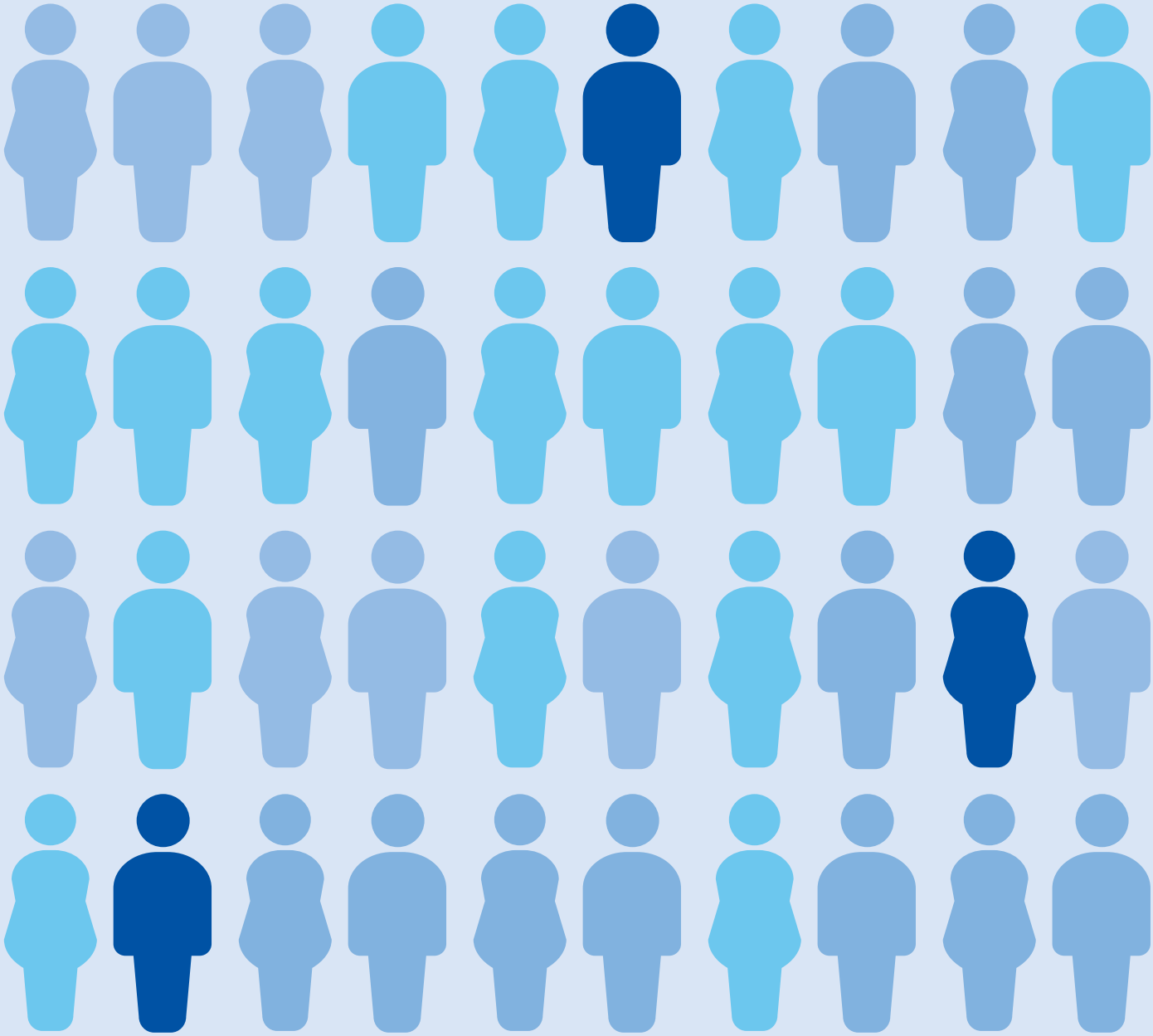
Psychosocial assessment following self-harm: A clinician's guide



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SUICIDE AWARENESS FOR EVERYONE

Authors and acknowledgements

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Foreword

My clinical and research colleagues and I have had a long-standing interest in helping patients who have presented to hospitals or other clinical services having self-harmed - that is, intentionally having taken an overdose or injured themselves. The crucial beginning to provision of help is to conduct a psychosocial assessment. The aim of a psychosocial assessment is to help patients understand why they self-harmed, the problems that led up to it, and what would be helpful for them in both the short-term and the longer-term, including how to keep themselves safe.

A key aspect of conducting a psychosocial assessment is to develop a warm and empathic relationship with the individual, demonstrating that one is concerned about what has happened to them and also what will happen both immediately after leaving the clinical setting and in the longer term. This will be aided by avoiding using checklists (except where absolutely necessary) and of appearing hurried. Conducting the assessment in a private setting, where the interaction will not be overheard, with a clear indication of confidentiality, is also conducive to an effective interaction. Where appropriate, it is important to talk to others, such as relatives, friends, workmates, who may provide useful information and may be able to provide help for the individual.

The clinician should aim to assist the patient to understand their problems through telling the story of what led up to their self-harm and why the act occurred. This may include identifying problems in a variety of areas, for example, mental health difficulties, psychological, social and physical problems, and also longer-term difficulties that may have started earlier in life. The overall aims are to work collaboratively with the individual to develop an understanding of why they self-harmed, including what they wanted to happen as a result of the act, such as to stop bad feelings, show other people how bad they were feeling, or perhaps to end their life, and to identify what will be helpful both in the short and longer-term, and especially, what the individual can do to remain safe. The ultimate aim is to collaboratively develop a management plan that can help lead to positive changes.

This guide is intended to introduce clinicians to why a psychosocial assessment is important, to guide them on how to do it, and to provide information on the range of problems that individuals they assess may be facing. The overall aim is to help them conduct full and effective psychosocial assessments that can help individuals who have self-harmed - and in some cases to save lives.

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Introduction

Psychosocial assessment following self-harm

The National Institute for Clinical Excellence (NICE) defines psychosocial assessment following self-harm as 'a comprehensive assessment including an evaluation of the person's needs, safety considerations and vulnerabilities that is designed to identify those personal psychological and environmental (social) factors that might explain an act of self-harm' (1). NICE advises that all people who self-harm should be offered a psychosocial assessment at an early stage.

Psychosocial assessment should include biological factors alongside psychological and socio-environmental aspects and is often termed 'biopsychosocial assessment'. Whilst this guidance uses the term psychosocial assessment in line with NICE guidance, the biological component is included and should be seen as implicit.

Psychosocial assessment should include evaluation of the social, clinical, psychological and motivational factors specific to the act of self-harm, including presence of suicide ideation and intent, as well as a full mental health and social needs assessment. The assessment should lead to a formulation and aftercare plan.

Definition of self-harm

Self-harm is defined as any non-fatal intentional act of self-poisoning or self-injury carried out by an individual irrespective of degree of suicidal intent or other motives (1, 2).

Why is a psychosocial assessment important?

Psychosocial assessment following self-harm which results in admission to the general hospital setting can provide a crucial opportunity for an individual facing a crisis to share their problems with a mental health professional and to be offered aftercare. It may be associated with a reduced risk of repetition of self-harm (3-5). The psychosocial assessment may be the first and only time that vulnerable individuals have contact with mental health professionals. Therefore, it is an important opportunity to provide brief interventions, education and information, as well as facilitating engagement with, and signposting to appropriate resources and services.

Aim of Guidance

The aim of this document is to provide clinicians with guidance to help them conduct a comprehensive psychosocial assessment. To support this, associated signposting to supporting evidence and useful reading is included. It is recommended that all clinicians are familiar with the NICE Guidance 225; Self-harm: Assessment, Management and Prevention of Recurrence. Whilst this resource refers to people presenting to the emergency department following self-harm, it will also be of relevance to clinicians working in other clinical settings.

This guide consists of three sections:

Setting the scene for a psychosocial assessment – this section presents information about what patients and carers find helpful and unhelpful about the psychosocial assessment, along with tips for the practitioner to consider before and during the assessment.

Special considerations for particular groups – this section addresses considerations that need to be taken into account when assessing older people, adolescents, people with neurodiversity, middle-aged men, and minority groups. It also covers the importance of addressing the impact of significant societal crises or stressors (such as recession) within assessments. Special considerations for people with learning disabilities are not included in this resource due to the importance of this population receiving an assessment by a suitably trained and experienced individual in line with NICE (2022) guidance. Clinicians should seek to facilitate a speaciliast assessment for people with earning disabilities.

Carrying out the psychosocial assessment – this is the main section of the document and covers all the components of the assessment. Key headings are provided with an explanation as to why they should be covered in the assessment, along with pointers for practice and signposting to relevant evidence and helpful reading.

An aide memoire is available as appendix 1. This can be photocopied to assist clinicians during assessments.

The online version of this document includes direct links to relevant evidence, films of people with lived experience, and acted out scenarios for training and reflection purposes. The online version can be accessed via Oxford Health NHS FT , University of Oxford Centre for Suicide Research and Berkshire Health NHS FT websites. You can access it at www.tvsuicideprevention.uk via this QR code.

Suggested reading

(NICE), 2022. Self-harm: Assessment, Management and Preventing Recurrence (NICE Guidance 225). Available at https://www.nice.org.uk/guidance/ng225/resources/selfharm-assessment-management-and-preventing-recurrence-pdf-66143837346757.

Setting the scene for a good psychosocial assessment

1. What do patients/service users find helpful?

Research consistently tells us that people who present to emergency departments (EDs) following self-harm most value having the time to talk and being listened to by a skilled, empathetic, competent, and non-judgemental clinician who treats them as an individual in their own right, validates their distress, and instils hope (4, 6-8). The psychosocial assessment should be seen as an intervention. Individualised and collaborative assessments which involve looking at problem-solving strategies and carefully considered discharge and safety planning can lead to improved outcomes (3). A person who experiences a good psychosocial assessment is more likely to engage with services they are offered or signposted to. Conversely, a poor assessment experience is more likely to result in disengagement (4).

Additional thoughts from those with lived experience are for the assessor to:

- Remain authentic and curious.
- Remember empathy is essential for a person to feel able to talk.
- Always distinguish between the 'person' and the 'behaviour'.
- Remain in the 'here and now'. For example, it is important to ask about historic abuse, and to check for any ongoing risks to the patient or others, but not necessary to explore it in detail within the assessment as this may exacerbate the person's distress. However, if a person is experiencing abuse at the time of assessment it will be necessary to obtain some detail for safeguarding purposes.
- Before seeing carers alone or with the patient, always first see the patient alone. This allows the patient to share their perception of the relationship and share any information they do not wish the carer to hear.

2. What do patients/service users find unhelpful?

Patients find the assessment experience unhelpful when they do not understand its purpose, they have no privacy (e.g., bedside assessments), they feel labelled,

assessments are conducted in a scripted and impersonal manner, and when they perceive clinicians as critical, cold, or judgemental. The language used by clinicians is important and when this is perceived as insensitive, stigmatising or jargonistic the patient is unlikely to engage. Additional unhelpful factors are when patients feel clinicians do not fully understand the phenomenon of self-harm, and when perceived promises of follow-up do not materialise (4, 6-8).

3. What do family members/carers/significant others find helpful/unhelpful?

Family members or carers often feel upset, worried, and shocked by the patient's self-harm and are sometimes experiencing their own physical or mental health problems in addition to, or as a result of their caring role. In addition, they may be managing their own social problems, and some identify themselves as being in need of professional support (9, 10).

Carers find being involved, informed, and listened to helpful. Lack of privacy, negative attitudes, and not being listened to or communicated with are found to be unhelpful (10, 11).

In addition, carers have said that it is helpful when:

- Clinicians recognise that the crisis for the patient and family did not begin when they presented at ED; they have often been dealing with difficulties for some time.
- They have reassurance that their family member/friend's anxieties, concerns, and thoughts are taken seriously and that someone is listening to them.
- Following the assessment, the resulting plan is conveyed to the family member or carer.
- The family member or carer are invited in to talk to the mental health practitioner so that their thoughts can be sought on what precipitated the event.
- Information for the family is readily available, or they are advised where to go for advice (including, for example, a website or support group).

Practice pointers:

Relationship: The clinical and interpersonal skills of the mental health practitioner will have a significant impact on the experience of the patient (6).

Validation and empathy: Psychosocial assessment has the potential to promote or challenge hope, depending on whether it is experienced as accepting or critical. In order to understand how the person is feeling and the extent of their distress, clinicians must learn to empathise with the mental pain the person may be experiencing (12).

Understand the impact of trauma: Many people who self-harm, particularly those who repeat self-harm, have experienced adverse childhood events (13). Adverse childhood events are potentially traumatic events experienced before the age of 18 years, for example abuse, neglect, or distressing family events such as domestic violence, suicide, parental substance dependency, or a parent in prison. Clinicians should recognise that the individual may have a history of trauma, and take care to try and ensure they are not further traumatised by the hospital environment or assessment process. This might involve, for example, asking the person if they feel safe where they are sitting/waiting, or if they would like a chaperone to be present during the assessment.

A good understanding of the functions of self-harm: It is important that the clinician:

- Understands the potential intentions or motives involved in self-harm.
- Can apply this during the assessment to develop both their and the patient's understanding of the self-harm.

Professional Curiosity is essential to gain a full understanding of the person and their wider context, the self-harm episode, and their motivation and ability to engage in therapeutic interventions. Ask yourself:

- Am I hearing the patient's story as opposed to my own internal narrative?
- Am I remaining inquisitive about what I'm seeing and assessing? (being curious in the here and now …."I'm thinking"….. I'm wondering"…… "I suppose I'm feeling a bit concerned that" ……")
- Am I open to and seeking out new information?
- Am I making use of collateral information?
- Am I picking up and responding to dissonance (e.g., agitation with neutral statements or unusual calmness while clearly articulating distress)?
- Am I being alert to any contradictions in the patient's narrative (address these by probing e.g., "earlier you said …… but just now you said ……. so I'm wondering if…..")
- Have I got preconceived ideas?
- How might my interview approach be influencing this assessment?

'What' and 'how' questions that gently assume a certain behaviour or thought is occurring might elicit more accurate responses (14) e.g., for an individual whose self-harm appeared to involve high suicidal intent, "**what** other ways of ending your life have you considered", or "how else have you thought of ending your life".

Family/carer involvement can enable the clinician to obtain important collateral information to help build a complete picture of the patient's presentation and needs. If families/carers are involved in safety planning, they are likely to feel more informed and equipped to help the patient manage future periods of distress. In addition, clinicians are in a prime position to attend to the needs of family/carers by asking how they are managing, what support they have and feel they need, and signposting to relevant support agencies.

Special considerations for particular groups

Older adults

There is a stronger relationship between self-harm and depressive illness in older adults than in younger adults (15). Depressive illness is common but may be hard to identify in older people. Adults over the age of 65 tend to present with higher suicidal intent compared to other age groups and have higher rates of completed suicide following self-harm than other age groups, especially in the subsequent year (16, 17).

Common risk factors:

Relationships: Isolation, loneliness (even if the person has close family relationships), recent bereavement (especially of spouse/partner), loss of friendships due to death, carer burnout (e.g., caring for a spouse with dementia), spousal suicide pact in the context of ageing.

Physical health: Recent changes in physical health (e.g., recent diagnoses), even if this is minor, long-term conditions (often co-morbid), subjective reporting of increase in pain, sensory loss (e.g., vision, hearing, taste, smell), recent diagnosis of dementia, fear of continuing physical decline or dying in an institution, deliberate medication non-compliance.

Care needs and independence: Perceived burdensomeness linked to ageing (e.g., increased care needs, frailty, loss of mobility), loss of independence, perceived end of their natural lifespan.

Social Needs: Change in housing situation or suitability of housing due to increased care needs.

Mental Health: Depressive disorder (past and/or present) and/or other mental health difficulties.

Acute confusional states (e.g., delirium): May contribute to impulsive acts of self-harm, which are not in keeping with the individual's usual mental state.

Cognitive impairment: Patients may present with giving vague and non-specific answers, disorientation, difficulties distinguishing past and present events, and changes in their ability to carry out activities of daily living, all of which may indicate cognitive impairment.

Do not overvalue protective factors: : Older adults may have close family relationships but might perceive themselves to be a burden on family members, which may increase thoughts of suicide.

Children and adolescents

Children and adolescents in England who present to ED following self-harm are at a significantly increased risk of suicide than other young people in the general population (18).In particular, males, older teenagers, and those with a history of self-harm (especially involving hanging or asphyxiation) and repeat self-harm. It is not uncommon for young people to switch method from self-harm to suicide, notably from poisoning to hanging/asphyxiation. Death by accidental poisoning due to substance misuse is also an issue with male young adults following presentation to ED with self-harm.

Common risk factors:

Common themes related to adolescent self-harm are family factors (such as mental illness and substance misuse), child sexual abuse, bullying, physical health issues, bereavement (especially by suicide), academic stress, being LGBTQ+, being a looked after child, mental ill health and substance misuse (19). Cumulative stress is a particular concern, i.e., where early traumatic experiences are followed by adverse childhood events and then further psychosocial stress.

Mental imagery ('seeing in the mind's eye') (20, 21) about self-harm prior to self-harm acts is common amongst young people (22). This typically involves prospective visual imagery about the act or consequences of self-harm, which may be triggered by changes in affect or psychosocial stress. Mental imagery might lead directly to self-harm, or conversely may have a protective effect and help the young person resist urges to self-harm. Understanding if and how a young person experiences mental imagery is an important element of the psychosocial assessment.

Eating disorders are relatively common in the adolescent years (23) and it is important to ask about eating disorder symptoms.

Use of the internet for searching about suicide is common amongst adolescents and social media can be both harmful (e.g., cyberbullying, transmitting self-harm images, games inciting self-harm) and beneficial (e.g., help-seeking, supportive communities, psychoeducation) (24).

Practice pointers:

- Be aware of the developmental level of the child/young person you are assessing and take this into account when communicating with the young person.
- Assess the family situation and gather information from the family as part of the psychosocial assessment, particularly given that family relationships will be key in developing safety or crisis plans.
- Where possible share and obtain information from the young person's school to get a fuller picture of the individual, particularly how they are functioning in the school context.
- Try and establish the functioning of the individual's peer groups (e.g., are they supportive or otherwise, is the person able to confide in peers, is self-harming behaviour a current issue within peer groups etc.).
- Partnership working with relevant agencies (e.g., education, social care, youth justice, mental health services) is essential.
- Safeguarding issues should always be explored and concerns attended to before discharge.

Links to evidence & useful reading

Townsend, E., Ness, J., Waters, K., Rehman, M., Kapur, N., Clements, C., Geulayov, G., Bale, E., Casey, D. and Hawton, K., 2022. Life problems in children and adolescents who self-harm: findings from the multicentre study of self-harm in England.- *Child and Adolescent Mental Health, Early View 27*(4), pp.352-360. https://doi.org/10.1111/camh.12544.

Marchant, A., Hawton, K., Stewart, A., Montgomery, P., Singaravelu, V., Lloyd, K., Purdy, N., Daine, K. and John, A., 2017. A systematic review of the relationship between internet use, self-harm and suicidal behaviour in young people: The good, the bad and the unknown. *PLOS One*, 12(8), p.e0181722. https://doi.org/10.1371/journal.pone.0181722.

Warne, N., Heron, J., Mars, B., Moran, P., Stewart, A., Munafò, M., Biddle, L., Skinner, A., Gunnell, D. and Bould, H., 2021. Comorbidity of self-harm and disordered eating in young people: Evidence from a UK population-based cohort. *Journal of Affective Disorders*, 282, pp.386-390. https://doi.org/10.1016/j.jad.2020.12.053.

People with neurodiversity

Neurodiversity is a term used to describe a range of neurological differences including Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Condition (ASC).

Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is associated with increased risk of self-harm in young people (27, 28) and also of suicide in young people and adults (29). Attending hospital following self-harm may be the first presentation of ADHD in adolescents, particularly given the condition is underdiagnosed in girls. Mechanisms for increased levels of self-harm and suicide in ADHD include:

- impulsivity
- emotional dysregulation
- recklessness
- drug and alcohol misuse
- social and academic exclusion (with lower self-esteem)
- co-morbid depression
- sleep problems

Some people with ADHD may experience certain challenges with communication due to difficulties organising their thoughts. This might include tangential speech or impulsive responses to questions before they are fully processed, resulting in the person not saying what they mean. Conversely, a person may clam up.

Practice pointers:

- If the patient has a known diagnosis of ADHD ask them if there are any aspects of communication they find difficult, and if they have any tips to help you try and ensure the assessment is easier for them.
- The movement and sounds of an emergency department may be distracting for someone with ADHD so try and ensure a calm and quiet environment.
- Take time to ensure you have the person's attention before asking questions.
- Try to ensure that questions asked of the individual are unambiguous, give the person time to organise their thoughts and offer to rephrase questions if necessary. Share your interpretation of their answers to achieve a shared understanding.

Links to evidence & useful reading

Allely, C.S., 2014. The association of ADHD symptoms to self-harm behaviours: a systematic PRISMA review. BMC Psychiatry,14, 133. https://doi.org/10.1186/1471-244X-14-133.

Ward, J.H, and Curran. S., 2021. Self-harm as the first presentation of attention deficit hyperactivity disorder in adolescents. Child and Adolescent Mental Health, 26(4), 303-309.

ADDitude. (2019). ADD & ADHD Symptom Tests, Signs, Treatment, Support. [online] Available at: https://www.additudemag.com.

Autistic Spectrum Condition (ASC)

People with ASC, both young people and adults, are considerably more likely to self-harm than those without the condition (25). Adults with ASC also have a significantly increased risk of completed suicide compared with the general population. Females with ASC have been found to be over three times as likely to die from suicide as females without ASC, and young people with ASC have over twice the risk of suicide as those without ASC (26). People with ASC are more likely to experience the risk factors shared with the general population, such as housing, unemployment, previous non-suicidal self-injury, social isolation, depression and anxiety, but ASC-specific risk factors have also been found:

- Individuals with ASC are more likely to camouflage (mask) their condition as a way of coping in social situations. Camouflaging can act as a barrier to timely professional support and can itself have a negative impact on mood and insight.
- People with ASC tend to be less connected to psychiatric services. Those who are asking for help may have difficulties with their social communication, causing a misunderstanding of their needs. Professionals are often unaware of the different needs of those with ASC. Individuals recently diagnosed who have no support are at particularly high risk of suicide ideation.

Practice pointers:

- Consider the sensory needs of the individual before and during assessment, i.e., sounds, lights, how busy the location is (people and decor).
- The person may have Alexithymia (difficulties describing their own internal experiences), which might make assessing mood and emotions difficult. Consider using visual aids to help the individual identify and label their emotions.
- Even if the person can express themselves well, they may not understand meanings and might interpret questions literally. Due to this they may under or over-report suicidal feelings. Probe specific circumstances and check with the individual about their understanding of questions.
- People with ASC are likely to have some reduced cognitive flexibility making their thoughts more concrete; to them suicide may come across as a logical solution to a problem rather than an emotional response.
- Talking to the individual about their special interests may distract them from an assessment they are finding difficult. Reduced interest in such interests might indicate a lowering of mood. Be aware that suicide may present as the individual's special interest, and this could increase risk even if the person is not depressed.
- Some behaviours related to depression in neurotypical individuals may be a coping strategy in ASC. Withdrawing, high anxiety and hopelessness may be an essential part of regulating emotions and managing self-care. Individuals with ASC tend to have sleep issues and be socially withdrawn. Ensure that you get a good idea of their normal presentation and behaviour. Consider whether the self-harm could be a response to sensory overload.
- The individual may camouflage their suicidal thoughts and symptoms of depression and anxiety as they are so used to doing this on a day-to-day basis.
- Individuals with ASC are more likely to be victims of bullying. Ensure this is explored; it may be that an individual does not realise they are being bullied by people they identify as friends.
- The ability to process information (especially spoken) may be slower than usual. Extra time may be needed to carry out assessments and short breaks may be need to be offered.

Middle aged men

Three quarters of individuals who die by suicide in the UK are male. Rates are highest amongst men aged 40-54 years, although suicide is also the biggest cause of death in men 35 years and under (30, 31). Following the 2008 recession both self-harm resulting in ED presentation and suicide in males increased (32, 33). Common problems precipitating self-harm in this population include relationship difficulties, harmful alcohol use, unemployment, financial concerns, and housing issues. These problems are also reflected in completed suicides (30). Approximately half of men in midlife presenting to the ED after self-harm have a previous history of self-harm and a similar proportion have had previous or current contact with mental health services (34).

Subsequent suicide risk of this population has been found to be highest in the 12 months following presentation to ED (34). Around half of middle-aged men who died by suicide in the UK in 2017 had a history of self-harm and half had physical health problems, mainly circulatory system diseases such as hypertension but also respiratory problems, digestive illnesses and chronic pain. (30).

Men are sometimes reluctant to seek help. Reasons for this include embarrassment and fear, social pressure, the need for emotional control, viewing symptoms as insignificant, and poor communication and rapport with healthcare professionals. These factors may be associated with masculine norms and a lack of knowledge about symptoms and available services (35).

The psychosocial assessment is an opportunity to develop effective rapport with male patients and subtly address barriers to help-seeking through problem solving and signposting, particularly given that subsequent self-harm may involve a more lethal method (30).

Links to evidence & useful reading

Clements, C., Hawton, K., Geulayov, G., Waters, K., Ness, J., Rehman, M., Townsend, E., Appleby, L. and Kapur, N., 2019. Self-harm in midlife: analysis using data from the Multicentre Study of Self-harm in England. *The British Journal of Psychiatry, 215*(4), pp.600-607. https://doi.org/10.1192/bjp.2019.90.

Yousaf, O., Grunfeld, E.A. and Hunter, M.S., 2015. A systematic review of the factors associated with delays in medical and psychological help-seeking among men. *Health Psychology Review, 9*(2), pp.264-276. https://doi.org/10.1080/17437199.2013.840954.

National Confidential Inquiry into Suicide and Safety in Mental Health (2021). *Suicide by middle-aged men.* [online] The University of Manchester. Available at: https://documents.manchester.ac.uk/display.aspx?DocID=55305.

Minority groups

LGBTQ+

LBGTQ+ young people have higher rates of self-harm and suicide than their cisgender and heterosexual counterparts (36). Victimisation (such as homophobic bullying, cyber victimisation and peer bullying), mental health difficulties, interpersonal problems, and low self-esteem are associated with self-harm in this population (37, 38). It is also suggested that difficulties processing sexual and gender identity and not feeling accepted by family and friends contribute to self-harming behaviour (39).

Practice pointer:

- Asking about and acknowledging sexual and gender identity in an open and supportive manner and encouraging young people to talk about their experiences of victimisation may facilitate a therapeutic rapport and thus enable a comprehensive psychosocial assessment.

Ethnic minorities

There is a lack of current research regarding self-harm within ethnic minorities, and existing research does not comprehensively cover the diverse ethnic groups within the UK (40). In addition to risk factors that can affect majority ethnic groups, people from ethnic minorities may experience additional factors, including discrimination,

cultural and language barriers, and higher socioeconomic disadvantage (41). There may also be differences in help-seeking behaviour, possibly due to previous experiences of inadequate care (42, 43). Furthermore, minority groups may be affected by stigma associated with mental illness and suicidal behaviour linked to cultural or religious beliefs (44). Specific factors linked to repeat self-harm resulting in hospital presentations in Black and ethnic minority groups include symptoms of mental illness in Black people, and not having a partner in South Asian people, with alcohol misuse being strongly linked to multiple presentations of repeat self-harm in both groups. (45). Presentations to hospital following self-harm by children and young people from ethnic minority groups have increased over time compared to white ethnic groups, and this population is more likely to experience socioeconomic disadvantage, and less likely to receive a psychosocial assessment (46).

Migrants and refugees

Migrants and refugees may be affected by pre-migratory circumstances, including trauma as well as experiences within their host country (47). The latter might include separation from family members, worrying about family left behind in their home country, language difficulties, and adjusting to an unfamiliar culture (42). Risk of self-harm linked to poor mental health due to traumatic experiences has been identified in asylum seekers who are housed in detention centres and also in unaccompanied migrant minors (48). Young migrants have higher rates of self-harm than young non-migrants (47), but may avoid disclosing associated mental health difficulties due to negative perceptions and perceived stigma around mental illness, including beliefs about possible consequences (such as incarceration or social isolation) (49).

Practice pointers:

- Ensure a culturally sensitive approach, and take time to understand language, cultural and spiritual needs.
- Remember Westernised notions of self-harm and mental health difficulties will not necessarily reflect those of other cultures.
- Be mindful of the possibility of stigmatised views which may be held by both the patient and their family. Ensure the individual is encouraged to talk away from their family in case they feel unable to speak openly in front of family members. This needn't exclude family members from sharing their perspectives but gives the patient time and space to speak for themselves.
- If an interpreter is required this should be from a professional agency to ensure impartial translation.

- Be aware of the trauma that refugees and migrant populations may have experienced and ensure adequate measures are taken to help them feel safe during assessment, such as having a chaperone present.
- Be alert to previous experiences of discrimination and recognise that this might lead to mistrust of services.

Special considerations for contemporary societal crises or stress

In the event of national/international crises which might affect mental health and contribute to self-harm, such as a pandemic, cost of living crisis, recession or war, it is important to assess the impact of these circumstances on the patient.

From research carried out during the COVID-19 pandemic, an assessment aid for identifying potential factors contributing to self-harm was developed (See Appendix 2). It may be helpful to consider developing similar aide memoires if future similar circumstances occur.

Links to evidence & useful reading

Barnes, M.C., Gunnell, D., Davies, R., Hawton, K., Kapur, N., Potokar, J. and Donovan, J.L., 2016. Understanding vulnerability to self-harm in times of economic hardship and austerity: a qualitative study. *BMJ Open*, 6(2), p.e010131. http://dx.doi.org/10.1136/bmjopen-2015-010131.

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Hawton, K., Lascelles, K., Brand, F., Casey, D., Bale, L., Ness, J., Kelly, S. and Waters, K., 2021. Self-harm and the COVID-19 pandemic: a study of factors contributing to self-harm during lockdown restrictions. *Journal of Psychiatric Research, 137*, pp.437-443. https://doi.org/10.1016/j.jpsychires.2021.03.028.

Carrying out the psychosocial assessment

In practice, the psychosocial assessment should flow in accordance with patient need and clinician style. Thus, the order of the components addressed below may vary. Individuals respond better to a curious and conversational style of assessment in which, rather than a scripted discourse, the clinician shows appropriate curiosity. However, it is important that all aspects of the assessment are covered.

Environment, introduction and explanation

The ED is a noisy, hectic, and intimidating environment for many people. Due to this, as well as people with ADHD and ASC, those who have experienced trauma might experience sensory overload. Ideally there should be a separate and quiet room in which psychosocial assessments can be conducted. Ensure the room is comfortable and clear of unnecessary equipment, and that there will not be interruptions during the assessment.

To help develop a therapeutic rapport and enable the patient to feel as comfortable as possible, consider the following:

Practice pointers:

- Introduce yourself clearly and explain your role and why you are there.
- Offer the individual a drink of water to bring into the assessment (they may not have eaten or drunk for a while, and they may be experiencing side-effects such as dry mouth from medication or substances taken as part of the self-harm act).
- Describe the purposes of the psychosocial assessment and prepare the person for the fact that you will be asking personal questions.
- Explain confidentiality and discuss information sharing (i.e., with GP, relevant healthcare providers).

- Ensure the person is seen separately from family members/carers in the first instance. However, explain that it can be helpful to speak with significant others as part of the assessment and ask if there is a family member or friend the patient is agreeable to being involved. Reassure the patient that this does not mean disclosing the information the patient shares with you, but that it enables you to obtain a fuller picture and may help others to support the individual and help keep them safe.

Precipitants, circumstances, motives & desired consequences of self-harm

Most people involved in acts of self-harm have experienced negative life events in the days or weeks preceding the act and it is important to understand any recent changes in circumstances whilst acknowledging that longstanding problems may also have contributed to a person's self-harm.

Frequently reported problems precipitating self-harm are relationship difficulties (especially with partners), mental and physical health problems, and issues regarding finances, employment, housing and alcohol. Individuals who repeat self-harm are more likely to report problems with housing, mental health and dealing with the consequences of past abuse (34, 50). Domestic violence is strongly associated with self-harm (51).

Bullying, familial conflict and school or academic stress are common problems for teenagers who self-harm (19, 52).

Many people will present with several concomitant problems e.g., interpersonal conflict, employment concerns, excessive alcohol use, and psychiatric disorder. Life problems should be identified during the assessment process to try and clarify the primary problems, which can assist with later care and safety planning.

Functions of self-harm include the following (53, 54):

- **Affect-regulation** (stabilising mood and alleviating negative emotions)
- **Self-punishment** (in response to self-loathing and anger towards the self)
- **Interpersonal influence** (to elicit a response from others)
- **To prevent or end dissociation** (causing physical pain to stop numbness and regain feeling)
- **To attempt suicide**
- **To avert suicide** (for example by inflicting non-lethal injury, perhaps as a compromise or distraction)

- **Personal mastery** (by being in control of self-harm)
- **Sensation seeking** (to achieve a sense of exhilaration)
- **Self-validation strategy** (to demonstrate strength or suffering)

It is helpful to try and develop an understanding of the psychological processes involved in the act of self-harm, including for example, the individual's thoughts and feelings before, during and after the self-harm, warning signs and triggers, motives for the self-harm, who they communicated with, whether they anticipated harm, death, or rescue and how they came to be in hospital. This can enable the clinician to build a full picture of the self-harm, including the intent behind the act (55). If a motivational understanding of the act cannot be developed it likely suggests that some important aspects of the behaviour remain unknown.

It is important to elicit whether alcohol or drugs were involved before, during, or after the self-harm, the rationale for selecting the method used to self-harm, whether the act was planned or impulsive, and the presence and level of suicide ideation and intent.

Links to evidence & useful reading

Rodham, K., Hawton, K. and Evans, E., 2004. Reasons for deliberate self-harm: Comparison of self-poisoners and self-cutters in a community sample of adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*(1), pp.80-87. https://doi.org/10.1097/00004583-200401000-00017.

Edmondson, A.J., Brennan, C.A. and House, A.O., 2016. Non-suicidal reasons for self-harm: a systematic review of self-reported accounts. *Journal of Affective Disorders, 191*, pp.109-117. https://doi.org/10.1016/j.jad.2015.11.043.

Townsend, E., Ness, J., Waters, K., Kapur, N., Turnbull, P., Cooper, J., Bergen, H. and Hawton, K., 2016. Self-harm and life problems: findings from the Multicentre Study of Self-harm in England. *Social Psychiatry and Psychiatric Epidemiology, 51*(2), pp.183-192. https://doi.org/10.1007/s00127-015-1136-9.

Klonsky, E.D., 2007. The functions of deliberate self-injury: a review of the evidence. *Clinical Review, 27*(2), pp.226-239. https://doi.org/10.1016/j.cpr.2006.08.002.

Asking about suicide

Because of the close association between self-harm and suicide (56) it is always necessary to ask about suicide even when self-harm appears to be non- suicidal in nature. Many people experience suicide ideation when they self-harm even when the act itself does not involve suicidal intent. This might, for example, reflect a person's sense of feeling so bad they wish they were dead, but not of actually wanting to die.

Research has indicated that clinicians can sometimes ask closed and negatively phrased questions such as "no thoughts of harming yourself?", which are not conducive to honest disclosure (57). It is important not to fall into this trap and to be open and clear when asking about thoughts of suicide. Ensure the patient understands what you are asking e.g., questions about bad thoughts or thoughts of hurting oneself may not be interpreted as questions about suicidal thoughts but as questions about non-suicidal self-harm.

It is also important to try and understand the patient's suicidal thinking by asking about its components, including:

Mental pain typically comprises strong negative emotions such as shame, guilt, self-loathing, humiliation, loneliness, fear, angst, and dread. Suicide can be an act of escape from unbearable mental pain (58).

Hopelessness is significantly related to eventual suicide (59-61). Paradoxically, people contemplating suicide will often also think about, and may plan for the future, almost as if they were living in a parallel universe. Therefore a probing dialogue is necessary to elicit true thoughts and feelings related to suicidality.

Mental imagery of suicide or self-harm alongside suicide ideation can indicate a higher likelihood of a future suicide attempt than suicide ideation alone (62). Also, mental imagery about an act of suicide or self-harm can evoke very strong emotions. Asking the patient how they experience their thoughts of self-harm might help to elucidate mental imagery, especially if the clinician asks specifically about such images.

Psychological models can help to guide clinicians' assessment of suicide ideation and intent, particularly those which explain the transition from suicide ideation to suicidal behaviour. A lack of sense of belonging, feeling defeated, the belief that one is a burden, a sense of hopelessness about resolution and feeling trapped in the situation, can all contribute to development of suicidal thoughts. Such thoughts are more likely to develop into suicidal behaviours when the prospect of death is not viewed as frightening and the person considers themselves competent in their ability to end their life. In addition, past suicidal acts, exposure to suicide, access to means, and impulsivity might all increase the likelihood of acting on suicidal thoughts (63, 64).

Links to evidence & useful reading

O'Connor, R.C. and Kirtley, O.J., 2018. The integrated motivational–volitional model of suicidal behaviour. *Philosophical Transactions of the Royal Society B: Biological Sciences,* 373(1754), p.20170268. https://doi.org/10.1098/rstb.2017.0268.

Van Orden, K.A., Witte, T.K., Cukrowicz, K.C., Braithwaite, S.R., Selby, E.A. and Joiner Jr, T.E., 2010. The interpersonal theory of suicide. *Psychological Review, 117*(2), p.575-600. https://doi.org/10.1037/a0018697.

The practice pointers below, will help assess intent associated with self-harm. (informed partly by the Beck Suicide Intent Scale (55))

Practice pointers:

- Elicit when the crisis leading up to the self-harm started.
- Ascertain the patient's perspective of why they self-harmed.
- Probe to achieve a shared understanding e.g., if the patient says they just wanted to sleep ask what they mean by that – why, how long for, did they want to wake up etc.
- Ask for general detail about what the patient was doing in the hours and days prior to the self-harm to help obtain an idea of how they were functioning, thinking, and feeling.
- Ask when thoughts of self-harm started and about their frequency, intensity, and duration. Establish the point at which the thoughts turned into action.
- If alcohol or drugs were involved, ascertain which, what quantity, whether this deviated from normal usage, and the patient's perspective about how substances influenced their self-harm.
- Establish the patient's knowledge and decision-making regarding their method of self-harm: how they knew about it, how/where they obtained it, where they stored it, and what other methods had been considered.
- Obtain a detailed understanding of the act itself e.g., for self-poisoning, what substance and how many pills the individual ingested, whether they were taken one by one or in handfuls, did they take all available tablets, etc.

- Establish perceptions of likely medical seriousness.
- Ask if the patient was alone or in company. What did they think the chances of them being found or interrupted were. How did they get to hospital.
- Ask clear questions about whether the patient had thoughts of dying leading up to this episode of self-harm – whether or not suicide ideation is expressed.
- Explore suicidal thoughts; don't just ask whether or not they were/are present, but also, for detail, including about their duration and intensity.
- Did the individual communicate their intent or action and if so, to whom and in what manner (i.e., direct/indirect, verbal, text, social media, handwritten note).
- Did they make any preparations prior to the self-harm e.g., making efforts to see family and friends, arrangements (e.g., for funeral, pets, will, insurance etc.).
- Establish if there are ongoing thoughts of self-harm or suicide; do they regret their actions or have any emotional response to them; are they experiencing ongoing thoughts, plans or intent to repeat. If so, obtain details.
- Can they think of anything that might have prevented their self-harm.
- What might the individual do next time they experience the strong emotions that led to this episode of self-harm. Their answer may be protective or risky. **Probe**.... how do they know, what might an alternative to self-harm be etc.

History of previous self-harm and possibility of repeat self-harm or suicide

People who attend the emergency department following self-harm are many times more likely than the general population to die by suicide in the subsequent 12 months, with risk being highest in the first few weeks (56). A significant proportion of people who self-harm and attend ED present again following further self-harm, often relatively soon afterwards. This population is at even greater risk of subsequent suicide (65).

Repetition of self-harm is particularly common in children and young people and also in people with emotionally unstable personality disorder (66, 67).

Functions of self-harm might vary over time, with some episodes being in the context of suicide ideation and others being non-suicidal in nature. People often switch methods of self-harm (68), and a combination of methods and repetition of self-harm may indicate escalating risk (69, 70). Potential lethality of the method or extent of self-harm does not necessarily determine risk of repeat self-harm or suicide; the last self-harm act prior to completed suicide may be superficial cutting. Indeed, in individuals who present to ED following self-harm, self-cutting is associated with a higher risk of repetition, and the risk of suicide is at least similar to that for self-poisoning (56).

Practice pointers:

- Ask about self-harm history and establish a timeline including circumstances, thoughts and feelings, methods, behavioural changes, outcomes/consequences, reflections.
- Identify patterns of self-harming behaviour.
- The patient themselves is likely to have the most accurate idea of whether they will self-harm again, although this should not be relied on (71). Ask for perspectives of likelihood of repeat, what might lead to a further act, what might prevent repetition and elicit motivation to develop alternative strategies.
- Link your understanding of previous self-harm to the possibility of future episodes.

A complete psychosocial assessment may not be required for individuals who frequently attend ED following self-harm and are well known to services. However, these individuals should still be assessed; each contact is an opportunity to assess for new information which might help plan improved therapeutic interventions.

On each presentation it is necessary to elicit:

- What precipitated the self-harm
- Reasons for the self-harm
- Mental state assessment and changes in this since previous assessment
- Changes in circumstances, relationships, and substance use since the previous assessment
- Changes in method of self-harm and rationale for the change
- Changes in functions of self-harm or the motives involved (including suicidal intent)
- Perspectives on the future
- Social support network and changes in this since the previous assessment
- Motivation to engage in safety planning, including review of existing safety plan

Always ensure effective collaboration with the patient and also information sharing with GP/mental health professionals and family or carers where appropriate.

Links to evidence & useful reading

Carroll, R., Metcalfe, C. and Gunnell, D., 2014. Hospital presenting self-harm and risk of fatal and non-fatal repetition: systematic review and meta-analysis. *PLOS One, 9*(2), p.e89944. https://doi.org/10.1371/journal.pone.0089944.

Witt, K., Milner, A., Spittal, M.J., Hetrick, S., Robinson, J., Pirkis, J. and Carter, G., 2019. Population attributable risk of factors associated with the repetition of self-harm behaviour in young people presenting to clinical services: a systematic review and meta-analysis. *European Child & Adolescent Psychiatry, 28*(1), pp.5-18. https://doi.org/10.1007/s00787-018-1111-6.

Geulayov, G., Casey, D., Bale, L., Brand, F., Clements, C., Farooq, B., Kapur, N., Ness, J., Waters, K., Tsiachristas, A. and Hawton, K., 2019. 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), pp.1021-1030. https://doi.org/10.1016/S2215-0366(19)30402-X.

Witt, K., Daly, C., Arensman, E., Pirkis, J. and Lubman, D., 2019. Patterns of self-harm methods over time and the association with methods used at repeat episodes of non-fatal self-harm and suicide: a systematic review. Journal of Affective Disorders, 245, 250-264. https://doi.org/10.1016/j.jad.2018.11.001.

Psychiatric disorder, history and current care

Psychiatric disorders are common in individuals who present to hospital following self-harm, notably depression, anxiety, and substance (mainly alcohol) misuse disorders, with eating, bipolar and psychotic disorders also being relatively frequent (72). Psychiatric disorders, particularly depression, are especially common in older people who self-harm (15).

In children and adolescents presenting to hospital following self-harm, psychiatric disorders are also common with depression, ADHD, substance misuse and anxiety disorders being most frequent (72). Autism spectrum condition is increasingly recognised as being associated with self-harm. Eating disorders are also common in children and adolescents who self-harm (23).

Psychiatric disorder will often be a key influence on an individual self-harming. Many patients will already have a diagnosed disorder. In these cases, it will be important to gather information about contact with services, including mental health, primary care and non-statutory services, as well as any current pharmacological and psychological treatments. However, a self-harm presentation will in some cases be the first indication

of a possible psychiatric disorder. A psychosocial assessment provides an opportunity to detect mental health problems in these cases. Therefore, assessment of mental state and of other possible indicators of disorder (e.g., weight loss, poor sleep, loss of energy, anxiety symptoms) should be a key part of the assessment procedure. In some patients this may provide a clear diagnostic picture, while for others it may identify possible disorders which require subsequent further assessment.

Personality disorder

A substantial proportion of individuals presenting to hospital following self-harm will have a personality disorder, with many of these also having psychiatric disorders (73). A history of multiple episodes of self-harm, and repeated self-harm following discharge from hospital is common in this population (73).

While detection of personality disorders in patients where these have not been diagnosed before is potentially very important, especially because of the implications for future risk and treatment options, in reality it is difficult to make a formal diagnosis within a time-limited psychosocial assessment. However, the clinician might suspect that a personality disorder may be present, which can then be further assessed after the patient is discharged from hospital. Often information from family and friends may help clarify this. This may help in identifying what treatment may be most appropriate for the individual (e.g., Dialectical Behavioural Therapy).

Practice pointers:

- Where patients are known to mental health services, obtain information about the current level of support/therapy that is being received, including any recent/pending changes (e.g., transitions in care, therapy ending, or a key professional leaving), and the degree to which care is experienced as helpful. By understanding an individual's mental health history and current involvement with services, collaborative care and safety planning can be more effective.
- Always obtain information about any current medication, including doses and the amount the person has at home.
- It is important to carefully assess for cognitive impairment in older adults.

Links to evidence & useful reading

Reichl, C. and Kaess, M., 2021. Self-harm in the context of borderline personality disorder. *Current Opinion in Psychology, 37*, pp.139-144. https://doi.org/10.1016/j.copsyc.2020.12.007.

Hawton, K., Saunders, K., Topiwala, A. and Haw, C., 2013. Psychiatric disorders in patients presenting to hospital following self-harm: a systematic review. *Journal of Affective Disorders, 151*(3), pp.821-830. https://doi.org/10.1016/j.jad.2013.08.020.

Dennis, M.S., Wakefield, P., Molloy, C., Andrews, H. and Friedman, T., 2007. A study of self-harm in older people: mental disorder, social factors and motives. *Aging and Mental Health, 11*(5), pp.520-525. https://doi.org/10.1080/13607860601086611.

Mental state examination

To help understand the individual's level of psychological functioning and whether a mental disorder might be present, a mental state examination must be part of all assessments.

It is essential to elicit a baseline of usual functioning as part of the mental state assessment and where the individual's current presentation deviates from their normal levels try and obtain a timeline of how things have developed.

Practice pointers:

- **Appearance and behaviour** - whether dishevelled/clean clothing, eye contact, rapport, facial expressions, body language, psychomotor activity, abnormal movements or postures.
- **Speech** – rate, tone, content, rhythm.
- **Mood** – subjective and objective view of mood, check for early morning wakening, diurnal variation, affect, loss of appetite, disturbed sleep, loss of libido.
- **Thoughts** – flight of ideas, tangential thoughts, thought disorder, paranoid thoughts, thought possession, delusional ideation, obsessional thoughts, thoughts of harming others, suicide ideation.
- **Perception** – auditory, visual, olfactory disturbance, depersonalisation, derealisation.
- **Cognition** – orientation to time, person, place, memory, concentration. Formal cognitive testing e.g., Mini-mental state examination or Montreal Cognitive Assessment if cognitive impairment is suspected.
- **Insight** – the patient's understanding of what has happened and what their problems are.
- **Mental Capacity** – the patient's ability to understand, retain and relay information and make decisions about their care.

Where an eating disorder is suspected it may be appropriate to ask the **SCOFF** questions (74). These are not diagnostic questions but used for screening; if a patient answers yes to two or more questions, referral to an Eating Disorders service may be appropriate.

- Do you make yourself **S**ick because you feel uncomfortably full?
- Do you worry that you have lost **C**ontrol over how much you eat?
- Have you recently lost more than **O**ne stone (14 lb) in a 3-month period?
- Do you believe yourself to be **F**at when others say you are too thin?
- Would you say that **F**ood dominates your life?

Substance misuse and addiction

Substance misuse, particularly alcohol, can increase the risk of self-harm and suicide (75, 76). This may be due to impulsivity because of intoxication, or feelings of despair and a desire to escape addiction.

In addition to substances misuse other addiction issues can increase risk of self-harm or suicide and should be asked about. For example, problem gambling is associated with suicide attempts in both young men and women (77).

Practice pointers:

- Obtain information about all illicit substances taken and any misuse of prescribed drugs.
- Ask from where drugs are obtained (e.g., online).
- Look for signs of harmful alcohol use as well as dependency. Observe for signs of withdrawal or delirium.
- Consider completing a screening tool such as the Alcohol Use Disorder Identification Toolkit (AUDIT).
- Offer to refer to substance misuse services if this is indicated; patients may respond to contact from services, but may be less likely to self-refer.

Physical health

The physical health of people who present to the emergency department following self-harm can be compromised, due in some cases to poor lifestyle behaviours, leading to reduced life expectancy (78).

Physical health conditions, especially those that involve chronic pain, can elevate suicide risk (79, 80) and are particularly associated with suicide risk in older adults (81). Certain neurological conditions e.g., multiple sclerosis, epilepsy and Parkinson's disease are associated with both self-harm and suicide (82).

Times of hormonal change, including puberty (especially early puberty), menstruation, pregnancy and the post-natal period, and menopause can be associated with depression and self-harm (83-86).

Practice pointers:

- Obtain a comprehensive physical health history, including relevant family history.
- Establish the impact that physical health problems are having on the patient's life and the patient's perspective of any links between physical health and the self-harm episode.
- Obtain information on lifestyle behaviours: diet, exercise, smoking, sleeping patterns. Incorporate basic healthy living tips and sleep hygiene into assessment. Signpost to smoking cessation services if appropriate.

Links to evidence & useful reading

Borges, G., Bagge, C.L., Cherpitel, C.J., Conner, K.R., Orozco, R. and Rossow, I., 2017. A meta-analysis of acute use of alcohol and the risk of suicide attempt. *Psychological Medicine, 47*(5), pp.949-957. https://doi.org/10.1017/S0033291716002841.

Wardle, H. and McManus, S., 2021. Suicidality and gambling among young adults in Great Britain: Results from a cross-sectional online survey. *The Lancet Public Health, 6*(1), pp.e39-e49. https://doi.org/10.1016/S2468-2667(20)30232-2.

Tang, N.K. and Crane, C., 2006. Suicidality in chronic pain: a review of the prevalence, risk factors and psychological links. *Psychological Medicine, 36*(5), pp.575-586. https://doi.org/10.1017/S0033291705006859.

Personal and social history/current circumstances

Individuals exist within interrelated social and cultural systems. It is important to obtain a comprehensive picture of this wider context in order to understand the person's world and the factors that might have directly or indirectly contributed to their self-harm, or which may indicate future vulnerability. It is necessary to build up a picture of the person's individual, familial, and social context to understand any adversity or trauma they may have experienced; adverse childhood experiences are closely linked with self-harming behaviours (13).

Family history of mental illness and adversity should be obtained to establish a picture of possible interfamilial and genetic factors. Family history of suicide or self-harm and bereavement by suicide are risk factors for suicide (87). Transgenerational transmission of suicidal behaviour may be associated with genetics (e.g., of transmission of depression, bipolar disorder or certain personality traits) or social learning (e.g., through awareness of parental or sibling self-harm/suicidal behaviour in the home when growing up).

Social factors associated with self-harm and suicide include, but are not limited to, bullying, dysfunctional familial relationships, criminality, domestic violence, isolation, and loneliness (41, 51, 88-91). Incidence of self-harm and suicide is more frequent in socio-economically deprived groups (92-94). Where community-based support is lacking, social isolation may be perpetuated.

Domestic violence is strongly associated with self-harm (51, 95). Perpetrators, as well as victims, may have an increased risk of self-harm (96). In addition, individuals facing criminal prosecutions related to child sexual abuse or indecent image offences have a higher risk of suicide (97).

Exposure to self-harm or suicide, for example knowing someone who has self-harmed, learning of a peer or celebrity who has died by suicide, or reading about a new method of suicide, can increase risk of suicidal behaviour in already vulnerable individuals due to its contagious effect (98). Exposure can be through a personal relationship with a person who self-harms or has died by suicide, print and social media coverage of suicide, TV and film, and witnessing a suicide (e.g., finding the deceased). Contagion occurs more commonly in young people, and vulnerable settings are schools, universities, mental health units, and prisons (98, 99).

Social factors should be considered from both risk and strength/ protective perspectives; protective factors may include a supportive local social network, availability of community-based support, a healthy local economy or employment opportunities (41).

Widespread health and social issues (e.g., recessions) will have an effect on individuals' social systems and it is important to gain an understanding of the extent of this impact.

The box below lists key points to ask about during the psychosocial assessment in order to obtain an understanding of personal and social history and circumstances.

Ask about:
History, including:
• Birthplace.
• Early life/development.
• Childhood adversity.
• Familial and key relationships and quality of those relationships.
• Family history of mental illness, self-harm or suicide.
• Schooling and school life.
• Further education.
• Occupation/work-life.
• Relationships.
• Hobbies/interests.
Current circumstances, including:
• Living arrangements/housing.
• Familial and other relationships and social network.
• Psychosexual issues.
• Physical health problems.
• Employment/student situation.
• Parenting and additional caring responsibilities (e.g., spouse, parents, adult children).
• Finances: income, debt.

- Current and anticipated social stressors (e.g., financial outgoings; criminal proceedings, threatened relationship break-up; expected loss).

- Recent exposure to self-harm and suicide.

- Perceived impact of current societal stressors (e.g., recession).

Ask about the difficult things even if not volunteered including past or current:

- Abuse/trauma.

- Domestic violence (victim or perpetrator).

- Bullying including cyberbullying (victim or perpetrator).

- Offending or violent behaviour.

- Criminal prosecutions.

- Addiction issues.

Older adults: Assess in relation to any physical healthcare needs and cognitive impairment, including support going into the home and caring ability and wellbeing of those in the home e.g., spouse.

Adolescents: Assess for any child protection issues.

Exposure to self-harm or suicide:

- Explore any identification with individuals (real or fictitious) who have ended their lives by suicide.

- Where there is a family history of self-harm or suicide ask for details, including method used, and seek the patient's perspective about whether this might have influenced their own self-harm episode.

Links to evidence & useful reading

Cleare, S., Wetherall, K., Clark, A., Ryan, C., Kirtley, O.J., Smith, M. and O'Connor, R.C., 2018. Adverse childhood experiences and hospital-treated self-harm. *International Journal of Environmental Research and Public Health, 15*(6), p.1235. https://doi.org/10.3390/ijerph15061235.

Niederkrotenthaler, T., Braun, M., Pirkis, J., Till, B., Stack, S., Sinyor, M., Tran, U.S., Voracek, M., Cheng, Q., Arendt, F. and Scherr, S., 2020. Association between suicide reporting in the media and suicide: systematic review and meta-analysis. *BMJ, 368*:m575. https://doi.org/10.1136/bmj.m575.

Hawton, K., Hill, N.T., Gould, M., John, A., Lascelles, K. and Robinson, J., 2020. Clustering of suicides in children and adolescents. *The Lancet Child & Adolescent Health, 4*(1), pp.58-67. https://doi.org/10.1016/S2352-4642(19)30335-9.

Internet and social media

Use of internet and social media can be both harmful and protective in relation to self-harm and suicide.

Harms include anxiety and depression; poor sleep; disturbed body image; cyberbullying; fear of missing out (FOMO); contagious effects of others' self-harm; self-harm-related images and introduction to new methods of self-harm or suicide (24).

Benefits include access to other people's health experiences and expert health information; emotional support and community building; self-expression and self-identity; making, maintaining and building upon relationships; and access to professional or therapeutic support sites/apps (24).

Practice pointers:
Assume internet and social media use and ask all age groups about use.
Consider the following questions:
• What social media platforms and internet sites are you currently using?
• What self-harm or suicidal content have you come across online?
• Have there been any recent changes in your internet/social media use?
• Is anything about the sites you visit troubling you?

- Are you, or have you been involved in any online discussions about self-harm (or suicide)?
- Do you deliberately access social media/internet platforms that promote self-harm or suicide?
- Did you use the internet to research self-harm on this occasion?
- Did you communicate your intent to self-harm or your act of self-harm on social media? How?
- Do you generally seek out social media that promotes self-care and help seeking?

Engage the patient in a dialogue to explore their motives for accessing potentially harmful material. Discuss the implications for the patient and others and consider alternatives.

- Why do you think you look at these sites/access this social media?
- How does it make you feel?
- How does it influence your thinking?
- What benefits do you experience?
- What do you think the potential harms are for you?
- What might the potential harms be for others who read your social media postings?
- How might you be able to get the support/information/feelings you need by doing something that involves less potential harm?

Links to evidence & useful reading

Marchant, A., Hawton, K., Burns, L., Stewart, A. and John, A., 2021. Impact of web-based sharing and viewing of self-harm–related videos and photographs on young people: systematic review. *Journal of Medical Internet Research, 23*(3), p.e18048. https://doi.org/10.2196/18048.

Sedgwick, R., Epstein, S., Dutta, R. and Ougrin, D., 2019. Social media, internet use and suicide attempts in adolescents. *Current Opinion in Psychiatry, 32*(6), p.534. https://doi.org/10.1097/YCO.0000000000000547.

John, A., Glendenning, A.C., Marchant, A., Montgomery, P., Stewart, A., Wood, S., Lloyd, K. and Hawton, K., 2018. Self-harm, suicidal behaviours, and cyberbullying in children and young people: Systematic review. *Journal of Medical Internet Research, 20*(4), p.e9044. https://doi.org/10.2196/jmir.9044.

Usual personality including strengths, coping strategies & protective factors

It is important to establish the person's perspective of their 'usual' self, including cultural, religious and spiritual practices and beliefs, and their sense of self-worth. This should include their usual level of social functioning and their strengths, problem solving-ability and coping strategies. This helps to elicit usual ways of coping and how far from their usual self they are at assessment as well as their level of motivation to regain their usual level of functioning.

Patients might have certain psychological factors and personality traits that indicate ongoing vulnerability e.g., pessimism, neuroticism, negative thought processes, or which indicate resilience e.g., problem-solving ability, effective coping strategies.

Practice pointers:

Ask the patient:

- To describe their 'usual self' (If possible, also seek family or carer perspectives as it may be difficult for the individual to describe their usual self when they are in crisis).
- About their cultural/religious practices/spiritual beliefs and how these ordinarily bring comfort or strength.

- How they usually manage stressful situations – if they say they don't know, remind them that everyone manages stressful situations and ask them to think of a non self-harm related stressor that they have managed.
- If they think they are impulsive (ask in what way and for examples).
- What they see as being their strengths.
- How they think others see them.
- How they think a good friend/close family member would describe them.
- In what way they think they are currently different from their normal self?
- How would they like to see themself in the future?
- What would it take to help them achieve this (consider the miracle question – "if you woke up tomorrow and everything was ok, what would have had to happen to enable that?").

Links to evidence & useful reading

O'Connor, R.C. and Nock, M.K., 2014. The psychology of suicidal behaviour. *The Lancet Psychiatry, 1*(1), pp.73-85. https://doi.org/10.1016/S2215-0366(14)70222-6.

Malone, K.M., Oquendo, M.A., Haas, G.L., Ellis, S.P., Li, S. and Mann, J.J., 2000. Protective factors against suicidal acts in major depression: reasons for living. *American Journal of Psychiatry, 157*(7), pp.1084-1088. https://doi.org/10.1176/appi.ajp.157.7.1084.

Safeguarding

Clinicians should always elicit whether there are safeguarding concerns related to the individual (e.g., sexual or psychological abuse; domestic abuse; financial exploitation; elder abuse). In addition, if the patient has caring responsibility for children or vulnerable adults it is important to ascertain whether there are any risks to those individuals' safety or wellbeing.

Practice pointers:

- Be alert to possible observable indicators of domestic abuse e.g., a significant other insisting involvement in the consultation, or unexplained bruising (see also NICE quality standard 116).
- Consider other forms of exploitation e.g., financial exploitation, radicalisation.
- Ask about abuse – remember to stay in the here and now; don't attempt to explore past abuse, but it will be necessary to understand current abuse and ask about ongoing risk from the abuser.
- Does the patient have caring responsibilities? If so, for whom. If children:
  - Document names and dates of birth of children under 16.
  - Where are they now, who is looking after them.
  - What support does the patient have with their caring responsibility.
  - Are there any potential child protection issues.
  - What is the potential impact of the patient's mental health problems/substance misuse/self-harm on the lived experience of children under their care.

If assessment of family and social circumstances raises safeguarding concerns for the patient, their dependants or anyone else, obtain additional information from involved care agencies such as primary care, social services, or school and seek advice from the relevant safeguarding lead.

Organisational safeguarding policies and procedures must be followed at all times.

Links to evidence & useful reading

National Institute for Health and Care Excellence (NICE), 2016. *Domestic violence and abuse* (Quality Standard 116). Available at https://www.nice.org.uk/guidance/qs116/resources/domestic-violence-and-abuse-pdf-75545301469381.

Read, J., Hammersley, P. and Rudegeair, T., 2007. Why, when and how to ask about childhood abuse. *Advances in Psychiatric Treatment, 13*(2), pp.101-110. https://doi.org/10.1192/apt.bp.106.002840.

Third party information & information sharing

It is important to share relevant information with involved agencies (Primary Care, Social Care, Education, Criminal Justice etc.). Collateral information from carers, family members, friends, other relevant care agencies can provide crucial information and helps to establish a full picture. If there are carers actively involved with the patient these are likely to know the person particularly well. Confidentiality is an important aspect of care; however, effective communication with carers can take place without breaching confidentiality.

If the clinician is concerned about imminent harm to or by the person it may be necessary to share information with family members without patient consent. The person should always be informed about information sharing unless there are clear reasons why this is not appropriate. Seek advice – this should be a team decision.

Practice pointers:

Professional agencies (e.g., GP, secondary mental health care, school nurse/ counsellor, probation):

- At the start of the assessment explain that it can be helpful to speak to relevant others and that information sharing is an important aspect of care.
- Ask the patient who might it be helpful to talk to and offer additional suggestions.

Family members/carers:

- Explain that family/carers can be helpful in both assessment and safety planning and that good practice involves carer involvement.
- Explain that you can hear family/carer's perspectives and questions without breaching confidentiality.
- Where necessary negotiate what can be discussed with carers and ensure clarity as to what the patient does not want to be disclosed.
- Listen to carers' perspectives and provide relevant general information.
- If a carer is involved and you are concerned about imminent risk, ask the patient for their permission to express this to the carer. If permission is not given and you are not reassured about the patient's safety, consider breaching the patient's request for confidentiality. Ensure you give the individual a clear explanation for your decision making and document the same. Seek support and advice from senior clinicians or managers as required. Clearly document the reasons for any decision that is made.

If a patient does not want you to talk to a carer who is actively involved:

- Be curious as to why the patient doesn't want you to speak to the carer. Observe for signs of interpersonal conflict or abuse.
- What evidence does the individual have that involving their carer is a bad idea? Do they feel unsafe? Unsupported? Are they concerned about the impact on their carer?
- Think aloud and wonder if the individual's carer might want to try and help and be supportive.
- Ask the patient to imagine scenarios e.g., what's the worst thing that could happen; what might be good about letting your carer know you sometimes think about suicide/acting on your thoughts of suicide; if a friend of yours told you what you have told me today, what would you say to them?

Formulation

At the end of the assessment the clinician should summarise their understanding of the information gained during the assessment with the patient. The aim is to achieve a shared understanding of the precipitants of and reasons for the self-harm and what the persons ongoing needs are in order that a suitable aftercare plan can be agreed. This includes consideration of ongoing risk of self-harm or suicide.

Epidemiological evidence and psychological models can help identify demographic, clinical, social, and psychological factors that might indicate vulnerability. However, stratifying risk by low, medium, or high is ineffective (100), as several research studies have shown that we cannot accurately predict the likelihood of future self-harm or suicide. Best practice indicates that we should instead focus on therapeutic and individualised assessment, risk formulation and safety planning (101).

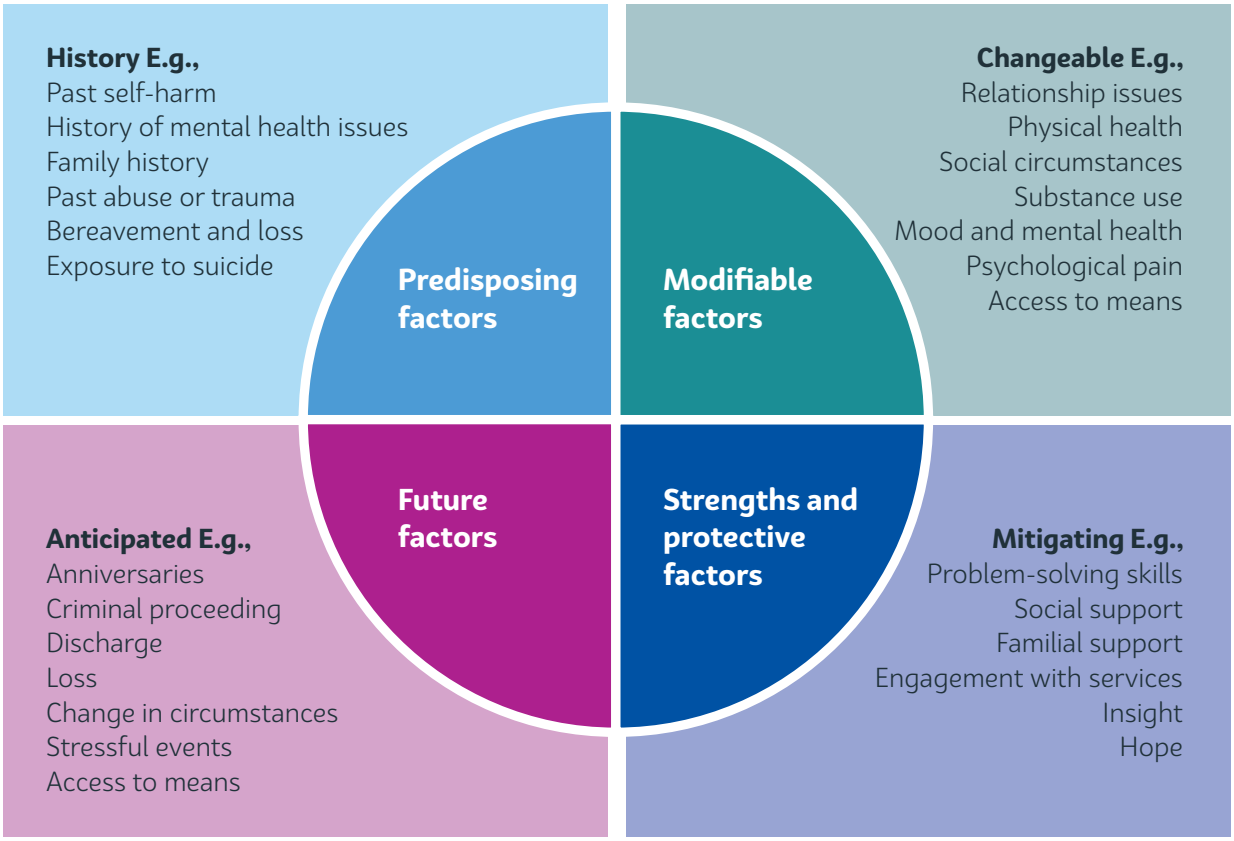
The information obtained from a patient's self-report, collateral sources, and clinical observation, including detailed information about suicidal ideation and behaviour, risk factors, and warning signs, should be synthesised into a dynamic formulation of an individual's risk. This formulation should provide a distilled understanding of personality factors, seriousness and nearness of risk, and circumstances that might increase or mitigate risk (101) and be clearly documented in the patient's risk management or aftercare plan.

To achieve a comprehensive formulation it can be helpful to assimilate the information obtained throughout the psychosocial assessment to provide a picture of predisposing, modifiable, future, and protective factors and how these might interact to elevate or reduce psychological distress and therefore the possibility of self-harm.

- **Predisposing Factors:** historical e.g., previous self-harm, previous mental health issues, family history of suicide, past abuse, past bereavement.
- **Dynamic & Modifiable Factors:** (clinical, social, psychological) these fluctuate in terms of intensity and duration and may be precipitated by identifiable triggers, e.g., interpersonal difficulties, financial or employment concerns, deterioration in mental health, increase in substance misuse, or recent loss. Warning signs should be considered, such as mood changes, behavioural changes (e.g., withdrawing, talking about suicide, rehearsing the suicidal act), and cognitive signs (e.g., hopelessness, perceived burdensomeness).
- **Future Factors:** anticipated e.g., discharge from services, impending criminal prosecution, difficult dates such as anniversaries, exams, expected loss or bereavement.

- **Strengths and Protective Factors:** personal and social factors that may mitigate against risk e.g., engagement with services, social support; problem-solving ability, motivation to change behaviours, hope, and reasons for living e.g., family or friends. Remember not to overvalue factors that appear to be protective and be mindful that in the same way that risk is changeable so are protective factors.

Figure 1 Interactive components of risk assessment that can inform risk formulation and therapeutic management (taken with permission from Hawton et al 2022 (101)



Links to evidence & useful reading

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Hawton, K., Lascelles, K., Pitman, A., Gilbert, S. and Silverman, M., 2022. Assessment of suicide risk in mental health practice: shifting from prediction to therapeutic assessment, formulation, and risk management. *The Lancet Psychiatry.* https://doi.org/10.1016/S2215-0366(22)00232-2.

Brief intervention, discharge & signposting

The psychosocial assessment is itself an opportunity to deliver brief interventions such as motivational interviewing, problem solving and solution-focused approaches, and these should be utilised in the safety planning process.

In addition, as part of the discharge plan it will be necessary to inform patients about local agencies that may help them address their problems going forward, e.g., counselling or IAPT services, substance misuse support, Mind, Citizens Advice, third sector, and community support groups, and so on.

Where substance use is a concern, consider referring the patient to a substance misuse service or sitting with them whilst they self-refer as they may be more likely to engage if a referral is agreed or made prior to discharge.

For adolescents it may be necessary to liaise with school nurses/counsellors, and for university students with relevant pastoral support teams.

Where formal referrals to services are not made, patients should be advised to see their GP for review of their mental health needs. If the patient has a mental health worker, contact should be established to provide a handover.

Where patients do not meet the threshold for referral to secondary mental healthcare, but their presentation indicates a deficit in problem solving skills and negative thought processes that are associated with their self-harming behaviour, outpatient follow-up interventions should be considered. Where it is possible for these to be delivered by the clinician who assessed the individual it may be particularly beneficial, as a therapeutic relationship has already been established, which might facilitate engagement.

Research indicates that adults benefit from CBT, problem-solving interventions, and also DBT (103), and that adolescents may benefit from similar tailored interventions. (104). Current NICE guidance (1) advises that patients who present following self-harm should be offered CBT-informed psychological therapy that is specifically tailored for people who self-harm.

Links to evidence & useful reading

Hawton, K., Witt, K.G., Salisbury, T.L.T., Arensman, E., Gunnell, D., Hazell, P., Townsend, E. and van Heeringen, K., 2016. Psychosocial interventions following self-harm in adults: a systematic review and meta-analysis. *The Lancet Psychiatry*, *3*(8), pp.740-750. https://doi.org/10.1016/S2215-0366(16)30070-0.

Witt, K.G., Hetrick, S.E., Rajaram, G., Hazell, P., Salisbury, T.L.T., Townsend, E. and Hawton, K., 2021. Psychosocial interventions for self-harm in adults. *Cochrane Database of Systematic Reviews*, (4). https://doi.org/10.1002/14651858.CD013668.pub2

Witt, K.G., Hetrick, S.E., Rajaram, G., Hazell, P., Salisbury, T.L.T., Townsend, E. and Hawton, K., 2021. Interventions for self-harm in children and adolescents. *Cochrane database of systematic reviews*, (3).

Safety Planning

Once the assessment has been completed and the patient, clinician, and where possible family member or carer have achieved a shared understanding of what will happen next, the clinician should move on to safety planning. Collaborative safety planning can help patients identify triggers and warning signs and establish plans and strategies to mitigate against these to reduce risk of a suicidal crisis (105). A comprehensive risk formulation should identify factors that might exacerbate and alleviate risk and the safety plan should incorporate these. The steps involved in safety planning involve: (taken with permission from Hawton et al 2022 (101).

Step one: warning signs

Patients will not always be aware of their warning signs, but by reflecting on previous episodes the clinician and patient can together identify thoughts, feelings (both emotional and physiological), and circumstances that might mean a potential suicidal crisis is developing.

Step two: coping strategies

The clinician can support the patient to imagine what they might use for distraction and self-management in the event that they are alone and experiencing warning signs. Strategies should be individualised and congruent with the emotions identified in step one.

Step three: enabling distraction by connecting with people or settings

Implicit in safety planning is the reality that not all strategies work all of the time. The clinician can assist the patient to think about who or what they can connect with if step two does not ease their suicidal thoughts or urges. The emphasis is again on distraction, rather than on talking about suicidal thoughts. The clinician must remain mindful that not all patients have people they can readily be with, so other means of achieving a sense of connection should be considered. It might be useful at this point to help the patient think about how they can form meaningful relationships when their mental health is more stable, perhaps by joining a third sector organisation or a therapeutic or peer support group. This could, in time, make it easier for them to engage with others when they are feeling vulnerable. Strategies to aid distraction in this step might include going for a walk, playing a game with a friend, or going to a favourite place or somewhere other people go for a common reason, such as a coffee shop or cinema. For patients who are socially isolated and find it difficult to leave the home environment, digital means of connection can be explored (e.g., online mental health peer support forums, streamed TV series or podcasts, or ready-made playlists).

Step four: engaging support by approaching social contacts

The patient should be encouraged to identify personal contacts they can approach for support if the steps above are not sufficient to help them feel safe. They should be advised to consider what they might need from their support person or persons and whether they think the individual or individuals will be able to provide the support they need. If the patient finds it difficult to communicate their feelings, the clinician and patient can together consider ways for the patient to access support, such as use of code words or emojis.

Wherever possible, the identified supportive contacts should be involved in, or made aware of, the safety plan to ensure they understand and accept what is expected of them. If a patient is reluctant to share their plan, the clinician should seek to understand their reasoning and reflect that, for a safety plan to be effective, it has to be feasible.

A contingency dialogue is important throughout the whole safety planning intervention, but particularly in this step to prepare the patient for the possibility that their supportive contact will not be available, consider possible reasons for this, explore and rationalise potential reactions of the patient, and plan the next step.

Step five: approaching professional contacts

If the above self-management steps do not help the patient resolve a crisis, they are advised to call identified professional teams, whether mental health, primary care or voluntary sector services, or out of hours and emergency services. As with step four, the patient should be guided to think about what response they might need from professionals and helped to think about how they might express their needs.

Step six: making the environment safe

The clinician should remind the patient how to ensure their safety by removing potentially harmful means. A clinician might, for example, prompt a patient to dispose of medication, or walk away from dangerous environments such as busy roads or high places.

When discussing these six steps, the patient or clinician should record in writing the agreed plan (see Appendix 3).

Links to evidence & useful reading

Nuij, C., van Ballegooijen, W., De Beurs, D., Juniar, D., Erlangsen, A., Portzky, G., O'Connor, R.C., Smit, J.H., Kerkhof, A. and Riper, H., 2021. Safety planning-type interventions for suicide prevention: meta-analysis. *British Journal of Psychiatry, 219*(2), pp.419-426. https://doi.org/10.1192/bjp.2021.50.

Oxford Health NHS Foundation Trust, 2021. Safety Planning Film. [online] Available at: https://www.youtube.com/watch?v=7J0j8lkV9-Y.

Looking after yourself

Conducting a psychosocial assessment can be draining and the experience of discharging people from ED following self-harm can be anxiety provoking. In addition, repeated exposure to the trauma of others can have a detrimental impact on wellbeing.

You should expect to work in a climate of psychological safety in which you are able to take breaks, engage in regular supervision and reflective practice and have ready access to clinical advice and support.

It can be helpful to develop positive rituals to end your working day so that you can leave work behind and optimise your own time. This might include changing into casual clothes before leaving work, listening to a particular song on the way home, putting your work bag into a cupboard out of sight when you get home, and so on.

If you experience the death of a patient by suicide, the effect on you can be profound. Talking to colleagues, managers, supervisors, and support staff can help. In addition, the link below takes you to a resource for psychiatrists following the death of a patient by suicide, which is helpful for clinicians from all disciplines.

Links to evidence & useful reading

Gibbons, R., Brand, F., Carbonnier, A., Croft, A., Lascelles, K., Wolfart, G. and Hawton, K., 2019. Effects of patient suicide on psychiatrists: survey of experiences and support required. *BJPsych Bulletin, 43*(5), pp.236-241. https://doi.org/10.1192/bjb.2019.26.

Croft, A., Lascelles, K., Brand, F., Carbonnier, A., Gibbons, R., Wolfart, G. and Hawton, K., 2022. Effects of patient deaths by suicide on clinicians working in mental health: a survey. *International Journal of Mental Health Nursing* [accepted].

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Appendix 1

Appendix 1: Aide memoire for psychosocial assessment following self-harm

COMPONENTS OF ASSESSMENT	PROMPTS
Setting the scene	Purpose of psychosocial assessment Communication needs? Chaperone required?
Confidentiality and information sharing	Explain and check for understanding. Identify agencies involved for information sharing
Next of kin/family/carer details	Name and contact details of NoK Discuss family/carer involvement. Confirm or otherwise consent.
Precipitants to self-harm act	What led up to self-harm (cover days and weeks prior) When did the crisis start Warning signs and triggers When thoughts of self-harm started When thoughts turned to action
Circumstances of self-harm	Where the act occurred Who was there Were substances involved (before/during/after) Check for impulsivity What happened immediately afterwards What resulted in ED presentation
Motives	Reasons for self-harm (i.e., release of emotions/control/interpersonal response/death etc)
Suicidal thoughts	Always ask even if not suicidal in nature When did ideation start, when (if) thoughts turned to action. Explore: mental pain, mental imagery, sense of belonging, sense of defeat and entrapment, hopelessness, burden-someness, fear and competence
Method	Reason for choice of method Where was method sourced and when Check for evidence of stockpiling Check what potential methods patient still has Seek detail about method and act e.g., did patient take all tablets (at once, one by one etc)
Intent	Was the patient alone, was interruption likely Did the patient seek help/rescue What did they think would happen as a result of self-harm Check knowledge about lethality of method What communication took place before act (including mode of communication) Level of preparation Reflections – how do they feel about it now Ongoing suicidal thoughts Thoughts about repeat What might prevent repeat

History of self-harm	Establish patterns in thoughts, behaviours, triggers etc Similarities/differences between previous and current self-harm acts Perspectives on future self-harm Motivation to develop alternative strategies
Repeat presentation	Check for changes in circumstances, precipitants, functions, methods, severity, suicidal thoughts, intent, reflections, pans to repeat, motivation to engage
Psychiatric History	Diagnoses and treatments including medication Current contact with mental health and other services
Mental state examination	Establish usual baseline Appearance & behaviour, speech, mood (include sleep, appetite, libido, motivation, lethargy etc), thoughts, perception, cognition, insight, capacity
Substance misuse	History, current consumption (estimate alcohol units), AUDIT, past or current engagement with services, motivation to engage currently
Physical health	History and current concerns, pain, family history, lifestyle behaviours
Personal and social history and current circumstances	Comprehensive history early to current, family circumstances and history, childhood adversity, past/current abuse and trauma, education and occupation, forensic history/current issues, relationships, domestic violence, housing and financial issues, parenting/caring responsibilities. Current and future stressors that may not have already been covered. Exposure to self-harm or suicide.
Internet and social media	Helpful and harmful use
Usual self	Obtain family perspective if possible, include cultural and spiritual aspects, problem solving ability, coping strategies, personality factors, interpersonal relationships
Safeguarding	Consider patient and others in their wider context e.g., children, other family members
Family/carer involvement (in agreement with patient)	Family/carer perspective on the circumstances and precipitants of self-harm
Formulation and safety planning	Assimilate predisposing factors, dynamic and modifiable factors, future factors, strengths and protective factors. Identify interventions to address modifiable factors, consider ongoing and future vulnerability and strategies to mitigate risk. Complete safety plan with all patients with family/carer support where possible

Appendix 2

Special considerations due to the COVID-19 Pandemic (Produced through research funded by the Department of Health and Social Care at the Centre for Suicide Research, University of Oxford, and the Multicentre Study of Self-harm in England, with the assistance of clinicians in Oxford Health NHS Foundation Trust's Emergency Department Psychiatric Service at the John Radcliffe Hospital, Oxford, and in Derbyshire Healthcare NHS Foundation Trust's Adult Mental Health Liaison Team South at the Royal Derby Hospital Service at Derby).

COVID RELATED PROBLEMS	EXAMPLES/EXPLANATION
Mental health problems	Worsening of existing mental health problem/condition or a new mental health problem
Access to services	Mental health problem exacerbated by cessation or reduction of usual support services e.g., not finding virtual care delivery as effective as face to face
Isolation and loneliness	E.g., consequences of reduced contact with friends or family; people living alone and/or with limited social support networks who now have less access to the outside world
Reduced contact with family	E.g., children unable to visit due to parent being at high risk; or usual contact/support from family reduced; parents unable to have contact with children
Reduced contact with friends	E.g., virtual contact not the same as face to face and not able to see friends due to restrictions
Disruption to normal routine	E.g., unable to engage in usual activities such as sport. Include disruption to planned events e.g., house move, holiday etc
Entrapment	E.g., feeling trapped in the house or with people they would rather not be with; simply finding lockdown difficult
Interpersonal conflict	E.g., strains in relationship with partner/family member due to being together so much more of the time

Employment	E.g., furlough, job loss, lack of job opportunities, unhappy working at home
Education/training	E.g., struggling with virtual learning; coping with returning to school following lockdown; apprenticeships stopped
Financial concerns	E.g., as a result of job loss/income reduction
Accommodation/housing	E.g., loss of accommodation or having to stay in accommodation they are unhappy with due to the pandemic
Substance misuse	E.g., increase in intake since lockdown; breading lockdown rules to obtain drugs or alcohol
Domestic abuse	Actual or threatened
Fear of COVID-19 infection	Fear of self becoming infected, fear of self infecting others, fear of others becoming infected
General COVID-19 related concerns	E.g., fears of the impact of the pandemic on the future; a sense of being generally overwhelmed by the pandemic
Bereavement issues	E.g., loss of someone who died following COVID-19 infection or loss not COVID-19 related but unable to carry out usual rituals such as family visits or funeral processes
Other	E.g., disturbed sleep due to concerns about the pandemic; reversed sleep pattern due to lack of routine; difficulties carrying out caring or home schooling; boredom

Appendix 3

My name	**Date**
Warning signs that things are becoming difficult for me	
Things I can do when I am on my own to take my mind off my difficulties and help me cope (make sure there's a backup plan)	**Who and what would be good to help distract me; things I can do to help me connect with the people and/or the world around me (make sure there's a backup plan)**
Things I can do to keep my environment safe (removing or moving things that you might use to hurt yourself).	

Who would be good to contact when I am worried about acting on thoughts of hurting myself; friends or family I can call when I need support? (Make sure there's a back-up plan)

Name	Number	Do they know I might call?	I am going to give them a copy of this plan
What can they do to help?			
Professionals I can call in a crisis		What can they do to help?	
Useful numbers and Apps			
Stay Alive App: available at App Store		Copy this safety plan into the safety plan on the app	
DistrACT App: available at App Store		Strategies to reduce self-harm	
Hub of Hope: available at App Store		Signposts to local services	
Samaritans: 116123		24 hour	
Shout Text Service: 85258		24 hour	

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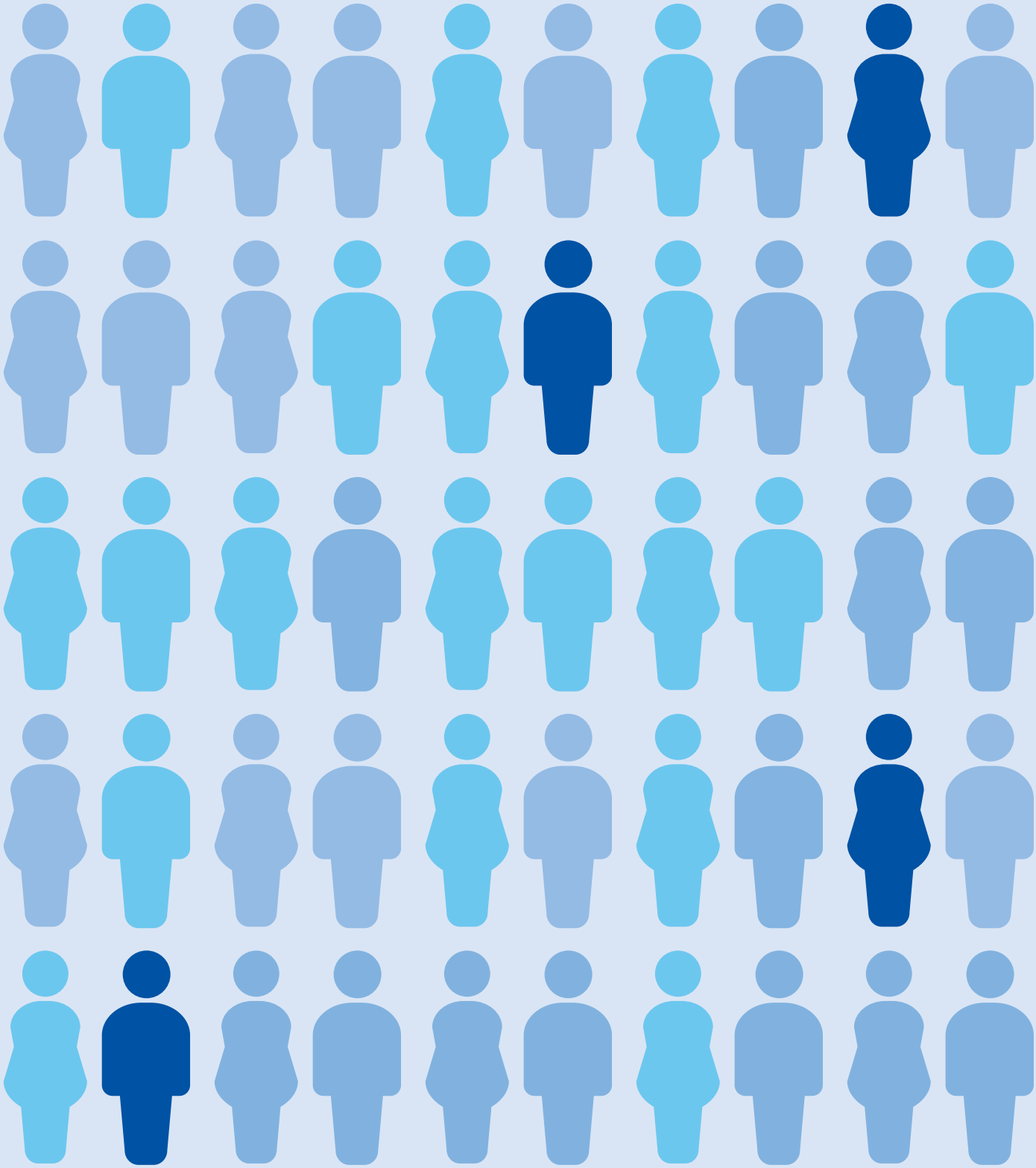

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