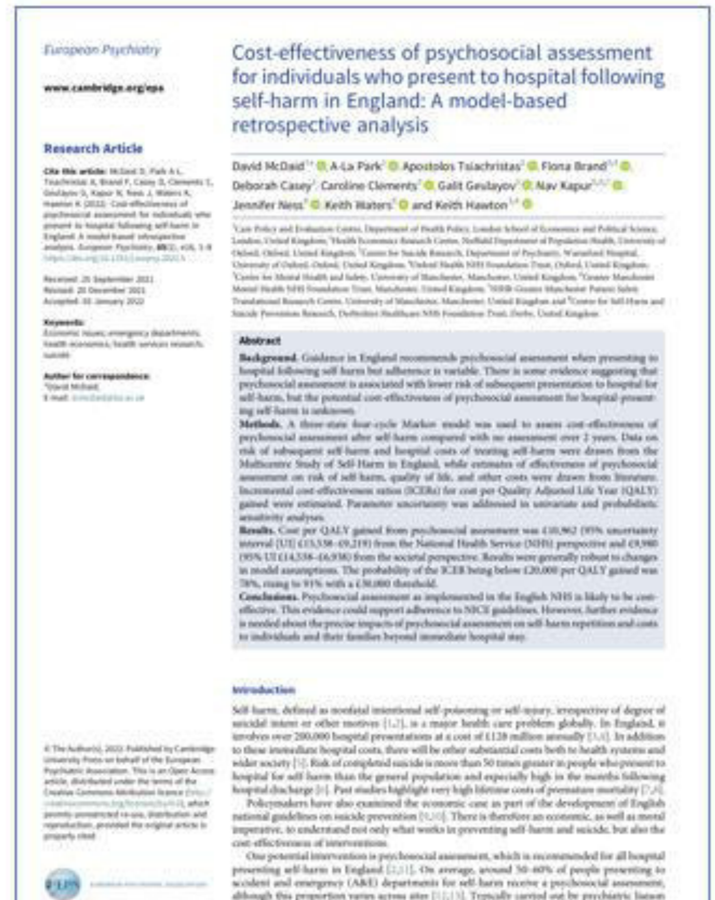
Introduction

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/epa

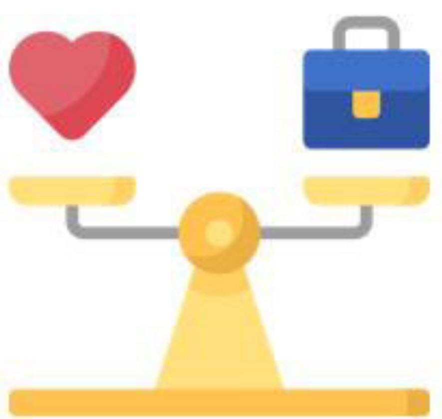
Research Article

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

David McDaid, A-La Park, Apostolos Tsiachristas, Fiona Brand, Deborah Casey, Caroline Clements, Galit Geulayov, Nav Kapur, Jennifer Ness, Keith Waters and Keith Hawton

Abstract

Introduction



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.

Recommended by clinical guidelines

NICE guideline

Self-harm: assessment, management and preventing recurrence

NICE guideline
Published: 7 September 2022
www.nice.org.uk/guidance/ng225

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This standard is based on NG225 and CG136.

This standard should be read in conjunction with QS8, QS14, QS15, QS48, QS88, QS102, QS95, QS115, QS159, QS175 and QS189.

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.

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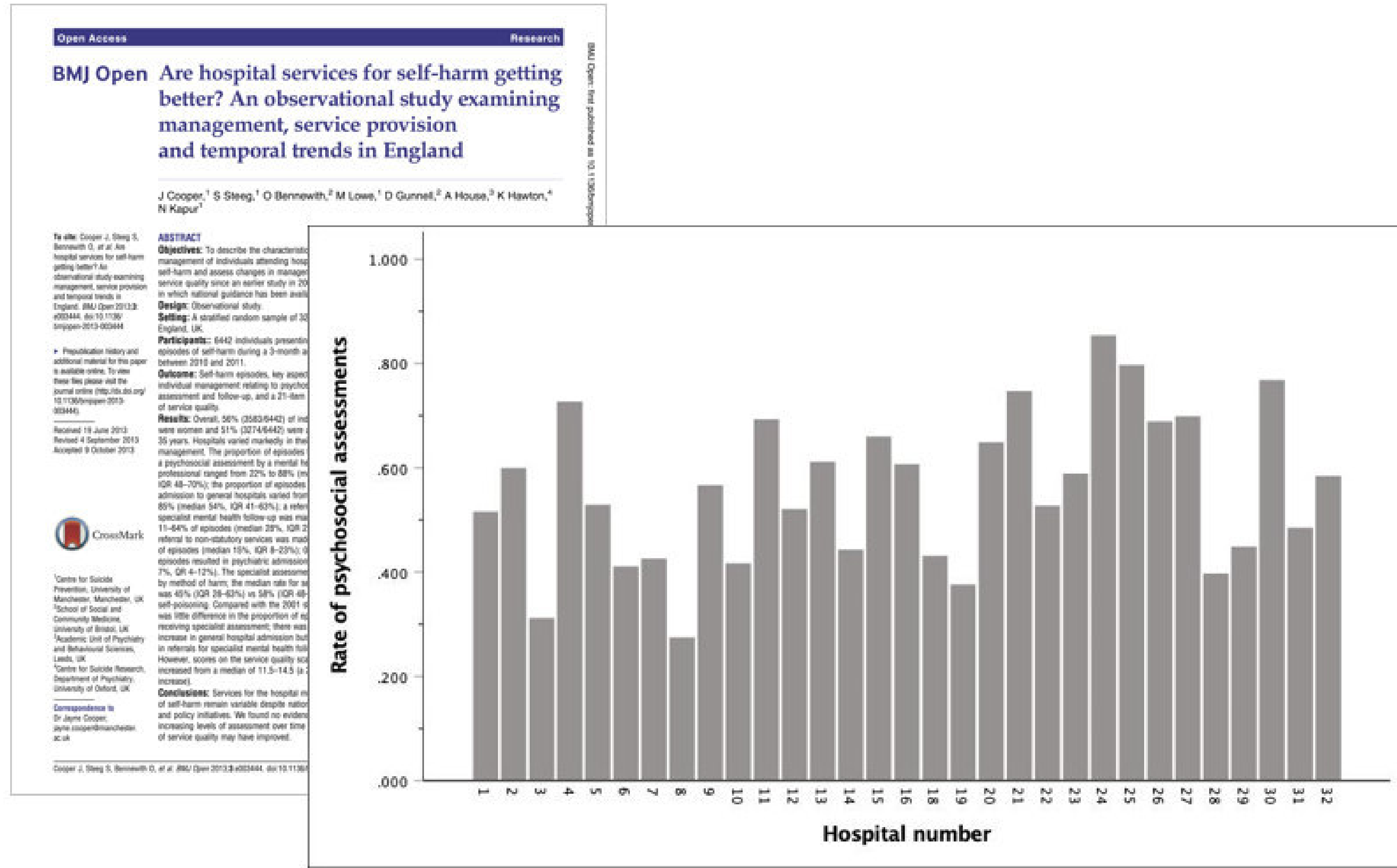
https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#psychosocial-assessment-and-care-by-mental-health-professionals



Source: Cooper et al BMJ Open (2013) doi:10.1136/bmjopen-2013-003444
Mdn: 58% , Range: 22%-88%*

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 r
assessment of their individual needs.

Evidence suggests that the psychological treatments and r
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
who self-harm. Not everyone receives an assessment or r
psychological services.

150 patients/carers

32 hospitals

51 clinician interviews

Non-assessed patients

Research

'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

Australian & New Zealand Journal of Psychiatry
1–10
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SAGE

Leah Quinlivan[1,2,3], Louise Gorman[1,2,3], Donna L Littlewood[1,2,3], Elizabeth Monaghan[3], Stephen J Barlow[3], Stephen Campbell[3], 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. Aronsman 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).

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[2]Manchester Academic Health Science Centre, The University of Manchester, Manchester, UK
[3]NIHR Greater Manchester Patient Safety Translational Research Centre, The University of Manchester, Manchester Academic Health Science Centre, Manchester, UK
[4]Greater Manchester Mental Health NHS Foundation Trust, Manchester, UK

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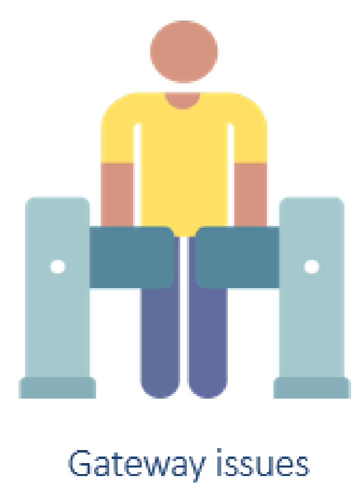
Falling through the statistical net

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,[1,2] Louise Gorman,[1,2] Donna L Littlewood,[2] Elizabeth Monaghan,[2] Steven J Barlow,[2] Stephen M Campbell,[2] Roger T Webb,[1,2] Navneet Kapur[1,2,3]

ABSTRACT

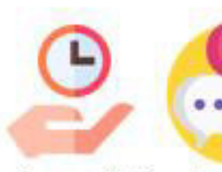
Strengths and limitations of this study

INTRODUCTION

Psychosocial assessments: What helps?

Humanising care

Collaborative



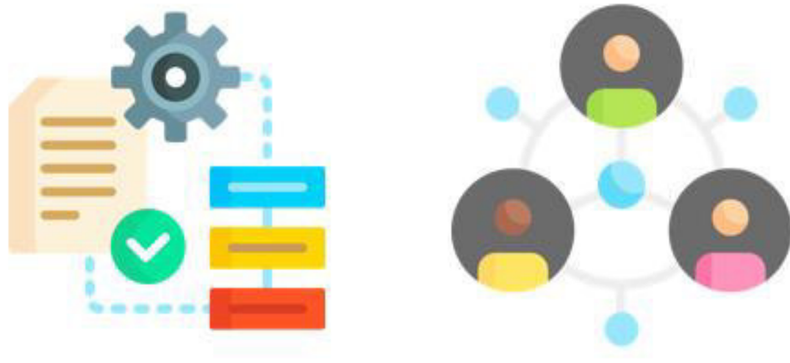
Space & time to talk

Compassion & reassurance

Receiving help

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

Engaging with policy & practice



Indicator Specification

CCG12: Biopsychosocial assessments by MH liaison services

Description	Achieving 80% of self-harm[1] 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: • Assessment of needs • Risk assessment • Developing an integrated care and risk management plan[2]	
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Exclusions	N/A	
Data reporting and performance	Quarterly submission via national CQUIN collection. See the section on *Understanding Performance* in the CQUIN 2022/23 guidance 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

East Surrey Hospital Liaison Psychiatry Service, SABP

What did we achieve in the first six months?

84.8% of referrals receiving a biopsychosocial assessment

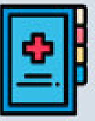
Increased quality of assessments

Increased quality of GP letters

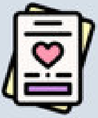
Increase in copies of GP letters sent to patients

Next steps

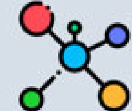
Involve carers



Improve risk assessments



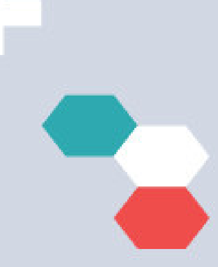
Use a trauma-informed approach to assessment



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

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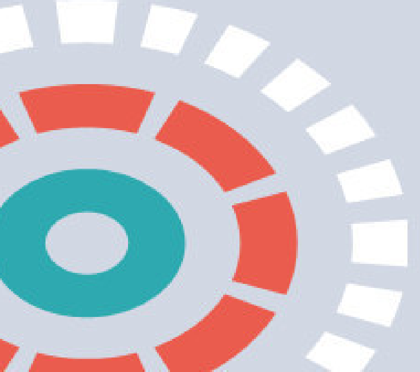
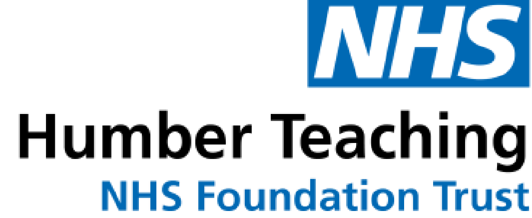
NIHR GM PSTRC Team: Dr Leah Quinlivan, Dr Louise Gorman, Dr Donna Littlewood, Elizabeth Monaghan, Stephen Barlow, Professor Roger Webb, Professor Nav Kapur

& thanks to the MS4MH-R PPI group





Improving the Psychosocial Assessment Experience and Pathway

Emma Thompson, Team Lead
Emma Hooley, Clinical Lead

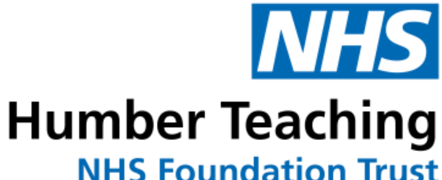
The Mental Health Liaison Service

NHS
Humber Teaching
NHS Foundation Trust

Hull Royal Infirmary

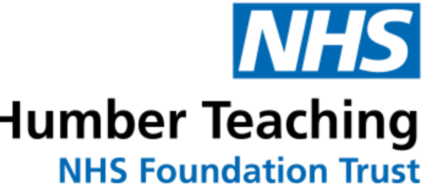
- 24/7 Core 24 Model
- Hull Royal Infirmary and Castle Hill Hospitals
- Population served 600,000
- 1085 Bedded hospital
- Our average per month 375 referrals.
- 78% of the referrals come from ED at source.
- June 2023 introduced ‘ED Streaming’ into our model of care.

The Vision



- 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.

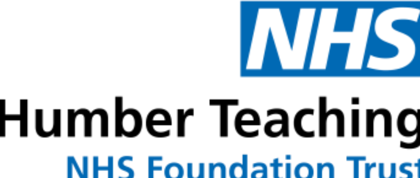
Caring, Learning
& Growing Together



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'



Caring, Learning
& Growing Together

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Caring, Learning
& Growing Together

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Patient Safety Translational
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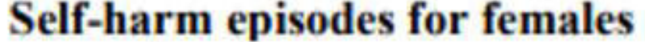
Self-harm: what next after the CQUIN?

Webinar July 2023

Professor Nav Kapur

Self-harm in primary care



Rate (per 100,000 person-months)

100
80
60
40
20
0

2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022

Year

Expected   Observed

The Lancet Child & Adolescent Health DOI: (10.1016/S2352-4642(23)00126-8)

The NICE guideline

NICE National Institute for Health and Care Excellence

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Self-harm: assessment, management and preventing recurrence

NICE guideline [NG225] Published: 07 September 2022

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

Assessments

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%**

Source: Kapur et al (2013) https://doi.org/10.1371/journal.pone.0070434

Interventions

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.

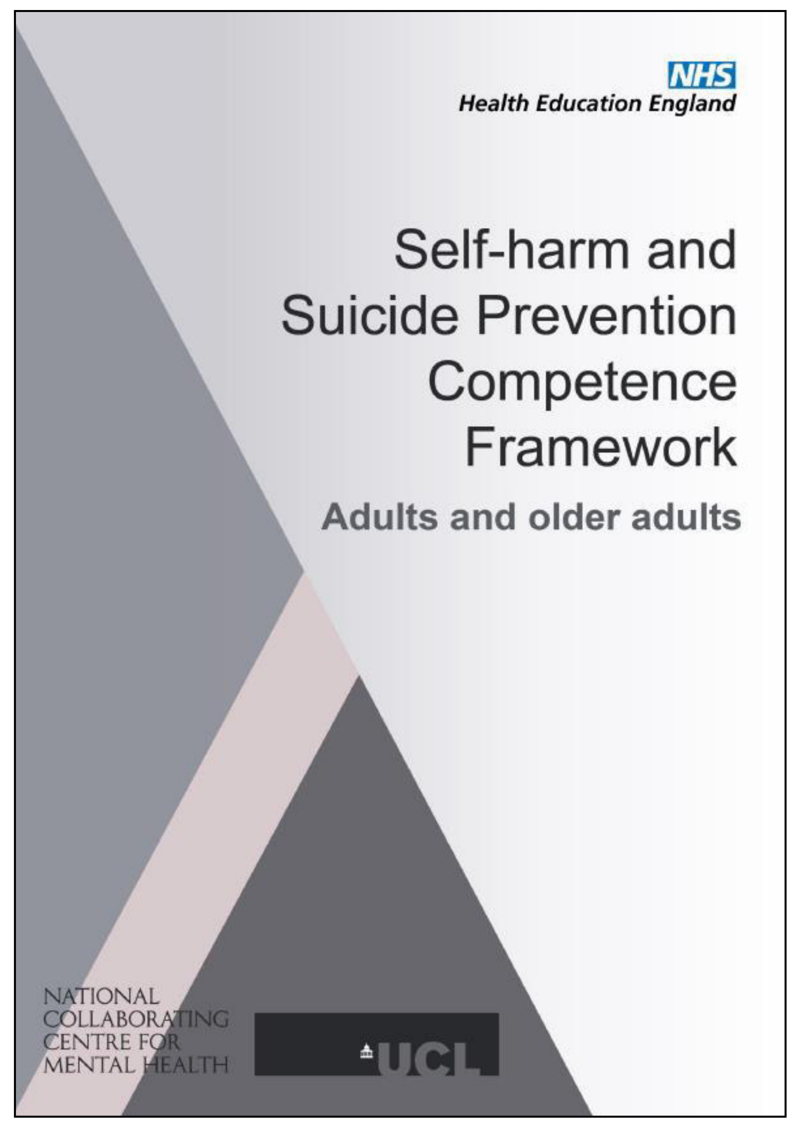
Study or Subgroup	CBT-based psychotherapy Events	Total	Comparator Events	Total	Weight	Odds Ratio M-H, Random, 95% CI
Brown 2005	9	50	18	52	10.6%	0.41 [0.17 , 1.04]
Davidson 2014	4	10	4	4	0.9%	0.08 [0.00 , 1.81]
Evans 1999b	10	18	10	14	4.1%	0.50 [0.11 , 2.21]
Guthrie 2001	5	58	17	61	7.8%	0.24 [0.08 , 0.71]
Husain 2014	1	102	1	111	1.2%	1.09 [0.07 , 17.64]
Lin 2020	11	72	24	75	13.7%	0.38 [0.17 , 0.86]
Owens 2020	7	30	12	32	7.4%	0.51 [0.17 , 1.54]
Salkovskis 1990	0	12	3	8	0.9%	0.06 [0.00 , 1.44]
Tapolaa 2010	2	9	4	7	2.0%	0.21 [0.02 , 1.88]
Tyrer 2003	64	213	77	217	47.9%	0.78 [0.52 , 1.17]
Wei 2013	1	35	4	40	1.8%	0.26 [0.03 , 2.49]
Weinberg 2006	12	15	14	15	1.6%	0.29 [0.03 , 3.12]
Total (95% CI)		**624**		**636**	**100.0%**	**0.52 [0.38 , 0.70]**
Total events:	126		188			

Heterogeneity: $Tau^2 = 0.01$; $Chi^2 = 11.26$, $df = 11$ ($P = 0.42$); $I^2 = 2\%$
Test for overall effect: $Z = 4.22$ ($P < 0.0001$)
Test for subgroup differences: Not applicable

Odds Ratio M-H, Random, 95% CI: 0.1 0.2 0.5 1 2 5 10 — Favours CBT / Favours comparator

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

A workforce who are trained and supervised



The framework map for adults and older adults

Attitudes, values and style of interaction when working with people who are suicidal or self-harming

Self-harm and Suicide Preve

Basic knowledge of issues related to self-harm and suicide

Basic knowledge of mental health presentations

Knowledge of suicide and self-harm

Understanding suicidal ideation, suicidal behaviour and self-harm

Professional competences for all workers

Knowledge of organisational policies and procedures relevant to self-harm

Ability to operate within and across organisations

Knowledge of, and ability to operate within, professional and ethical guidelines

Professional competences for healthcare workers

Generic communication skills

Communication skills

Communicating with people with neurodevelopmental conditions

Signposting/ enabling

Education and training

Suicide and self-harm awareness training

Postventio

Support for individuals bereaved b suicide

Generic therape competences

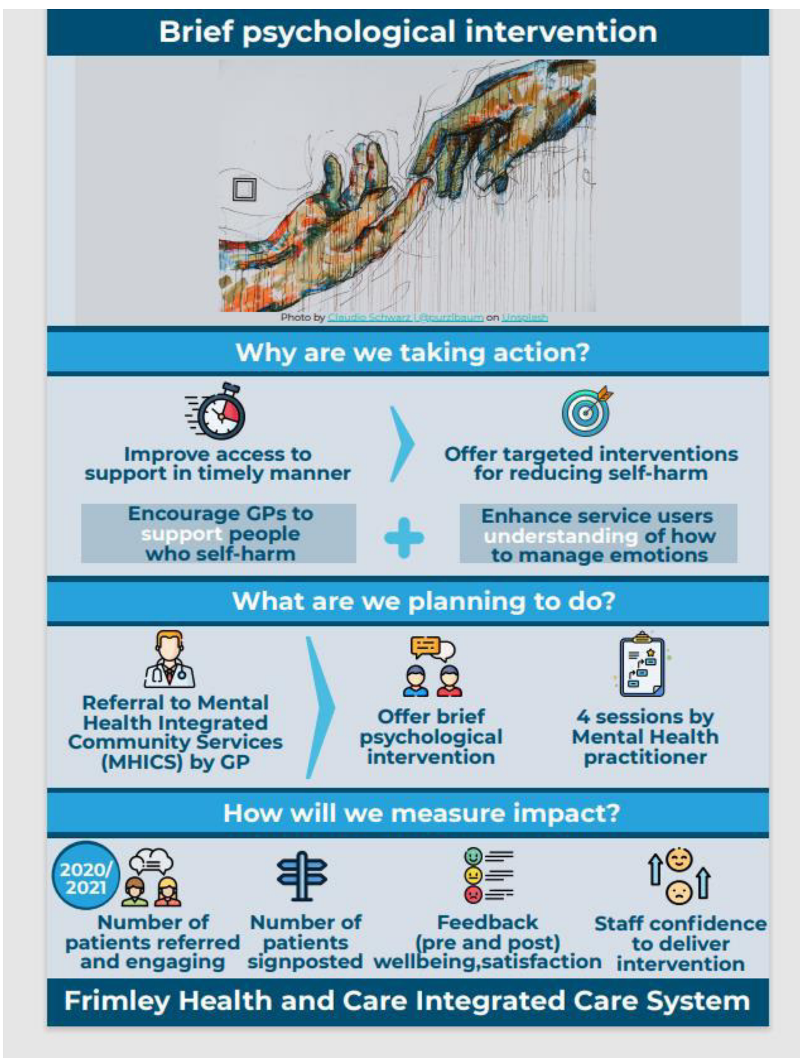
Specific knowledge mental health proble

Specific knowledge suicide and self-harm

Ability to collaborati

Source: UCL https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks/self

Local innovation, implementation and QI

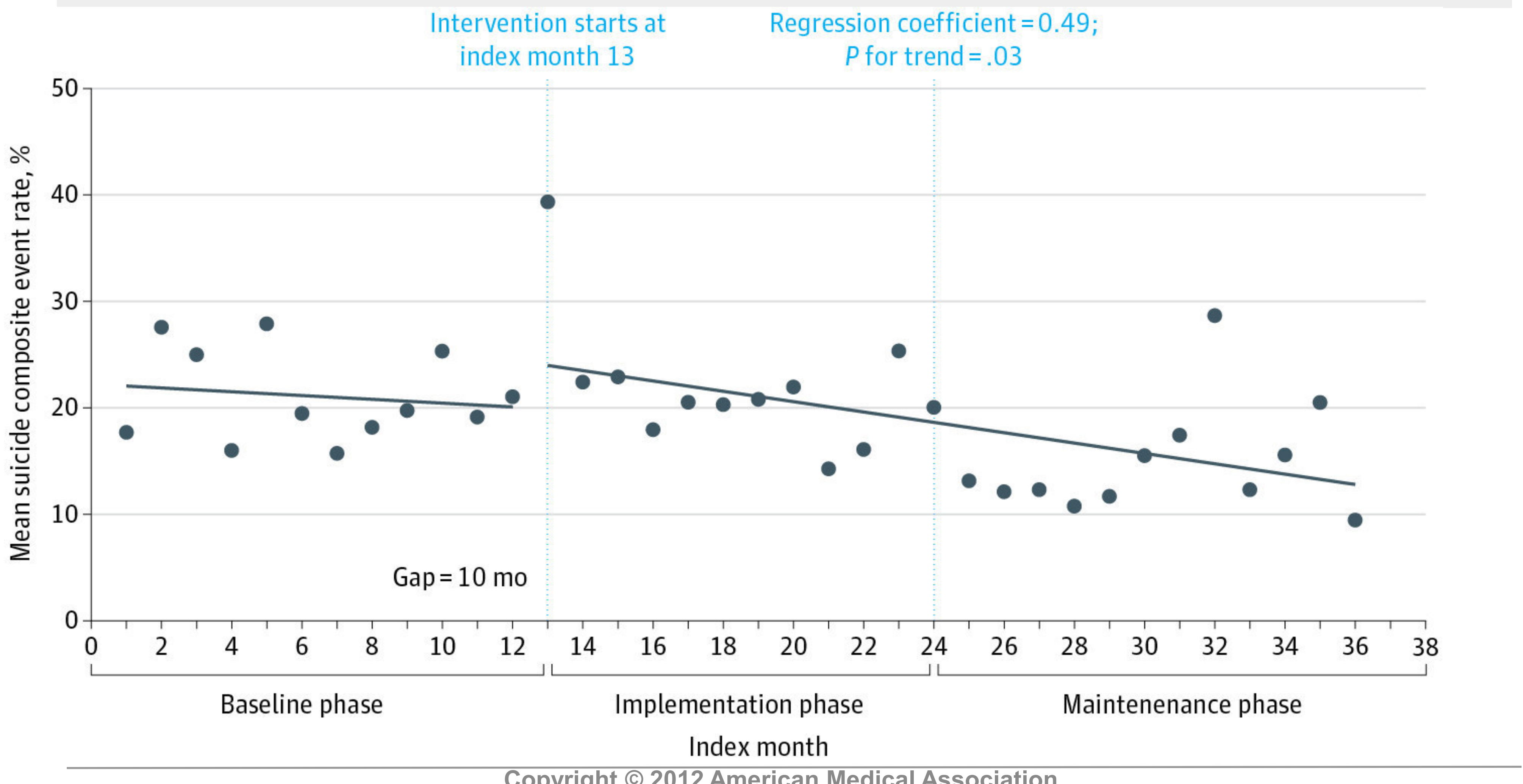


https://sites.manchester.ac.uk/mash-project/support-for-improving-community-based-care-for-self-harm/

JAMA Network™

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



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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.[1] Reducing rates of self-harm is a national policy priority but research suggests that self-harm presentations to general practice are increasing.[2] Self-harm is defined as intentional self-injury or poisoning regardless of suicidal intent and can occur at any age.[3] In young females, around one in four have a lifetime history of self-harm.[4] In older adults who have self-harmed the risk of suicide is particularly high.[5] 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.[6] Even though some people have a single episode of self-harm, around one in five repeat self-harm within 1 year of hospital presentation.[7] 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'*.[3] 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'*.[3] 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.[12]

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%.[13] 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.[3]

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.[3,14] 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

Faraz Mughal, Liam Clarke, Rachel Connolly, Amanda Yenn Teng Lee, Leah Quinlivan and Nav Kapur. Improving the management of self-harm in primary care. British Journal of General Practice 2023; 73 (729): 148-149. DOI: https://doi.org/10.3399/bjgp23X732297

New opportunities and existing evidence

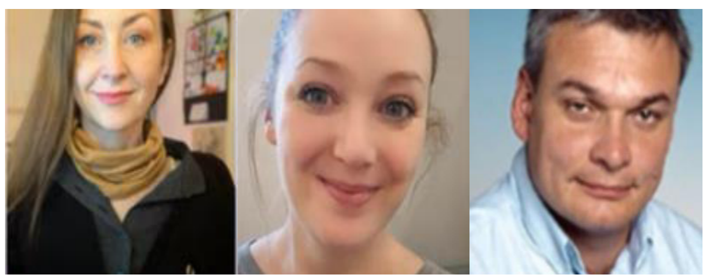
New Suicide Prevention Strategy

- Ethnicity
- Online harms
- Economic stresses
- Pre-Covid trends in CYP
- Data
- LGBT
- Covid impact
- Gambling
- Domestic violence

Summary

- 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)

Centre for Mental Health and Safety



Greater Manchester
Patient Safety Translational
Research Centre

Q&A

Dr Leah Quinlivan (University of Manchester)

Thank You

Mental Health CQUIN - FutureNHS Collaboration Platform

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