Attitudes towards and satisfaction with services among deliberate self-harm patients: A systematic review of the literature

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Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO)

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The Report

Executive Summary

The prevalence of deliberate self-harm (DSH) and the possibility of repetition and / or eventual suicide make DSH a major health care problem, both in the UK and in many other countries. The main objective of this study was to conduct a systematic review of the international literature on patients' attitudes to, and satisfaction with, health services (specifically medical management, in-hospital psychiatric management and post-discharge management) following DSH to inform the development of improved services.

Method

We sought to identify all relevant qualitative and quantitative studies where participants of either gender or of any age group had engaged in deliberately initiated self-poisoning or self-injury and had contact with hospital services. We also included studies of patients' friends or relatives. Search terms relevant to DSH patients' experiences of care were used to search electronic databases. Reference lists of relevant studies were searched and experts in the field were contacted.

Data was extracted by two reviewers. Quality assessments examining study design, centrality, analysis and reporting, and generalisability were carried out by at least two reviewers. All studies were included in the review, regardless of quality. However, more weight was given to studies of stronger design. Relevance to the review was also taken into consideration. Studies were considered separately for adults and adolescents.

Findings

Thirty-one studies met the inclusion criteria. The majority (62%) were solely qualitative studies, while three used solely quantitative methods and ten used both. Sixteen studies were based on service users' experiences in the UK. Service users who had self-poisoned accounted for the majority of participants in 16 studies. The main findings are presented below.

General perceptions of management:

- Participants (the terms participants, patients, service users, and respondents are used interchangeably in this report)

appreciated when staff kept them informed and engaged in their management but for many this was not the case.

- Several patients that were kept informed said they could not understand the information provided to them by staff.
- Many wished staff were better educated about both DSH and how to manage patients after a DSH episode.
- Some service users said staff lacked sympathy for patients.
- Many participants said staff focused on their physical problems rather than their mental health.
- Participants called for sensitivity to personal preferences.
- Many service users said they were told a member of staff would contact them regarding their care but they were never contacted.
- Some service users said they would not return to hospital if they experienced another DSH episode.

Accident and emergency (A&E) department:

- Wait times were perceived to be too long by many participants.
- Participants' reactions to having a separate waiting room were mixed.
- Many service users said they were not informed of possible effects of physical treatments.
- Several participants described a lack of privacy while in A&E.
- Perceived threats to withhold treatment, for example anaesthetic during suturing, were reported by several participants.

Psychosocial assessment:

- Not all patients receive a psychosocial assessment while in hospital.
- Participants had a more positive experience of assessment when they were given information about it beforehand.
- Several participants perceived assessment to be superficial.
- Several service users felt they were not given enough time to talk.

Discharge and referral:

- Discharge was often a negative experience for participants as many felt they were not ready to leave hospital, for either physical or psychological reasons.

- Several service users said they did not receive referrals for aftercare.
- Contact numbers for helping organisations were often provided but some participants did not feel comfortable making contact with services they had no connection to.

Post-hospitalisation management:

- Several participants experienced long waits for aftercare.
- Opportunity to talk was described by many participants as a positive result of aftercare.
- Participants who did not attend aftercare appointments said this was for a variety of reasons, for example did not think they needed the help, did not think therapy would be helpful, referral instructions were difficult to understand.
- Service users who ended treatment early cited difficulties opening up to therapists, feeling that the sessions did not help, feeling uncomfortable with the therapist or the location of the sessions and feeling that they had got all they could out of therapy.
- Some participants said they did not have a good rapport with their therapist, which led to negative experiences.
- Many patients admitted to psychiatric hospital inpatient care felt they had no sense of personal control while on the ward. Some suggested that staff give patients more responsibility for preventing their self-harm.
- Participants who had been admitted to psychiatric inpatient care had positive experiences of constant observation when staff kept them occupied and engaged, while others reported negative experiences when staff were perceived as ignoring them.
- Lack of privacy was an important issue for participants during constant observation.
- Some older adolescents (the terms adolescents, young people, and youth are used interchangeably in this report) said they experienced difficulties when put on adult or adolescent psychiatric wards.
- Family involvement in therapy was beneficial for some adolescents but not for all.

- Parents who were involved in their child’s management reported positive experiences.
- Parental and adolescent reactions to medication were mixed.

Suggestions by participants for service improvement:

- Increased sympathy towards those who self-harm.
- Greater staff knowledge of DSH.
- Increased and improved communication between service staff and those who deliberately self-harm.
- Provision of better information about DSH for patients, carers and the general public.
- Improved access to local services and aftercare.

Implications

Although there were difficulties in research design in several of the studies, and a strong likelihood of participant bias, there was marked consistency in the findings. Therefore, the implications of the findings can be synthesized with reasonable confidence. The key implications for clinical practice and service improvement of the findings are as follows.

In-hospital management:

- Education and training for clinical and non-clinical staff on DSH and how to manage patients after a DSH episode. This programme might include service users as educators and address topics of sensitivity, communication and appropriate behaviours.
- Patients regularly informed of their health status and engaged in management decisions.
- Staff sensitivity to patients’ personal preferences.
- Protocols for management of DSH patients, for example psychosocial assessment, designed to maximise therapeutic benefits.
- All patients who present with DSH receive a psychosocial assessment by someone trained to do this.
- Patients observed until they may be discharged appropriately, for example recovered from physical and / or psychological effects; have a discharge plan.

- Local alternatives to A&E may be an effective way of providing physical treatment for those who do not wish to attend hospital.

Aftercare:

- Hospitals' protocols ensure all patients have an aftercare plan at the time of discharge.
- Patients given advice and help regarding specific problems, for example substance abuse, low self-esteem, and information about local services upon discharge.
- Flexible aftercare arrangements planned according to the acuteness of the patient's problems.
- Staff assistance in making contact with local services by acting as the link (with the patient's permission).
- Therapists build up a rapport with patients before attempting to discuss problems related to self-harm.
- Aftercare should, wherever possible, be evidence-based and also tailored to meet individual patient's needs.
- Information about DSH, advice and support available to carers.

Adolescents:

- Staff involved in the management of adolescents have relevant specialist training.
- Adolescents kept informed and involved in their management.
- Parents, where appropriate, encouraged to be involved in management.
- Special attention to possible difficulties in care that may be experienced by older adolescents.
- Therapists work with adolescents and their families to create effective treatment plans.
- Local community services easily reached by public transport.

Furthermore, hospitals should have a planning group focused on the management of DSH patients. This might ensure that all patients receive certain aspects of care, for example pain relief, psychosocial assessment, and that effectiveness and patient satisfaction are assessed.

Future research

This review has shown that many DSH patients are unhappy with particular aspects of their management, both in and outside hospital. It has also identified several gaps and weaknesses in knowledge which need to be addressed by further research. Four broad areas for future research emerged from the literature.

Improvement of service evaluation:

- The development of a standard interview schedule to allow better evaluation of services across the UK. These components should include: satisfaction with physical treatment, psychosocial management, discharge, referral, aftercare and perceptions of, and satisfaction with, staff.
- Research evaluating DSH patients' perceptions of specific psychosocial assessments and comparisons of different types of assessments, for example long versus short forms.
- Evaluation of service users' attitudes towards psychosocial and pharmacological treatments offered after a DSH episode.

Improvement of service delivery:

- Research focusing on how to address the key implications and evaluate the impact of these changes on patient satisfaction.
- Development and evaluation of training and education about DSH for both clinical and non-clinical staff, including general practitioners.
- Measurement of the impact of training on staff attitudes and patient perceptions of staff.
- Examination of the most effective ways of linking changes in attitudes to changes in behaviour.
- Evaluation of the impact of community services already in place and the development of alternatives to hospital for minor physical injuries.
- Large-scale clinical studies evaluating different styles of services, for example dedicated DSH services versus generic psychiatric services, to compare the impact on patients.

Improvement of services for subgroups of individuals who self-harm:

- Research to determine the most effective way of managing older adults, as little research has been conducted this area.
- Qualitative research on older adults' perceptions of care.

- Research to determine whether different minority groups have special needs and how these needs can be addressed during their management.

Provision of support for those affected by DSH:

- Examination of the impact of DSH on relatives, their role in management, and its effects.
- Evaluation of special information about DSH tailored specifically for the use of family and friends of individuals who self-harm.

Conclusions

Despite studies in this review being from different countries and health care systems, the attitudes of patients to services and their perceptions of care showed remarkable consistency across studies. While participants often reported they were satisfied overall with their management, many highlighted specific aspects of their care with which they were unhappy. Our findings highlight several key implications that may improve the experience of care and the effectiveness of management, as well as research implications that may improve services and their evaluation.

1 Background

Suicide is among the leading causes of death for men and women, both in the United Kingdom (Griffiths, Rooney and Brock, 2005) and in other countries (Department of Mental Health and Substance Dependence, 2000). The strongest predictor of suicide is a previous episode of deliberate self-harm (Sakinofsky, 2000). Deliberate self-harm (DSH) is defined as any intentional self-poisoning or self-injury regardless of suicidal intent (Hawton, Harriss and Zahl, 2003a). An estimate of the prevalence of DSH is difficult because not all people seek help after an episode. In a national survey, an estimated four per cent of respondents said they had attempted suicide in the past, and two per cent said they had deliberately harmed themselves without suicidal intent (Meltzer, Lader, Corbin *et al*. 2002). Only half of respondents who reported attempting suicide (52%), or deliberately harming themselves without suicidal intent (50%), said they sought help after the event. On the basis of information collected in general hospitals in England, at least 200,000 individuals per year present to hospital following DSH (Hawton, Bergen, Casey *et al*. 2007).

After an individual's first DSH episode, there is a marked risk of repetition. In a review of international literature conducted by Owens and colleagues (2002), it was estimated that the proportion of individuals repeating non-fatal self-harm within one year of the index episode was between 15-16 per cent, with a slow rise to 20-25 per cent over the next few years. Hawton and colleagues (2003b) reported the risk of suicide within the first year after a DSH episode to be 66 times the annual risk of suicide in the general population of England and Wales. Furthermore, they found no major reduction in the risk of suicide for this group during the 20-year study period. The prevalence of DSH and the possibility of further repetition and / or eventual suicide make DSH a major health care problem both in the UK and across the globe. As a result, the management of individuals who present to hospital after a DSH episode is a priority.

Decreasing the number of individuals who engage in DSH is a goal for governments around the world. In the UK there has been increasing pressure to address the issues surrounding DSH and its management. As a response, professional and government bodies have produced several reports on DSH and suicide. Improved management of deliberate self-harm (DSH) patients is highlighted in the *National Suicide Prevention Strategy for England* (Department of Health, 2002). Management of DSH is also the subject of the recently published guideline *Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*, commissioned by the National Institute for Clinical Excellence (National Collaborating Centre for Mental Health, 2004). This document has highlighted standards of care and noted the often negative experiences of DSH patients of current services. These reports provide the UK with goals to increase the effectiveness of measures to prevent DSH and suicide, as well as management for those who self-harm.

Although the severity of the problem of DSH has been acknowledged, and recommendations and guidelines have been proposed, the delivery of suggested changes does not occur nationwide. As a result, the nature and quality of DSH services varies throughout the UK (Kapur, House, Creed *et al*. 1998; Slinn, King and Evans, 2001; Bennewith, Gunnell, Peters *et al*. 2004). Furthermore, the characteristics of some individuals who engage in DSH can make the implementation of management guidelines difficult.

1.1 Services available

Services for DSH patients can be divided into those addressing medical care following the episode, and psychosocial care both in the hospital and subsequently. The Royal College of Psychiatrists' consensus statement on hospital management of DSH patients (1994) emphasised the importance of a clear guideline for service provision, adequate training for staff and planning. However, many hospitals are still struggling to meet the recommendations. In a postal survey of 129 trusts, 40 per cent did not have a clear guideline for management in place and 30 per cent did not routinely refer all patients with DSH for an assessment (Slinn *et al*. 2001). In an audit of 32 hospitals across England, 11 hospitals were found to have less than half the Royal College of Psychiatrists' recommendations in place (Bennewith *et al*. 2004). The most commonly implemented recommendations were guidelines for medical management and 24-hour access to specialist psychological assessments (in place in 31 and 30 hospitals, respectively). As a result, the care which an individual presenting with a DSH episode receives is not uniform but instead depends on where he or she lives. It is not known if patient experiences or satisfaction with services vary across dimensions, such as receiving services from a general compared with a specialised DSH team, primary care compared with specialised care providers, patient characteristics such as age, and frequent compared with one-off users of services. These issues require further exploration.

1.2 Research into satisfaction with services

Studies concerning the medical care of DSH patients have focused mainly on the attitudes of medical and nursing staff providing this care. DSH patients' attitudes towards hospital care will, in fact, reflect perceived attitudes of healthcare staff towards them and their problems. Several studies have suggested that staff responsible for medical care have, or are perceived by DSH patients as having, negative attitudes towards those who deliberately harm themselves (for example Herron, Ticehurst, Appleby *et al*. 2001). Also, nursing staff may feel both ambivalent and resentful towards DSH patients (Hopkins, 2002). However, one study which used case vignettes suggested that nursing staff were generally more sympathetic to DSH patients than medical staff, but that perceived motivation behind the act, especially suicidal intent, markedly influenced attitudes (Ramon, Bancroft and

Skrimshire, 1975). Personal attitudes towards suicide prevention, beliefs about suicide, training and experience appear to influence the intervention skills of staff working with those who have engaged in DSH (Herron *et al*. 2001; Neimeyer, Fortner and Melby, 2001). Research into staff attitudes towards individuals who self-harm is important in understanding patient experiences with, and attitudes to, care. However, this research warrants a review unto itself. Therefore, the present review will not seek to provide an analysis of staff attitude research, except where such research directly informs a better understanding of patient attitudes to self-harm services.

Research indicates both positive and negative patient experiences of psychosocial care from health services. For example, Suominen and colleagues (2004) interviewed patients in Finland who received a psychiatric consultation following DSH. These authors found that similar numbers of patients reported they were eager to be assessed, as compared to those who were indifferent to the consultation, although indifference was mediated by depression and hopelessness. Nearly half felt the consultation took place too soon after the DSH event. However, the majority felt the consultation influenced their use of aftercare. A follow-up study of 965 young adults in New Zealand, about help-seeking for self-harmful behaviours, found that most rated their contact with general practitioners, psychiatrists and psychologists favourably but their contact with emergency services less favourably (Nada-Raja, Morrison and Skegg, 2003), although it is not known if the latter views differ from other users of emergency services. Research has also suggested that those individuals who were dissatisfied with a suicide intervention counselling service, which commenced in hospital and continued on an outpatient basis, reported higher rates of repetition of DSH and suicide ideation than those were satisfied (Aoun and Johnson, 2001). In another study, adolescent DSH patients who were more satisfied with hospital management and subsequent therapy appeared to have better therapeutic outcomes (Burgess, Hawton and Loveday, 1998).

1.3 Characteristics of deliberate self-harm patients

Many studies have shown that DSH patients may have characteristics which distinguish them from the general population, or patients with psychiatric disorders without a history of DSH. These factors include a range of interpersonal problems and difficulties, deficits in problem-solving skills, low self-esteem, a tendency to become pessimistic or hopeless in the face of adversity, and also to see problems in an all or nothing (black and white) fashion (Williams and Pollock, 2000; Williams, Crane, Barnhofer *et al*. 2005). The characteristics may influence their interaction with services. Some patients, especially those with a long-term history of abuse or other negative experiences, may have particular difficulties in interpersonal interactions, especially with professionals, which are likely to influence their perception of services. Individuals who self-harm are also more likely to experience low self-esteem, poor affect regulation and a tendency to interpret events and behaviour negatively, which mean that in a crisis they are likely to feel bad about themselves and their relationships, and that no one cares about them.

Many people who self-harm do not attend Accident and Emergency (A&E). (The term A&E will be used because the majority of participants use this term to discuss experiences in the emergency department.) In the UK, one study found that less than 30 per cent of DSH patients who had had previous hospital contact for DSH presented to hospital following a further episode (Guthrie, Kapur, Mackway-Jones *et al*. 2001). One reason for failure to seek treatment after an episode may be linked to previous negative experiences or negative associations with management.

Furthermore, after discharge, many DSH patients do not attend aftercare treatment if they are offered this service. Kreitman (1979) found that up to 50 per cent of patients given appointments a week after an episode fail to attend. O'Brien (1987) found that 60 per cent of patients did not attend their scheduled appointments a week after the index episode. Although similar results are commonly found in all patients with mental illness, it is an important characteristic of DSH patients that affects how these patients should be treated.

1.4 Importance of service users' experiences

Obtaining information from DSH patients about their experiences of, and attitudes to, care received is an important component of the process of assembling evidence that can assist in the design of improved services. This is especially important given the consistent finding that a previous DSH episode is one of the strongest predictors of further episodes (Sakinofsky, 2000), including those that result in death (Beautrais, 2002; Hawton, Zahl and Weatherall, 2003b). The views held by patients about treatment following an episode of suicidal behaviour not only provide information about how services are, or are not, meeting needs, they may also have an impact on the likelihood that DSH patients will seek help instead of carrying out a further DSH act.

A previous review of the research literature on the effectiveness of aftercare of DSH patients indicated relatively disappointing results (Hawton, Arensman, Townsend *et al.* 1998; Hawton, Townsend, Arensman *et al*. 1999). However, a recent update of this review by some of the present authors and colleagues has indicated more positive findings, specifically for the efficacy of psychological therapies in terms of their impact on repetition of DSH, depression, and improvement of problems (in preparation). Studying patient experiences of services might assist in the development of more patient-orientated care and services, and ultimately increase the effectiveness of interventions. It is possible that satisfaction with services, provided to DSH patients in hospital, influences attendance at subsequent outpatient care and therapy. Factors such as psychiatric diagnosis, suicide intent, or demographic variables did not predict outpatient attendance among DSH patients in one study (O'Brien, Holton, Hurren *et al*. 1987), suggesting that other factors are important. An interview study of suicidal outpatients with serious mental illness showed that many of them perceived their contact with services as positive. However, they also perceived the stigma of mental illness as being a negative influence on suicide prevention (Eagles, Carson, Begg *et al*. 2003). Research conducted with adolescents who have deliberately self-harmed suggests they often perceive their contact with hospital services to be unhelpful due to poor continuity of care requiring frequent repetition of their 'story' (Dower, Donald, Kelly *et al*. 2000) and negative expectations about post-discharge therapy (Rotheram-Borus, Placentini, van Rossem *et al*. 1996).

Despite the widespread variation in services, and the general trend towards greater inclusion of consumer views in the evaluation of health service outcomes (Eager, 2000; Bennewith *et al*. 2004), there appears to have been little attempt to draw together the available evidence on DSH patients' attitudes towards, and satisfaction with, DSH services. No systematic review of patient attitudes to care following DSH is currently available in the published literature. A more complete understanding of consumer perspectives on services is important for the development and improvement of services.

2 Objectives of this study

The main objective of this study was to conduct a systematic review of the international literature on patient attitudes to, and satisfaction with, health services following DSH, in order to provide information to assist in the design and development of improved services for those engaging in deliberate self-harm. The specific aims were to investigate user attitudes to (a) medical management, (b) in-hospital psychiatric management and (c) post-discharge management.

3 Method

3.1 Criteria for considering studies for this review

3.1.1 Types of studies

We sought to identify all qualitative and quantitative studies investigating DSH patients' attitudes toward, and satisfaction with, services. DSH is defined as any deliberate self-poisoning or self-injury regardless of whether or not death was the intended outcome (Hawton *et al*. 2003a).

The objective of this report was to inform clinical practice. Therefore, we will also make mention of additional studies relevant to the objectives of the review.

3.1.2 Types of participants

Participants were males and females of all ages who had engaged in any type of deliberately initiated self-poisoning or self-harm and received medical, in-hospital psychiatric or post-hospital management for the episode. We also included studies which examined the experiences of patients' friends or relatives of such care. Studies of patients admitted to hospital due to suicidal ideation were included if the majority of the study's participants had also engaged in DSH behaviour. Patients whose care was solely provided in the community were not included.

3.1.3 Types of interventions

Participants may have experienced any type of management, for example medical, in-hospital psychiatric or post-hospital, for their DSH episode.

3.1.4 Types of outcomes measures

Primary outcomes

The primary outcome was DSH patients' attitudes and experiences of services.

Secondary outcomes

The secondary outcomes were relatives' and friends' attitudes and experiences of services.

3.2 Search strategy for identification of studies

3.2.1 Search terms

The search terms used in this review were taken from the National Collaborating Centre for Mental Health report on self-harm (NCCMH, 2004). The list of terms is presented below:

- suicide/ or suicide, attempted/ or overdose/ or exp self-injurious behavior/
- exp suicidal behavior/ or automutilation/ or drug overdose/
- suicide or attempted suicide/ or self destructive behavior/ or self inflicted wounds or self mutilation/ or drug overdoses/
- suicide/ or suicidal ideation/ or suicide, attempted/ or self-injurious behavior/ or injuries, self inflicted/ or overdose/
- suicide/ or suicide attempted/ or exp self injurious behavior/
- (self-harm$ or self?harm$ or self-injur$ or self?injur$ or self-mutilat$ or self?mutilat$ or suicid$ or self-destruct$ or self?destruct$ or self-poison$ or self?poison$ or (self adj2 cut$) or cutt$ or overdose$ or self-immolat$ or self?immolat$ or self-inflict$ or self?inflict$ or auto-mutialt$ or auto?mutilat$).tw.
- 1 or 2 or 3 or 4 or 5 or 6
- nursing methodology research/
- qualitative studies/ or ethnological research/ or ethno nursing research/ or focus groups/ or grounded theory/ or phenomenological research/ or exp qualitative validity/ or phenomenology/ or ethnography/ or exp observational methods/ or life experiences/
- (ethnon: or emic or etic or ethnograph: or participant obser: or constant comp: or focus group: or grounded theory or narrative analysis or thematic analysis or lived experience or life experience: or user experience: or patient experience: or inside$ perspective$ or discourse analysis or content analysis or social constructi$ or semi-structured or group interview$).tw.
- (qualitative research or qualitative stud$ or qualitative approach or qualitative method$ or qualitative analysis).tw.
- phenomolog$.tw.
- 8 or 9 or 10 or 11 or 12

- 7 and 13
- remove duplicates from 14
- exp *health surveys/ or *health care surveys/
- exp *surveys/
- *health survey/ or *short survey/
- (survey$ or question$).ti.
- (survey$ or question$).ab.
- (experien$ or attitude$).ti.
- (experien$ or attitude$).ab.
- (assisted adj suicide).mp. [mp=ab, hw, ti, sh, it, tn, ot, dm, mf, rw, ty, id]
- suicide/
- euthanasia.mp. [mp=ab, hw, ti, sh, it, tn, ot, dm, mf, rw, ty, id]
- *patient attitude/
- 16 or 17 or 18 or 19 or 20
- 21 or 22 or 26
- 23 or 24 or 25
- 7 and 27 and 28
- 30 not (29 or 15)
- remove duplicates from 31

All terms were adapted for each database searched in order to retrieve the most relevant studies**.**

3.2.2 Electronic searches

The electronic databases used to search for applicable articles were:

- EMBASE (1980 – 2006 Week 24)
- MEDLINE (1950 – June Week 1 2006)
- PsychINFO (1806 – June Week 2 2006)
- AMED (1985 – June 2006)
- British Nursing Index (1985 – June 2006)
- CINAHL (1982 – May Week 2 2006)
- Global Health (1973 – May 2006)
- HMIC (May 2006)

- International Bibliography of the Social Sciences (1951 – June Week 2 2006).

3.2.3 Other sources

Grey literature

The electronic databases Sociofile (1952 – 2006) and SIGLE (1980 – 2005/03) were used to identify grey literature on the subject.

Reference lists

The reference lists of all relevant papers known to the investigators were checked. A search of studies citing included studies was not conducted.

Correspondence

Experts in the field, working in both English and non-English-speaking countries, were consulted in order to determine if they knew of any published, or unpublished, literature concerning DSH patients' attitudes to services.

3.3 Selection of studies

One researcher screened all relevant abstracts of articles obtained by the search strategy. A distinction was made between: (1) eligible studies, in which DSH patients and / or their relatives' or friends' attitudes towards, and experiences of, services were documented and (2) ineligible studies, in which DSH patients and / or their relatives or friends were interviewed but did not include references to attitudes towards, or experiences of, services.

3.4 Data extraction and management

3.4.1 Qualitative data

A list of important topics, for example staff satisfaction, informed consent, and types of management were created by the research group prior to data extraction. The data was extracted independently by two reviewers. Articles were read twice by each author. Quotations and themes regarding attitudes and experiences of services were coded using a pen and paper method by a single reviewer (TT). The second reviewer (SF) independently extracted data from a proportion of the studies. The reviewers then compared their data to ensure that all relevant quotations and topics were recorded. SF then read the remaining articles and checked TT's data extraction sheets to reduce possible bias in reporting findings. The individual article data extraction sheets were combined using the pre-determined list of topics mentioned above. Similarities and differences between participants' accounts were noted.

3.4.2 Quantitative data

Quantitative data were extracted independently by two reviewers (TT and SF). The data were not subject to meta-analyses due to the lack of studies providing similar data. Instead, they were used to provide evidence about the general experiences of a larger population of DSH patients, with qualitative data used to deepen our understanding through the recounting of specific examples and incidents.

3.5 Assessment of methodological quality of included studies

Methodological quality of included studies is important because of the ease with which methodological shortcomings can bias results. The quality of all included studies was assessed using a combination of the Social Care Institute for Excellence's (2006) qualitative literature quality assessment and the Critical Appraisal Skills Programme's *10 questions to help you make sense of qualitative research* (2002). Quality was assessed using four categories: (1) design, (2) centrality, (3) analysis and reporting and (4) generalisability (Social Care Institute for Excellence, 2006). The detailed instruction sheet can be seen in Appendix 1. Studies were rated as Strong, Strong / Acceptable, Acceptable, Acceptable / Weak or Weak for each category. The assessment tool ensures that research is rigorous, credible and relevant by examining the appropriateness of a qualitative methodology, the research question and the collection of data as well as assessment of the ethical implications of the research, the researchers' potential bias and the rigour of data analysis. All included studies were assessed, independently, by at least two members of the research group. Where reviewers disagreed, the opinion of a third member of the review group was used to reach a decision. All studies were included in the review, regardless of their quality. However, more weight was given to studies with strong design.

Articles were rated for their relevance to the purposes of this review. Each article was independently rated by two reviewers. Relevance of qualitative studies was assessed using a dichotomous (strong or weak) rating scale (see Appendix 2). Qualitative articles of strong relevance were defined as:

> At least one primary focus is on the views of DSH patients in relation to their attitudes towards and satisfaction with services (for example medical, in-hospital psychiatric or post-hospital management) for their DSH episode. The study should use qualitative methods and reporting which provides a detailed description or, in the case of quantitative work, investigation of relationships between concepts, not just frequency counts. (Social Care Institute for Excellence, 2006 p.18)

Qualitative articles of weak relevance were defined as:

> At least one primary focus is on the views of DSH patients in relation to their attitudes towards and satisfaction with services (for example medical, in-hospital psychiatric or post-hospital management) for their DSH episode. However, reporting is thin on description or largely limited

> to basic frequency counts, so that only on or two possible insights into the nature of DSH patients' subjective views have been generated. (Social Care Institute for Excellence, 2006 p.18)

The relevance of quantitative studies was assessed separately based on whether or not at least one primary focus of the study was on the perceptions and / or attitudes of DSH patients towards care. Ratings were only intended to determine relevance to the purpose of this review and do not reflect relevance to the field in general.

Where two reviewers disagreed about the rating of relevance of a study, a third member of the review group was consulted and a consensus reached.

4 Description of studies

A total of 1014 relevant studies were identified through electronic searches (see Figure 1). After further inspection of the abstracts by TT, 946 studies were excluded due to duplications, irrelevance to service user's experiences, and study population, for example not all exhibited DSH behaviour. Thirty-one studies met the inclusion criteria and were assessed for quality (see Table 1; for assessment instructions see Appendix 1). Ratings of the relevance of the studies to the purpose of this review are presented in Table 2. All included studies are summarised in Appendix 3. Excluded studies are presented in Appendix 4.

Figure 1. Study flow chart

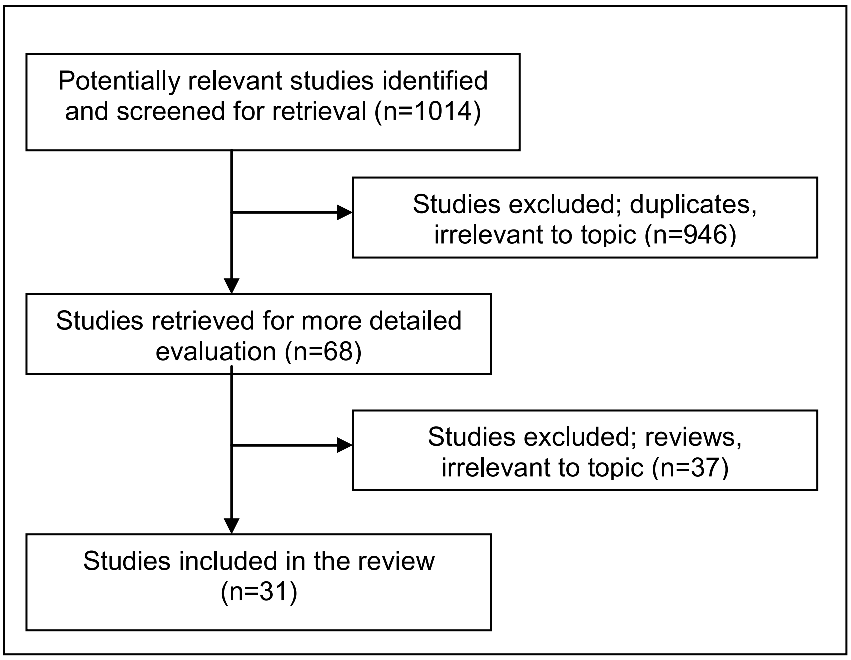

Table 1. Methodological quality of included studies

Study name	Design	Centrality	Analysis and reporting	Generalisability
Arnold 1995	Acceptable/Weak: provides information regarding the recruitment of subjects; does not explain why some women participated in interviews and others only questionnaires	Weak: no explanation for how data was selected from the overall sample; no examination of research's own bias; author consistently provides collected data to support findings	Weak: researcher does not discuss his/her potential bias or influence; no in-depth description of analysis method or validation	Acceptable/Weak: high participant count; all women; recruited through advertising; majority were self-cutters but exhibited comorbid disorders
Bolger *et al*. 2004	Strong: reasonable justification for design; good description of how cases selected; good discussion around recruitment and non-participation	Acceptable/Weak: some discussion about how material was selected; little discussion of interviewers' potential bias	Acceptable/Weak: methods adequately described; no clear description of analysis, no description of method of analysis or validation; data presentation quite sparse	Acceptable/Weak: two stage recruitment; only 1/3 followed-up; reasonable sample; bias in sample selection and among those who participated
Brophy 2006	Acceptable/Weak: limited justification for design; no discussion of method; no discussion of characteristics of non-participants	Acceptable/Weak: participants' quotes were used to add validity to the findings from the synthesis of other research; unclear how data were selected from the original sample; potential bias and influence of the researcher were not discussed	Acceptable/Weak: unclear how and where data were collected from the consultation group; data presented are sufficient to support the findings; contradictory statements examined; no consideration of saturation	Acceptable/Weak: included the views of 40 young people who had contact with a self-harm organisation; highly selected population

Burgess *et al*. 1998	Strong: explanation of participant selection and non-participation; good design with two interviews conducted by same researcher; no information provided about choice of research method	Quantitative study	Strong: data collection and methods clearly described; limited data on views of services collected	Acceptable: good mix of younger and older respondents, gender mix is described and reflects the mix of young people presenting to this hospital following self-harm; selected sample
Bywaters and Rolfe 2002	Acceptable/Weak: no justification of research design; little examination of differences between participants and non-participants	Acceptable/Weak: the voice of young people who harm themselves is central; no discussion of the impact of the fact that the organisation they were involved with was conducting the research	Acceptable/Weak: method of data collection is clear; no theoretical underpinning to the data collection nor analysis; findings were validated with participants; balanced discussion; data saturation	Acceptable/Weak: predominantly self-injury; interviewees were almost exclusively late teenage/young adults females; the quantitative study had a response rate of about 33%
Cardell and Pitula 1999	Weak: little justification for method; no information on non-participants; good discussion of participant characteristics	Weak: bias/influence of the researcher is not discussed; the voice of the participants is central; unclear how data were extracted from transcripts	Strong/Acceptable: methods of collection and analysis are made clear; all participants were interviewed twice; balanced view	Acceptable/Weak: convenience sample 20 men and women;; all hospitalised in psychiatric ward; over-selected samples in a particular time and place
Carrigan 1994	Acceptable: good justification for method used; sample described as ‘convenience’ but no detail on response rates etc.	Acceptable: the researcher examines his position in relation to the research; clear theoretical framework used; potential researcher bias	Acceptable: methods of collection and analysis are made clear (content analysis); insufficient data are presented to support findings	Acceptable/Weak: admitted patients only; small convenience sample; generates some valid themes which may be generalisable

Cerel *et al*. 2006	Acceptable: justification and description of method; robust questionnaire-based study with a good sample size; sample was recruited from web-site of a self-help group; no information on non-participants	Strong/Acceptable: questionnaire was derived from previous literature and the views of service users; voice of the participants is central to the arguments; bias/influence of researcher is not discussed	Strong/Acceptable: detailed description of analysis and reporting of methods provided; method of analysis is clear for the quantitative data but not for qualitative data	Strong/Acceptable: a large sample; includes data from both patients and their friends and family; method of sample recruitment may have introduced systematic bias
Crockwell and Burford 1995	Acceptable: research design is described as an integral part of clinical practice; little information on the population from which participants were sampled	Acceptable: some explanation of how data were selected from original sample; limited examination of researcher's role	Strong: the data collection method and analysis are clearly described and theoretically driven; saturation discussed; balanced view; rich data	Acceptable/Weak: the sample size is small and many of the experiences relate to long-term social services involvement; all female respondents; multiple suicide attempts
Dorer *et al*. 1999	Acceptable: there is a clear description of the sample and differences between those who took part and those who did not	Acceptable: development of the semi-structured interview appears driven by the researchers rather than participants but focuses on issues of importance to patient experiences in other studies	Acceptable: the data are reported clearly; analysis is at a relatively descriptive level	Weak: only 33% of potential participants took part in the study
Dower *et al*. 2000	Strong: the sampling methodology and sample population are clearly described	Strong: the pathways to care and experiences of young people who self-harm are the focus of the study	Acceptable: the analysis is clear and very detailed; the results are descriptive only	Acceptable/Strong: representative sample with almost equal gender distribution
Dunleavey 1992	Acceptable: justification of design; limited explanation of participant selection	Weak: some description of how data were selected; the interpretation of the author dominates the voice of the participants; no discussion about researcher bias	Weak: a theatrical approach to analysis is described; results section is relatively small; issue of credibility is not addressed	Weak: the study utilises some assumptions about the nature of self-harm and terminology which have since been superseded

Harris 2000	Strong/Acceptable: the researcher justifies a correspondence design and qualitative approach; participant recruitment is described clearly; no information regarding response rate	Acceptable: unclear how data were selected from the original sample; the views of women who have self-harmed are central to the study; some explanation of researcher bias	Acceptable/Weak: the method of data collection is clearly described; no information on saturation or method of analysis used; insufficient data are presented to support the findings and synthesis; inadequate discussion of the evidence both for and against the author's arguments	Acceptable/Weak: information on the characteristics of the sample are provided; small sample of women who regularly self-harm; limited discussion of positive experiences
Hengeveld *et al*. 1988	Strong: authors do not justify research design; methods described; inclusion bias discussed; information on recruitment provided	Acceptable/Weak: includes patient responses but described through a professional lens rather than patient centred	Acceptable/Weak: no description of method of analysis; full description of patient characteristics; participants interviewed twice; discussion of study limitations	Strong/Acceptable: large heterogeneous sample of people presenting to hospital within a fixed period
Hood 2006	Strong: the research design and participant recruitment are clearly described	Strong: the views of young people, their parents and therapists following self-harm are central to the study; method of data selection is explained	Strong: an in-depth description of the analytical process is provided; researcher examines her potential bias and influence; conflicting data are discussed	Acceptable: the triangulation of data and reasonable sample size have a positive impact on the generalisability of the study
Horrocks *et al*. 2005	Strong: strong rationale for a qualitative approach; difficulties concerning study recruitment are outlined	Strong/Acceptable: the views of people who self-harm are central to the study; limited discussion of role of researcher	Strong: the method of analysis is stated and adequate results are presented; saturation implicit; balanced presentation; group discussion provides extra credibility	Strong/Acceptable: large and varied sample; poor response rate

Hume and Platt 2007	Strong: authors provide justification of research design; methods clearly described; non-participants are not discussed	Strong: views of participants are central to the study; method for selecting data explained; researcher's own position described	Strong: method of analysis clearly described; full description of patient characteristics; provides number of patients sharing specific experiences/perceptions; good use of quotes; addresses study limitations	Strong: participants quota sampled to ensure range of ages and included both genders
Kreitman and Chowdhury 1973	Strong/Acceptable: justification for research design; good description of how participants were selected and why; some discussion of issues of recruitment; good discussion regarding sample's relationship to total population	Acceptable/Weak: the sample selection is described, there is no discussion of the role of the interviewer or the potential influence on findings	Strong/Acceptable: analysis is clear and examines the relationships between certain factors	Acceptable: selected samples of self-harm patients and persistent callers to Samaritans; may not be relevant to current practice (published in the 1970s)
Nada-Raja *et al*. 2003	Strong: clear justification for study design which is relevant to this review; clear description of participant selection	Acceptable/Strong: the researchers do not examine their own role in data collection or potential bias, however they mostly present quantitative data based on a structured interview and prompts about types of help	Weak: data collection methods are clearly described; the data on barriers to help seeking are not accompanied by any description of the method of analysis nor are quotes provided in the results section; clinically-trained researchers conducted interviews	Strong: large sample; includes people in the community who are not accessed via hospital-based studies

National Collaborating Centre for Mental Health 2004	Acceptable: method clearly described; no justification for method; does not discuss those who declined to participate	Acceptable/Weak: the views of people who self-harm are central to the study; unclear how the data were selected from the original example; report does not explain possible bias and influence of investigators on findings	Weak: method of analysis is not described; provides quotes and relays situations but does not provide any of in-depth synthesis of data; possible reasons for the skewed data are not examined	Weak: small sample size; participants were all involved in self-help groups; no discussion of the demographics of those who declined to participate
Palmer *et al*. 2006	Acceptable: method clearly described; large-scale survey; no discussion of non-participants	Strong/Acceptable: unclear how qualitative data presented were chosen but backed up by quantitative data; no discussion of possible researcher influence or bias; participant voice is central	Strong/Acceptable: no in-depth synthesis of data; balanced presentation; good use of quotes; quantitative data included many aspects of care	Weak: large sample size from 30 hospitals in various regions; 86% female; highly selected convenience sample
Perseius *et al*. 2003	Weak: no justification of design; method clearly described; purposive sample; limited discussion of non-participants	Weak: some discussion of how data were chosen from transcripts; authors' potential bias is not discussed	Acceptable: method of analysis is clearly described; analysis and coding of data done independently by two researchers; no negative responses provided	Weak: possibility of bias due to research design and small population; unbalanced presentation of data
Pitula and Cardell 1996	Weak: no justification for design; method clearly described; no discussion of non-participants	Acceptable/Weak: unclear how data presented were chosen; no discussion of researcher influence or possible bias; participants' voices are central	Weak: method of analysis is described; unbalanced presentation of data	Acceptable/Weak: two different psychiatric wards in two different regions; gender balanced
Rotheram-Borus *et al*. 1999	Acceptable: no justification for design; method clearly explained; discussion of reasons for non-participation and loss to follow-up	Quantitative study	Strong: method of analysis clearly described; data clearly presented	Weak: highly specified population (Latina adolescents, low socioeconomic background) which makes it difficult to generalise to rest of population

Smith 2002	Acceptable/Weak: choice of participants justified by author; unclear description of design; discussion of sample representation; no information on sample characteristics	Acceptable/Weak: quotes strengthened previous findings from the literature; orientation of researcher outlined; quotes mixed with staff views	Acceptable/Weak: theoretical orientation used was described; unknown whether or not all participants shared the experience or perception; limitations discussed	Weak: individuals who self-harm that are in contact with voluntary sector; small number; author did not intend study to be representative
Suominen *et al*. 2004	Strong: part of a much larger study with a clear research question and methodology; discussion of issues concerning participation	Quantitative study	Strong: methods of data analysis are clearly described and detailed; good presentation of data	Acceptable: participants were admitted to general hospital
Treloar and Pinfold 1993	Strong: a clear rationale for the design of the study and development of the questionnaire measure; includes information on respondents and non-respondents and response rate	Strong/Acceptable: quantitative data were inclusive of all participants; no explanation of how qualitative data was selected for inclusion was provided	Strong: data collection methods are clearly described and included a pilot development phase; large amount of data is presented in the results section; conflicting experiences are discussed	Acceptable: the participants comment on a particular ward in a particular hospital which may operate in a very different way to other services
Warm *et al*. 2002	Weak: the rational for conducting online research is not clearly stated; limited discussion of issues around recruitment	Weak: some discussion of how material was chosen; little discussion of role of researcher	Acceptable: method of analysis is clearly outlined	Weak: the sample is almost all women who cut themselves and who use online methods of support
Whitehead 2002	Acceptable: good rationale for design; clear description of methods; convenience sample; discussion of issues of non-participation	Strong: mostly quantitative data; answers from two open-ended questions provided to participants	Strong: in-depth description of the analysis process; discussion of limitations	Acceptable: compares the experiences of those receiving a psychosocial assessment to those that did not receive one during the same period of time; small sample

Wiklander *et al*. 2003	Strong: good rationale for design; description of case ascertainment; discussed recruitment and issues of non-participation	Strong: some discussion of how data selected from sample; influence of research methods and researchers' role on findings addressed	Strong: a clear description of the qualitative methods utilised; validated by checking with a second researcher	Strong/Acceptable: specialised ward for suicidal persons
Wolk-Wasserman 1985	Strong: multiple interviews conducted by the same researchers	Strong: clear statement of therapeutic and research orientation of researchers	Strong: An in-depth description of the analysis process is provided; interview transcripts and tapes were analysed by two independent groups as well as author; findings are strengthened by triangulation	Strong/Acceptable: findings limited to patients in a specific intensive care unit; participants heterogeneous in terms of age, sex, and history of self-harm

Table 2. Relevance of included studies to the review

Study	Relevance to review
Arnold 1995	Strong
Bolger et al. 2004	Weak
Brophy 2006	Strong
Burgess et al. 1998 (quantitative study)	Strong
Bywaters and Rolfe 2002	Strong
Cardell and Pitula 1999	Strong
Carrigan 1994	Strong
Cerel et al. 2006	Strong
Crockwell and Burford 1995	Strong
Dorer et al. 1999	Weak
Dower et al. 2000	Strong
Dunleavey 1992	Strong
Harris 2000	Strong
Hengeveld et al. 1988	Strong
Hood 2006	Strong
Horrocks et al. 2005	Strong
Hume and Platt 2007	Strong
Kreitman and Chowdhury 1973	Strong
Nada-Raja et al. 2003	Weak
National Collaborating Centre for Mental Health 2004	Strong
Palmer et al. 2006	Strong
Perseius et al. 2003	Strong
Pitula and Cardell 1996	Strong
Rotheram-Borus et al. 1999 (quantitative study)	Weak
Smith 2002	Weak
Suominen et al. 2004 (quantitative study)	Strong
Treloar and Pinfold 1993	Strong
Warm et al. 2002	Strong
Whitehead 2002	Strong
Wiklander et al. 2003	Strong
Wolk-Wasserman 1985	Strong

The majority (n=18; 62%) of included studies were entirely qualitative (Kreitman and Chowdhury, 1973; Wolk-Wasserman, 1985; Dunleavey, 1992; Carrigan, 1994; Crockwell and Burford, 1995; Pitula and Cardell, 1996; Cardell and Pitula, 1999; Dorer, Feehan, Vostanis *et al*, 1999; Harris, 2000; Bywaters and Rolfe, 2002; Smith, 2002; Nada-Raja *et al*, 2003; Wiklander, Samuelsson and Asberg, 2003; Bolger, O'Connor, Malone *et al*, 2004; National Collaborating Centre for Mental Health, 2004; Horrocks, Hughes, Martin *et al*, 2005; Hood, 2006; Hume and Platt, 2007). Twelve of these studies were based on individual, face-to-face interviews with DSH service users (Kreitman and Chowdhury, 1973; Dunleavey, 1992; Carrigan, 1994; Crockwell and Burford, 1995; Pitula and Cardell, 1996; Cardell and Pitula, 1999; Bywaters and Rolfe, 2002; Nada-Raja *et al*, 2003; Wiklander *et al*, 2003; Bolger *et al*, 2004; Horrocks *et al*, 2005; Hume and Platt, 2007). One study included joint interviews with adolescent service users and their parents (Dorer *et al*, 1999), while two conducted separate interviews with service users, their significant others and professionals (Wolk-Wasserman, 1985; Hood, 2006). Smith (2002) interviewed service users and mental health workers. Harris (2000) collected letters from females with a history of DSH. The NICE guideline on self-harm (2004) conducted focus groups.

Ten of the 31 included studies used both qualitative and quantitative methods (Hengeveld, Kerkhof and van der Wal, 1988; Treloar and Pinfold, 1993; Arnold, 1995; Dower *et al*, 2000; Warm, Murray and Fox, 2002; Whitehead, 2002; Perseius, Öjehagen, Ekdahl *et al*, 2003; Brophy, 2006; Cerel, Currier and Cooper, 2006; Palmer, Strevens and Blackwell, 2006). Arnold (1995) conducted interviews with some participants (n=26) and collected written questionnaires from the rest (n=50). Three studies collected solely quantitative data (Burgess *et al*, 1998; Rotheram-Borus, Piacentini, Van Rossen *et al*, 1999; Suominen, Isometsä, Henriksson *et al*, 2004).

Of the 31 studies, 23 included both male and female respondents (Kreitman and Chowdhury, 1973; Wolk-Wasserman, 1985; Hengeveld *et al*, 1988; Treloar and Pinfold, 1993; Carrigan, 1994; Pitula and Cardell, 1996; Burgess *et al*, 1998; Cardell and Pitula, 1999; Dorer *et al*, 1999; Dower *et al*, 2000; Bywaters and Rolfe, 2002; Warm *et al*, 2002; Horrocks, House and Owens, 2002; Whitehead, 2002; Nada-Raja *et al*, 2003; Wiklander *et al*, 2003; Bolger *et al*, 2004; Suominen *et al*, 2004; Brophy, 2006; Hood, 2006; Cerel *et al*, 2006; Palmer *et al*, 2006; Hume and Platt, 2007). In six studies, participants were all female (Crockwell and Burford, 1995; Arnold, 1995; Rotheram-Borus *et al*, 1999; Harris, 2000; Perseius *et al*, 2003; National Collaborating Centre for Mental Health, 2004). Two studies did not provide information on the gender composition of participants (Dunleavey, 1992; Smith, 2002).

Over half of the studies included in the review were based upon service users in the UK (Kreitman and Chowdhury, 1973; Dunleavey, 1992; Treloar and Pinfold, 1993; Carrigan, 1994; Arnold, 1995; Burgess *et al*, 1998; Dorer *et al*, 1999; Harris, 2000; Bywaters and Rolfe, 2002; Smith, 2002; Whitehead, 2002; National Collaborating Centre for Mental Health, 2004;

Horrocks *et al*, 2005; Brophy, 2006; Palmer *et al*, 2006; Hume and Platt, 2007). The other studies were based upon service users' experiences in Ireland (Bolger *et al*., 2004), North America (Crockwell and Burford, 1995; Pitula and Cardell, 1996; Cardell and Pitula, 1999; Rotheram-Borus *et al*, 1999; Warm *et al*, 2002; Cerel *et al*, 2006), Australia (Dower *et al*, 2000), New Zealand (Nada-Raja *et al*, 2003; Hood, 2006), Finland (Suominen *et al*, 2004), Sweden (Wolk-Wasserman, 1985; Perseius *et al*, 2003; Wiklander *et al*, 2003) and The Netherlands (Hengeveld *et al*, 1988). All studies included were published in English in spite of an international literature search. Adults made up the majority of participants in 24 studies. Six studies were focused on the experiences of adolescent service users only. One study did not provide information relating to participant age (Smith, 2002).

Service users who had self-poisoned accounted for the majority of participants in 16 studies (Dunleavey, 1992; Carrigan, 1994; Crockwell and Burford, 1995; Burgess *et al*, 1998; Dorer *et al*, 1999; Rotheram-Borus *et al*, 1999; Dower *et al*, 2000; Nada-Raja *et al*, 2003; Wiklander *et al*, 2003; Bolger *et al*, 2004; Suominen *et al*, 2004; Horrocks *et al*, 2005; Cerel *et al*, 2006; Hood, 2006; Hume and Platt, 2007). This reflects the fact that most DSH patients presenting to hospitals have self poisoned (Schmidtke, Bille Brahe, De Leo *et al*, 1996; Hawton *et al*, 2003a). Fewer studies (n=10; 32%) included an unspecified mix of self-harm service users (Kreitman and Chowdhury, 1973; Wolk-Wasserman, 1985; Hengeveld *et al*, 1988; Treloar and Pinfold, 1993; Bywaters and Rolfe, 2002; Smith, 2002; National Collaborating Centre for Mental Health, 2004; Brophy, 2006; Palmer *et al*, 2006). Participants who self-cut accounted for the majority of participants in 10% (n=3) of studies (Arnold, 1995; Harris, 2000; Warm *et al*, 2002). Two studies included a small proportion of participants who had not self-harmed (Bolger *et al*, 2004; Hood, 2006). Two studies included participants who experienced constant observation while suicidal on a psychiatric ward (Pitula and Cardell, 1996; Cardell and Pitula, 1999). These studies were included because of the lack of available research concerning experiences of inpatient psychiatric care for DSH service users.

5 FINDINGS

The studies described above address the experiences and perceptions of a range of services utilised by individuals who self-harm. These services span treatment provided by emergency services and in hospital as well as post-hospital management. In presenting the results, we first focus on DSH patient experiences with emergency services involved in transporting them to hospital. (The terms patients, participants, service users, and respondents are used interchangeably in this report.) We then consider studies of patient experiences in the A&E department, including waiting times, the physical environment and physical treatment. Thirdly, we review studies of service users' experiences of psychosocial management in hospital. We then consider findings of studies regarding perceptions of hospital staff. Subsequently we summarise the findings of investigations about experiences of patients at the time of discharge from hospital and regarding aftercare, both in the community and in psychiatric hospitals. Lastly, users' suggestions about how services might be improved are discussed. Participants' perceptions of, and interactions with, staff are discussed throughout in regard to the relevant stage of management. The research findings were subdivided into those for adults and those for adolescents (The terms adolescents, young people, and youth are used interchangeably in this report.)

5.1 Ambulance and emergency call services

There were few studies of service users' views on ambulance and emergency call services. In a UK study, service users reported that ambulance staff explained what they were doing and ensured that the patient agreed with the treatment provided (Palmer *et al*, 2006). Some of these participants described paramedics as 'cheerful', 'kind' and 'patient' (Palmer *et al*, 2006 p.13). One interviewee found the paramedics 'didn't make me feel like I was wasting time or attention seeking, which was important to me' (Palmer *et al*, 2006 p.13). In another UK study, a participant praised staff for being able to 'take the heat out of the situation', while another described a telephone operator as 'extremely helpful… reassuring, calm' (National Collaborating Centre for Mental Health, 2004 p.234).

While some service users described ambulance staff as helpful and swift, several individuals felt the quality of management to be poor (National Collaborating Centre for Mental Health, 2004; Brophy, 2006). Negative experiences were mostly based upon their perceptions of staff and staff behaviour. Several individuals felt that staff approached them with prejudice or talked about them as though they were not there.

> They were great on the surface but I saw one of them pull a face at the other as they put me in the ambulance and this made me feel really bad. (Palmer *et al*, 2006 p.13)

Some service users described hostile reactions (Brophy, 2006). For example, one woman said ambulance staff threatened to call the police after she locked herself in the bathroom, which she perceived as inappropriate (National Collaborating Centre for Mental Health, 2004). Due to the lack of responses reported regarding experiences of emergency services, it is unclear whether or not the majority of service users were satisfied with the care they were given. It is important to note that, when questioned, more than 60% of ambulance staff felt they had limited knowledge about DSH to communicate effectively with DSH patients (Palmer *et al*, 2006).

5.2 Accident and Emergency department

Treatment received in hospital and satisfaction with that treatment varied greatly among study participants. However, many participants from different countries and health systems recounted similar hospital experiences. In this section, we consider findings of studies about arrival at A&E and physical management.

5.2.1 Arrival at Accident and Emergency

> A&E isn't usually a positive experience [for DSH patients]. (Brophy, 2006 p.50)

The A&E department can be distressing for patients regardless of the reason for their attendance. For DSH patients, the experience can be both physically, and psychologically, taxing. Sixty-two per cent of New Zealand respondents said they were happy with the help they received in the A&E department (Nada-Raja *et al*, 2003). However, in UK studies, several respondents described a perceived lack of personal attention in their care (Carrigan, 1994; Arnold, 1995; National Collaborating Centre for Mental Health, 2004; Horrocks *et al*, 2005). Feeling ignored was a theme that echoed throughout the studies.

> [Nurses] don't even speak to you. Just come, have a look at you, do what they've got to do, don't say a word. They seem very cold about it, they don't smile, they don't even make eye contact with you. They just do their job, get on with it, and go. (Bywaters and Rolfe, 2002 p.29)

Some service users in the UK perceived they were being treated differently to other patients in A&E and attributed this perception to the fact that they had harmed themselves (Harris, 2000; Horrocks *et al*, 2005).

> They wouldn't touch me… They looked at me as if to say "I'm not touching you in case you flip on me…" They didn't actually say it, it was their attitude… (Horrocks *et al*, 2005 p.12)

Some respondents who had previously presented to hospital due to a DSH episode felt ostracised by staff who were interpreted as 'act[ing] as if to say "Not you again"' (Brophy, 2006 p.50).

In a Swedish study, many patients held prejudices or negative expectations regarding admission to hospital (Wiklander *et al*, 2003). Many were afraid of hospital staff reactions to their DSH episode, and 72% of patients expressed feelings of shame while in A&E. It is possible that negative interpretations of care at A&E are a result of common characteristics of this patient group, for example low self-esteem, negative attribution biases, rather than a reflection of the quality of the actual care given.

Wait times

Many service users and carers interviewed experienced long wait times once they arrived at A&E departments. This was reported in studies from both the US (Cerel *et al*, 2006) and UK (Arnold, 1995; National Collaborating Centre for Mental Health, 2004). Some service users interpreted this lack of immediate care as a result of staff attitudes towards patients who self-harm.

> People that self-harm […] also get left at A&E departments for hours and hours. You could sit there for eight, nine, ten hours for you to see a doctor, because they don't want to waste their time, basically that's their attitude. (Bywaters and Rolfe, 2002 p.29)

However, more than half of UK service users were treated in less than two hours (Palmer *et al*, 2006). In an Australian study, Dower (2000) found that 75% of service users were attended to within 30 minutes of arrival at A&E, with only 9% waiting an hour or more before being seen.

In a study in Leeds, the majority of UK service users interviewed did not require immediate physical care upon entry to A&E (Horrocks *et al*, 2005). Unfortunately, their psychological state was not factored into the urgency of their care. A long wait time with no access to information about their physical status made some service users feel anxious and frightened.

> [Staff was] just walking past and ignoring you. (Horrocks *et al*, 2005 p.10)

> I felt very lonely and desperate at the time and I needed support. (Cerel *et al*, 2006 p.5)

Positive patient experiences were associated with being updated and 'regular check-ups' while they waited (Palmer *et al*, 2006 p.16). One participant said the 'nurse was very friendly and chatty and explained what would happen next' (Palmer *et al*, 2006 p.16).

Waiting areas

Many service users had negative opinions of A&E waiting areas. Several service users said they were forced to wait in a general waiting area (National Collaborating Centre for Mental Health, 2004; Horrocks *et al*, 2005). Individuals said that waiting, with an often large number of people, increased their inability to soothe themselves after the traumatic experience of a DSH episode and left them feeling exposed and vulnerable (Horrocks *et al*, 2005). Two patients said they became highly distressed when they were required to show and explain their injuries during triage and felt they could be overheard by other patients. Another patient said she tried to move the trolley she was lying on out of a busy area. Staff refused to allow her to do this and, eventually, a security guard was assigned to watch over her.

Although many service users advocated having a separate waiting area, some patients who were placed in a quiet, private area expressed unhappiness. These patients found that separate wait areas made them feel even more alone and isolated, increasing their distress (Horrocks *et al*, 2005). Some patients felt that they were 'shoved out of sight' and left alone (Horrocks *et al*, 2005 p.9). The feeling of being left alone seemed to be a major factor in patients' dislike of private wait rooms. One patient remarked, 'All they have to say is, we're here if you need us, don't think you're on your own…' (Horrocks *et al*, 2005 p.9).

5.2.2 Physical management

Physical treatment of individuals following DSH can take many forms, for example gastrointestinal decontamination, suture, resulting in a variety of service user experiences. The general perceptions of physical management of DSH patients in hospital were mixed. A UK study found the majority of interviewees were satisfied with their overall physical management (Palmer *et al*, 2006). However, some aspects of care were criticised by respondents.

Patient involvement in treatment and treatment administration decisions was one of the most important aspects of hospital care for many participants in a UK study (Horrocks *et al*, 2005). Nearly half (45%) of service users in another UK study said they were given enough information about the nature of their injury or condition (Palmer *et al*, 2006). Service users appreciated when 'they tried to tell me what they could' and 'they explained everything that they were doing' (Horrocks *et al*, 2005 p.13). Service users in a Swedish study felt respected when they were included in the discussion of care (Wiklander *et al*, 2003). Some service users reported being offered a choice of anaesthetic (National Collaborating Centre for Mental Health, 2004). One female said that while receiving stitches 'she [the nurse] asked me first – "I'll [either] talk to you or be quiet" and was concerned when I got upset' (Horrocks *et al*, 2005). Occasions like these contributed to positive recollections of physical management.

> The nurses were really friendly, they were really helpful and understanding, because that were the one thing that I thought they were going to be, "you did it" sort of thing, but they weren't, they were understanding and they explained everything that they were doing. (Horrocks *et al*, 2005 p.13)

Inclusion in treatment decisions was not experienced by all participants. In one study, some patients perceived they were left with no information about blood tests results and felt staff carried out procedures without discussing options with, or providing explanations to, them (Horrocks *et al*, 2005). Some UK service users said that their needs and concerns were not addressed by staff (Harris, 2000; National Collaborating Centre for Mental Health, 2004). Insufficient information about the different treatment options available was reported by 49% of participants in a nationwide UK study of service users (Palmer *et al*, 2006). In the same study, 45% felt they were given insufficient information about the likely effects of the treatment, and 49% felt they were given insufficient updates about treatment. Similar findings from earlier UK studies strengthen these findings (National

Collaborating Centre for Mental Health, 2004; Horrocks *et al*, 2005). In an American study, Cerel and colleagues (2006) found that A&E staff explained treatment to the majority of patients' family and friends, but only to a minority of the actual patients. However, it is unclear if the patients had the physical and mental capacity at the time to be included in treatment decisions.

When patients had been involved in treatment decisions, they responded with mixed feelings. Although service users preferred to be included in treatment decisions, some still did not fully comprehend the information that staff shared with them. Studies in the UK (Horrocks *et al*, 2005) and Sweden (Wiklander *et al*, 2003) found that participants reported concern that they did not fully understand what was being communicated to them.

Some service users said treatment rooms did not provide privacy, either due to the location of treatment, for example in a waiting room, or lack of respect given by medical staff, for example showing patient off to other members of staff (Harris, 2000; National Collaborating Centre for Mental Health, 2004; Horrocks *et al*, 2005; Palmer *et al*, 2006). Often service users said their feelings had not been considered during physical treatment. Several people said that staff were inconsiderate of the possibility of cultural and religious differences and personal preferences during treatment (Palmer *et al*, 2006). For example, the gender of the staff member providing physical care was important to some respondents.

Service users' negative perceptions of interactions with staff dealing with their physical management centred upon perceived inappropriate behaviours and lack of sympathy. Several patients recalled being told that they were not really hurting and requests for pain relief being ignored (National Collaborating Centre for Mental Health, 2004). Perceived threats and humiliation were common reasons for negative experiences of management (National Collaborating Centre for Mental Health, 2004). Some service users reported that staff had threatened to withhold anaesthesia, or even treatment, if patients returned with a repeated episode of DSH. Patients recalled being treated without anaesthetic (Arnold, 1995; National Collaborating Centre for Mental Health, 2004). One patient described being teased by the emergency doctor with an anaesthetic syringe (National Collaborating Centre for Mental Health, 2004).

Some service users said they thought staff intended to shame them. Upon counting her scars, a nurse said, 'Well, what's the point of stitching you up?' (Bywaters and Rolfe, 2002 p.29). Some patients recalled being told they overdosed incorrectly (Harris, 2000).

> In a way [the doctor] put me down for the tablets I took, "they don't do as much damage as paracetamol", I thought "I'll try better next time then", I just felt, again, stupid. (Horrocks *et al*, 2005 p.10)
>
> The last time I had a blood transfusion the consultant said that I was wasting blood that was meant for patients after they'd had operations or accident victims. He asked whether I was proud of what I'd done… (Brophy, 2006 p.50)

Patients reacted with positive comments when they felt staff did consider their situation during physical treatment. One patient was impressed by the staff member who sutured his wound.

> He took great pains to suture very neatly – when I commented on this he said 'I don't want it to leave any scars' to which I replied that I am covered in them. He said 'not on my watch'. (Palmer *et al*, 2006 p.18)

Staff's refusal to offer certain treatments was another factor that added to a few patients' negative perceptions of management. Some patients said they were refused access to local psychiatric services (National Collaborating Centre for Mental Health, 2004). Several patients said they were refused physical treatment (Horrocks *et al*, 2005; Palmer *et al*, 2006).

5.2.3 Psychosocial management in hospital

Official guidelines indicate that psychosocial assessments are a suggested requirement of care for patients presenting at hospital after a DSH episode (Royal College of Psychiatrists, 1994; National Collaborating Centre for Mental Health, 2004). However, not all patients receive these assessments (Kapur *et al*, 1998; Hickey, Hawton, Fagg *et al*, 2001; Bennewith *et al*, 2004). Individuals who are not assessed may be more likely to repeat self-harm (Kapur, House, Dodgson *et al*, 2002). Hickey and colleagues (2001), found that patients leaving hospital without a psychiatric assessment were more likely to have a previous history of DSH and display non-cooperative behaviours. Patients are less likely to receive an assessment when presenting between 5pm and 9am. Since this is the peak time for presentations, this has implications for the availability of out-of-hours services (Bergen and Hawton, 2007).

Patients who receive a psychosocial assessment may encounter a wide range of experiences with regard to the professionals they come across, the assessment itself and its administration, and the environment. Service users' experiences of psychosocial management after a DSH episode varied across studies. Many patients welcomed the chance to discuss their problems and the issues that led up to their DSH episode. However, service users' expectations of the assessment and the way in which they interpreted staff management of their psychosocial assessment had a large impact on their satisfaction.

In a UK study, the majority of participants (10/12) felt that their assessor understood their difficulties, and how they were feeling, and that their assessment was helpful (Whitehead, 2002). Participants were found to display significantly decreased levels of hopelessness and a near significant increase in self-esteem after the assessment when compared to pre-assessment scores. Respondents with positive experiences said their assessment gave them 'every opportunity to speak and talk about problems' (Palmer *et al*, 2006 p.21). For some, the assessment provided hope for recovery.

> [I]t left me feeling more positive about the future and what I am going to do. (Whitehead, 2002 p.47)

The majority of adolescents consulted in hospital by a member of a Child and Adolescent Psychiatric team found the experience to be positive (Dorer *et al*, 1999). The opportunity of 'talking through problems in detail with another person' was an important aspect (Dorer *et al*, 1999 p.415).

When staff involved patients in treatment decisions and explained the reasons for, and goals of, the assessment to patients, most found the experience positive.

> The nurse consultant who assessed me was very easy to talk to. She explained everything clearly in a non-threatening way. I felt like a friendly chat. She was great! (Palmer *et al*, 2006 p.21)

When staff clearly explained the goals of the assessment, it helped some patients understand that the assessment was meant to assess their level of risk. These patients acknowledged the limitations of the assessment.

> I realise it was general procedure. I could work out that it were just to work out if I were safe to go home... She's not going to be able to do a quick fix thing, she were really good. (Horrocks *et al*, 2005 p.15)

Fifty-eight per cent of service users in a UK study said they had received the care that they wanted (Whitehead, 2002).

Similar to patients' reactions to physical care, some respondents said there was a lack of information shared with them and a lack of opportunity for involvement in treatment decisions. In a UK study, patients who reported being disappointed with their psychosocial management found fault primarily with their lack of involvement in decisions (Horrocks *et al*, 2005). In a Finnish study, some patients were not given prior notice of the psychiatric assessment and 21% of patients were given no information explaining the reasons for, and goals of, the assessment (Suominen *et al*, 2004).

> [It was a] bit scary, I didn't know what was going on. I thought I was being tricked. (Whitehead, 2002 p.47)

Sixty per cent of patients found the information provided to them regarding the assessment adequate. Some participants also felt that their diagnosis was inadequately explained to them.

> It might have been better to have someone who could have sat down and talked me though the depression from start to finish… Someone to give you an explanation of depression so that you don't feel you've gone out of control and you life isn't going to be the same again. (Horrocks *et al*, 2005 p.10)

Staff sensitivity to cultural differences, and religious and personal preferences, was also important during psychosocial management. For example, one service user said her family was contacted by a psychiatrist without her consent. Another young female said she was denied the opportunity to have her mother attend her psychiatric assessment. The gender of the psychiatrist was an issue for at least one female service user at a Canadian hospital who remembered:

> Just two males and that made me feel uncomfortable because I would have preferred to have a female around… I think you should have the option to have someone stay even though they were psychiatrists. (Crockwell and Burford, 1995 p.8)

Respondents' reactions to the timing of the assessment were related to perceptions of their physical and mental health. The timing of the assessment was perceived as appropriate by 42% of patients in a Finnish study (Suominen *et al*, 2004). In a British study, some interviewees said that they could not respond fully to the assessment because they were not physically ready (Horrocks *et al*, 2005). In a Dutch study, 48% of patients could remember little or nothing about their psychiatric consultation (Hengeveld *et al*, 1988).

Interviewees were also concerned with the time given to them during the assessment. Some patients criticised the assessment because 'they'd just ask three or four points, I might give them the wrong reason because the time is not long' (Horrocks *et al*, 2005 p.15). The questions themselves were sometimes seen as superficial.

> I got the impression that [the psychiatrist] wanted to get it over and done with as quickly as he could and get on with whatever it is he had to do next. There was nothing personal about it. (Horrocks *et al*, 2005 p.16)

Some service users said that the assessment did not give them enough time to adequately discuss their feelings (Hengeveld *et al*, 1988; Horrocks *et al*, 2005).

> She, she were very nice but you could tell you were allocated your hour, just over your hour whatever, because right at the end when she's gone into depth, everything gets rushed, because you've got to answer all the questions on the thing and some of them seem so pointless really, but I suppose they always like to have the fuller picture don't they. (Horrocks *et al*, 2005 p.16)

One respondent said an assessor 'was asking exactly the same questions I'd already been asked', leaving the patient to feel 'I was repeating myself… I weren't in the mood for answering questions and I'd already answered them anyway' (Horrocks *et al*, 2005 p.15). Twenty-four per cent of service users in a Dutch study felt that their consultant did not understand them (Hengeveld *et al*, 1988). Some service users felt the assessor did not try to put their feelings in context or identify underlying factors (Horrocks *et al*, 2005).

> O.K. The first interview was just "so tell us what happened" and he wrote it up and said "um hm, um hm" and wrote notes and he didn't look at me but he was nodding and looking at the other guy. And they looked at each other and exchanged nods. It was very factual like "So what did you take?" and "What happened at the house?" Um, you know I felt like saying "I can understand English, doctor". It was just very factual. They filled out their little form and that was it. (Crockwell and Burford, 1995 p.8)

Some service users felt pressure to agree to what their psychiatrist requested of them. One Canadian respondent said:

> I feel like if you ever go to the hospital, you're forced to have to tell people even though you might be seeing other people. You still have to tell these strangers you don't know… I find doctors really expect that because you're there and they're working there and they're professionals that you have, they have the right to ask you anything and you're a difficult patient if you don't, and you're looked at like oo, oo, as trouble if you don't. And people that come in usually have the biggest problems, they have been abused or violated already. They don't want to talk to a stranger. To me it's like being violated again. (Crockwell and Burford, 1995 p.9)

Several service users who were interviewed said they did not want to talk about their DSH episode during the assessment and some explained that they said what they thought their assessor wanted to hear.

> I just didn't want to talk and I just felt like I was being pushed into it sometimes… Some stuff I didn't actually mention, you know, that I feel as if I couldn't talk about, maybe I should've because if you don't then they're still there. (Horrocks *et al*, 2005 p.19)

Perceived lack of staff experience was a problem mentioned by many respondents. Service users felt their management was compromised by staff members who they believed were unsure of or unable to provide care.

> [The psychiatrist] didn't really say owt, he just said he'd have to go back and discuss it with his boss and that was the last I heard from him. (Horrocks *et al*, 2005 p.18)

Although in the UK it is common, if not compulsory, for junior psychiatrists to discuss assessments and treatment suggestions with a senior psychiatrist, stories similar to this were relayed by many service users, with most of them never being contacted by psychiatric staff again.

5.3 General perceptions of hospital staff

Interactions with staff made a large impact on the way service users felt about their experience in hospital, as evidenced by the prominence of this theme within and across studies. The characteristics of staff most commented on were associated with issues of sympathy, knowledge about DSH and communication.

5.3.1 Sympathy

In the majority of studies included in this review, service users emphasised, both directly and indirectly, the importance of sympathy during hospital management. (The term 'sympathy' is taken from patient accounts rather than professional or academic accounts. The latter might more often use the term 'empathy'.)

In two UK studies, service users rated staff as generally sympathetic (Treloar and Pinfold, 1993; Hume and Platt, 2007). In another study, staff were viewed as sympathetic by service users when they were perceived as wanting to help and being sensitive to potential discomfort (Horrocks *et al*, 2005). Many patients in this study were more satisfied with staff when they observed:

> They treat you like they would anybody really. Most of the nurses were really nice… Talking to me as if I was a normal person, not somebody who'd just tried to kill myself, like a lot of them talk to you as if you're stupid. (Horrocks *et al*, 2005 p.13)

In an Australian study, Dower (2000) found that most service users rated nurses and social workers as showing the most sympathy and providing the most help.

> There's a nice nurse at the A&E, and she's usually the triage nurse. And if I'm lucky enough to get her when I go, then she's understanding, and she says, "How are you? Obviously you're not so well…" And she's seen me since I first did it, to now, and she says "Well, obviously you're doing a lot better. Stick with it, you're a lot better than what you was", but she's one of the only nice ones there. (Bywaters and Rolfe, 2002 p.27)

In a UK study, respondents appreciated it when staff were friendly and remembered when a staff member 'came across more like a friend' (Horrocks *et al*, 2005 p.17). They were also more satisfied with their treatment when they felt that they 'could stop any time [they] wanted' during a psychological assessment or were offered a choice of anaesthetic (National Collaborating Centre for Mental Health, 2004; Horrocks *et al*, 2005 p.17). In a Canadian study, service users responded positively when staff appeared to respect them and when they provided 'just a validation of your feelings' (Crockwell and Burford, 1995 p.9).

Although patients described situations in which they felt staff were sympathetic, and sensitive to their situation, some patients did not believe staff were sympathetic enough. In an Australian study, the majority of staff were found to be unsympathetic and non-supportive by service users (Dower *et al*, 2000). In two studies in the UK, A&E and psychiatric staff were described as blunt and unsympathetic (Harris, 2000; National Collaborating Centre for Mental Health, 2004).

In a study from Northern Ireland, several interviewees explained that nurses did try to understand what they were going through, but they felt they wanted understanding on a deeper level (Carrigan, 1994). In another UK study, nurses were perceived as unavailable to talk (Hume and Platt, 2007). Several service users indicated that, although some staff did make themselves available to talk, they did not try to get patients to discuss what caused them to self-harm, or attempt to help them deal with the problems that contributed to the act.

Service users in studies from Ireland (Bolger *et al*, 2004), Sweden (Wiklander *et al*, 2003), and the UK (Harris, 2000; National Collaborating Centre for Mental Health, 2004) often said staff ignored how they felt and belittled them, which was attributed to the fact that their injury was self-inflicted. Several participants in one study described feeling like ‘naughty children’ (Smith, 2002 p.598). One service user compared the experience to ‘…being on a production line, you weren’t a patient you were a number’ (Horrocks *et al*, 2005 p.11). Some service users said they felt staff impatience or annoyance without being able to pinpoint a specific event.

> As soon as he walked in [nurse entering the cubicle] he was like, as if he was pissed off that it were somebody that had done it to themselves… It was his attitude. (Horrocks *et al*, 2005 p.12)

Many service users interviewed said A&E staff were unconcerned with their mental health and concentrated entirely on their physical problems.

> On the occasions I have been admitted to an A&E department they have concentrated on medically patching me up and getting me out. Never have I been asked any questions regarding whether this is the first time I have self-harmed or if I was to do it again or how I intend to deal with it. (Brophy, 2006 p.50)

However, at least one service user was happier to simply have just his physical problems addressed in hospital and not have to worry about staff trying to tend to his psychological issues.

> When I go to A&E I just want appropriate medical care. Sometimes I want to see the duty psychiatrist but this shouldn’t be inflicted on me [as often as it has been]. I feel that hospital staff are just covering their backs rather than actually being concerned about me when they make the referral straight away. (Brophy, 2006 p.50)

5.3.2 Knowledge about DSH

Several service users felt that hospital staff did not have sufficient knowledge about DSH, or training in how to deal with patients who had self-harmed (Arnold, 1995). Although some service users in studies from the UK (Carrigan, 1994; National Collaborating Centre for Mental Health, 2004) and Sweden (Wolk-Wasserman, 1985 p.568) thought staff were ‘awfully competent’ and ‘well trained’, they also felt staff lacked knowledge about DSH, which participants perceived as a factor which contributed to their negative attitudes towards DSH patients. When patients felt staff did not know about or understand self-harm they were perceived as operating on misconceptions about why people self-harm (Carrigan, 1994; National Collaborating Centre for Mental Health, 2004). For example, one patient in a UK study felt like she was ‘being sent to prison’. She interpreted staff’s behaviour as meaning ‘instead of helping her, let’s punish her so she’ll stop doing it’ (Bywaters and Rolfe, 2002 p.30).

5.3.3 Communication

The reports of communication between service users and medical staff were mixed. Some patients reported positively about their communication with staff. However, patients often felt a lack of rapport between themselves and staff members (Arnold, 1995; Horrocks *et al*, 2005). Many patients said that hospital staff did not listen to them or include them in discussions about their physical and psychosocial management (Carrigan, 1994; National Collaborating Centre for Mental Health, 2004; Horrocks *et al*, 2005). Inadequate sharing of information by medical staff with patients was perceived as an important problem in studies from the UK (Carrigan, 1994) and the US (Cerel *et al*, 2006).

Many service users described a lack of opportunity to ask questions, or that their requests for information were ignored (Horrocks *et al*, 2005). In a Canadian study, some service users explained that the lack of opportunity to become involved in discussions about their care made them feel disrespected (Crockwell and Burford, 1995). Other reactions were anger, withdrawal and cynicism. Several respondents in a study from Sweden described their readiness to leave hospital if they felt disrespected, although the majority did not leave (Wiklander *et al*, 2003). Many said they hoped that staff would have an open discussion of treatment with them.

Several patients said that staff talked about them as though they were not in the room (National Collaborating Centre for Mental Health, 2004). Service users also disliked having to tell their story to several different staff members (Dorer *et al*, 1999). Some service users noted that when they came in contact with someone new, they were asked questions they had previously answered (National Collaborating Centre for Mental Health, 2004). Sometimes, having to repeat their story and answer questions made respondents feel worse.

5.3.4 Interactions with family and friends

Often DSH patients are accompanied to A&E by a friend, partner or relative (Palmer *et al*, 2006). Although few studies included individuals from patients' social networks as participants, in one American study that did almost 75% of friends and family reported feeling staff treated them with respect and provided them with information regarding their friend or relative (Cerel *et al*, 2006).

> It was very helpful that they gave me truthful and accurate information about his physical condition – it gave me confidence in their treatment and allowed me to make realistic decisions. (Cerel *et al*, 2006 p.5)

However, many carers also relayed anecdotes of negative experiences in A&E. Their experiences were very similar to those of patients. Friends and relatives in an American study described inappropriate staff behaviour and felt they were not being taken seriously (Cerel *et al*, 2006).

> Nurses scolded [my mother] in front of students and other patients – telling her she will end up in hell and asking how she could do that to her family. (Cerel *et al*, 2006 p.5)

5.4 Discharge from hospital

Many service users did not feel ready to leave hospital upon their discharge. A lot felt their problems had not been adequately addressed and were frightened of being on their own. ‘I didn’t really want to leave in case it happened again… I wanted to get to the root of the problem’ (Horrocks *et al*, 2005 p.20). Another patient recalled being ‘sent home still feeling very alone and unsafe’ (Palmer *et al*, 2006 p.20). Some patients who had taken overdoses still felt disoriented, dizzy or sick when discharged. Some interviewees were unhappy that staff did not ask how they were getting home – especially patients discharged after an overdose. ‘You’re out the next morning walking to the bus stop thinking what the hell’s gone on’ (Horrocks *et al*, 2005 p.20). Many patients were unsure of what to expect once they returned home.

> [When I got home] I just kept feeling sick and tired. But I thought if I go to sleep I might not wake up. So that were really hard… See, I’d have preferred it if hospital had’ve said, “all right, your body’s level, it’s all going normal, but stay for the night because at least then we can keep an eye on you.” Because I’d have felt more safe then. (Horrocks *et al*, 2005 p.10)

Some carers were also left with little or no information on what they should do once they got the patient home. One American parent remembered:

> No one in the ER [emergency room] explained what was going to happen, what we should expect, what to do and not to do in relation to the admission of a child to a psychiatric unit. (Cerel *et al*, 2006 p.6)

A few service users said that errors during their discharge made for negative experiences. A patient was mistakenly discharged because he shared the same name as another patient (Horrocks *et al*, 2005). Walking home he recalled, ‘I felt down, depressed and wanting to do it again, thinking nobody’s going to help me… I could have done anything that night, it were unbelievable’ (Horrocks *et al*, 2005 p.20). In the same study, another patient said she was almost discharged without a referral because a nurse incorrectly read her chart.

Some service users said they self-discharged after negative experiences in hospital. Palmer and colleagues (2006) reported that four per cent of patients self-discharged against medical advice prior to physical treatment and five per cent prior to psychosocial assessment. One service user from Canada, who left before physical treatment, reported a negative encounter with a receptionist.

> I think it was the way he said it and his attitude towards me, not what he said but how he said it… As if he weren’t bothered. (Horrocks *et al*, 2005 p.12)

Participants described inappropriate behaviours by staff during discharge. One Irish adolescent said he was told he was lucky and sent home without a follow-up referral (Bolger *et al*, 2004). When being discharged another patient asked what she should do about pain and was told, ‘Well you’d better not take any tablets had you’ (Horrocks *et al*, 2005).

5.5 Referral for aftercare

Post-hospitalisation management was an area in which interviewees had a variety of experiences. Many patients never receive follow-up care following self-harm (National Collaborating Centre for Mental Health, 2004). In one study information was collected on emergency admissions for self-harm in 30 locations (Palmer *et al*, 2006). Thirty-four per cent of patients were discharged and referred to community mental health teams or their general practitioner. Eleven per cent of patients were discharged with no follow-up, 27% were admitted to medical wards, and seven per cent were admitted to psychiatric wards.

Participants were often provided with contact numbers to helping organisations in place of, or in addition to, a referral (National Collaborating Centre for Mental Health, 2004). Although the majority of participants made use of these numbers, some explained they felt uncomfortable initiating their own aftercare by dialling these organisations (Hume and Platt, 2007).

> If you're really down the chances of you picking up the phone are really slim. They say it is free to go but how can a patient suffering with mental health problems go and knock on a door… You have to invite me, or there has to be a link. (Horrocks *et al*, 2005 p.23)

Many service users interviewed said they were told they would be contacted to schedule aftercare (National Collaborating Centre for Mental Health, 2004). However, they often heard nothing further:

> They said they'd get me to see a psychiatrist but I haven't heard nothing from them at all you know, so it's like I've had to cope by myself and I ain't seen no psychiatrist or nothing, no counsellor… I'm still waiting to this day to hear from them, I know I should get on the phone to them but it's not my job really it's their job as well… I do feel let down in a big way, because it feels like all the information now that I've given, that they've just put it to one side and left it. (Horrocks *et al*, 2005)

Some of those that did receive referrals faced a long wait for psychotherapy (National Collaborating Centre for Mental Health, 2004; Hume and Platt, 2007). Half of service users in a Scottish study disliked the lag time between discharge and their appointments (Hume and Platt, 2007). Long waits for appointments may leave patients discouraged and decrease their compliance.

> I had to wait 12 weeks. A lot can happen in 12 weeks. When the appointment came I was, like, I didn't really see the point. (Hume and Platt, 2007 p.5)

Some individuals interviewed were concerned over how A&E staff determine who needs aftercare (National Collaborating Centre for Mental Health, 2004). Overall, the feelings of many DSH patients are best conveyed by one participant who remarked, 'I was going back to where I started, I felt confused, I thought "what were the point of coming to hospital"' (Horrocks *et al*, 2005 p.20).

5.5.1 Adolescents

All adolescents (n=25) participating in a UK study were offered some form of aftercare (Bolger *et al*, 2004). Several adolescents who presented at hospital in New Zealand after a DSH episode said they experienced a sense of relief upon being provided with aftercare at a community mental health service (Hood, 2006). 'Like as long as it was going to help that's all I really cared about' (Hood, 2006 p. 80). However, some adolescents perceived their parent's discomfort with their contact with psychiatric services.

> I thought they could just kind of help me deal with it or something. I was pretty hopeful about it. I was kind of anxious about it I guess 'cause my mum… She's not really comfortable with psychologists and things, she was like, "Oh no, they'll mess up your head…" Just kind of nervous, anxious, a bit hopeful as well I suppose. (Hood, 2006 p.81)
>
> I think my dad had a bit of a problem with it. He was sort of it's our own family we can sort it out ourselves sort of thing. (Hood, 2006 p.83)

5.5.2 Parents

Some parents in a New Zealand study were uncomfortable with their adolescent's referral to aftercare because it increased their feelings of failure and fear and they were worried about the stigma attached to it. One parent confirmed 'there was some shame' because they could not help their child (Hood, 2006 p.82). For some parents, their own experience with mental health services made them wary. Fathers were found to worry more than mothers about stigmatisation (Hood, 2006)

5.6 Feelings about returning to hospital

Few studies addressed participants' feelings about returning to hospital if they experienced another DSH episode. Although DSH is a strong predictor of further self-harm episodes, it is unclear how the quality of care received in A&E affects future behaviour. However, evidence has shown that while negative experiences can stop some individuals from attending A&E, self-harming behaviour does not decrease. In a study of Irish adolescent patients, a minority (19%) reported they would return to A&E if they harmed themselves again (Bolger *et al*, 2004). Adult service users were less likely to report that they would return to A&E after negative experiences. One patient, who cut herself, reported not calling an ambulance after several bad experiences and said she had begun caring for her own wounds (National Collaborating Centre for Mental Health, 2004). Poor accounts from others were enough to keep one UK respondent away from hospital.

5.7 Post-hospitalisation management

Aftercare for DSH patients can include treatment by a wide range of professionals: psychologists, psychiatrists, social workers, nurses, community services, general practitioners. As previously discussed, many service users said they were put on a waiting list for treatment and some were never given an appointment (National Collaborating Centre for Mental Health, 2004). For those who were provided with referral appointments, some were positive about their experiences of aftercare. Dower (2000) found that 67% of Australian respondents were satisfied with care six weeks after their first aftercare appointment. However, some service users never attend their referral appointment and those with negative experiences may have already left treatment earlier.

5.7.1 Positive experiences of management

The majority of patients indicated a willingness to engage in services to help them minimise their self-harm (Hume and Platt, 2007). In a Canadian study, some patients welcomed aftercare referrals because they felt they received no support while in hospital (Crockwell and Burford, 1995).

> Yea, I thought that was good because I didn’t like the way it was left. I wouldn’t like to think that other people are just left hanging. They just sent me off, “are you fine?” “Yes, I’m fine, O.K.” and they let me go. I wouldn’t have wanted to be admitted because it wouldn’t have made things better but you’re kind of… left hanging… He was absolutely no good to me se… um… the only good thing I got out of that was the social worker so I wouldn’t say I minded that my name had been given to somebody because usually if you end up in the hospital like that you’re at the end of your rope so I’d think you’d be kind of grateful to get something back. (Crockwell and Burford, 1995 p.9)

Some service users were satisfied with post-hospitalisation management because they were given the opportunity to talk about the issues that contributed to their self-harm episode (Crockwell and Burford, 1995).

> It has been very, very useful, because there are lots of things that I never really talked about that happened in my past that I’d never been able to fact before, and we’re actually in the process of starting to work through those things, which I never thought I’d be able to do. (Bywaters and Rolfe, 2002 p.30)

For adolescents in a New Zealand study, the opportunity to talk was the most important aspect of their aftercare experience (Hood, 2006). Both adolescents and their parents appreciated ‘talking to someone on the outside’ with whom the family had ‘no emotional attachment’ (Hood, 2006 p.84).

While there is a lack of studies concerning service users’ attitudes towards specific treatments, one study (Perseius *et al*, 2003) examined DSH patients’ satisfaction with psychological therapy, specifically dialectical behaviour therapy (DBT). Dialectical behaviour therapy is a treatment combining behavioural, cognitive and supportive therapies, which includes weekly individual and group sessions (Linehan, Armstrong, Suarez *et al*, 1991; Linehan, 1993). Participants reported positive experiences of DBT. Many said that DBT gave them the opportunity to take responsibility for their behaviour and be involved in their treatment.

> I have got a responsibility, it’s me that has to change things with support from my therapist. (Perseius *et al*, 2003 p.222)

This was contrasted with their perceptions of their psychiatric care before DBT.

> They have always taken over the decision-making and responsibility, all of them, they never asked what I thought or wanted. (Perseius *et al*, 2003 p.223)

Group therapy was another aspect of DBT that participants had positive experiences of.

> I felt very lonely in my suffering, but in the group I felt, my god, here’s a bunch of people that all struggle like I do, just to survive another day. (Perseius *et al*, 2003)

Satisfaction was also connected to perceptions of staff behaviour towards patients. Service users were more satisfied with their treatment when they felt that the professional was genuinely concerned about them, respected them and did not try to belittle them (Bywaters and Rolfe, 2002).

5.7.2 Reasons for not attending treatment

Respondents gave various reasons for failing to start, or continue, treatment. In an Australian study, some patients found hospital referral instructions too difficult (Dower *et al*, 2000). Some did not believe aftercare would be helpful and some did not think they needed help.

> It’s pointless, there’s nothing they can do, you can’t stop a self-harmer. (Hume and Platt, 2007 p.4)

For others, the stigma associated with an appointment with a psychologist or psychiatrist was too much to bear and caused individuals to miss their appointments.

> I hated it. Couldn’t stand the psychiatrist... Just thought “I must be crazy” that’s all that came into my head. That’s what I thought “if you see one of them, you’re crazy”. (Crockwell and Burford, 1995 p.10)

Other service users did not attend appointments because they were afraid it would involve them telling and retelling their story. One participant described the difficulty in asking for help:

> Because of the fact that you’ve got to start all over again, explaining, because it’s not like you’re just explaining. You’re going through everything again – just as much pain, just as much heartache, you’re going through it all again, because you’re having to drag everything back up. (Bywaters and Rolfe, 2002 p.31)

One UK study found that individuals unwilling to use aftercare services were more likely to have a history of repeated DSH or to feel that they were ‘beyond help’ (Hume and Platt, 2007 p.4).

5.7.3 Reasons for the early termination of aftercare

Although service users who completed post-hospital treatment said that the ability to talk to someone about their problems was a valuable aspect of care, many service users in studies from the UK (Bywaters and Rolfe, 2002) and Australia (Dower *et al*, 2000) found opening up difficult and anxiety provoking. Some service users found it difficult to open up to someone they did not know (Bywaters and Rolfe, 2002). Others were frightened that telling someone their problems would intensify their distress or bring back memories they were trying to repress.

> Because they want to know about my past, and the more I talk about it, the more the flashbacks come back, and the more I cut into my arms. It felt like the counselling was making the self-harm worse, because they want to know every niggly detail to get a full picture. I don't want to go through that again. I've been through it once. I don't need to go through it twice. (Bywaters and Rolfe, 2002 p.31)

Some adolescent service users thought talking did not make a difference to the way they felt.

> I've talked and stuff and I still don't really feel a hell of a lot better… 'Cause you know sometimes even just talking about it doesn't really help, sometimes just a hug or something would be cool, more helpful than sitting here talking about it… The talking and things didn't really help me too much. I don't feel that it changes anything… It just seems to scare a person, that's about it. (Hood, 2006 p.85)

Some of the reasons for the early termination of follow-up care, reported by service users in an Australian study, were that they felt they had got as much out of treatment as possible, or felt uncomfortable with the professional providing care or the location of the care, or the care they received was deemed unhelpful (Dower *et al*, 2000). Some participants in a study from Northern Ireland found the quality of professional assistance and support following discharge to be poor (Carrigan, 1994).

5.7.4 Perceptions of staff

Respondents' perceptions of staff were important to their compliance with care. Crockwell and Burford (1995) found Canadian service users they interviewed placed a lot of responsibility upon professionals and expected their clinician to 'fix them'. Therefore, the relationship between client and clinician was an important measure of the quality of care.

Many service users in studies from the UK (Bywaters and Rolfe, 2002), and New Zealand (Hood, 2006), welcomed the opportunity to discuss problems associated with their self-harm with a mental health professional. Respondents commented on the usefulness of having someone to talk to (Bywaters and Rolfe, 2002).

> She's understanding. She listens to you. She'll ask your point of view. She'll not just shove you out of the room. (Bywaters and Rolfe, 2002 p.27)

> I was very lucky with my first psychiatrist. She was lovely… She was absolutely wonderful… She was so caring. She really did seem to give a shit, and she didn't label me. She just talked to me, and tried to help me through it. (Bywaters and Rolfe, 2002 p.27)

Although many service users said aftercare had helped them, some patients had negative reactions to their therapists. In an international study, the majority of service users were dissatisfied with their psychiatrists' response to their DSH (Warm *et al*, 2002). Service users provided a variety of reasons for their negative experiences with therapists. Several respondents in an American study said that their psychiatrist did not help them. One participant described a psychiatrist as 'cold, clinical, [and] impersonal' (Arnold, 1995 p.18). Some respondents in a Canadian study said that they felt they were not given a sufficient amount of time for their appointments:

> I can't believe I forgot his name but he… um… called me into the office. People were just bing, bing, bing, in and out of his office. I've gone to [psychiatrist's name] and [psychiatrist's name] and I complain because I have to wait so long but they give their patients time to talk and that's why you have to wait because not everybody takes the same amount of time. But he was like ping, ping, ping. So anyway, I went into the office and… He might have said two words to me the whole time. He took notes. (Crockwell and Burford, 1995 p.8)

> [W]hen I left he gave me a prescription for anti-depressants so we hadn't talked, he didn't once say it's O.K. or give me any bit of feedback. He just wrote me out a prescription. I'd say I was only in there about 15 minutes, 20 at the most, and he wrote me out a prescription for anti-depressants and sent me on my way. (Crockwell and Burford, 1995 p.9)

5.7.5 Management on the psychiatric ward

Some patients presenting to hospital are admitted to a psychiatric ward after discharge for further treatment. Individuals admitted to psychiatric wards had mixed reactions to their care. The majority of interviewees in a Swedish study were satisfied with their overall physical management on the ward (Wolk-Wasserman, 1985). However, admission to a psychiatric ward was often described as frightening and could result in heightening the service users' sense of a loss of control (Hume and Platt, 2007). One 34-year-old male said:

> I speak positively about it now, but back at the time it was terrible. Locked wards, psychopaths, they used straightjackets and straps. (Hume and Platt, 2007 p.6)

Several patients in the UK, who were admitted to a psychiatric ward, felt they were merely being watched and did not receive any sort of therapy for their self-harm (Bywaters and Rolfe, 2002). Some perceived that hospitalisation was a punishment. Several respondents said staff confiscated any object that could be used to self-harm, which increased patients' feelings of a lack of control and contributed to the desire to self-harm again (Smith, 2002; Brophy, 2006). Patients also explained that, while on a psychiatric ward, they sometimes felt the need to act in exaggerated ways, and even self-harm, in order to get the attention of staff (Bywaters and Rolfe, 2002).

Respondents believed ward management could be improved. In one study, patients said they wanted staff to give them more responsibility for themselves and their management (Bywaters and Rolfe, 2002). The importance of staff tact and respect for patients was also highlighted. Recognising patient individuality was another aspect of care that patients deemed important to service improvement. It was also hoped staff would be sensitive to DSH patients' situations and lessen their demands on patients, for example bathing, dressing.

Adolescents

Almost half of adolescent patients admitted to hospital or inpatient psychiatric wards in the UK rated their stay as positive (Dorer *et al*, 1999). However, almost one third of adolescents rated their stay as negative or very negative. These patients found their stay to be unpleasant and boring and some had negative experiences of the noise in the hospital. Several patients described their fear while on a ward. Some female patients communicated a fear of being on a mixed ward while some older adolescent patients had negative experiences of being placed on adult wards (Bywaters and Rolfe, 2002). Older adolescents described being afraid of other patients and wished to be on an adolescent ward.

> If you get sectioned, for example, they have a ward which goes up to 16, and then you're on an adults ward, and that is a problem. At 16, 17, 18, 19, 20, you're not an adult. You know, we like to think we are, but we're not. It's the most scary thing… There should be some sort of in-between ward, like for 17 to 20 year olds, because there is such a big difference between a 17-year-old, and a 40-year-old man, for example. (Bywaters and Rolfe, 2002 p.33)

In a UK study, two sixteen year-old patients said they felt uneasy and had a difficult time being the eldest in the adolescent ward (Dorer *et al*, 1999).

Constant observation

There were only two studies regarding patients' experiences of being placed on constant observation during their stay on a psychiatric ward, both from the USA (Pitula and Cardell, 1996; Cardell and Pitula, 1999). Patients reported mixed feelings about the experience of being under constant observation. Many respondents acknowledged that observers were there for the patients' protection. These patients felt they were in a highly vulnerable state. Several participants admitted to watching their observer's movements carefully in order to find an opportunity to engage in DSH but, due to the nature of constant observation, they never found a chance (Cardell and Pitula, 1999). However, the invasiveness of the action was too much for most to handle, especially for long periods of time.

Patients were mostly satisfied with their care when they perceived staff members as having a positive attitude, and being friendly and willing to help. Some patients explained that staff optimism stimulated problem-solving and helped maintain a positive attitude and self-concept. Some participants who had been on constant observation reported a decrease in their dysphoria as a result of an observer appearing to acknowledge them as a human being, while others reported feeling less lonely and anxious (Pitula and Cardell, 1996; Cardell and Pitula, 1999). Having someone constantly with them who engaged them in activities served as a distraction from suicidal thoughts for some patients (Cardell and Pitula, 1999). Many patients reported improvement in sleep.

Several patients believed some observers to be non-empathetic or aloof (Cardell and Pitula, 1999). These patients reported no response to initiation of a conversation and perceived hostile facial expressions from observers. Respondents also said these interactions increased anxiety and feelings of anger. Participants generally rated lay observers more positively than mental health staff because they felt lay workers did not invade privacy, were more likely to engage patients in conversation or activity and their shifts tended to last longer (Pitula and Cardell, 1996). A few patients reported hourly shift changes and did not perceive the intervention as beneficial. Some participants had little or no experience of constant observation or knowledge of its goals (Cardell and Pitula, 1999). In some situations, they were not provided with substantial information about the intervention.

Lack of privacy was the single most important issue respondents had with constant observation (Cardell and Pitula, 1999). Many patients reported that this caused them to feel uncomfortable and embarrassed – particularly during bathroom use. Some patients also reported feeling confined and claustrophobic. Patients in one study said that constant observation became almost intolerable after 30 – 36 hours (Pitula and Cardell, 1996).

5.7.6 Management of adolescents

A chance to talk

In a study of adolescents offered aftercare, the majority of service users were satisfied with the treatment they had received after their index DSH episode (Burgess *et al*, 1998). Most adolescents felt they were taken seriously by service staff and that their treatment was useful. In studies of adolescents conducted in the UK (Burgess *et al*, 1998), Ireland (Bolger *et al*, 2004) and New Zealand (Hood, 2006), the opportunity to talk was an important aspect contributing to their positive experience of aftercare. However, not all participants welcomed the opportunity.

The relationship between adolescent and therapist is an integral part of the adolescent's experience of management. Several participants in a New Zealand study described situations in which they felt that their therapist did not understand them. These feelings hindered the resolution of the adolescent's problems.

> I mean there's lots I'd like to have happen in terms of like client and counsellor relationship… I really still don't feel she quite understands

> me… I just feel like a lot of times what I say isn’t, it feels like it’s not valid. (Hood, 2006 p.90)

Another respondent described being angry ‘when my psychologist was just tried to get me to talk about something and kept pushing the button and I didn’t want to go there’ (Hood, 2006 p.85). Later in her interview, however, she acknowledged that being challenged by her psychologist was beneficial.

Other participants explained that their relationship with their therapist made them feel ‘acknowledged’, ‘heard’, ‘cared for’, ‘reassured’, ‘supported’ and ‘understood’ (Hood, 2006 p.89). A positive relationship between patient and therapist was often associated with perceived positive outcomes by the patient.

Family involvement

Treatment for adolescents often took the form of family therapy, or at least family involvement in aspects of the treatment approach. In Hood’s (2006) study of New Zealand adolescents and their parents, adolescents were usually less enthusiastic about parental involvement, while parents were often very happy to have the opportunity to be involved their child’s therapy. Hood asserted that two views can arise when a family partakes in therapy: either the family is seen as part of the solution, or as part of the problem.

When a family was seen as part of the solution, adolescents described family therapy as positive.

> Well first, I don’t know, it felt strange. I got used to it ‘cause I sort of started realising that my problems were probably linked with that and that they needed to be solved for me to get better and for us to have a better family relationship. (Hood, 2006 p.102)

Parents also saw the value in their involvement.

> I think it was important from two points of view really. It was important for me to understand what was actually happening with James and what they were trying to do with him and what the aim was of what they were trying to do and how he was reacting to that. And then also from his perspective because he often said he wanted us there as well so that he is not there on his own, he has got some support. (Hood, 2006 p.101 – 02)

Parents explained that they felt supported through their involvement in therapy. It enabled parents and adolescents to recover. One parent explained that ‘The fact that he [the adolescent] had somebody else to talk to… Was like sharing the burden…’ (Hood, 2006 p.107)

Adolescents acknowledged that having a therapist there to mediate the discussion allowed them to talk to their parents about issues they found difficult to bring up on their own.

> [I]t is helpful because there’s some stuff you can’t really talk about or just having the psychologist there, like having someone else there,

> there’s some stuff that I could talk to my mum about that I couldn’t talk to her one on one. (Hood, 2006 p.103)

Negative experiences of therapy arose when the family was primarily seen, by the adolescent, as part of the problem. Some adolescents felt they had to censor themselves and their actions when taking part in family therapy. This was because the presence of parents ‘inhibits me from fully unleashing’ or because they did not want to disclose information to their parents (Hood, 2006 p.103).

> I wanted to be more by myself because there were things I couldn’t say in front of my parents… I just wouldn’t be able to say that whole thing because I didn’t want my parents to know or something. (Hood, 2006 p.103)

Family therapy also caused adolescents’ anxiety to rise when divorced or separated parents and family members were in attendance. Some adolescents found it difficult to participate in therapy while worrying about family tensions.

> [I]t was really nerve racking at the first one because my step-mum was there who doesn’t even talk to me… It was difficult like I could feel the tension in the room because I know D [stepmother] and mum don’t like each other. And dad was being, he looked relaxed but you could tell he wasn’t, he was just really nervous and stuff. (Hood, 2006 p.103)

Medication

A New Zealand study reported adolescent service users’ and their parents’ experiences of medication (Hood, 2006). The majority (n=6; 60%) of adolescents interviewed were prescribed antidepressants as part of their management. Their feelings regarding their experiences with medication were mixed.

> I absolutely hated taking my medication when I first started a couple of years ago. Then it became part of my life and a part of being able to live so I just don’t get all down about things… I don’t know how it works but I mean I know the medication’s always an option for me now so if things start to get bad and stay bad then it’s here. (Hood, 2006 p.98).

Some adolescents did not feel that the medication worked for them. They also did not enjoy the side-effects.

> [B]eing on medication I didn’t deal with things or just had trouble with my memory for a while. I didn’t know what day of the week it was… I just had no idea where I was or what was happening… (Hood, 2006 p.99)

Parents were also divided on their feelings about medication. Some parents were concerned with the side-effects, the negative effects of coming on and off medication, changing medication and the long-term effects. Some parents were happy that their child was on medication because they saw the beneficial nature of the antidepressants. However, not all parents agreed. One father explained that he was never consulted about putting his son on medication. He felt 'the medication was basically stuffing up his whole head and he wasn't receptive to what they were trying to do' (Hood, 2006 p.100).

5.7.7 General Practitioners' role in management

General practitioners can potentially play an important role in helping individuals who deliberately self-harm (Bennewith, Stocks, Gunnell *et al*, 2002; National Collaborating Centre for Mental Health, 2004). General practitioners are in a position to help patients who do not attend hospital and also to assist in the aftercare of those who do. Therefore, general practitioners are potentially vital in the prevention of suicidal behaviour. As a result, their interaction with DSH patients should ideally be positive and supportive.

In a New Zealand study on help-seeking, 84% of service users who had sought help from a general practitioner rated the experience as positive (Nada-Raja *et al*, 2003). Patients in the UK were more likely to describe positive experiences with their general practitioner when he or she appeared to be non-judgemental and genuine (National Collaborating Centre for Mental Health, 2004). General practitioners were perceived as genuinely concerned with their patients and, as a result, patients felt that they could open up to their doctor (Bywaters and Rolfe, 2002). An expertise in self-harm is not the only important aspect of care for patients. A general practitioner was praised because although she 'admitted in the past she doesn't know what to do to help… She has the right attitude to self-harm' (Brophy, 2006 p.49). Service users who cut themselves were also pleased when general practitioners provided them with dressings which allowed them to care for their own wounds instead of having to go to hospital.

> The GP and surgery nurse now give me dressings and other things so I can do the cleaning and dressing myself, which I find best for me. (Brophy, 2006 p.54)

Experiences such as these helped patients to be more involved in, and assume more responsibility for, their care.

Negative experiences of care were similar to service user experiences with hospital staff. Some patients felt they were treated differently by their general practitioner because their injuries were self-inflicted (Bywaters and Rolfe, 2002; Brophy, 2006).

> My doctor looked at me differently once I told her why I was there. It was as if I were being annoying and wasting her time. She saw my arm and told me that it was superficial and that she would make enquiries as to what should be done with me. (Brophy, 2006 p.53)

Some adolescent patients felt their general practitioner did not care about them and were insensitive to their situation (Brophy, 2006). Almost half of respondents in one study explained they were not believed when they told their general practitioner that they had injured themselves and were pressured to show their wounds.

5.8 Service improvement

The majority of studies included respondents' suggestions for improving services for individuals after a DSH episode. Suggestions spanned all stages of care. Five key areas for service improvement emerged from the studies:

- Increased sympathy towards those who self-harm
- Greater staff knowledge of DSH
- Increased and improved communication between service staff and those who deliberately self-harm
- Provision of better information about DSH for patients, carers and the general public
- Improved access to local services and aftercare.

Recommendations for improvement from youth with a history of DSH were similar to those of the general population who self-harm. However, specific needs were identified, which are also discussed below.

5.8.1 Increased sympathy towards those who self-harm

The majority of respondents' negative experiences of services arose from interactions with hospital staff and other service professionals. Participants often felt that they were maltreated because their injuries were self-inflicted (Harris, 2000; Horrocks *et al*, 2005). Professionals were often accused of being unable to focus on their patients' underlying psychological issues which were manifested in self-harm.

> It would have been better if someone had understood – the psychological side of it they didn't seem bothered about, they should not have put me down for what I did but tried to talk to me about it and help me. (Horrocks *et al*, 2005 p.11)

The need for clinicians to understand the problem individuals were facing was a frequent plea:

> Look at the individual, not the harm. Look at the person beyond the scars. Scars aren't important. It's the person that did them that's important. (Bywaters and Rolfe, 2002 p.41)

Some participants wanted service professionals to take DSH seriously and acknowledge their psychological pain and suffering.

> She didn't understand how bad I felt, I think, and because I couldn't express it in words I didn't get the help. I didn't get the help I needed… I read my notes in the morning at the end of the bed and they'd put… Says she feels "awful" in inverted commas and I was cross about it because I thought, I couldn't, I can't explain how I feel when I feel like that. (Horrocks *et al*, 2005 p.12)

Many felt that people who did not self-harm could not truly understand their experiences (Bywaters and Rolfe, 2002). Participants explained they did not always want understanding but wanted to be listened to and not judged. It was important that nurses were 'more aware that there's a certain way to deal with people who self-harm, it's not enough to just be a good nurse' (Horrocks *et al*, 2005 p.11).

Participants hoped that staff would '…listen and respond in a natural way – showing concern and wanting to support you' (Brophy, 2006 p.69). Several participants called for staff to be sensitive to their situation and understand the difficulty many faced when trying to explain how they felt.

5.8.2 Greater staff knowledge of DSH

The provision of better information about DSH for professionals dealing with individuals who self-harm was called for by several respondents in an Australian study (Dower *et al*, 2000). Some service users acknowledged that better information and specific training on how to deal with DSH patients might increase professionals' understanding and interactions with self-harm patients. Interactions with staff who were perceived as inexperienced and / or not trained to deal with self-harm patients were viewed as mostly negative by participants in studies in both the UK (Carrigan, 1994; National Collaborating Centre for Mental Health, 2004) and Sweden (Wolk-Wasserman, 1985). Service users hoped that staff were not only taught about the complexity and psychological trauma of DSH but were also trained to interact better with patients after a DSH episode.

> The most important thing is not to tell people to stop, but to listen to them, find out what they need to stop and help them find ways of achieving that. This way people heal in their own time. Telling people to stop makes them more secretive, more dangerous and more dishonest about it. People need to not feel threatened by people that are ultimately trying to help them. (Brophy, 2006 p.70)
>
> The only staff who helped were those that knew self-harm was a positive thing – a way of staying alive. (Brophy, 2006 p.69)

5.8.3 Increased and improved communication between service staff and those who deliberately self-harm

Patients often felt belittled for their actions (Harris, 2000; Bywaters and Rolfe, 2002; National Collaborating Centre for Mental Health, 2004). Some participants recalled being treated like children or spoken down to (Brophy, 2006).

Many service users said they were not given the opportunity to play an active role in their treatment. Patients in studies in both the UK (Horrocks *et al*, 2005) and Finland (Suominen *et al*, 2004) perceived that treatments had often been given or forced upon them without any information as to why this was being done. One patient suggested:

> They just need to listen to the person and try to understand, and if they don't know something, put the person in touch with someone who does know. (Bywaters and Rolfe, 2002 p.41)

The majority of patients called for staff to give them some responsibility in deciding their care. Treating patients with respect and allowing them to participate in treatment decisions by keeping them informed of their status was very important to those interviewed in studies in the UK (Bywaters and Rolfe, 2002) and Australia (Dower *et al*, 2000). It was also suggested by patients in an Australian study that staff should communicate better with each other about the patient's history so that they did not have to tell and re-live the details of their self-harm over and over again (Dower *et al*, 2000). One participant in a UK study said he / she 'was asked the same questions over and over' which 'just added to my distress' (Palmer *et al*, 2006 p.23). The patient recommended 'professionals involved… liaise with each other more to lessen the anxiety' (Palmer *et al*, 2006 p.23).

More time for patients to talk during psychological assessments and follow-up appointments was an aspect of care requested by some participants. A service user commented, 'if I'd have spent more time I probably could have opened up to him a lot' (Horrocks *et al*, 2005 p.15). Although some participants refrained from attending their referral appointments because they were afraid of reliving the pain, several service users in studies from the UK (Bywaters and Rolfe, 2002), and New Zealand (Hood, 2006), explained they felt that talking to someone about their problems really helped them. Some service users wanted 'long-term relationships with healthcare workers' which could 'provide continuity and the chance to build rapport' rather than offers of 'time-limited work' (Brophy, 2006 p.69).

5.8.4 Provision of better information about DSH for patients, carers and the general public

Some respondents appreciated aftercare, presumably in a group setting, because it put them in touch with other people like them.

> The fact that you talk to other people and there were other people who felt exactly the same as you, no matter what state they were in, no matter what part of life they came from, there were people that felt like you. It felt good to feel that you weren't on your own. (Bywaters and Rolfe, 2002 p.33)

Individuals who self-harm do not always understand what is happening to them or why they do it. Furthermore, because DSH is shrouded in stigma, many people may feel they are alone and that no-one understands them. Many service users suggested that more information be provided to them about self-harm and its prevalence.

> Information on how common self-injury is would be helpful. I used to feel abnormal and weird as I thought I was the only person to do this. Information could have helped reduce the shame and isolation this caused me. (Arnold, 1995 p.27)

> It has helped her tremendously to read articles on self-harm and learn that she is not the only on in the world who does it – I think this a very common feeling among harmers. (Brophy, 2006 p.69)

Support and information for carers was suggested, not only by DSH patients, but also their friends and families (Bywaters and Rolfe, 2002). Family and friends regularly have to cope with an individual's self-harm without any information about DSH or support. Several participants said a family member or friend was their greatest source of support (Hume and Platt, 2007).

> My wife… She's a diamond, if it wasn't for her I don't know what I'd do. (Hume and Platt, 2007 p.6)

Unfortunately, many family members or friends are ill-equipped to deal with suicidal ideation or behaviour. Carers explained that information should be readily available for 'people who look after, or care, or are family, anything, in anyway related to someone who self-harms' (Bywaters and Rolfe, 2002 p.24).

> There should be something for the other person really. All doctors say is "Are you going to be alright?" to the person who's self-harmed. They don't ask about the other person, but they should, whether it's a relative or whatever. They should ask, but they don't. (Bywaters and Rolfe, 2002 p.24)

Individuals who self-harm further highlighted this need.

> He's had no support really. Just left on his own. Everyone's been rallying round, trying to sort me out, but what about Craig [partner]? In trying to make sure I'm okay, he completely doesn't look after himself, and obviously that has its own effects. (Bywaters and Rolfe, 2002 p.24)

The stigma attached to DSH may frighten people from getting help (Dunleavey, 1992). Better information for the general public was also called for to help alleviate some of the stigmatisation faced by individuals who self-harm (Bywaters and Rolfe, 2002).

5.8.5 Improved access to local services and aftercare

Respondents urged that there be improved access to care in hospital as well as through local services. Service users in an Australian study suggested hospitals ensure that DSH patients are not sitting in waiting rooms for long periods of time (Dower *et al*, 2000). They also recommended hospitals provide a separate waiting area for DSH patients where they could have some privacy and sit in a quieter environment if they wished. In the UK, the need for more NHS psychiatrists and clinical psychologists was highlighted by respondents.

> Having arrived at A&E late at night, I had to wait until early the following morning before seeing a psychiatrist. (Palmer *et al*, 2006 p.21)

More mental health professionals available to provide aftercare was also requested because 'waiting lists are long to gain access to their services' in some locations (Brophy, 2006 p.69).

> My only concern [is] the length of time it will take for me to get my treatment ongoing. (Palmer *et al*, 2006 p.20)

Many study participants were unaware of local services that provide support to individuals who self-harm. They often urged professionals to provide patients with more information about local formal support services and how to contact them (Bywaters and Rolfe, 2002; Brophy, 2006). Several respondents interviewed explained that they wished they had known about the types of support services available to them before they self-harmed (Bywaters and Rolfe, 2002).

Requests for services in a non-clinical setting were made by some participants from the UK (Bywaters and Rolfe, 2002). Ensuring that service staff are approachable, understanding and trained to deal with DSH patients was recommended (Bywaters and Rolfe, 2002; Brophy, 2006). Participants felt it was essential that services be as accessible as possible by being staffed 24 hours a day, providing walk-in services and minimal waiting times for appointments (Bywaters and Rolfe, 2002). It was also suggested that services offer alternatives to hospital such as having nurses working in the community who can treat self-inflicted wounds (Bywaters and Rolfe, 2002; Brophy, 2006).

An accessible and fully staffed helpline was also suggested by participants. Some respondents explained they had received contact numbers for services at hospital but upon ringing, no-one was there to answer their call (Horrocks *et al*, 2005). It was also suggested that helplines should not be ‘anonymous phone lines but shifts of staff you can get to know’ (Brophy, 2006 p.69).

5.8.6 Service improvement recommendations from youth

Young people had a variety of suggestions about how services could be improved for young DSH patients. Many believed services were not adequately tailored for youth. Young people in studies in both Ireland (Bolger *et al*, 2004) and Australia (Dower *et al*, 2000) called for services specifically for adolescents and young adults.

> You really do feel very much on your own on the evening and weekends and you talk to the crisis team and they are always incredibly busy with adults… I think they actually need a teenage crisis system to be honest they are quite different to adults. I mean crises happen incredibly quickly and if you’ve got nobody to turn to life become pretty desperate. Both for them and for the parents. (Hood, 2006 p.111)

Adolescents and young adults called for their inclusion in planning services (Bolger *et al*, 2004). Specialist services for youth with special needs, for example pregnancy, substance abuse, were requested by some participants. Accessibility also emerged as a key aspect to the success of DSH services for youth. It was suggested services be centrally located. Walk-in services and telephone access as well as decreased wait time for appointments were suggested. In an Australian study, young people interviewed hoped for more time during their appointments with professionals (Dower *et al*, 2000).

Specialised training was also recommended by young people in an Australian study to help staff deal better with young people from a variety of cultures and lifestyle backgrounds (Dower *et al*, 2000). Adolescents and their parents described therapists with minimal training and experience which hindered their treatment.

> I’ll go in and I’ll be ready to talk and I’ve got all these things to say and new things I’ve discovered about myself and she wants to stick to these workbook things that she’s pulled out… So I don’t want that I’ve come here to talk. (Hood, 2006 p.91)

In a New Zealand study, continuity of care was an aspect of treatment that adolescents and their parents felt was inadequate (Hood, 2006). One parent believed the lack of continuity was primarily a reflection of the limited number of specialist psychiatrists. Some parents and adolescents said they found adolescent psychiatrists were often unavailable for continued care because they were too busy, or had left the service during the adolescent’s treatment period.

> The only problem was that the psychiatrist who I’d been seeing in hospital was meant to follow me up but couldn’t and I ended up sort of being left in the dark a bit because I couldn’t see him and every time I booked he cancelled or couldn’t make it. So that was rather distressing at that point ‘cause that was when I did need these medication changes. (Hood, 2006 p.110)

6 Discussion

The primary objective of this study was to conduct a systematic review of the international literature concerned with DSH patients' attitudes and satisfaction with health services following a self-harm episode. Specifically, we aimed to provide a synthesis of patient experiences with (a) medical management, (b) in-hospital psychiatric management and (c) post-hospitalisation management.

6.1 Limitations

The findings of this systematic review must be considered in the light of several limitations. The majority of the included studies were qualitative. This makes it difficult to say precisely how many people experienced a particular event or had specific attitudes or perceptions about services. Some studies included open-ended or semi-structured interviews, which makes it difficult to ensure that all respondents answered the same questions in the same way as is more possible in quantitative designs. Therefore, interview questions may have evoked different memories from respondents and caused some to leave out particular details of experiences. The qualitative approach may, however, have also permitted more in-depth investigation of such experiences (Hood, 2006).

6.1.1 Bias

Qualitative studies are subject to many of the same biases as quantitative studies. Selection bias must be acknowledged within individual studies as well as in this review. The sensitive nature of research into DSH patients' experiences may create problems with participant recruitment. The majority of studies focusing on patient experiences and satisfaction provided more negative than positive findings. This may be an accurate picture of service users' perceptions. However, it is also plausible that patients who had a negative experience of management are more likely to be vocal about their experiences and agree to participate in interviews.

The included studies are based upon patients' perceptions of management following a DSH episode. It is important to consider how the psychological state of the patient and the experiences of staff members might bias responses when interpreting findings. For example, patients with persistent problems may be more likely to view experiences of services in a negative light.

Publication bias may also present a problem. The majority of studies were heavily weighted with negative experiences of care. This may be because aspects of management are not acceptable to many DSH patients. However, it may also be the case that studies with negative findings about services are more likely to be published. We have attempted to get around this by searching through the grey literature. Unfortunately, only one study was found using this strategy (Hood, 2006).

Researcher bias is another aspect of research that must be taken into account. It is difficult to be objective when conducting qualitative research. Just as participants bring with them previous experiences, so do researchers. A researcher's attempt to draw conclusions from interviews can be subject to considerable bias. Therefore, it is imperative that authors make the potential for bias clear so that findings may be evaluated in the light of the authors' backgrounds and experiences.

In reviewing qualitative studies, reviewers can only synthesise findings that have already been synthesised by the original author. This can have unintended consequences such as over- or underestimation of effects, which may be influenced by the background of the reviewers. This review has been undertaken by four authors from both clinical and non-clinical backgrounds. Three authors have had personal experience in the clinical management of DSH patients. Two authors have conducted their own qualitative research. We believe the variety of previous experience of the authors has limited the potential biases in the interpretation of the findings.

6.1.2 Study quality

The quality of the studies included in this review, shown in Table 1, may also limit the generalisability of the findings. Fourteen studies (45%) were rated as having a Strong or Strong / Acceptable design, nine (29%) as having an Acceptable design, and eight studies (26%) as having an Acceptable / Weak or Weak design. Although the majority of study designs were Strong, Strong / Acceptable or Acceptable, several included studies were rated as being of lesser design quality. We included studies with weak ratings due to the lack of agreement among qualitative researchers on the issue of quality assessment (Mays and Pope, 2000). While in presenting the results we gave more weight to the studies of stronger design, the inclusion of all the studies could have influenced the findings.

6.2 Strengths

Although the findings of this review should be considered in the light of its limitations, the strengths of this research must also be acknowledged. Through this review we were able to pool the findings from 29 studies from several countries. Qualitative research is sometimes discounted because of the small numbers of participants. Through a review of the literature, we have been able to combine results and participants across a number of studies, creating a large population from which to draw evidence and strengthen findings. Furthermore, the range of countries included in the review provides for a fuller understanding of the experiences, of individuals who self-harm, around the world. The primary purpose of this review was to focus on service users' experiences of care in the UK. However, by also including the experiences of service users' from other countries, this review adds to findings based on the responses of UK participants, as well as providing insights into patient reactions to services which may be different to those currently available in the UK. Interestingly, there was considerable consistency in the findings from different countries.

The inclusion of both positive and negative responses from participants also adds to the strength of our findings. As previously discussed, one of the possible limitations of qualitative studies is the trend towards accounts of negative experiences of services after a DSH episode. The ability to provide responses from different perspectives regarding similar aspects of services increases our understanding of the complexity of service users' experiences and the variability of care dependent upon patient, staff and location.

A review of this size offers an opportunity to synthesise information covering a range of services. The majority of qualitative research on service-user satisfaction and experiences focus on specific aspects of care, for example assessments, hospital management, aftercare. This review has allowed for an examination of many aspects of care and the different services used by individuals after a DSH episode. This enables us to provide recommendations regarding management in general, specific services and the transition from service to service, for example the transition between discharge and aftercare.

6.3 Findings and implications

Investigating service users' experiences of care is integral to improving the management of DSH patients and to the possible prevention of DSH and suicide. Including service users' perceptions and experiences of hospital services in recommendations for care and service planning may increase the probability that individuals will seek help before, or after, engaging in DSH and their compliance, with hospital management and aftercare. In this section, we consider DSH service users' suggestions in the context of government and professional recommendations regarding the management of DSH patients in an attempt to provide suggestions for how management can be improved, for individuals presenting to hospital, after a DSH episode. The key implications for clinical practice and service improvement of the findings are presented in Table 3. It is important service providers ensure all services are in keeping with national mental health service standards.

Table 3. Key implications for clinical practice and service improvement

In-hospital management

Education and training for clinical and non-clinical staff on DSH and how to manage patients after a DSH episode. This programme might include service users as educators and address topics of sensitivity, communication and appropriate behaviours.

Patients regularly informed of their health status and engaged in management decisions.

Staff sensitivity to patients' personal preferences.

Protocols for management of DSH patients, for example psychosocial assessment, designed to maximise therapeutic benefits.

All patients who present with DSH receive a psychosocial assessment by someone trained to do this.

Patients observed until they may be discharged appropriately, for example recovered from physical and / or psychological effects; have a discharge plan.

Local alternatives to A&E may be an effective way of providing physical treatment for those who do not wish to attend hospital.

Aftercare

Hospital protocols ensure all patients have an aftercare plan at the time of discharge.

Patients given advice and help regarding specific problems, for example substance abuse, low self-esteem, and information about local services upon discharge.

Flexible aftercare arrangements planned according to the acuteness of the patient’s problems.

Staff assistance in making contact with local services by acting as the link (with the patient’s permission).

Therapists build up a rapport with patients before attempting to discuss problems related to self-harm.

Aftercare should, wherever possible, be evidence-based and also tailored to meet individual patient’s needs.

Information about DSH, advice and support available to carers.

Adolescents

Staff involved in the management of adolescents have relevant specialist training.

Adolescents kept informed and involved in their management.

Parents, where appropriate, encouraged to be involved in management.

Special attention to possible difficulties in care that may be experienced by older adolescents.

Therapists work with adolescents and their families to create effective treatment plans.

Local community services easily reached by public transport.

6.3.1 In-hospital management

Protocols

There exists marked variation in the type and quality of services available to patients presenting to A&E after a DSH episode (Bennewith *et al*, 2004). In order to attempt to decrease the variety and increase the quality of care for DSH patients, it is important hospitals create and maintain a group to assess issues relating to care. The Royal College of Psychiatrists (1994;

2004 p.14) recommended that 'all major trauma centres should have in place a self-harm services planning group' to deal with issues of staff training and to develop a protocol to be followed when treating DSH patients. Both professional guidelines and participants' suggestions call for the inclusion of service users in the planning of management protocols for DSH patients (Bolger *et al*, 2004 p.82; Royal College of Psychiatrists, 2004 p.34). Such protocols might include guidelines on what steps should be taken upon admission, during physical and psychological management, and during and after discharge. This would ensure that all patients receive essential aspects of care, for example pain management, psychological assessment, that are tailored to their personal preferences as suggested by patients (Palmer *et al*, 2006). These planning groups should provide a 'clearly understood and [staff] agreed' referral policy for DSH patients (Royal College of Psychiatrists, 1994 p.35). Furthermore, hospitals should set up a monitoring system 'so that the relevant aspects of the self-harm services can be regularly audited' (Royal College of Psychiatrists, 1994 p.35).

Staff training

Respondents reported both positive and negative perceptions of hospital staff. The majority of studies found that many respondents discussed the lack of staff sympathy and knowledge about DSH, problems with communication and what patients perceived as inappropriate actions. Many patients noted that although staff treated them for their physical conditions, they were often mechanical and impersonal.

A large number of respondents felt hospital staff were inadequately prepared to deal with DSH patients and, as a result, did not provide the support or care they wanted. Some attributed the lack of knowledge to the lack of staff experience in general. These patients said they were treated by junior staff members, who were perceived to be unable or unsure of how to provide care, although staff may have been following protocol. This was often in relation to psychosocial care.

Although a myriad of reasons may have accounted for perceived negative experiences with staff members, research has shown that medical staff respond differently to DSH patients. Nurses, doctors and medical students have been found to hold negative attitudes towards individuals who self-harm (Barber, Hodgkin, Patel *et al*, 1975; Dans, 2002; McCann, Clark, McConnachie *et al*, 2006), with doctors appearing to be more negative than nurses (Ramon *et al*, 1975). For example, paramedics acknowledge that dealing with DSH patients is challenging and difficult (Brophy, 2006). They also said they received no specific training on how best to manage individuals after a DSH episode. Although service providers' perceptions of their role and expectations of services were beyond the scope of this review, they are important aspects to consider in improving clinical practice and services.

Training specific to DSH patients

Individuals presenting to hospital after a self-harm episode often have complex problems that can be difficult to manage, even when staff are trained. Specific training about DSH and how to manage individuals after a DSH episode may decrease patient perceptions of staff behaviour as threatening, belittling or inappropriate. In a UK study, Crawford and colleagues (2003) found medical staff to hold less negative feelings towards DSH patients when they felt more effective in treating them. In another study, short-term training of both clinical and non-clinical staff increased feelings of effectiveness in dealing with patients and perceiving patient risk (Berlim, Perizzolo, Lejderman *et al*, 2006). In an Australian study, nurses that attended in-service education were found to have more positive attitudes towards DSH patients (McCann *et al*, 2006).

Both the NICE guideline on self-harm (2004) and the Royal College of Psychiatrists (1994) recommend specialist training for professionals dealing with individuals who self-harm:

> Clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed. (National Collaborating Centre for Mental Health, 2004 p.48)

Training should include formal procedures to be followed when working with DSH patients. However, training about DSH and issues of sensitivity and communication as well as appropriate behaviours should also be addressed. The use of service users to help train staff may be effective in decreasing possible negative attitudes towards this patient group (Simpson and House, 2002). The Royal College of Psychiatrists (1994; 2004 p.18) suggests training be set up within one week in post and a specified degree of competency be reached before staff provide independent [psychosocial] assessment.

Sensitivity

The Royal College of Psychiatrists (1994; 2004) and the NICE guideline on self-harm (2004) recommend that staff pay special attention to the care of DSH patients. Individuals presenting to hospital after a DSH episode are likely to be under tremendous psychological stress and ‘healthcare professionals should take full account of the likely distress associated with self-harm’ (National Collaborating Centre for Mental Health, 2004 p.48). The NICE guideline on self-harm states that ‘people who have self-harmed should be treated with the same care, respect and privacy as any patient’ (National Collaborating Centre for Mental Health, 2004 p.48). However, many service users believed their negative experiences with staff were due to the fact that their injuries were self-inflicted.

DSH patients’ experiences compared to patients presenting for other reasons

DSH patients’ reactions to care received in A&E are, in some ways, similar to experiences recalled by patients presenting for a variety of other reasons. For example, many patients, regardless of why they have presented at A&E, complain of long wait times. In an American study of patients attending emergency departments, patients' perceptions of unreasonably long wait times, rather than the actual waiting time, affected satisfaction with care (Thompson, Yarnold, Williams *et al*, 1996). In a Swedish study, 20% of patients questioned said they did not receive pain relief and more than 20% said nurses did not show interest in them as people (Muntlin, Gunningberg and Carlsson, 2006). In an Australian study many patients described a perceived lack of privacy while in A&E (Karro, Dent and Farish, 2005). In a review of the literature on patients' perceptions of emergency department care, Taylor and Benger (2004) found the most frequently identified service factors influencing responses were the nature of relationships with staff, provision of information regarding care and perceived waiting times. Therefore, even though DSH patients may attribute negative experiences to the fact that their injuries were self-inflicted, it may not always be the case.

Staff attitudes

Studies of staff attitudes towards DSH patients suggest patient perceptions may often be correct. However, patients may hold negative expectations and prejudices about attending A&E. Feelings of shame and guilt about self-harming may precondition patients to feel as though they are being treated differently, or negatively, because their injuries are self-inflicted. Furthermore, the common characteristics of individuals who self-harm (for example: low self-esteem, interpersonal communication and relationship difficulties, hopelessness, poor problem-solving skills, previous experiences of trauma) may make them more prone to negative interpretations of events and interactions. Therefore, it is important that staff show positive attitudes towards these patients and appear supportive and caring. Education and training of staff about DSH patients, and their problems and management, is likely to greatly assist staff in this direction.

Improved communication

Keeping patients informed and engaged in their care

The majority of patients had negative reactions about their experiences of communication with staff. Patients often said they were not given the opportunity to participate in discussions regarding their care and that they were given inadequate information as to their physical and mental health. Patients who felt they were kept involved were generally more satisfied with their experience. However, several were worried that they did not fully understand explanations given to them. Such explanations, therefore, need to be straightforward. The need to keep patients informed of, and engaged in, their management is emphasized in national guidance (National Collaborating Centre for Mental Health, 2004 p.48), which also proposes that all patients should have 'regular contact with a named member of staff' while waiting for treatment.

> Staff should provide full information about the treatment options, and make all efforts necessary to ensure that someone who has self-harmed can give, and has the opportunity to give, meaningful and informed consent before any and each procedure or treatment is initiated. (National Collaborating Centre for Mental Health, 2004 p.52 - 3)

This may be particularly effective in increasing compliance and satisfaction with care. For example, many participants had negative experiences of the psychosocial assessment. Often, patients said they were not given sufficient information about the goals and format of the assessment. As a result, patients may not understand how the assessment might be beneficial to them. One participant who was sufficiently informed was satisfied because she understood that a major aim was risk assessment; although, of course, this is not the sole aim of the psychosocial assessment.

Often a hierarchy exists between the patient and medical staff, which may cause the patient to lose the confidence to ask questions or give opinions, and may cause staff members to forget to keep the patient informed of his or her status and included in the current management plan. It is imperative that staff are sensitive to this possibility and act accordingly.

Patient differences

It is important for staff to recognise that DSH patients come from a variety of backgrounds and experiences. Patients will want or expect different outcomes from their management. As a result, staff should try to be sensitive to personal preferences and / or differences in cultures or religions that might lead to different needs. For example, the NICE guideline (2004 p.48) recommends that, if a patient must wait for treatment, 'he or she should be offered an environment that is safe, supportive and minimises any distress'. Several service users expressed a desire for a separate waiting room so that they did not feel as though they were on display. However, some participants did not want to be placed in a separate waiting room because it increased feelings of isolation. Furthermore, although many patients pressed for more communication with staff, some did not want to talk about the problems that led them to self-harm. Allowing patients to voice their opinions and preferences in regard to their care is likely to increase compliance with treatment and, as a result, improve outcomes. Therefore, it is important that staff are sensitive to patient cues which might reveal personal preferences.

6.3.2 Improved access to local services

Discharge

Discharge from hospital was an aspect of care about which many patients reported having negative experiences. Several patients felt they did not receive the support they had wished for, the problems that led them to self-harm had not been resolved or they were not physically ready to leave hospital upon discharge. These patients recalled fearing what might happen when they returned home. It is important that management, for example psychosocial assessment, is designed to maximise any therapeutic benefits so that patients feel supported and that their problems are being addressed. Also, patients might be observed by staff to ensure they do not leave hospital until they have sufficiently recovered from the physical and psychological effects of the episode.

Referrals

Although many patients were provided with a referral for aftercare, some were unhappy about the type of referral they received. Often patients were given contact numbers for community organisations. However, some patients were uncomfortable dialling these organisations without any prior connection to them. In order to increase the likelihood of patients using local services, for example Relate, Alcoholics Anonymous, self-harm support groups, after discharge from A&E, staff might try to assist patients in making contact by acting as the link between patients and services – with the patient's permission – rather than simply providing a list of telephone numbers.

Some participants reported being told they would be contacted to schedule aftercare but they said they heard nothing further. The Royal College of Psychiatrists guideline on the management of self-harm patients recommends that hospitals contact general practitioners within three days of a patient's admission to A&E (Royal College of Psychiatrists, 1994). Unfortunately, general practitioners are not always notified. To ensure DSH patients continue to receive support after discharge, A&E departments should have systems in place to ensure that all patients are seen after leaving hospital. This might include engaging the patient's general practitioner in a management plan.

Patients who receive referrals for treatment may not get the support they need due to long waits for psychotherapy. For some service users, long waiting times for aftercare increased non-compliance. Therefore, it is important that aftercare be arranged in keeping with the acuteness of patients' situations. It may also be beneficial for staff to provide patients with practical help with possible environmental problems and stressors (for example: physical and sexual abuse, substance abuse, low self-esteem, problem solving). Furthermore, continuity of care may help patients make a better transition from hospital to aftercare and increase treatment compliance.

Importance of local services

The majority of individuals who self-harm in the community do not attend hospital or receive professional treatment for a variety of reasons, for example injury not serious enough, feel they have recovered, believe nothing will help them (Jenkins, Griffiths, Wylie *et al*, 1994; Hawton, Rodham, Evans *et al*, 2002). For some participants, negative interpretations of staff behaviour aroused feelings of guilt and shame in relation to their self-harm. 'I felt bad enough about myself as it was… I felt like a complete trouble to everybody, like a complete inconvenience' (Horrocks *et al*, 2005 p.8). Several service users did not want to take up a professional's time, which they believed would be better spent helping people with 'real' problems (Wiklander *et al*, 2003). These types of individuals may be better served by local services. However, many participants said they did not know about the local psychiatric services which might help them deal with their self-harm. Many wished that they knew about these services, as they believed it may have helped prevent the episode. Access to local services may play an important role in increasing the numbers of individuals that receive physical and / or psychological treatment after self-harm among a population already known for low compliance.

Improved access to local services was called for by many participants, with some service users requesting an alternative to presenting at hospital. These participants – mostly people who cut themselves – suggested a local service which employed a nurse or other medical staff qualified to deal with cuts and other less severe injuries. Services like this may persuade many non-attenders to get physical and, possibly, psychological assistance for their self-harm, for example minor injuries units in some areas will do this. Several patients preferred being treated at local services because social workers and community psychiatric nurses often have some specialist knowledge in regard to DSH and participants felt they might be better equipped to help them.

Services for family and friends

Local services may also be used to address concerns from family and friends of individuals who self-harm. Carers said that they were given little or no information on what to do once they returned home. Both service users and their friends and families suggested that more be done to include and support those caring for individuals who self-harm. Group sessions and / or individual counselling for those affected by self-harm with the aims of teaching carers about DSH and equipping them with the practical skills to deal with episodes and the patient's low self-esteem and interpersonal difficulties should be offered. Provision of an outlet for carers to share their stories and learn from others can potentially help carers to better deal with the situation and support their loved one.

6.3.3 Aftercare

Service users' perceptions of aftercare were mixed. Participants were more likely to be satisfied with their care if they felt staff genuinely cared for them. For many service users, being given the opportunity to talk contributed to positive experiences. Although little research has been conducted examining service users' attitudes towards specific psychosocial and pharmacological treatments, in one study the majority of participants receiving DBT reported high satisfaction with care (Perseius *et al*, 2003).

Compliance

Many participants had positive expectations of aftercare and were willing to engage in therapy. However, not all participants attended referral appointments. Reasons for non-attendance included feeling that the treatment would not help them, the stigma of seeing a therapist and fear of the pain they would experience when talking about their problems. Furthermore, some service users terminated treatment early. Some reasons for early termination of care given by participants were feeling uncomfortable with the therapist or the location of treatment sessions, feeling treatment was not helping and fear of talking about problems related to their DSH.

Patient-therapist relationship

The relationship between therapist and client can have a significant impact on individuals' perception of the quality of their care. Many participants did not attend treatment, or stopped attending treatment, because of issues related to their therapist. Therefore, therapists should be supportive of patients and build up a rapport with patients before asking them to divulge possibly sensitive information. Although aftercare should be evidence-based, this is not always possible. Due to variation in service users' preferences aftercare should, wherever possible, be tailored to meet individual patients' needs to ensure the best chance of compliance.

6.3.4 Adolescents

Protocol

In designing services to manage adolescents presenting at A&E, attention should be paid to the recommendations discussed above. However, a protocol specific to adolescent management should be followed. The Royal College of Psychiatrists' (1998) report on self-harm management for youth recommends that episodes of DSH in children and adolescents should always be taken seriously. Carers should also be informed and involved during the management of children and adolescents, while accounting for the age-appropriate consent issues.

When dealing with older adolescent patients, staff should show increased sensitivity as this group is more likely to experience difficulties in terms of continuity of care, because of the transition between services.

> Particular care should be taken to ensure that the arrangements for young people between the ages of 16 and 18 years are clear and effective [because] young people in this age range may fall into the gaps between the medical and mental health services for children and those for adults. (Royal College of Psychiatrists, 1998 p.6)

It is recommended that youth are moved to a paediatric or adolescent medical ward after discharge from A&E 'in order that adequate further physical and psychosocial assessments can occur and management / crisis intervention be planned and initiated' (Royal College of Psychiatrists, 1998 p.8). A later report strengthens this recommendation for referral to child and adolescent specialist services (Royal College of Psychiatrists, 2004).

Engagement in management decisions

Ensuring that patients are involved in decisions relating to their care may lead to increased satisfaction with services. Control appeared to be a major theme among this population. After a DSH episode some adolescents described feeling a loss of control. Some participants who were admitted to psychiatric wards said the sense of lack of control exacerbated their urge to self-harm (Brophy, 2006). Many adolescents said they wanted staff to give them more control over their care. In keeping youth informed, and involved in their care, staff may help them regain control over their situation.

Specialist training for staff

Adolescent service users sometimes said that staff did not understand them. These participants called for staff dealing with adolescents to be specially trained and experienced to work with the age group. The Royal College of Psychiatrists (1998 p.11) also recommends that staff dealing with youth 'have had training specifically oriented to work with young people and their families after deliberate self-harm; be skilled in risk assessment; and have consultation and supervision available to them'. Furthermore, consultant child and adolescent psychiatrists should be 'available to teach, supervise and consult to non-medical and junior medical staff who are involved in assessment and managing young people who deliberately harm themselves' (Royal College of Psychiatrists, 1998 p.11).

Aftercare

Management of adolescents also usually involves working with families. Therapy consists of individual therapy, family therapy or a combination of the two, as appropriate. Therapists should work with adolescents and their families to determine an effective management plan. While many adolescent service users were relieved to have someone to talk to, family therapy sometimes caused distress to the youth and led to non-compliance. In one study, only 33.3% of adolescents completed family therapy while 51% completed individual therapy (King, Hovey, Brand *et al*, 1997). Burgess and colleagues (1998) found adolescents appreciated short-term therapy, mostly on an individual basis. Group therapy may also be effective as several service users said they enjoyed meeting other adolescents with similar problems and experiences and this made them feel less isolated. However, providing support for parents and keeping them informed and involved in their child's management may increase compliance. It is important that professionals providing therapy to adolescents, either individually or with their families, are sensitive to possible tensions that may undermine compliance or the success of therapy.

It is also important that local services are accessible to youth. Most adolescents are restricted in terms of transportation and many participants suggested that community services are located in areas easily accessible by foot or public transport.

6.3.5 Older adults

A gap in the research

Older adults generally show greater suicidal intent when compared with younger populations and risk of death by suicide following DSH is highest among this group (Hawton *et al*, 2003b). Marriott and colleagues (2003) found that patients aged 55 and older were more likely to be admitted to a ward as compared to younger patients (59% versus 46%). Also, more older patients received a specialist psychosocial assessment (78% versus 62%). Although older adults are at increased risk of death by suicide, little is recommended specifically for their management. The Royal College of Psychiatrists (2004 p.33) suggests that 'patients over the age of 65 who have harmed themselves should always be referred for a specialist old age psychiatry assessment regardless of the medical seriousness of the event'. The NICE guideline echoes this recommendation (National Collaborating Centre for Mental Health, 2004).

General perceptions of services

An American study, on the perceptions of older adults presenting to an emergency department for a variety of reasons, found patients reported satisfactory experiences when they said they did not have to wait too long for treatment, staff answered their questions, kept them fully informed and involved in care and efforts were made to relieve pain (Nerney, Chin, Jin *et al*, 2001). In an Irish study, Dunnion *et al* (2005), make an argument for the importance of continuity of care during the patient's transfer from hospital to their home. This can be helped by involving the patient's general practitioners. However, the study found that many general practitioners did not receive notice regarding the patient's hospitalisation. Although these findings are similar to those we would expect, it is necessary that research specifically on the experiences of older DSH patients and their reactions to the services they receive is carried out.

Health care costs

Clearly, improving services for and care of DSH patients along the lines suggested by the results of this review will have cost implications. However, these need to be offset against the fact that service improvements similar to some of those suggested have been shown to reduce use of general hospital inpatient beds (Hawton, Gath, and Smith, 1979; Whyte, Dawson, Buckley *et al*, 1997). In addition, they are likely not only to improve user satisfaction but also to decrease repetition of DSH, and hence hospital costs (Crawford and Wessely, 1998; Hickey *et al*, 2001; Kapur *et al*, 2002), and in addition, provide general hospital and psychiatric service staff with greater work satisfaction.

6.4 Future research

Findings from the review found that DSH patients were unhappy with particular aspects of their management, both in hospital and after discharge. The review also identified several gaps and weaknesses in the literature which need to be addressed by further research. Four broad categories for future research emerged from the literature: (1) improvement of service evaluation, (2) improvement of service delivery, (3) improvement of services for subgroups of individuals who self-harm and (4) provision of support for those affected by deliberate self-harm.

6.4.1 Improvement of service evaluation

As discussed previously, the nature of the methodologies used in qualitative research makes it difficult to state precisely the number of people who experienced a particular event or shared specific perceptions of, or attitudes toward, their management. The development of a standard interview schedule for service users may reduce this potential bias by providing a standardised evaluation of services for use across the UK. The interview schedule should include patient satisfaction with physical treatment, psychosocial management including the psychosocial assessment, discharge, referral and aftercare and perceptions of and satisfaction with staff. This interview schedule may also be used in conjunction with open-ended or semi-structured interviews.

The superficial nature of psychosocial assessments was commented on by several service users. Research evaluating DSH patients' perceptions of specific assessments and comparisons of different types of assessments, for example long form versus short form, may increase patient satisfaction and therapeutic benefits.

Patient satisfaction with specific treatments was an area in which little research has been conducted. Further research evaluating service users' attitudes towards psychosocial and pharmacological treatments given after a DSH episode is needed.

6.4.2 Improvement of service delivery

The development and evaluation of hospital services should include attention to the key points raised in this report. Future studies focusing on how to address these key points should be carried out. Furthermore, an evaluation of the impact of these changes on patient satisfaction should be conducted.

Service user perceptions of staff have a significant impact on satisfaction with services. The findings of this review as well as government and professional guidelines recommend that staff working with DSH patients are specifically trained in best practices for providing care to this group. Further research is needed in developing effective and practical training for both clinical and non-clinical staff, including general practitioners. Research is also needed to measure the impact of training on staff attitudes and patient perceptions of staff and on the most effective ways of linking changes in attitudes to changes in behaviour.

Some people who self-harm do not attend hospital due to guilt or the stigma attached to DSH. The provision of alternatives to hospital management of DSH may be an effective way of providing care for this group. Several participants said they would like to have an alternative in the community where they could receive psychosocial care and physical treatment of less serious injuries. Research is needed to evaluate the impact of community services already in place and develop more alternatives. The inclusion of DSH patients in the planning stages of developing these services may increase the chance of success.

Large-scale clinical studies evaluating different styles of services, for example dedicated DSH services versus generic psychiatric services, to compare the impact on patients is another area which would benefit from further research.

6.4.3 Improvement of services for subgroups of individuals who self-harm

Older adults are highly susceptible to death by suicide following a DSH episode when compared to the general population. However, a large gap in the research was found through this review. Research concerning both the management of older adults and their perceptions of, and attitudes towards, care has been neglected. It is imperative research be conducted to determine the most effective way of managing this population. Qualitative research on patient perceptions of care is needed to inform and assist in shaping services for this high-risk group.

No research including the experiences of gay, lesbian, bisexual or learning disabled service users was identified through this review. Little research was found which examined the experiences of ethnic minorities. These minorities may have different personal, religious and cultural preferences, which can affect their interaction with DSH services and their perceptions of management. More research is needed to determine whether different minority groups have special needs and how these needs can be addressed during their management.

6.4.4 Provision of support for those affected by deliberate self-harm

When providing management for DSH, the patient is usually the focus. Often family members and friends who deal with the stress and reality of caring for the patient are left with no support. In order to better assist those caring for individuals who self-harm, larger studies examining the impact of DSH on relatives, their role in management and its effects should be carried out. Another possible area for research may be the development and evaluation of information about DSH tailored specifically for the use of family and friends of individuals who self-harm.

7 Conclusions

The 31 studies included in this review came from a variety of countries, often with different health care systems. In spite of these differences, participants’ reactions to, and perceptions of, their management showed remarkable consistency. Generally, many participants reported they were satisfied overall with their management. However, many also highlighted specific aspects of their care that they were unhappy with. These aspects included perceived inappropriate staff behaviour and lack of staff knowledge, lack of patient involvement in management decisions, problems with the format of psychological assessments and issues with access to aftercare. This review has shown there is much that can be done to improve service user satisfaction among patients presenting to services after a DSH episode, from developing and implementing protocols for staff to follow in caring for individuals after a DSH episode, to adding a personal touch when providing care. While more research is needed to strengthen our understanding of service users’ needs and address the issues of specific subgroups, for example older adults, ethnic minorities, the findings of this review provide some clear directions for improving clinical practice and services.

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Appendix 1 Quality Assessment Instructions

Please describe the study using the four categories below.

	Definition	Important questions to answer
Design	Provides material most relevant to our question	• Has the researcher justified the research design (e.g. discussed how they decided which methods to use)? • How have the participants been selected? • Has the researcher explained why the participants were selected? • Are there discussion around recruitment (e.g. why some people chose not to take part)?
Centrality	Provides a central position to the views of individuals who self-harm	• Is an explanation for how the data were selected from the original sample? • Has the researcher critically examined his/her own role, potential bias, and influence during analysis and selection of data for presentation?
Analysis and reporting	Reports in enough depth and detail to give confidence in the findings	• Is it clear how data was collected? • Are methods made explicit? • Were methods modified? • Has saturation of data been discussed? • Has the researcher examined his/her own potential bias/influence? • Is there an in-depth description of the analysis process? • Is sufficient data presented to support the findings? • To what extent are contradictory data taken into account? • Is there adequate discussion of the evidence both for and against the researcher's arguments? • Has the credibility of findings been discussed (e.g. triangulation, respondent validation, more than one analyst)? • Are the findings discussed in relation to the original research questions?
Generalisability	Provides information that would permit some generalisation beyond the immediate context in which the data were collected	

Appendix 2 Relevance of Qualitative Studies to the Review

Please categorise the study's relevance as strong or weak based upon the descriptions below.

Strong	"At least one primary focus is on the views of DSH patients in relation to their attitudes towards and satisfaction with services (e.g. medical, in-hospital psychiatric or post-hospital management) for their DSH episode. The study should use qualitative methods and reporting which provides a detailed description or, in the case of quantitative work, investigation of relationships between concepts, not just frequency counts" (Social Care Institute for Excellence, 2006 p. 18).
Weak	"At least one primary focus is on the views of DSH patients in relation to their attitudes towards and satisfaction with services (e.g. medical, in-hospital psychiatric or post-hospital management) for their DSH episode. However, reporting is thin on description or largely limited to basic frequency counts, so that only one or two possible insights into the nature of DSH patients' subjective views have been generated" (Social Care Institute for Excellence, 2006 p. 18).

Appendix 3 Characteristics of Included Studies

Study	Arnold, 1995
Participants	Inclusion criteria: women with a history of self-harm. Numbers: 76 participants. Profile: 100% (n=76) female; age range of 18 years to late 50s; 90% (n=68) had self-cut; 39% (n=30) reported no longer hurting themselves.
Location	Bristol, UK.
Methodology and assessment	Participants were recruited through local and national advertising. 50 participants completed written questionnaires. 26 participants participated in semi-structured interviews.
Outcomes	Included: i) experiences with staff; ii) hospital management; iii) service improvement. Excluded: i) descriptions of self-injurious behaviour; ii) patient's understanding of her self-harm.
Notes	

Study	Bolger *et al*, 2004
Participants	Inclusion criteria: young people aged 14-20 years who attended A&E with suicidal ideas or self-harming behaviour. Numbers: 89 participants. Loss to follow-up: 58/89 (65%). Profile: 61% (n=54) female; 90% (n=80) presented to A&E due to DSH episode; 61% (n=67) presented after an overdose; 45% (n=40) had previous history of DSH; 46% (n=41) had previous contact with mental health services.
Location	Dublin, Ireland.
Methodology and assessment	Participants followed-up after A&E attendance; letter sent to contact address followed by telephone call. Follow-up: six months after index episode. Face-to-face interviews in participant's home or hospital psychiatry department.
Outcomes	Included: i) hospital management; ii) referral; iii) support sought in intervening period; iv) service improvement.

	Excluded: i) circumstances leading up to DSH; ii) depression; iii) suicidal ideation; iv) suicidal intent; v) repetition; vi) substance abuse.
Notes	
Study	Brophy, 2006
Participants	Inclusion criteria: young people with experiences of self-harm. Numbers: 40 participants across five consultation sites; 142 participants completed an online survey; an unknown number provided personal testimonies; some 150 individuals joined a ‘virtual consultation site’. Profile: unknown.
Location	UK.
Methodology and assessment	Five small consultation groups of young people with self-harm experiences from five different community service organisations with a sixth online consultation group; online questionnaire; calls for personal testimonies were advertised via newspapers, magazines, and other publications.
Outcomes	Included: i) hospital management; ii) experiences with staff; iii) post-hospitalisation management. Excluded: i) interventions; ii) reasons for self-harm; iii) effects of self-harm; iv) myths and stereotypes; v) at-risk populations; vi) primary prevention of self-harm.
Notes	
Study	Burgess *et al*, 1998
Participants	Inclusion criteria: adolescents (aged 11-18 yrs) presenting to hospital after self-poisoning (overdoses of alcohol alone were excluded). Numbers: 33 participants. Loss to follow-up: 3/33 (24%). Profile: 27% (n=9) had previous history of overdose.
Location	Oxford, UK.
Methodology and assessment	Participants were initially interviewed using a quantitative questionnaire as close as possible to index episode. Follow-up: approximately three months after index episode.
Outcomes	Included: i) post-hospitalisation management. Excluded: i) DSM-IIIR diagnoses; ii) depression; iii) global functioning; iv) attitudes of subject and others towards overdose and its sequelae.

Notes	Selected sample; all subjects interviewed alone; all 25 patients were offered some form of aftercare after index episode.
Study	Bywaters and Rolfe, 2002
Participants	Inclusion criteria: young people and adults with a history of self-harm and friends or partners of people who had self-harmed. Numbers: 24 participants. Profile: 80% (n=19) female; 21% (n=5) friends or partners; age range of 16 - 49 years (but most in late teens or early twenties).
Location	UK.
Methodology and assessment	Participants were recruited by NCH, the children's charity, from other projects it was conducting. Most interviews were tape recorded; when permission was denied, interviewer recorded notes. Tapes and notes from interviews were sent to participants for validation; alterations were made in two cases. Interview length: from 45 minutes to over two hours.
Outcomes	Included: hospital management; ii) experiences with staff; iii) post-hospitalisation management; iv) effect on family and friends; v) service improvement. Excluded: i) reasons for self-harm behaviour.
Notes	The sample was not representative. The report was commissioned by a charity organisation.
Study	Cardell and Pitula, 1999
Participants	Inclusion criteria: suicidal adult inpatients placed under constant observation on hospital ward within the two weeks before interview. Numbers: 20 participants. Loss to follow-up: 0/20 (0%). Profile: 65% (n=13) female; mean age of 32 years; 60% (n=12) at state-owned psychiatric institution; 40% (n=8) at general medical centre with psychiatric inpatient units.
Location	USA.
Methodology and assessment	Participants participated in at least two extensive in-depth interviews regarding their experiences of constant observation.

Outcomes	Included: i) post-hospitalisation management; ii) experiences with staff. Excluded: none.
Notes	Not all participants had experienced a self-harm episode. Study was included as a study of interest due to the lack of research focused on service users' satisfaction with care on wards.
Study	Carrigan, 1994
Participants	Inclusion criteria: individuals who have survived an episode of deliberate self-poisoning. Numbers: six participants. Loss to follow-up: 0/6 (0%). Profile: 50% (n=3) female.
Location	Northern Ireland.
Methodology and assessment	Consent sought while patient was still in hospital; participants were visited shortly after discharge to provide more detailed information and answer questions; consent was sought a second time. Focused, face-to-face interviews were given. The interviews were non-directive but interviewers provided previously prepared questions to keep participants on track.
Outcomes	Included: i) experiences with staff; ii) post-hospitalisation management; iii) service improvement. Excluded: i) psychosocial needs; ii) relationship with family; ii) social networks.
Notes	A convenience sample was used.
Study	Cerel *et al*, 2006
Participants	Inclusion criteria: individuals who had made a suicide attempt and presented to emergency department or their family members and friends who had accompanied an individual to the emergency department after suicidal behaviour. Numbers: 719 participants (465 consumers; 254 family members). Profile: 86% (N=306, n=355) female; 56% (n=260, N=465) aged between 25-44 years; 35% (n=162, N=465) had an attempt within previous year; 63% (n=293, N=465) presented after an overdose.
Location	USA.

Methodology and assessment	Survey was made available on National Alliance on Mental Illness (NAMI) website. Survey included yes / no questions and an open-ended response.
Outcomes	Included: i) experiences with staff; ii) hospital management; iii) discharge. Excluded: i) method of attempt; ii) method of arrival to emergency department.
Notes	A convenience sample was used.
Study	Crockwell and Burford, 1995
Participants	Inclusion criteria: individuals with a history of self-harm by overdose during adolescence. Numbers: three participants. Profile: 100% (n=3) female; aged 16-23 years; 66% (n=2) were residents in a group care programme; 33% (n=1) undergoing counselling at a local community service agency.
Location	Newfoundland, Canada.
Methodology and assessment	Participants were first invited by counsellors at their agencies to participate. Consent for researcher to contact them and for participation was requested. Outcome measures: interviews with open-ended questions. Interviews were taped and transcribed, then analysed from a phenomenological perspective using Constant Comparative Method.
Outcomes	Included: i) hospital management; ii) experiences with staff; iii) discharge; iv) post-hospitalisation management; v) service improvement. Excluded: i) psychological state before episode; ii) expectations of care; iii) family reactions to self-harm.
Notes	
Study	Dorer *et al*, 1999
Participants	Inclusion criteria: adolescents attending hospital following an overdose. Numbers: 63 participants. Loss to follow-up: 20/63 (32%). Profile: 83.7% (n=36) female; aged 8-17 years; mean age of 14.3 years; 32% (n=14) reported significant parental physical or mental illness; 23% (n=10) reported past physical or sexual abuse.

Location	Birmingham, UK.
Methodology and assessment	Follow-up: ranged from six days to six weeks after index episode. In-home, semi-structured interview with adolescent and parent.
Outcomes	Included: i) emergency services; ii) hospital management; iii) initial contact with mental health service. Excluded: i) overdose event; ii) outcomes of overdose.
Notes	93% (n=40) of patients were admitted to hospital after overdose; 40% (n=17) stayed overnight.
Study	Dower *et al*, 2000
Participants	Inclusion criteria: i) individuals presenting to emergency after deliberate self-harm; ii) aged 18-24 years; iii) evidence of or strong suspicion self-harm was deliberate or suicidally motivated. Numbers: 147 participants. Loss to recruitment: 47/147 (32%). Profile: 47% (n=69) female; mean age of 21 years; 57% (n=83) received some form of treatment for a psychological problem in the past; 54% (n=79) had previous history of DSH.
Location	Brisbane, Australia.
Methodology and assessment	All cases of DSH in study population over nine month period were identified; individuals were contacted when able to provide informed consent. Follow-up: six weeks and three months after index attempt. In-depth psychosocial assessment including a telephone or face-to-face interview and questionnaire.
Outcomes	Included: i) hospital management ii) referral; iii) post-hospital management; iv) treatment compliance; v) previous suicidal behaviour. Excluded: i) precipitating events, ii) personal circumstances; iii) psychosocial stressors; iv) subsequent suicidal behaviour; v) current clinical status; vi) further contact with hospital.
Notes	
Study	Dunleavey, 1992
Participants	Inclusion criteria: i) overdose patients on ward over six hours; ii) not current psychiatric inpatients.

	Numbers: 17 participants. Profile: all aged over 16 years.
Location	London, UK.
Methodology and assessment	Interviews took place on ward before discharge or after first outpatient appointment by a psychiatric nurse. All interviews were taped. Interviews lasted from 30 minutes to one hour.
Outcomes	Included: i) expectations of hospital management; ii) hospital management; iii) experiences with staff; iv) service improvement. Excluded: none.
Notes	Memories of time in A&E were vague but largely focused on physical needs. Limited sample size.
Study	Harris, 2000
Participants	Inclusion criteria: individuals who regularly self-harm. Numbers: six participants. Profile: 100% (n=6) female; aged 20-45 years; 100% (n=6) self-cut; participants reported harming for 5 to 39 years.
Location	UK
Methodology and assessment	Participants were recruited from a penpal network and were encouraged to write letters about their experiences Two participants wrote one letter and four wrote two letters.
Outcomes	Included: i) experiences with staff. Excluded: i) significant life events; ii) understanding self-harm; iii) psychosocial needs.
Notes	
Study	Hengeveld *et al*, 1988
Participants	Inclusion criteria: patients referred to hospital one or more times due to a suicide attempt (any type of self-injury). Numbers: 173 participants. Loss to follow-up: 64/120 (37%). Profile: 62% (n=108) female; aged 12-79 years; 43% (n=74) had previous history of DSH; 79% (n=137) complied with psychiatric consultant's referral.
Location	Leiden, The Netherlands.

Methodology and assessment	Participants were interviewed four to six weeks after discharge and followed up by telephone interview at seven months after discharge. Interviews included both open and closed questions regarding psychiatric consultation. Interviewers: two trained psychology students and two authors.
Outcomes	Included: i) experiences with staff; ii) hospital management. Excluded: none.
Notes	
Study	Hood, 2006
Participants	Inclusion criteria: adolescents referred to Community Mental Health Centres because of suicidal behaviour (ranging from ideation to attempted suicide); ii) suicidal intent; iii) engaged in therapy and an agreement was made that suicidal behaviour had been effectively addressed; iv) not Maori or Pacific Islander. Numbers: ten participants. Profile: 50% (n=5) female; aged 14-19 years; mean age of 15.7 years; 70% (n=7) made a suicide attempt; 50% (n=5) required hospitalisation.
Location	Auckland, New Zealand.
Methodology and assessment	Separate semi-structured interviews with adolescents, their primary caregiver, and their therapist. Participants were given choice of interview site. Interviews lasted one hour and were taped and transcribed.
Outcomes	Included: i) post-hospitalisation management; ii) experiences with staff; iii) service improvement.
Notes	Participants were not all attempters.
Study	Horrocks *et al*, 2005
Participants	Inclusion criteria: i) patients presenting to hospital after DSH episode; ii) of fixed abode; iii) not aggressive with staff. Numbers: 45 participants. Profile: 60% (n=27) female; aged 18-56 years; approximately 75% (n=34) presented after an overdose; 73% (n=33) received a psychosocial assessment.
Location	Leeds, UK.
Methodology	Patients were contacted for participation by letter after

and assessment	discharge. Interviews were non-directive, free association narratives given by the author. All interviews were taped and transcribed.
Outcomes	Included: i) hospital management; ii) experiences with staff; iii) discharge; iv) post-hospitalisation management. Excluded: none.
Notes	
Study	**Hume and Platt, 2007**
Participants	Inclusion criteria: i) patients presenting to hospital after a DSH episode; ii) aged 16-50; iii) history of at least one previous episode within the last three years; iv) no learning difficulties or cognitive impairment; v) medically fit; vi) not a habitual drug user following an overdose. Numbers: 14 participants. Profile: 43% (n=6) female; aged 20-49 years; majority presented after an overdose; all had at least two previous DSH episodes.
Location	Edinburgh, UK.
Methodology and assessment	Participants were selected using quota sampling based on age and sex. Semi-structured interviews were conducted face-to-face and took place in a private room near the unit the participants were located. The average interview length was 40 minutes. All interviews were taped and transcribed.
Outcomes	Included: i) hospital management; ii) post-hospitalisation management; iii) service improvement. Excluded: i) mental illness; ii) alcohol dependency; iii) management versus prevention.
Notes	Heterogeneity of sample was notable.
Study	**Kreitman and Chowdhury, 1973**
Participants	Inclusion criteria: individuals making their first presentation to hospital after suicide attempt. Numbers: 93 participants. Profile: 57 (61%) female; 51% (n=47) of patients aged under 20 years.

Location	Edinburgh, UK.
Methodology and assessment	Participants participated in semi-structured interviews after formal psychiatric examination by service staff was completed. Direct questioning provided only to get patients to discuss key topics. Interviews lasted approximately one hour.
Outcomes	Included: i) attitudes to help-seeking. Excluded: i) knowledge about DSH services.
Notes	This study was part of larger study dealing with patients presenting with suicidal ideation and / or DSH behaviour.
Study	Nada-Raja *et al*, 2003
Participants	Inclusion criteria: participants belonging to a cohort of 1037 children born in Dunedin between 1 April 1972 and 31 March 1973 with complete data for self-harm behaviour and help-seeking. Numbers: 965 participants. Profile: 49% (n=471) female; 100% (n=965) were 26 years old; 3% (n=25) reported one or more self-harm episodes in the previous year; 60% (n=15; N=25) reported an overdose; 36% (n=9; N=25) reported self-cutting; 12% (n=119) reported lesser forms of self-harm behaviours in the previous year; 14% (n=138) only reported substance abuse to deal with emotional pain; 71% (n=683) reported no self-harm behaviours in the previous year.
Location	Dunedin, New Zealand.
Methodology and assessment	Face-to-face, semi-structured interviews regarding self-harm behaviours and ideation. Interviews lasted 20 minutes.
Outcomes	Included: i) satisfaction with help received; ii) barriers to help-seeking. Excluded: i) help-seeking for self-harm.
Notes	The sample adequately represented all socioeconomic levels.
Study	National Collaborating Centre for Mental Health, 2004 (London)
Participants	Participants: individuals with a history of self-harm. Numbers: five participants. Profile: 100% female.

Location	London, UK.
Methodology and assessment	Participants were recruited by the central London branch of the Samaritans. Focus group held in lecture room at Samaritan offices related to experiences of services with the first 48 hours of care.
Outcomes	Included: i) experiences with hospital staff; ii) arrival to A&E; iii) physical management. Excluded: none.
Notes	Four women participated in a focus group; one woman participated in an individual interview. Results included in same report as National Collaborating Centre for Mental Health 2004 (Nottingham).
Study	National Collaborating Centre for Mental Health, 2004 (Nottingham).
Participants	Inclusion criteria: individuals with a history of self-harm. Numbers: seven participants. Profile: 100% (n=7) female; aged 21-44 years.
Location	Nottingham, UK.
Methodology and assessment	Self-harm self-help group in Nottingham contacted to see if members would be interested in taking part in a focus group. The focus group was held in National Self-Harm Network offices related to experiences of services with the first 48 hours of care.
Outcomes	Included: i) experiences with staff; ii) hospital management. Excluded: none.
Notes	Results included in same report as National Collaborating Centre for Mental Health 2004 (London).
Study	Palmer *et al*, 2006
Participants	Inclusion criteria: individuals presenting to general hospital after a self-harm episode in the last 18 months. Numbers: Quantitative data on waiting times and outcomes: 1818 ‘patient pathways’ recorded. Qualitative and quantitative data regarding service user experience: 206 participants. Profile of service users (qualitative participants): 86% (n=177) female. 29% (n=60) were first time users of emergency services following self-harm. 94% (n=194) were white British.

Location	UK.
Methodology and assessment	Waiting times and outcomes data were collected by staff at A&E departments. Service user experience data was collected from paper and online surveys.
Outcomes	Included: i) emergency services; ii) hospital management; iii) experiences with staff; vi) discharge. Excluded: i) staff training, support and supervision; ii) staff attitudes and opinions.
Notes	87% (n=179) of patients required physical treatment.
Study	Perseius *et al*, 2003
Participants	Inclusion criteria: i) patients who had been in DBT treatment for 12 months or longer with a history of DSH and diagnosed with borderline personality disorder; ii) DBT therapists. Numbers: 14 participants: 10 patients, four therapists. Profile of patients: 100% (n=10) female. Aged 22-49 years. 90% (n=9) had a diagnosis of depression, 90% (n=9) anxiety disorders, 30% (n=3) eating disorders, 20% (n=2) social phobia. Several patients reported substance abuse. Contact with psychiatric services ranged from 4 to 14 years.
	Profile of therapists: 50% (n=2) female. 25% (n=1) psychiatrist and senior cognitive psychotherapist, 25% (n=1) registered nurse and junior cognitive psychotherapist, 50% (n=2) attendants in psychiatric care and junior cognitive psychotherapists. Work in psychiatric care ranged from 12 to 23 years.
Location	Sweden.
Methodology and assessment	Participants were drawn from purposeful sampling. All participants gave consent. Socio-demographic variables and symptoms were collected using a semi-structured questionnaire. Then patients participated in individual, focused interviews with questions asked using a funnel approach (general questions followed by more specific questions). Interviews took place in the premises of the DBT team. Therapists were given free format questionnaires and participated in a group interview. Both were focused on areas corresponding to patient responses. The first author conducted all interviews and had not met any of the participants before the study. Interviews were

	audio taped. Burnard's content analysis method was used to analyse qualitative data.
Outcomes	Included: i) impact of DBT on suffering and life situation; ii) effect of specific components of therapy; iii) perceptions of DBT, iv) perceptions of previous psychiatric care. Excluded: i) symptoms, suffering and life situation.
Notes	
Study	Pitula and Cardell, 1996
Participants	Inclusion criteria: suicidal inpatients under constant observation. Numbers: 14 participants. Profile: 57% (n=8) female; aged 21 to 47 years.
Location	Midwest and Pacific Northwest, USA.
Methodology and assessment	Open-ended interviews were conducted after constant observation was discontinued. Transcripts were analysed using the phenomenological method.
Outcomes	Included: i) experiences with staff; ii) hospital management. Excluded: none.
Notes	Constant observation ranged from 16 hours to 3.5 days.
Study	Rotheram-Borus *et al*, 1999
Participants	Inclusion criteria: female adolescents presenting to A&E departments after a suicide attempt. Numbers: 140 participants. Profile: 100% (n=140) female; 88% (n=123) were Latin American; 89% (n=125) experienced an overdose; 31% (n=43) had made a previous attempt.
Location	New York City, USA.
Methodology and assessment	Adolescents and their primary carer were assessed after their emergency room visit and before outpatient treatment.
Outcomes	Included: i) maternal and adolescents' attitudes toward treatment. Excluded: i) diagnoses; ii) depression; iii) suicidal behaviours; iv) suicidal ideation; v) substance abuse; vi) impulsiveness; vii) maternal depression; vii) family

	relationships.
Notes	All participants were from families of low socioeconomic status. Thirty-five per cent (n=49) had been held back at least one grade in school.
Study	Smith 2002
Participants	Inclusion criteria: individuals who self-injure who were in contact with the voluntary sector. Numbers: 18 participants (3 consumers; 15 staff members). Profile: consumers: not provided. Staff members: 60% (n=9) nurses; 20% (n=3) occupational therapists; 13% (n=2) psychotherapists; 7% (n=1) psychiatrist.
Location	Leicestershire, UK.
Methodology and assessment	Unstructured interviews using study title, ‘Perceptions of service provision for clients who self-injury in the absence of expressed suicidal intent’, as a guide. Permission to interview was sought from the relevant consultant psychiatrist where appropriate. Interviewer: author. Interviews were taped and transcribed. Participants were asked to verify transcript. Analysis followed Burnard's thematic content analysis.
Outcomes	Included: i) experiences with staff; ii) hospital management. Excluded: i) staff attitudes; ii) staff perceptions.
Notes	Staff members had varying lengths of service and experience.
Study	Suominen *et al*, 2004
Participants	Inclusion criteria: individuals presenting to general hospital after suicide attempt. Numbers: 53 participants. Loss to follow-up: 0/53 (0%). Profile: 57% (n=30) female; mean age of 36.4 years; 92% (n=49) presented after an overdose.
Location	Helsinki, Finland.

Methodology and assessment	Patients were interviewed about their psychiatric consultation after a suicide attempt. Follow-up: one to 43 days after consultation (median = 6 days).
Outcomes	Included: i) hospital management; ii) experiences with staff. Excluded: i) suicidal ideation; ii) hopelessness; iii) depression.
Notes	This study formed an independent sub-project of the WHO/EURO Multicentre Study on Parasuicide.
Study	Treloar and Pinfold, 1993
Participants	Inclusion criteria: patients admitted to acute medical and surgical unit of district general hospital. Numbers: 105 participants. Profile; 63% (n=66) female.
Location	Dudley, UK.
Methodology and assessment	Questionnaires were distributed to consecutive patients admitted to the acute medical and surgical unit.
Outcomes	Included: i) experiences with staff. Excluded: none.
Notes	
Study	Warm *et al*, 2002
Participants	Inclusion criteria: self-defined self-harmers. Numbers: 243 participants. Profile: 84% (n=205) female; mean age for females = 21 years, males = 23 years; 97% (n=236) had self-cut; 54% (n=131) had prior history of DSH; 17% (n=41) reported of alcoholism; 15% (n=36) reported drug abuse; 21% (n=50) were from the UK; 55% (n=133) were from the US.
Location	Worldwide.
Methodology and assessment	Participants recruited to participate in an internet questionnaire via postings to eight internet discussion groups. The questionnaire was largely limited to pre-provided responses but participants were sometimes allowed to provide personal responses.
Outcomes	Included: i) experiences with staff; ii) past help-seeking.

	Excluded: none.
Notes	Participants were counted as only those giving valid responses to questionnaire.
Study	Whitehead, 2002
Participants	Inclusion criteria: i) admitted to local general hospital following an overdose; ii) aged 18-65 years; iii) deemed fit for psychosocial interview; iv) able to give informed consent; v) participation judged to be non-deleterious by clinical staff or research interviewer; vi) had not been assessed more than twice in 12 months before entering the study. Numbers: 20 participants. Profile: 70% (n=14) female; aged 19-60 years; 100% (n=20) presented after an overdose; 70% (n=14) had history of previous overdose; 50% (n=10) diagnosed with depression, 90% (n=18) anxiety disorder.
Location	Oxford, UK.
Methodology and assessment	Patients referred for psychosocial assessment were approached at 8.30am to participate. Participants then received a baseline interview. All participants were interviewed again at approximately noon regardless of whether or not they had received an assessment to determine whether or not a psychosocial assessment had an impact on patient outcomes. The interview consisted of questionnaires and qualitative data on treatment satisfaction and any perceived benefits of the psychosocial assessment.
Outcomes	Included: i) treatment satisfaction; ii) attitudes towards psychosocial assessment. Excluded: i) depression; ii) hopelessness; iii) self-concept.
Notes	
Study	Wiklander *et al*, 2003
Participants	Inclusion criteria: i) attempted suicide patients admitted to specialized ward for suicidal patients; ii) spoke Swedish; iii) discussed shame reactions during interview. Numbers: 13 participants. Loss to follow-up: 7/13 (54%). Profile: 38.4% (n=5) female; aged 22-53 years; 54% (n=7) presented after an overdose; 62% (n=8) had history of self-harm; 85% (n=11) diagnosed with major depression, 23% (n=3) alcohol dependence, and 31% (n=4) anxiety disorder.

Location	Stockholm, Sweden.
Methodology and assessment	Patients were provided with information leaflets and asked to participate in semi-structured interviews. Interviews took place at ward between eight and 77 days (median of 26 days) after suicide attempt and as close to discharge as possible. Interviews were taped and transcribed and lasted approximately one hour. All respondents were contacted for follow-up two years after interview; six agreed to participate.
Outcomes	Included: i) hospital management; ii) experiences with staff. Excluded: none.
Notes	All respondents who provided follow-up data confirmed their interpretations of shame.
Study	**Wolk-Wasserman, 1985**
Participants	Inclusion criteria: suicide attempters admitted to intensive care unit. Numbers: 40 participants. Profile: 43% (n=17) diagnosed with alcohol abuse and 35% (n=14) drug abuse; 93% (n=37) exhibited depressive symptoms.
Location	Stockholm, Sweden.
Methodology and assessment	Participants were given semi structured interviews; their significant others were given semi-structured interviewed; nondirective interviews were given to one member of staff who had watching functions and one member with supervisory responsibilities for each participant with participant's consent. Semi-structured interviews were conducted to complete results gained by nondirective interviews. Interviewers: participants - author; significant others - author and social worker; staff - author.
	Follow-up: participants were followed-up in connection with their admission and once again during the following year; significant others were followed-up during the first week after index episode and once again during the following year with patient's permission; staff involved in patient's care were followed-up during investigation period. Interviews conducted on intensive care unit were not

	recorded for ethical reasons; interviews with staff were recorded.
Outcomes	Included: i) hospital management; ii) experiences with staff. Excluded: none.
Notes	Interviews were conducted with the attempter’s significant other and intensive care unit staff.

Appendix 4 Characteristics of Excluded Studies

Study and Country	Reason for Exclusion
Eagles *et al*. 2003 UK	Fifty-nine psychiatric patients took part in a semi-structured interview about what factors they found helpful or unhelpful when they felt suicidal. Did not include experiences of services.
Harker-Longton and Fish 2002 UK	One woman's experiences with services for DSH. The participant was mildly learning-disabled and had resided long term in a medium security unit.
Sinclair and Green 2005 UK	Twenty participants were interviewed about why they no longer self-harmed. Did not include experiences of services.
Talseth *et al* 1999 Norway	Study of 21 psychiatric in-patients' experiences of care provided by mental health nurses. Not all participants displayed suicidal behaviour. Did not include experiences of services.
Talseth *et al*. 2001 Norway	Study of 21 psychiatric in-patients experiences of care provided by physicians. Not all participants displayed suicidal behaviour. Did not include experiences of services.

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Addendum

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