Liaison psychiatry practitioners' views on accessing aftercare and psychological therapies for patients who present to hospital following self-harm: multi-site interview study

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Background

Timely provision of aftercare following self-harm may reduce risks of repetition and premature death, but existing services are frequently reported as being inadequate.

Aims

To explore barriers and facilitators to accessing aftercare and psychological therapies for patients presenting to hospital following self-harm, from the perspective of liaison psychiatry practitioners.

Method

Between March 2019 and December 2020, we interviewed 51 staff members across 32 liaison psychiatry services in England. We used thematic analyses to interpret the interview data.

Results

Barriers to accessing services may heighten risk of further self-harm for patients and burnout for staff. Barriers included: perceived risk, exclusionary thresholds, long waiting times, siloed working and bureaucracy. Strategies to increase access to aftercare included: (a) improving assessments and care plans via input from skilled staff working in multidisciplinary teams (e.g. including social workers and clinical psychologists); (b) supporting staff to focus on assessments as therapeutic intervention; (c) probing boundaries and involving senior staff to negotiate risk and advocate for patients; and (d) building relationships and integration across services.

Conclusions

Our findings highlight practitioners' views on barriers to accessing aftercare and strategies to circumvent some of these impediments. Provision of aftercare and psychological therapies as part of the liaison psychiatry service were deemed as an essential mechanism for optimising patient safety and experience and staff well-being. To close treatment gaps and reduce inequalities, it is important to work closely with staff and patients, learn from experiences of good practice and implement change more widely across services.

Keywords:

Self-harm; health services; liaison psychiatry; staff views; psychological therapies.

Non-fatal self-harm is among the strongest known risk factors for subsequently dying by suicide.[1,2] Individuals who have harmed themselves are at especially high risk of suicide immediately after hospital presentation for self-harm, but timely provision of aftercare can save lives.[1–6] However, accessing support following self-harm is reported as challenging.[6–9] In England, progress in service provision for people who do seek help following self-harm is debated.[10,11] Even those with optimistic views of service provision improvements acknowledge an ongoing lack of routine aftercare for patients.[10] Others characterise services for self-harm as inadequate, with any investment focused on reducing waiting times and in-patient admissions.[11]

Liaison psychiatry, owing to its placement in acute hospitals and role in the provision of psychosocial assessments for patients who have self-harmed, provides an important pathway to aftercare.[6,12,13] Although significant service issues for patients seeking help for self-harm are indicated,[14–18] no studies have investigated barriers and facilitators to accessing aftercare from the perspective of staff referring on to services. Working closely with staff and patients to understand the service context may provide opportunities to improve patient safety and access to aftercare.[19,20]

To address this gap in the evidence base, we conducted a multi-site study with mental health clinicians to investigate access to aftercare following self-harm. Our specific objectives were to explore barriers and facilitators to accessing appropriate aftercare and psychological therapies for patients presenting to hospital following self-harm, from the perspective of liaison psychiatry clinicians.

Method

Design and sample

Using a pragmatist research approach,[21,22] we conducted a qualitative multi-site interview study with liaison psychiatry practitioners.

Recruitment

Between March 2019 and December 2020, we recruited participants from 32 randomly selected hospital sites from around England that were identified for a previous study.[9] The sample was stratified to include small and large hospitals with high and low admission rates for self-harm. Methodological details are reported elsewhere.[9,23] We also purposively sought to gain alternative insights from different team members and/or additional services where possible.

The interview schedule (Supplementary Appendix 1, available at https://dx.doi.org/10.1192/bjo.2023.2) was developed collaboratively with our patient and staff advisory panels. Questions were open, flexible and evolved to explore issues raised by the

participants, findings from previous interviews and the patient data. Interviews were audio-recorded and transcribed by a University of Manchester approved third-party transcription service. Additional methodological details are given in Supplementary Appendix 2.

Patient and public involvement (PPI)

Our patient and carer advisory members were involved throughout the research process. Our panel collaboratively developed the initial research and survey questions. Initial analyses of patient data conducted by the PPI panel also informed the staff study. Two panel members (E.M., S.A.) with lived experience in this area reviewed the results, contributed to interpretation and are co-authors. This research was also reviewed by a team with experience of 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), which is a free, confidential service in England provided by the National Institute for Health and Care Research (NIHR) funded Maudsley Biomedical Research Centre via King's College London and South London and Maudsley NHS Foundation Trust. There was PPI input into our dissemination plan, which includes communicating key findings to relevant patient groups, carers, and mental health services.

Ethics statement

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. All procedures involving human participants/patients were approved by Greater Manchester Central Research Ethics Committee (REC no. 18/NW/0839). Written or verbal consent to the inclusion of fully anonymised material was obtained from all participants. Verbal consent was formally recorded.

Analysis

Thematic analysis was used to explore patterns, shared meaning, similarities and differences across the study data-set.[24] Investigators L.Q. and L.G. independently coded the transcripts, after familiarisation with and immersion in the data. S.M. coded a random subset of the data. Codes and themes were iteratively generated, developed, revised and reviewed via collaborative discussion with L.Q., L.G., S.M., R.T.W, N.K. and the wider team. Interpretation and final themes were agreed by all authors. Descriptive quantitative analyses were performed using SPSS version 22;[25] NVivo 12 Software[26] was used for data management.

Results

In total, 51 practitioners from 32 liaison psychiatry services participated in the study. We recruited 22 men (43%) and 29 women (57%), including 13 (26%) consultant liaison psychiatrists, 22 (43%) mental health practitioners, 11 (22%) team managers/clinical leads, 4 (8%) psychologists/ psychotherapists and 1 (2%) higher speciality trainee doctor. Most participants were mental health nurses (35/51, 69%).

Themes and subthemes are presented in Fig. 1. We generated and grouped themes into barriers and facilitators to accessing aftercare following self-harm. The first three themes, titled using participants' words ('Between a rock and a hard place', 'The perennial problem of silo working' and 'Cycle of despair') categorise barriers when trying to access aftercare services for patients. The remaining

three ('Improving assessments and aftercare plans', 'Navigating, negotiating and testing boundaries' and 'Building relationships and integration between services') categorise facilitators and strategies to increase access to aftercare. Additional supporting quotations are tabulated in Supplementary Appendix 3.

Barriers to accessing appropriate aftercare and psychological therapies

Theme 1: 'Between a rock and a hard place'

Where to refer patients following a presentation to hospital for self-harm was a major issue at the forefront of clinicians' thoughts. Limited options resulted in many practitioners trying to fit patients into existing services. Some patients often did not reach thresholds for secondary care or need intensive treatment, but they were deemed as too risky for primary care. These issues left staff feeling caught between increasingly difficult options: 'a rock and a hard place' (S09, P02 (alphanumeric codes indicate anonymised participants)).

Primary care psychological therapies: IAPT, exclusion and 'the misnomer of improving access'. Many staff referred patients who harmed themselves to Improving Access to Psychological Therapies (IAPT) services. Although acceptance reportedly varied geographically, most staff reported that IAPT services had low thresholds for risk and rigid exclusion criteria for self-harm. Staff expressed concern that IAPT services stopped therapy or excluded patients who mentioned self-harm and/or suicidal thoughts without considering the context: 'as soon as you mention that somebody is self-harming, that's it, they'll just reject it, and then they'll refer it on to the community services' (S28, P01).

Risk, thresholds and 'psychiatric versus social crises'. Secondary care services (e.g. crisis and home treatment teams, community mental health teams and in-patient care) were reportedly dominated by high thresholds and perceptions of risk. Staff indicated that these services were generally reserved for patients deemed to have severe and enduring mental illness and/or the highest levels of need. One participant felt that secondary care services excluded patients who had self-harmed and did not have a diagnosable mental illness, irrespective of potential risk, because of perceived patient choice and capacity: 'a mental health team would say that person is making their own decision, do they have an underlying mental health issue? – no, that's a choice they are making' (S15, P01). Several liaison psychiatry staff felt that some secondary care services deemed self-harm to be a function of temporary social crisis: 'someone has to be in a psychiatric crisis, not a social crisis, not a relationship crisis' (S102, P02). Acute crises were reportedly given lower priority owing to their potential for resolution over a few days compared with longer-term severe and enduring mental illness. Referrals for patients with repeated self-harm and recent treatment in secondary care were also reported to be challenged by some home treatment teams, irrespective of risk.

Significant gaps in care and lack of intervention during the immediate aftermath of crises reportedly left some patients at heightened risk of repetition of self-harm. One staff member reported a concerning example of a threshold that had implications for patient safety and further harm because it was set so high:

> 'This morning we were reviewing yesterday's assessments, and yesterday the team saw somebody who was very suicidal. He had been cut down by the police from a noose. And referred to the crisis team, and they didn't take him on – I was a bit puzzled really – on the basis that he didn't have any mental health crisis. He was suicidal. Yeah. So yeah, he had alerted help – fair enough. And he was regretful – however … And

Barriers to accessing services		
'Between a rock and a hard place'	'The perennial problem of silo working'	'Cycle of despair'
– IAPT[a], exclusion and 'the misnomer of improving access' – Risk, thresholds and 'psychiatric vs social crises' – Guard the beds	– Bureaucracy, delayed assessments and strained relationships – Professional skill erosion via devaluing repeated assessments	– Waiting times – Inevitability of further patient harm – What comes next: 'bearer of bad news'

Facilitators to accessing services		
Improving assessments and aftercare plans	Navigating, negotiating and testing boundaries	Building relationships and integration between services
– Multidisciplinary teams (MDTs), skilled staff and clinical psychologists – Enabling staff to focus on psychosocial assessment as therapeutic intervention	– Crafting referral letters – Probing boundaries and opening up communication – 'Pull the consultant card'	– Building relationships – Joint working and open, accessible services – Provision of psychological therapies and follow-up clinics

[a]Improving Access to Psychological Therapies

Fig. 1 Themes and subthemes generated from the data.

he was using lots of drugs and alcohol and all the rest of it, but still just maybe to have kept an eye on that situation for 48 h.' (S03, P01)

'Guard the beds'.   Staff indicated that high case-loads and reduced bed capacity resulted in a focus on risk, gatekeeping (i.e. restricting access to services) and preventing in-patient admission. Many staff reported issues related to reduced bed capacity and the loss of admitting rights to home treatment teams. Staff talked about their powerlessness and stress over the 'bed crisis', and the impact on service delivery, care quality and patient safety. Only one staff member reported limited problems when admitting patients, which alleviated some stress when considering aftercare: 'You don't have that kind of anxiety because you know that if you feel as though you need to admit this patient, then you can admit this patient' (S08, P01).

Theme 2: 'The perennial problem of silo thinking'

Bureaucracy, perceived risk, delayed assessments and strained relationships.   Challenges in negotiating access to services were some of the most difficult aspects of care reported by staff: 'We're constantly battling, and that's a big thing for us at the moment' (S13, P01). Challenges were particularly evident when trying to access crisis and home treatment teams, which was sometimes a time-consuming process. Fragmented working between services resulted in delays and additional bureaucracy when completing psychosocial assessments in the emergency department and in accessing aftercare without delay.

Professional skill erosion via devaluing repeated assessments. Liaison psychiatry staff reported making referrals based on a comprehensive psychosocial assessment. Referrals were often rejected outright or assessments were repeated by gatekeeping teams or other secondary care services. Referrals for patients who have self-harmed were also reportedly frequently rejected at initial assessments by IAPT staff on lower grades, who lacked experience in risk management. Patients were often referred to secondary care psychological services, with even longer waits to access treatment. Given the expertise of liaison psychiatry teams, most participants

felt frustrated and 'undermined' by the process of repeated assessments. Many staff felt frustration, powerlessness and hopelessness when faced with this process because there was a distressed patient lost in the middle of this complexity:

'[I] suppose it's a bit of a let-down, you feel almost sometimes like you're not doing your job and you get really frustrated at why isn't that there, you know. And there probably are times when you do ring people [staff in other services] and you snap at them because you're like, I've just seen this patient, I know what I'm on about, you know, I've not just walked out of Tesco and come into this job.' (S12, P01)

Theme 3: 'Cycle of despair'

Demoralising waiting times.   Long waiting times were a source of despondency for most staff when trying to gain access to services for patients who had self-harmed. Patients required prompt intervention during the acute risk period following self-harm, but many staff struggled with accessing timely interventions. Waiting times for care coordinators and secondary care psychological therapies varied, but were reported by some staff as being up to 18 months:

'I think the tardiness of access to those services, when you're talking about long waiting lists, everyone switches off. The practitioner switches off because you think well, there's nothing going to happen any time soon. The patient gets demoralised and either metaphorically pulls their socks up and acknowledges that they're just going to get on with life. Or sadly gets demoralised and the cycle of despair is set up.' (S102, P01)

Inevitability of further self-harm.   Many staff reported the considerable impact of exclusionary criteria and waiting times on patient safety and staff morale. Some patients reportedly harmed themselves during long waiting times for IAPT services, which increased their perceived risk and resulted in rejection at initial assessment by IAPT staff. Other staff reported that patients reattended the emergency department for repeated self-harm due to the lack of prompt intervention. Some clinicians felt that the focus on risk, gatekeeping and the cycles of rejection ultimately has created a

system in which people need to self-harm to a certain degree before they can access secondary care services:

> 'I think, particularly with self-harm, that what you see is somebody that will turn up who hasn't self-harmed enough […] It's the bottom line really. […] So ultimately, we're almost reinforcing a situation where people need to continue to self-harm before we will hear what they are saying.' (S27, P03)

Burnout and being the bearer of bad news.   Some staff felt that the lack of appropriate aftercare meant that they were not offering a good service for patients presenting with self-harm to hospital. Staff wanted to provide an intervention, but many felt defeated by the limited options for people who self-harm and that they were 'the bearer of bad news' (S13, P01). Some felt that this despondency carried through to the assessment unless they had adequate supervision or time to recharge: 'That helplessness, you know, can be communicated to the patient, which then leaves the patient feeling helpless' (S07, P02). Other staff felt that the lack of aftercare had a negative affect on the therapeutic relationship, leaving patients disappointed after the assessment and staff 'at risk of burnout' (S04, P01).

Facilitators to accessing appropriate aftercare and psychological therapies

Theme 4: Improving psychosocial assessments and aftercare plans

Multidisciplinary teams, skilled staff and clinical psychologists. Several participants felt that multidisciplinary teams improved the quality of assessments and referral plans. Occupational therapists, pharmacists and staff from community mental health backgrounds were deemed as valuable for sharing different approaches to assessments and experience: 'We've got now I think about three or four social workers, which really brings a different perspective to things, you know. And obviously a different knowledge base' (S101, P01).

Access to clinical psychologists and their role within liaison psychiatry was reported to partly depend on funding/commissioning. Most staff felt that these professionals supported staff to provide good-quality assessments and aftercare plans via training, supervision and contributions to case review. Participants felt that psychologists increased access to aftercare via their knowledge of available treatments, provision of stabilisation sessions, links between services and focus on patients' relational and motivational factors in referral letters:

> 'So, I guess a clinical psychologist, having that view really helps people get into the right bit of the services, because she never really got refused, whereas we used to be getting refused all the time, whether it was to say it's okay for IAPT or whatever. So, I think that would really help if we'd got that psychological input into the team. And also, you know, I think for staff morale and well-being, I think psychological support, to enable them to do good assessments.' (S07, P01)

Enabling staff to focus on psychosocial assessment as therapeutic intervention.   Staff valued the role of psychosocial assessments in therapeutically engaging patients. However, some participants felt that liaison psychiatry staff focused unduly on risk assessment and signposting, often because of service pressures: 'So, I think it's certainly well noticed within the medical profession that there's perhaps a bit too much assessment and not enough therapy' (S102, P01). Several participants felt reframing the assessment process as an opportunity for intervention and the provision of training in psychological therapies for all liaison staff helped to improve therapeutic engagement and staff morale. Participants felt that good teams, close-knit colleagues and supportive senior

staff provided a buffer against service tensions and enabled staff to focus on the provision of good-quality psychosocial assessments and care plans:

> 'I think thinking about assessment as a therapeutic concept and as a therapeutic intervention in its own right – so, just thinking about things in those terms – I think it's just really helpful to have somebody that reminds you of those things […] when you are in the thick of it and going, ahhh … ' (S27, P03)

Theme 5: Navigating, negotiating and testing boundaries

Crafting referral letters.   Many staff stated the benefits of crafting referral letters for patients who had presented to hospital following self-harm. Referrals, if not written in sufficient depth or tailored to the risk level of the service, were reported as more likely to be rejected. Limited aftercare services and gatekeeping necessitated staff to carefully craft assessments to meet restrictive criteria. Staff highlighted the importance of advocating for patients and also having to understand and 'game' the rules when negotiating aftercare for their patients:

> 'So, sometimes it's like you have to try and word things a little bit, which I know I hate doing but at the same time, I'm here to help that patient, I'm going to try and fluff the lines as much as I can, to try and help them.' (S30, P01)

Probing boundaries: seeking out discretions for accepting patients and opening up communication.   Directly addressing referral services' concerns about self-harm at an early stage and in person enabled some staff to alleviate those concerns, provide additional context and advocate for patients. For primary care therapies, some staff directly sought to open up communication around possible discretions for accepting patients who have self-harmed. One psychologist felt that IAPT services had gained a negative reputation for long waiting times and risk aversion. This participant actively encouraged staff to check local waiting times because of variability and because some IAPT staff have experience with managing significant risk:

> '[…] some have discretion with that, and use it, and others automatically say "No, this is too high risk". So, my experience of having referred in the past is that if you can have a conversation about that and be very clear about those aspects about self-harm, suicidal risk, then they can be more receptive to working with somebody.' (S101, P02)

'Pull the consultant card'.   Senior colleagues and consultant psychiatrists pushed boundaries when staff struggled to access services. For example, several staff felt that access to services varied across teams and depended on the personality of the person who answered the telephone: 'It depends who answers the phone to who gets accepted basically […] Because different teams have different personalities and different thresholds to what they'll accept' (S13, P01). At times, negotiations escalated and intensified. Senior colleagues helped to circumvent personality clashes and advocate for patients and staff to achieve an acceptable outcome:

> '[…] more so for my colleagues than me because I can generally pull the consultant card and say well, I'll talk to your manager, or I'll talk to the other consultant and I can get it straight away. Which shouldn't be the case.' (S23, P01)

Theme 6: Building relationships and integration between services

Building relationships.   Building relationships with the acute National Health Service (NHS) trust and other teams was beneficial for reducing tensions, improving knowledge of services and expediting access to aftercare. Some participants from services that

provided psychological interventions for people who had self-harmed had senior staff and consultant psychiatrists who built relationships with the acute trust, primary and secondary care services, and commissioners. These relationships, built on evidence of high-quality service provision and data from pilot studies, provided 'money in the bank' and enabled staff to negotiate access for clinic space and additional funding:

> 'But I think the relationships have been built. When I first started, all I did for two years was just go around and meet consultants, seeing nurses in hospital and you just get to know people. When we were first developing the critical pathways, they were incredibly helpful. […] So, I think what we did well was to make the relationship by being very helpful, which got us a lot of money in the bank, got us a big, positive balance, which we were able to spend.' (S106, P01)

Joint working, integrated care and accessible open services.   Although many participants reported siloed working, others provided good examples of integrated care. Some participants reported relatively strong relationships with the crisis team, helped by sound organisational structure (e.g. shared operational managers), prompt and open access between services, clear referral criteria, provision of aftercare and having staff with experience of working across teams:

> '[…] we get very few referrals rejected if I'm honest. I think that's unique. You see, we all worked there before. We all moved into liaison from having worked in the wider crisis home treatment team, so perhaps it's professional respect and relationships that enables us to do that […]' (S04, P01)

Another participant reported a proactive approach to the provision of integrated care. Patients presenting with self-harm had a direct pathway to liaison psychiatry on arrival at the hospital. Senior staff promoted the importance of psychosocial assessments for all patients who present following self-harm: 'Yeah, my manager, is pretty tough on that one, that everybody has to have a full assessment' (S22, P01). This enabled more people to receive an evaluation of their needs, risk and care plans. Advocacy at senior levels reportedly reduced bureaucracy between services. Liaison staff accepted patients on behalf of the crisis team. They also maintained a crisis line, for patients to re-contact the team, and had access to an out-patient clinic.

Provision of psychological interventions and out-patient services via liaison psychiatry.   Only a minority of participants reported having access to out-patient clinics and/or interventions for self-harm as part of the liaison psychiatry service. Some participants reported having dedicated self-harm services as part of the liaison team, or specific staff members trained in psychological therapies to provide brief interventions. Other teams utilised out-patient appointments to revisit and strengthen risk, care and safety plans. Criteria to access aftercare in these services varied. Out-patient clinics, where staff revisited safety/care plans following an episode of self-harm, had less restrictive inclusion criteria than services offering brief psychological interventions. Although the psychological intervention services addressed an urgent need for talking therapies, some participants felt that patients who did not meet the inclusion criteria (e.g., patients under the care of secondary care services, or on waiting lists to receive specialist interventions) were left to fall though the gaps.

Most staff felt that routine out-patient clinics were part of an optimal liaison service and addressed the urgent need for prompt follow-up for people who had self-harmed. Several participants felt that out-patient appointments, particularly with dedicated staff for the role, offset the limitations of conducting psychosocial assessments during times of acute distress. Staff felt able to gain a deeper evaluation of patient need, risk and safety planning and to strengthen care plans. Out-patient services also helped to stabilise patients, which staff indicated increased their likelihood of gaining access to additional psychological therapies for their patients. Participants with access to these services reported feeling greater satisfaction because they were able to offer prompt intervention and have the potential to see their patients recover. Staff felt that offering interventions from liaison psychiatry broke the persistent cycle of overassessment and frequent signposting to ill-equipped services:

> 'One of my things around having out-patients, and not all liaison services offer out-patients, but one of my things was that if you've got somebody in crisis, maybe they might have come back to A&E [the accident and emergency department] a few times in a very short period of time, they don't meet the thresholds for secondary mental health services. IAPT services, they're either going to have to wait quite a long time, or they might be too risky. It's actually just giving them something at the time that they need it really, which is obviously pretty rare in terms of psychological intervention in any other services.' (S16, P02)

Discussion

Main findings

Staff indicated significant gaps in care for patients in the immediate aftermath of crisis when risks of self-harm and suicide are highest. Perceived risk, exclusionary thresholds, long waiting times, siloed working and bureaucracy may heighten the risk of repetition of self-harm and increase the likelihood of staff becoming burnt out. We also found variations in care and strategies to mitigate service barriers. Provision of out-patient clinics and psychological therapies as part of the liaison service were perceived as an essential mechanism for improving patient safety and experience, as well as staff well-being. Other strategies to ease access to aftercare included supporting staff to focus on the quality and therapeutic nature of assessments, directly addressing concerns regarding perceived risk, advocating for patients and building functioning relationships across services.

Strengths and limitations

The focus of this study was referrers' views on accessing aftercare for patients who have self-harmed. Patients' views are, of course, essential too, and we have other ongoing work focused on their experiences. Most of the salient issues, including self-harm repetition risk and long waiting times, are germane to both types of investigation and are considered in other reports.[14–18] This paper highlights areas in which practitioners can act as advocates for patients when trying to gain access to services.

Clinician burnout was discussed in response to the challenges in accessing aftercare for patients who had self-harmed. However, we did not probe for nuanced relationships between service tensions, patient care and burnout or probe experiences of burnout in greater detail. Workforce burnout is a long-standing and significant issue in mental health services.[27] Future research should explore experiences and interventions to reduce potential burnout in healthcare staff.

We recruited participants from a large stratified random sample of 32 hospitals in England.[9,23] Our sampling approach enabled us to capture service variability from a wide catchment area. Therefore, it is likely that our results will be informative for the rest of the country and other healthcare settings. We explored broad contextual factors from the perspective of staff and not quantitative data on referrals

from the emergency department. Liaison services have transformed rapidly over the past decade.[28–30] Replication of the study conducted by Cooper et al[9] is required to evaluate any representative change in follow-up rates and focused site-specific studies are necessary to explore in-depth contextual issues.

Comparisons with existing research

Consistent with findings reported from other studies,[14–16,29] many staff reported inadequate service provision for patients who had self-harmed. Participants in our study reported a system reliant on perceived risk and heavily skewed towards exclusion, which could be detrimental to patient safety. Postcode variation, long waiting times, exclusion and implicit judgements of self-harm as being less deserving 'social' crises were common. Similar to Jasmin et al's findings,[29] our participants were frustrated over fragmented services, cyclical referrals, lack of care continuity and vague thresholds. Our data provide contextual insights into the challenges in accessing aftercare for patients who have self-harmed, particularly during the highest risk period for self-harm repetition and suicide.

However, we also found variability in accessing aftercare. Some practitioners developed strategies to navigate the system, negotiate acceptance into services and advocate for patients (e.g. directly addressing concerns about self-harm, speaking to staff in person, focusing on needs). Our findings highlight the importance of close-knit and multidisciplinary teams, which is consistent with findings reported by other studies.[19,28] Good organisational structure, multidisciplinary team working and supportive senior colleagues enabled staff to complete higher-quality assessments and care plans. Several staff felt that senior colleagues and consultant psychiatrists had key roles in advocating for staff and patients within their acute trusts and across services more widely.

Similar to previous reports,[31,32] we found variable access to psychologists. Although clinical psychologists are part of acute care pathways, some staff felt that they were elusive, expensive and hard to access in liaison psychiatry owing to lack of funding and complex commissioning arrangements. However, consistent with findings reported by Ebrahim,[32] most staff felt that psychologists played integral roles in multidisciplinary team meetings, clinical formulation, staff training and support. Further studies are needed to explore the role of psychologists in liaison psychiatry.

Clinical implications

The revised National Institute for Health and Care Excellence (NICE) clinical guidelines on self-harm[13] recommend that patients should receive follow-up within 48 h of their initial psychosocial assessment and that access to psychological interventions should not be determined by diagnosis, age, substance misuse or co-existing conditions. Our findings indicate that many people do not receive follow-up during this high-risk period because of lack of service provision, diagnoses, arbitrary thresholds and perceptions of risk. Despite clinical recommendations to the contrary,[12,13] the use of risk assessment to gatekeep and to determine patient treatment options may be widespread. Liaison staff overwhelmingly felt anxious and distressed about the lack of follow-up during this high-risk period, which may heighten a focus on risk as defensive practice. Future studies should evaluate barriers, opportunities and motivation for implementation of the new clinical guidelines for self-harm.[33]

Recent surveys indicate that around a tenth of referrals to liaison services in England are followed up in specialist out-patient clinics, and less than a quarter of liaison teams have psychological therapists.[27,30] Low referral rates from liaison psychiatry[28] may be partly explained by the interpersonal and structural challenges that we have identified in this study. Although little is known about liaison psychiatry out-patient clinics and the role of clinical psychologists, there is opportunity to learn from examples of nascent innovative service models.

In some areas of England, out-patient clinics in liaison psychiatry are emerging as a novel way of delivering enhanced acute care for people who have self-harmed. Although not a panacea for the lack of service provision, out-patient clinics provide an essential opportunity for timely interventions, stabilisation and greater collaborative safety planning during the highest risk period for self-harm repetition and suicide. Participants in our study reported feeling less anxious during the assessment process because they could offer follow-up and interventions to patients following an episode of self-harm. They cited the importance of strong relationships, multidisciplinary teams, networking, adequate staffing, protected time, clinic space, networking and pilot data for the development of out-patient clinics. Further research is needed to evaluate the effectiveness and role of out-patient services, using a range of patient-determined outcomes.

Many people who have self-harmed are excluded from primary care treatments for depression and anxiety or are deemed not sick enough to be treated by secondary care services. Clinical psychologists, owing to their expertise and roles across acute and community services, and multidisciplinary teams have significant potential to facilitate greater integration and care continuity for patients who have self-harmed.[32] Closer integration and working relationships between liaison psychiatry and primary care psychological services may also help to develop optimal care pathways and enhanced joint working.

We focused on access to NHS-provided primary and secondary care follow-up after for self-harm. Several third-sector services provide community care for patients who have self-harmed in England (e.g. Harmless, Self-Injury Support, and Battle Scars). Examples of integration between the NHS and the voluntary sector include the provision of follow-up after attending an emergency department by peer-led organisations in Leeds and Bristol (Battle Scars and Self-Injury Support respectively). Further research evaluating the provision of third-sector, peer-led provision of aftercare and psychological therapies can help to build evidence in this area.

Good-quality psychosocial assessments are a core component of care for patients who have self-harmed, but many patients do not receive one.[17,18] Emergency department attendance following self-harm is an essential opportunity for intervention and to build a foundation for patients to engage in aftercare.[6] We found that some clinicians underestimate the therapeutic value of assessments, which corroborates other research findings.[14] Frustration over limited available aftercare had a negative impact on staff well-being and their assessments, in the absence of adequate supervision. Our previously reported findings, findings reported from other patient experience studies and our public contributors have consistently emphasised the importance of compassion, listening and therapeutically engaging with patients in a non-judgemental manner when they are in the emergency department.[14,16–18] Participants reported that training in therapeutic interventions for all staff, access to clinical psychologists and reframing the psychosocial assessment process as an intervention may improve staff well-being and therapeutic engagement.

Patient involvement in healthcare services is central to policy for improving and commissioning mental health services.[34] Training that is co-designed and co-delivered by people with lived experience has been found to be acceptable and valued by mental health staff.[35] Co-designed and co-delivered training may increase confidence regarding patient safety and self-harm in primary care services, but further research is needed in this area.

Although staffing, cultural and structural problems are pervasive in mental health services, we have a significant opportunity

for transformation as part of the NHS Long Term Plan and the Commissioning for Quality and Innovation (CQUIN) framework for psychosocial assessment.[36] There is substantial emphasis on improving psychosocial assessments, developing co-produced community services for people who have self-harmed and building integration across NHS and voluntary, community and social enterprise (VCSE) services. Our study's findings highlight the essential role of liaison psychiatry services in the provision of acute crisis care and integration of mental healthcare. It is important that we build on the current momentum to transform services, learn from examples of best practice and implement this change more widely.

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Supplementary material

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Data availability

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

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Author contributions

All authors made substantial contributions to the study. 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 and staff advisory panel. S.M. was part of the staff advisory panel and facilitated set up. L.Q. coordinated data collection and conducted the interviews; led the analyses, with input from L.G., S.M. and the wider team (E.M., S.A., R.T.W., N.K.); interpreted the results, with input from L.G., S.M., E.M., S.A., R.T.W. and N.K.; and 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.

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Declaration of interest

N.K. is a member of the Department of Health and Social Care (England) National Suicide Prevention Advisory Group; he chaired the National Institute for Health and Care Excellence (NICE) Guideline Development Group for the Longer-Term Management of Self-Harm and the NICE Topic Expert Group (which developed the NICE quality standards for self-harm services); is currently chair of the updated NICE guideline on depression, topic advisor for the current NICE Guideline Development Group for the Longer-term Management of Self-harm; and is also supported by the Greater Manchester Mental Health NHS Foundation Trust.

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