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Video transcript: Managing self-harm in the emergency department

It's really important to think about how we can best help people who self-harm, what works for people when they present to hospital with self-harm.

The initial priority always has to be people's physical condition, so whether they've got an injury that needs attending to, whether they've got an overdose that needs an antidote. That's the first thing you'll always think about, but the other thing that's really important to consider is what you do in the longer term.

Just doing the simple things well can really help, so just doing a proper assessment of someone after they present with self-harm can reduce the risk of repetition. We know that from research studies. Just talking to someone, listening to them, understanding what's going on for them, might reduce repetition [of self-harm] by up to 40%.

That might be because of the connection you have as a clinician with them, that listening, that empathy, but it might also be that if someone gets a proper assessment then you can better plug them in to the appropriate aftercare. So it might be the assessment itself or it might be giving them the appropriate follow up. That's one thing that can help.

The other thing that clinicians are sometimes really keen on is something called risk assessment. Clinicians want to know; I've got this person in front of me, how likely are they to repeat self-harm or perhaps even die by suicide, I need to predict what's happening.

That's a bad idea. It's a bad idea because we can't do it. And it's not simply a case of the scales or the tools that we're using not being good enough. It's not that, it's the fact that outcomes are rare, so only relatively few people repeat or die by suicide, so it's a needle-in-a-haystack problem. That's something we won't be able to solve even with the best instrument in the world.

The current recommendation is we're not trying to use risk assessment to predict what happens, and we've put that in national guidelines.

Clinicians might very well ask, well what should we do instead? If we're not predicting risk, what should we do? And what we've talked about is a needs-based assessment. So you've got the patient in front of you, you've done a full assessment, and they've got needs which you then do your best to address.

They might be mental health needs, they might be needs to do with people's home circumstances, or things to do with their relationships, or what's going on for them more widely. So you focus on their needs and you try and address them and that is likely to help.

We also know that treating underlying conditions might help, be they physical or mental health conditions, and there's some evidence from research that specific talking treatments can help after self-harm.

Things like cognitive behavioural therapy where you look at people's thoughts and their behaviours, things like problem-solving therapy where you help people think about how they solve problems, and interpersonal therapy where you look at people's relationships and how they interact with others. Those things, those kinds of talking treatments can help. They are evidence-based treatments.

The other thing that has received quite a lot of attention recently are contact based-treatments. These are things like ringing people up after they've self-harmed or sending postcards. On the one hand they are really attractive because it's a simple thing to do, but it's probably too early to think about using those kind of contact interventions routinely.