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Primary care, voluntary sector and social services contact following self-harm: rates of referrals and care gaps

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Seminar series

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Three NIHR Research Schools' Mental Health Programme

NIHR | School for Primary Care Research

NIHR | School for Social Care Research

NIHR | School for Public Health Research

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Background

- Self-harm can involve self-poisoning and self-injury, with varying levels of suicidal intent
- There are over 200,000 ED attendances for self-harm annually (*Clements et al. 2015*)
- Risk of death from suicide is highly elevated among primary care and hospital emergency patients who have self-harmed (*Carr et al 2017; Geulayov et al 2019*)
- Primary care and emergency departments are therefore important settings for suicide prevention
- While evidence regarding the role of primary care is growing, there has been very little research into the roles of social services and voluntary, community and social enterprise (VCSE) services
- Many antecedents to self-harm involve social factors - there is strong rationale for social services-based and VCSE-based self-harm aftercare.

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The project…

Phase 1: Use of social services following self-harm

Phase 2: Rates of mental health, social and VCSE services and general practice follow-up among people presenting to hospital following self-harm and estimated care gaps

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Patient and public involvement

Workshops

- co-produced indicators of mental health treatment needs and significant social problems
- designed the epidemiological studies

Safety and wellbeing

- contributors were familiar with the topic and had been involved in previous work
- a co-designed, flexible approach which promoted safety and wellbeing.

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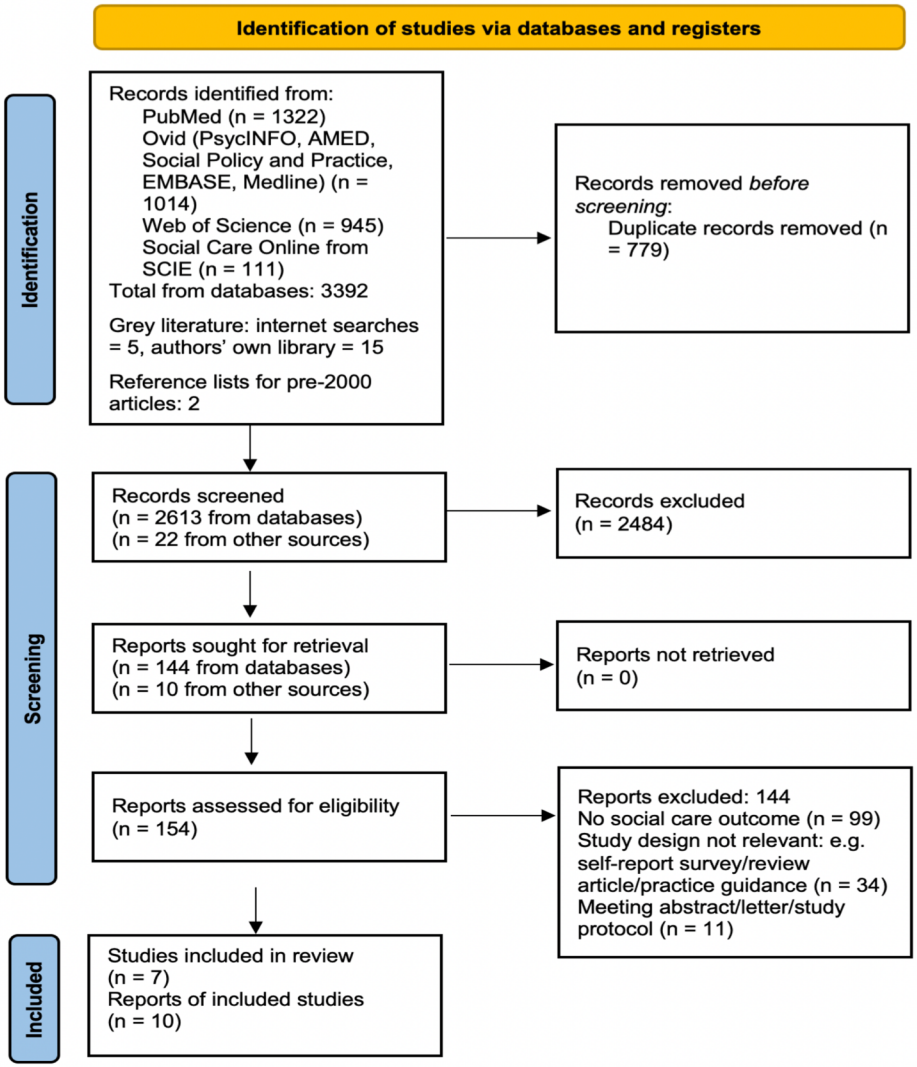
Phase 1: Use of social services following self-harm

We aimed to review evidence for social service utilisation and referrals among people seeking help following self-harm, using a systematic review with narrative synthesis design.

Study inclusion based on the following criteria:

- Peer-reviewed academic research and grey literature
- Studies of people of any age in contact with primary or secondary care health services following an episode of self-harm.
- Study outcomes including **referrals to** or **utilisation of** social workers and social services.



Sarah Steeg, Faraz Mughal, Nav Kapur, Shamini Gnani, Catherine Robinson (2023) **Social services utilisation and referrals after seeking help from health services for self-harm: a systematic review and narrative synthesis,** BMJ Public Health;1:e000559.

Key findings

10 reports of 7 studies were included.

Study quality: generally high to moderate.

All studies included in this review were based in EDs and were mainly UK based.

All but one study derived the outcome data solely from information recorded in hospital records.

Rates of referrals were generally relatively low—around 1%–4%. When actual service use data were captured, around one in five used social care services following self-harm—though evidence of this was limited to a single study.

Referral rates higher in instances where social workers are involved in psychosocial assessments.

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Conclusions

In general, few patients are referred to social services after an episode of self-harm.

Involving social workers in self-harm assessments could improve links between social services and people requiring support after self-harm.

Rates of contact with social services in the years following self-harm are likely to be higher than referral rates, and are considerably higher than in the general population.

Evidence from primary care settings and integrated health records is needed.

Social services-based and integrated aftercare and interventions for self-harm are important future directions for suicide prevention; suicide prevention approaches must address societal-level factors.

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Open access to article

Original research

BMJ Public Health

Social services utilisation and referrals after seeking help from health services for self-harm: a systematic review and narrative synthesis

Sarah Steeg ,[1,2,3] Faraz Mughal,[4] Nav Kapur,[1,3,5,6] Shamini Gnani,[7] Catherine Robinson[8]

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Phase 2: Rates of mental health, social and VCSE services and general practice follow-up and estimated care gaps among people presenting to hospital following self-harm

- Many people who have harmed themselves face social and economic adversities that exacerbate mental health problems. NICE guidance recommends joint approaches between social care agencies, healthcare professionals and VCSE services. The latest suicide prevention strategy for England highlights the pivotal role of VCSE services.

Department of Health & Social Care

Policy paper

Suicide prevention in England: 5-year cross-sector strategy

Published 11 September 2023

- While care gaps have been examined in general population samples and among people with specific mental disorders, there has been no assessment of care gaps for those seeking help after self-harm.

Self-harm clinical management at the ED

Table 1. Cohort characteristics by hospital management[1] at baseline[2].

Variable (% of treated with variable present)	All (31,725)	Specialist psychosocial assessment, 18,252/31,725 (57.5%)	No specialist psychosocial assessment, 13,473/31,725 (42.5%)	Medical admission, 15,738/25,270 (62.3%)	No medical admission, 9,532/25,270 (37.7%)	Psychiatric outpatient referral, 9,244/29,889 (30.9%)	No psychiatric outpatient referral, 20,645/29,889 (69.1%)	Psychiatric inpatient admission, 1,800/31,725 (5.7%)	No psychiatric inpatient admission, 29,925/31,725 (94.3%)
Female	58.0	58.9	56.8	59.3	56.2	58.4	58.3	51.9	58.4
Age 16 to 24	35.2	34.3	36.5	33.2	38.2	31.3	38.7	18.1	36.3
Age 25 to 44	45.1	44.6	45.8	44.2	46.0	45.8	44.6	46.3	45.1
Age 45 to 64	16.3	17.5	14.7	18.1	13.2	18.9	14.6	20.7	16.1
Age 65+	3.3	3.6	3.0	4.5	2.0	4.0	2.1	14.9	2.6
Self-poison	83.7	87.3	78.8	91.9	69.2	85.2	83.8	74.1	84.2
Self-cut	11.9	8.6	16.4	4.6	23.6	10.3	12.4	14.4	11.8
Other self-injury	4.4	4.1	4.9	3.5	7.1	4.5	3.8	11.5	4.0
Any current psychiatric treatment (including GP)	42.5	35.7	47.5	40.1	48.4	58.9	32.3	72.1	40.6
Any previous psychiatric treatment	54.7	51.2	59.4	54.8	60.1	67.2	47.2	79.2	53.4

Steeg S, Carr M, Emsley R, Hawton K, Waters K, et al. (2018) Suicide and all-cause mortality following routine hospital management of self-harm: Propensity score analysis using multicentre cohort data. PLOS ONE 13(9): e0204670. https://doi.org/10.1371/journal.pone.0204670

Contents lists available at ScienceDirect

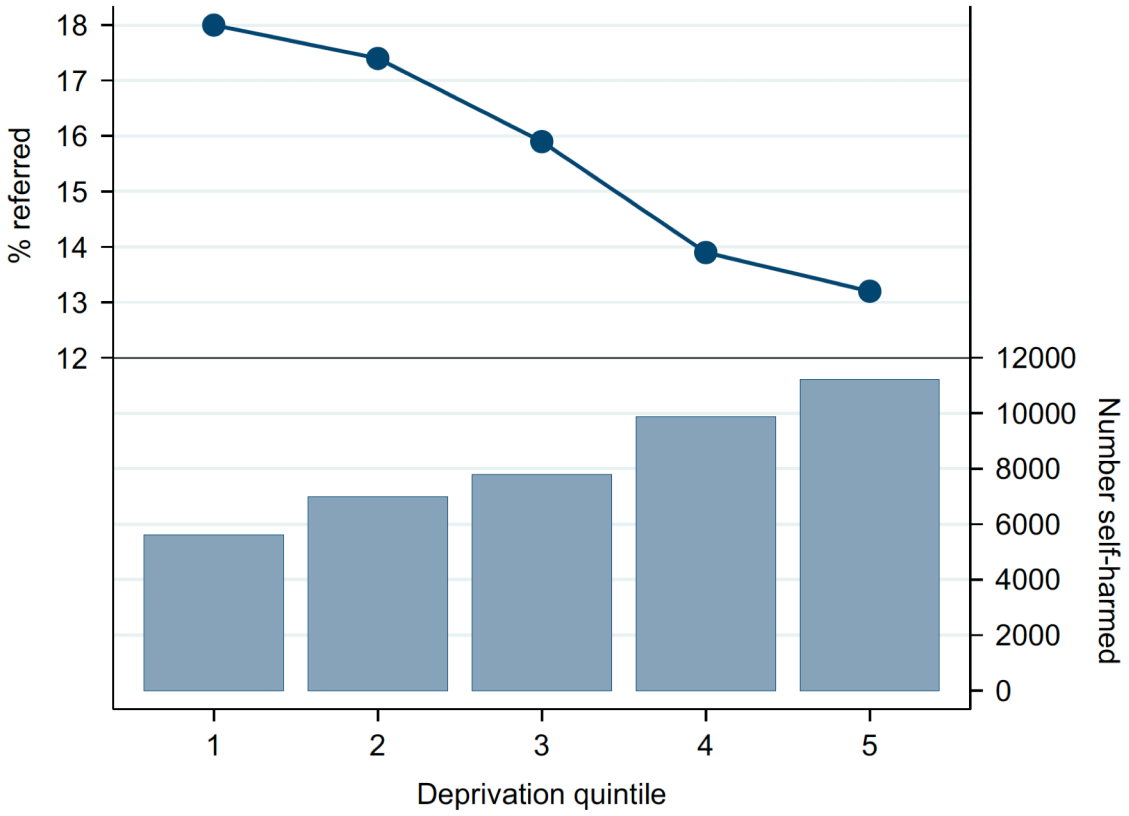
Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research paper

Clinical management following self-harm in a UK-wide primary care cohort

Matthew J. Carr [a,*], Darren M. Ashcroft [b,c], Evangelos Kontopantelis [d,e], David While [a], Yvonne Awenat [f], Jayne Cooper [a], Carolyn Chew-Graham [g], Nav Kapur [a,h], Roger T. Webb [a]



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Manchester Self-Harm Project

- A prospective cohort study of people presenting to emergency departments (EDs) in Manchester, UK

- Research administrators used validated search terms to identify presentations potentially involving self-harm. Where self-harm was confirmed, data were extracted using a two-stage process:

  – basic clinical and demographic data (including reason for attendance, method of self-harm, age, gender, ethnic group) were extracted from ED records for all episodes
  – further information was extracted from psychosocial assessments for episodes that were assessed by a mental health specialist.

- We examined the following categories of hospital management:
  – referral to **mental health services** (outpatient, crisis or urgent care services, community mental health services and drug and alcohol services)
  – referral to **social services**
  – referral to **VCSE services**
  – referral to **general practitioner**
  – individuals could be referred to **more than one** service for the same episode of self-harm.

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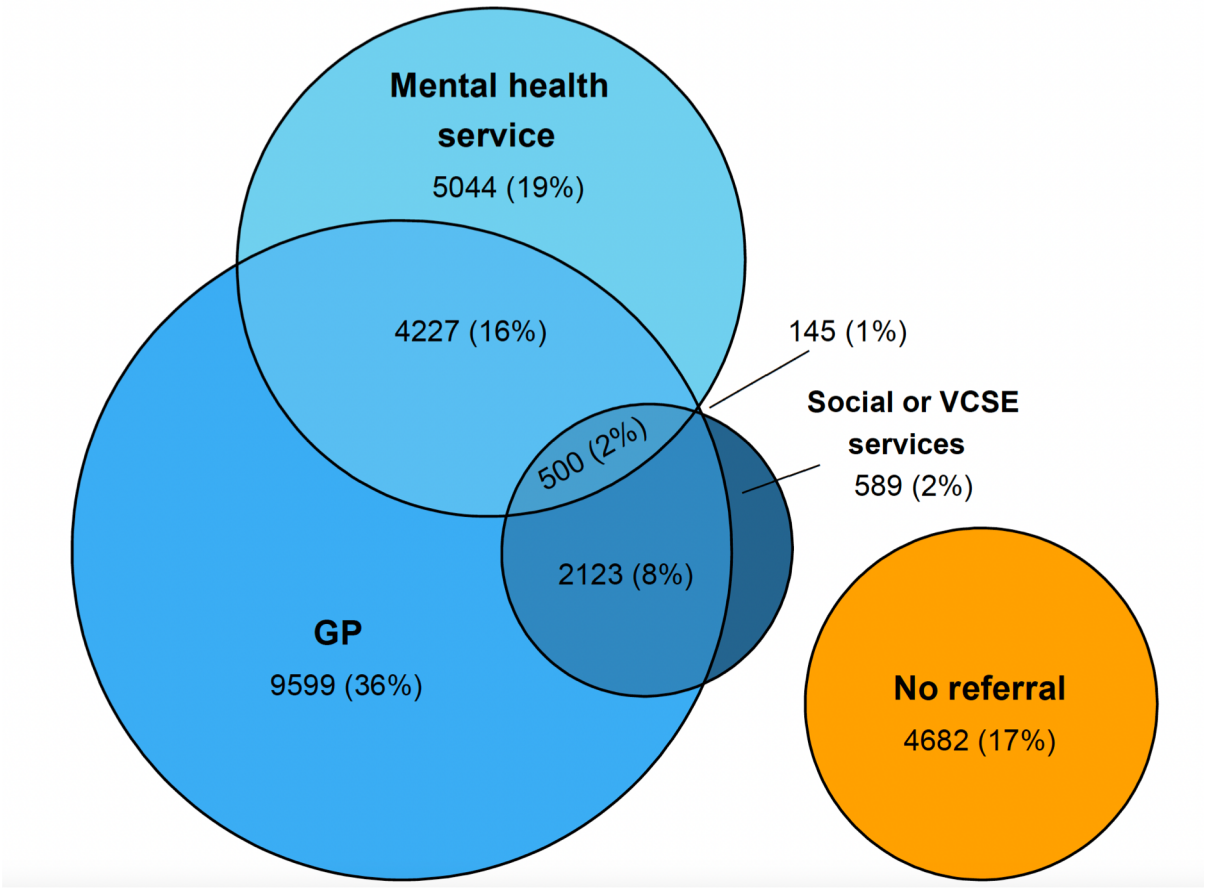
Percentages of patients referred to their GP, to mental health services and to social or VCSE services following hospital presentation for self-harm (N = 26,909)



Steeg S, Bickley H, Clements C, Quinlivan L, Barlow S, Monaghan E, Naylor F, Smith J, Mughal F, Robinson C, Gnani S, Kapur N (2024) **Care gaps among people presenting to the hospital following self-harm: observational study of three emergency departments in England.** BMJ Open 2024;14:e085672

Co-produced indicators of mental health treatment needs and significant social problems

		(i) Mental health treatment needs	(ii) Significant social needs
Patient characteristics	Homeless or living in a hostel		♦
	Currently misusing alcohol	♦	
	Currently misusing drugs	♦	
	Has a mental health diagnosis	♦	
Precipitants of self-harm or cause(s) of current distress	Housing problem		♦
	Employment or study problems		♦
	Legal problem e.g. criminal charges		♦
	Victim of crime		♦
	Financial problems		♦
	Direct response to mental symptoms	♦	
	Other mental health problems	♦	
	Abuse (physical, mental, sexual)	♦	♦
	Alcohol abuse	♦	
	Substance abuse	♦	
Circumstances of the self-harm	Suicide note	♦	
	Intention to die during act	♦	
	Symptoms of depression	♦	
	Suicidal thoughts	♦	
	Suicidal plans	♦	
	Hallucinations/delusions	♦	
	Looks depressed	♦	
	Feels depressed	♦	
	Sleep disturbance	♦	
	Appetite disturbance	♦	
	Feels hopeless	♦	
	Low energy	♦	
	Evidence of hostility	♦	

Factors associated with non-referral among people with mental health needs: risk ratios and 95% confidence intervals

	% of those with mental health needs who had no new or active referral (n/n)	Unadjusted RR (95% CI)	Adjusted RR (95% CI)
Total	29.9 (6503/21719)		
Gender (N = 21719)			
Men	31.8 (3046/9578)	1.12 (1.07 – 1.16)	1.14 (1.09 – 1.18)
Women	28.5 (3457/12141)	1.00	1.00
Age group (N = 21719)			
15-19	40.6 (1272/3137)	1.86 (1.51 – 2.28)	1.81 (1.47 – 2.23)
20-24	33.9 (1342/3954)	1.55 (1.26 – 1.91)	1.53 (1.25 – 1.89)
25-34	29.3 (1632/5579)	1.39 (1.09 – 1.65)	1.30 (1.06 – 1.60)
35-44	27.0 (1236/4686)	1.24 (1.00 – 1.52)	1.17 (0.95 – 1.44)
45-64	22.5 (948/4140)	1.05 (0.85 – 1.29)	0.98 (0.80 – 1.21)
65+	21.9 (73/334)	1.00	1.00
Ethnic group (N = 21230)			
White	29.0 (5452/18816)	1.00	1.00
Black	41.3 (239/579)	1.42 (1.29 – 1.57)	1.42 (1.29 – 1.57)
Indian/Pakistani/Bangladeshi	38.7 (368/951)	1.34 (1.23 – 1.45)	1.32 (1.21 – 1.43)
Mixed race	28.0 (128/458)	0.96 (0.83 – 1.12)	0.98 (0.85 – 1.14)
Chinese	61.8 (34/55)	2.13 (1.73 – 2.63)	2.09 (1.68 – 2.59)
Other	33.4 (124/371)	1.15 (1.00 – 1.33)	1.18 (1.02 – 1.36)
Area level deprivation (IMD quintile) (N = 20783)			
1 (least deprived)	29.5 (1260/4270)	1.00	1.00
2	27.9 (1169/4189)	0.95 (0.88 – 1.01)	0.97 (0.91 – 1.04)
3	28.5 (1165/4088)	0.97 (0.90 – 1.03)	0.97 (0.91 – 1.04)
4	29.6 (1225/4137)	1.00 (0.94 – 1.07)	1.01 (0.95 – 1.08)
5 (most deprived)	32.5 (1334/4099)	1.10 (1.03 – 1.18)	1.09 (1.03 – 1.17)

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Factors associated with non-referral among people with mental health needs

Among the group identified as having mental health needs, 30% (6503/21719) had no active or new referral to mental health services.

Proportions of non-referral were higher among **men**, **younger people** (e.g. among ages 15-19 years), people from **Black** ethnic groups, **Indian/Pakistani/Bangladeshi** groups and **Chinese** ethnic group.

We also observed higher rates of non-referral among people living in areas in the most **deprived** quintile.

Within the group who had a mental health diagnosis, people with **alcohol and substance misuse** disorders had higher non-referral rates than those with other diagnoses (e.g. alcohol misuse, 31.6% were not referred), as did people with an **anxiety or trauma-related** disorder.

Factors associated with non-referral among people with social needs: risk ratios and 95% confidence intervals

	% of those with social needs who had no referral to social or VCSE services (n/n)	Unadjusted RR (95% CI)	Adjusted RR (95% CI)
Total	79.6 (9469/11892)		
Gender (N = 11892)			
Men	82.3 (4439/5397)	1.06 (1.04 – 1.08)	1.06 (1.04 – 1.08)
Women	77.4 (5030/6495)	1.00	1.00
Age group (N = 11892)			
15-19	70.7 (1301/1841)	0.92 (0.83 – 1.02)	0.94 (0.85 – 1.05)
20-24	77.1 (1763/2287)	1.00 (0.90 – 1.11)	1.03 (0.93 – 1.14)
25-34	81.9 (2536/3095)	1.06 (0.96 – 1.17)	1.09 (0.99 – 1.21)
35-44	82.6 (2065/2500)	1.07 (0.97 – 1.18)	1.10 (0.99 – 1.21)
45-64	83.5 (1716/2055)	1.08 (0.98 – 1.20)	1.11 (1.00 – 1.21)
65+	77.2 (88/114)	1.00	1.00
Ethnic group (N = 11608)			
White	79.7 (8140/10213)	1.00	1.00
Black	76.5 (273/357)	0.96 (0.91 – 1.02)	0.96 (0.91 – 1.02)
Indian/Pakistani/Bangladeshi	79.3 (399/503)	1.00 (0.95 – 1.04)	1.00 (0.96 – 1.05)
Mixed race	83.6 (224/268)	1.05 (0.99 – 1.11)	--
Chinese	78.1 (25/32)	0.98 (0.82 – 1.18)	--
Other	83.0 (195/235)	1.04 (0.98 – 1.10)	--
Area level deprivation (IMD quintile) (N = 11205)			
1 (least deprived)	81.8 (1839/2249)	1.00	1.00
2	79.0 (1788/2264)	0.97 (0.94 – 0.99)	0.99 (0.96 – 1.02)
3	79.8 (1816/2277)	0.98 (0.95 – 1.00)	1.01 (0.98 – 1.03)
4	79.5 (1721/2166)	0.97 (0.94 – 1.00)	0.99 (0.97 – 1.02)
5 (most deprived)	77.5 (1742/2249)	0.95 (0.92 – 0.98)	0.98 (0.95 – 1.01)

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Factors associated with non-referral among people with social needs

Among people with social needs, 80% (9469/11892) had no new referral to social and/or VCSE services. 23% (3,269/14,219) also had no active or new referral to mental health services.

Proportions of those with no new referral to social and/or VCSE services were higher for **men,** people **aged 45-64**, and those who were **unemployed**.

With the exception of anxiety and trauma-related disorders, individuals with a **mental health diagnosis** who had social needs had higher rates of non-referral than those with no recorded diagnosis. People with **substance misuse** disorders had especially high rates of non-referral.

Strengths and limitations

This is the first study to examine care gaps in a population who have harmed themselves

Measures of mental health needs and social needs were co-developed with patients, carers and clinicians

However, measures were based on information that was collected as part of a psychosocial assessment following self-harm – rather than tailored to the research questions

Not everyone received an assessment. Factors associated with non-assessment include gender – so men were less likely to be assessed – and substance misuse. Which suggest that our findings may underestimate the care gaps in people who have harmed themselves.

Conclusions

We found substantial care gaps among people presenting to hospital following self-harm, with particularly large gaps for individuals with social needs.

Care gaps were particularly high among groups known to be at increased risk of suicide: men, those at middle age, unemployed individuals and those with a substance misuse disorder.

The greater mental health care gaps in ethnic minority groups suggests services are not adequately recognising and actioning appropriate aftercare following self-harm. Training and support for health and social care providers to work alongside people from ethnic minority groups to help develop appropriate services is recommended.

The role of social and VCSE services in self-harm aftercare is only recently being prioritised in suicide prevention policy. Our findings suggest this is a key area for closing the gaps and reducing inequalities in self-harm aftercare.

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Thank You!

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Steeg, S., Mughal, F., Kapur, N., Gnani, S., and Robinson, C. (2023) **Social services utilisation and referrals after seeking help from health services for self-harm: a systematic review and narrative synthesis,** BMJ Public Health;1:e000559.

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