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means of sharing experiences and inspiring hope for the future. The benefits of psychoeducation groups are recognised and there should be far greater opportunity to participate in these at the time of diagnosis. Self-help groups too provide a similar function and information on their availability locally should be widely available at the time of diagnosis and during the course of treatment.

Finally, there is a need for more training for mental health professionals on the impact of diagnosis and the support individuals need in relation to their diagnosis. The dearth of research in this area is unfortunately a sad indication of the importance placed on this area within the current services. Mental health services are increasingly emphasising the importance of promoting recovery and social inclusion. If mental health professionals are to respond effectively to this they require a better understanding of the impact that diagnosis can have on individuals and their lives. Only through incorporating this knowledge into their practice will they be able to genuinely support service users in their recovery and help to facilitate their participation in society on an equal basis.

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Sadly, Martina Kilbride died following the completion of this research; she had strong views about diagnosis and the other authors would like to dedicate this article to her memory.

Declaration of interest

None.

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NIKKI D. TOMS AND CRAIG W. RITCHIE

Management of self-harm in older people

AIMS AND METHOD
The epidemiology of self-harm in older people is poorly understood and a low incidence rate hampers research efforts. Regional surveillance for this may assist with research and improve clinical services accordingly. This study involved undertaking a scoping exercise to explore current management of self-harm in elderly people in selected North London hospitals, by interviewing healthcare professionals directly involved in their treatment.

RESULTS
The study showed varied methods of coding clinical information across trusts, with no consistent method of surveillance.

CLINICAL IMPLICATIONS
Implications of this exercise involve generation of a summary document that will educate stage two of the project, which is the convention of a working party to implement a surveillance system across the region.

Self-harm in the older person is important, not least because of the risk of further self-harm and suicide compared with younger populations.[1] National Institute for Health and Clinical Excellence (NICE) guidelines specifically recommend that older individuals should be assessed by mental healthcare practitioners experienced in the assessment of older people who self-harm; that all acts of self-harm should be regarded as evidence of suicidal intent until proven otherwise; and consideration should be given to admission for further assessment.[2]

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Rates of self-harm and suicide in the older population are similar,[3,4] suggesting they have a more closely related epidemiology compared with the younger population. However, difficulties in understanding the risks and thereby the optimal management of self-harm in older people occur because systematic enquiry is hampered by the low incidence rate of this behaviour. Given the clear association between self-harm and suicide, and the distress that self-harm in itself causes and signifies in older people, a clearer understanding of both clinical and demographic risks is overdue. To overcome the low incidence rate, surveillance across a number of centres would assist epidemiological intervention studies.[1] A surveillance system has been implemented by the University of Oxford Centre for Suicide Research since 1976, allowing collection of sociodemographic and clinical information on individuals presenting.[5]

This study aimed to explore interviewees' attitudes towards implementing a surveillance system with possible clinical and academic applications. We also sought to evaluate possible difficulties with setting up a surveillance system and highlight the relevant parties and their attitudes to such implementation.

Method

Relevant stakeholders at six North London Hospitals that receive individuals who self-harm in their Accident and Emergency (A&E) departments were contacted. This included consultant old age psychiatrists, liaison teams (both aged and adult), and representatives of casualty departments to include both clinical and managerial leads.

A list was made up of all possible contacts who were initially telephoned to arrange a face-to-face interview or a further telephone interview. After this, the contact was sent by email an explanatory letter from the study lead (C.W.R) explaining in detail the nature and purpose of the interview. The interview was then completed using a study-specific proforma.

Results

Across the six hospitals, 35 potential stakeholders were identified. From these we completed interviews with: 9 old age consultant psychiatrists (9/13), 3 liaison consultant psychiatrists (3/5), 2 liaison nurses (2/4), 2 nurse managers (2/6) and 1 liaison specialist registrar (1/2). However, despite five consultants in A&E being approached, none participated in the study. The following themes emerged.

Current systems in place for recording individuals presenting with self-harm

Different methods for recording were reported. The majority utilised paper records kept in A&E or emergency assessment centres. Four hospitals used a computerised record, which recorded basic demographics of the person rather than diagnostic details. One hospital reported a working database specifically for collection of patient data by the liaison service. Therefore in most hospitals a combination of both computerised and paper records were used.

Who to contact to gain access to this information?

Information was contained within different departments within the hospitals, either in A&E or emergency assessment centres where the nursing managers would need to be contacted in order to access this information. In other hospitals, information was held within the liaison psychiatry departments. Within our sample, apart from one hospital, it was not clear whether information was being stored or routinely accessed by clinicians or academics for either research or audit purposes.

Clinical practice

Elderly people presenting with self-harm were not automatically admitted. Some hospitals had dedicated old age liaison teams, but in the main these teams would only review people if admitted to medical wards. Individuals presenting acutely would be seen by nurses and/or senior house officers in emergency assessment centres/ liaison teams or crisis teams, especially if admission was considered. Opinion differed as to whether older people were treated differently, but it was unclear whether there were ever separate protocols for management of self-harm.

General attitudes towards systems in place

Although it was generally considered that the systems in place for patient management were adequate, areas of improvement included implementation of dedicated old age psychiatry liaison teams and a consistent system for monitoring. It was reported that systems for monitoring were often patchy and without a service level agreement.

Implementation of a surveillance system for monitoring self-harm

The Appendix shows the different views expressed regarding implementing a surveillance system.

Which departments need to be involved?

Which departments need to be involved in the implementation of a surveillance system depends on systems in place in particular hospitals, but generally those who need to be consulted would be: A&E; liaison psychiatry; old age psychiatry departments; emergency assessment/

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reception centres in mental health units; medical admissions units/medical wards; service managers of mental health services for old age psychiatry; and the modern matron.

Discussion

Approximately 1% of people who self-harm will go on to die by suicide in the subsequent 2 years, with the risk highest in the initial weeks. This equates to a suicide rate of 50–100 times that of the general population.[6] As the rate of suicide is highest in older people, there is a need for suicide prevention strategies to be based on high-quality evidence that identifies specific and quantifiable risk factors to ascertain those at highest risk.[1]

Establishing a computerised database that is standard across hospitals would enable storage of clinical information for healthcare professionals involved in the assessment of these individuals and aid risk evaluation as well as epidemiological research and act as a reservoir of individuals for complex intervention studies.

As shown earlier, our scoping exercise reveals that the majority of healthcare professionals involved in the care of such individuals recognise the benefits of implementing a surveillance system, as no standardised method of coding these individuals across trusts is currently available. However, concerns were expressed such as lack of resources and staff to do this. Inevitably, unless resources are directed towards this, it would involve an increased workload for those involved in the care of these people. It was noted that A&E consultants did not participate; and difficulty engaging this group would seriously undermine the implementation of surveillance.

Our study was limited by the small number of participants involved, and could have benefitted from more systematic recruitment of relevant stakeholders in all hospitals, including more professionals working in the A&E department. It was noted that data from these departments were not included because no consultants agreed to be interviewed. It may therefore have been useful to approach other professionals such as nurses and registrars who are based in A&E in order to access this data.

Despite these limitations the information gathered from this scoping exercise can be used to educate the establishment of a surveillance system across North London hospitals for self-harm in the older person. Such surveillance will help academics, clinicians and policy makers understand the nature and extent of self-harm in elderly people. Moreover, the data generated from this exercise will be available for answering many research questions with regard to risk factors for self-harm, effective management and outcome. Such surveillance will assist mental health practitioners in achieving Health of the Nation targets to reduce suicide rates and assist the deliberations of NICE with regard to this.

Appendix

Views expressed regarding implementing a surveillance system

Reasons for

1. Help guide service provision and development
2. A database for people presenting with self-harm would aid risk management
3. Provide information required to look into incidence, demography of population, methods of self-harm to aid academic and epidemiological research
4. Collection of prospective data and areas of focus for intervention
5. Aid diagnosis with emphasis on comorbid conditions/alcohol/drug use and previous psychiatric history
6. Would help provide information regarding the overlap between psychiatric conditions and self-harm
7. Allows comparison of data across trusts

Reasons against

1. No funding or staff available to implement such a system therefore leading to increased workloads for current staff
2. A surveillance system would aid academic research but could not see clinical purpose
3. Stated that there were systems in place for monitoring of these individuals in particular trusts and the purpose of an additional service would need to be considered
4. System for monitoring already in place and additional systems would not be any benefit. Real concern is follow-up procedures for people who present with self-harm as the risk of suicide increases
5. Difficulties deciding which staff would enter this information into the database, how to ensure this is reliable and whether additional training is needed

Declaration of interest

Since submitting this article, N.D.T. has moved into the pharmaceutical industry.

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