Public Health Agency

Self-Harm Symposium

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Conference Report

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Contents

Glossary of Terms

PHA	Public Health Agency
DHSSPS	Department of Health, Social Services and Public Safety
NI	Northern Ireland
RoI	Republic of Ireland
ED	Emergency Department
NSRF	National Suicide Research Foundation
HSWI	Health & Social Wellbeing Improvement
NIAS	Northern Ireland Ambulance Service
PSNI	Police Service of Northern Ireland
ASD	Autism Spectrum Disorder
KUF	Knowledge and Understanding Framework

Executive Summary

Introduction

The publication of the first Northern Ireland annual Self-Harm Registry report for 2012/13 provides the background and commitment for further examination of this important public health challenge in Northern Ireland.

At the same time as the desire to learn more, there is also an increasing recognition of the need to find ways to support families' and carers' understanding about what they can do to support someone who is self-harming and, most importantly, play a part in their recovery.

To address both these challenges the Public Health Agency commissioned two events, one was specifically tailored to meet the needs of families and carers and was commissioned through the Self-harm Service User Reference Group. This event sought to examine real life experiences alongside practical interventions and is reported on separately. The second event was a symposium to facilitate learning aimed specifically for professional staff from the statutory, community and voluntary sectors working in the field. The intention was to create an environment for learning and discussion, with a focus on key issues of concern as well as best practice and challenges in the context of future commissioning and service redesign. The planning of the events was designed to coincide with Self-Harm Awareness Week from 1- 8 March 2015.

Pre-event questionnaire

As part of the evaluation of the symposium a pre-event questionnaire was developed. During registration, participants were invited to complete the short pre-event questionnaire. The purpose of the questionnaire was to gauge the current understanding of self-harm behaviour in Northern Ireland (NI). Questions were directly related to the objectives of the event with the aim of increasing understanding of self-harm behaviour and care pathways throughout NI.
Key findings from the survey included the fact that:

- 40% of respondents indicated that their current understanding of the prevalence of self-harm in NI was 'very little' or 'average'
- Over two thirds (69%) indicated that their understanding of the service user perspective on self-harm services was 'very little' or 'average'
- 82% of respondents highlighted the importance of training for front-line staff as 'important' or 'essential'
- The majority (56%) of respondents indicated that the level of self-harm research was 'very little' or 'average'
- Two thirds (67%) indicated that their understanding of services in the C&V sector was 'average' or 'good'

Symposium

The event was formally launched by the Minister for Health, Social Services and Public Safety, Mr Jim Wells MLA, who highlighted the global challenge of self-harm

and suicide and focused in particular on the situation in NI and the opportunity of contributing to the consultation on the future suicide prevention strategy, a follow on from the Protect Life strategy.

Key Findings from the Registry in Northern Ireland

The context of the Minister's outline was further enhanced by the presentation of the data from the 2013/14 annual report and outlined by the CE of the PHA, Dr Eddie Rooney, who summarised key findings including:

- There were 8,453 self-harm presentations to Emergency Departments (ED) in Northern Ireland, involving 5,983 persons;
- The rate of repetition of self-harm was 20% for males and 19% for females;
- Persons aged 15-29 years accounted for almost half (44%) of all self-harm presentations;
- Drug overdose was the most common method of self-harm accounting for almost three quarters of presentations (74%);
- Although rare as a sole method of self-harm, alcohol was involved in almost half of the total presentations (49%);
- Based on the European Age Standardised Rate (EASR), the rate of self-harm for Northern Ireland was 327 per 100,000 (males: 333; females: 321);
- The EASR of self-harm in Northern Ireland was over two-thirds (64%) higher than that for the Republic of Ireland; and
- In addition to self-harm, data was also collated on suicidal ideation. There were 3,623 cases recorded in 2013/14. Almost two thirds of cases presenting with suicidal ideation were males (65%; n=2,371).

Skilling Up Staff

The need for skilled staff in Emergency Departments (EDs) that have contact with individuals who self-harm has increasingly been recognised as a vital requirement[1] to help build understanding about self-harm behaviour and provide the necessary care[2]. Professor Arensman outlined the challenge of training staff in ED settings and also reported on the evaluation of pilot work that had been undertaken in the Republic of Ireland.

The objectives of the training described were:

- To increase knowledge and understanding of self-harm and suicide;
- To promote a positive attitude regarding self-harm and suicide prevention; and
- To improve clinical confidence in the management of self-harm.

Dr Arensman reported that to date some 102 ED staff have been trained and of those trained, 87 showed significant changes in attitude, knowledge and confidence. Amongst the primary recommendations it was suggested that implementing

[1] HSE (2005). Reach Out – National Strategy for Action on Suicide Prevention 2005/2014

2 National Institute for Health and Clinical Excellence, NICE Guidelines, 2011

refresher courses would increase the sustainability and efficacy of the training, including increasing elements of skills-based learning.

A significant focus of the symposium was the learning from the data collection through the NI Self-harm Registry. In addition to the annual report for NI being launched, a longitudinal review from data collected over a 6-year period (2007-12) for the Western Health & Social Care Trust area was also published. The purpose of this report is to demonstrate how the Registry can be used to identify trends in Northern Ireland and allow comparable analysis with data collected in the Republic of Ireland. Given the extensive amount of data that is now available, a high level report was presented, together with a number of supplementary reports which focus on specific issues relating to self-harm.

The report reviewed data from 8,175 self-harm presentations to hospital, involving 4,733 individuals. The age-standardised incidence rate was 342 per 100,000 of the population. The most common method of self-harm was intentional drug overdose, which was involved in over two thirds of all presentations and more common among men than women.

The first supplement focused on the issue of repetition and suggested that the rate of repetition within 12 months was 33.8% based on presentations (2,266 of 6,706) and 18.0% based on persons (726 of 4,041). This implies that over one-third of all presentations were due to repeat acts.

A Service User Perspective

The symposium was addressed by a service user who sought to highlight the issue of patient experience. One of the key areas she raised concerned the issue of stigma and she commented that, 'If *we feel that we will be judged if we reach out to ask for help then we won't do it. The heart of stigma."* She described the challenge of layers and layers of stigma acting as barriers to accessing help. She felt stigma is born from a lack of understanding of the facts.

Best Practice

The symposium heard about a potential model of best practice as part of the commitments set out within the Scottish Suicide Prevention Strategy. The model includes a 'Distress Brief Intervention' (DBI) a time limited, assertive, supportive and problem solving contact between an individual in distress and a service provider. The model is still under consideration and implementation will include engagement with local focus groups over the coming months to review the applicability of the model and the evaluation of outcomes process.

The symposium also considered the issue of 'risk assessment' in particular after an act of self-harm. Specific reference was made to a large study of suicide which found that the majority of individuals who were assessed were categorised as 'low risk'. It was noted that risk assessment exercises were often designed to give a crude indication of the level of risk (for example, high or low) of a particular outcome, most often suicide.

Despite the widespread use of such risk assessment instruments, there is no clear evidence that their use makes any difference to patient outcome. The usefulness of any particular risk assessment scale for repeated self-harm depends on the ability to correctly distinguish all those people who do go on to self-harm from those who do not. Whilst the risk of repeated self-harm is important, healthcare professionals will be most concerned about the risk of suicide.

Recommendations included the need to offer an integrated and comprehensive psychosocial assessment of needs and risks to understand and engage people who self-harm and to initiate a therapeutic relationship. In line with NICE guidance, it was agreed that the model should include issues such as:

- Compassion, respect and dignity;
- An initial assessment of physical health, mental state, social circumstances and risk of suicide;
- A comprehensive psychosocial assessment;
- Monitoring required to keep people safe, in a safe physical environment; and
- Timely access to interventions, guidelines and support for families

Specific Themes from Workshops

In addition to the plenary sessions, there were also five workshops that provided participants with the opportunity to examine and discuss in depth key aspects of learning about self-harm, they were:

- Self-harm in a community setting
- Addressing training needs
- Self-harm and substances misuse
- Self-harm and research

Evaluation

A post evaluation of the symposium was undertaken with responses from 60 participants. The overwhelming feedback was extremely positive, with 97% of participants rating speakers and organisation of the event as either 'Excellent' or 'Good'. When asked how the day met expectations regarding the provision of information in relation to:

- The prevalence of self-harm in NI - 95% stated that the event 'met' or 'exceeded' expectations;
- The pattern of repetition of self-harm attendances to ED – 93% stated that the event 'met' or 'exceeded' expectations;
- The importance of service user input to service redesign – 63% stated that the event 'met' or 'exceeded' expectations;
- How self-harm can be addressed in the context of the new suicide prevention strategy – 58% stated that the event 'met' or 'exceeded' expectations;
- Understanding patient pathways – 60% stated that the event 'met' or 'exceeded' expectations;

- How NI is addressing self-harm in comparison to counterparts across UK – 73% stated that the event 'met' or 'exceeded' expectations; and
- Provide an opportunity for discussion amongst professionals – 72% stated that the event 'met' or 'exceeded' expectations.

Concluding Remarks

The level of interest in the subject of Self-harm and the span of media coverage demonstrated the desire to explore the issues related to self-harm, and more importantly, what can be done to support individuals who self-harm and their carers.

The launch of the two reports at the conference was an ideal opportunity to highlight the extent of self-harm and the importance of surveillance, demonstrating clearly how the data can be used in academic, policy and care settings. Whereas a separate event was held the following day for carers and families, the inclusion of a workshop on Self-harm in a community setting as part of the symposium, helped to ensure that the central issue of families and carers' needs was addressed. It is worth noting that this was the most popular of the 5 workshops hosted on the day.

The importance of increasing awareness of self-harm within a primary care setting was integrated as a key theme by all speakers and was also highlighted within the workshops; particularly the workshop looking at substance misuse and long-term management with mental health services.

The initial goal of the symposium was to attract between 100-120 delegates to the event. In fact over 200 delegates registered and participated in the symposium. Before the event some 40% of pre-registered delegates had indicated that their understanding of the prevalence of self-harm was 'very little' or 'average'. Post event, some 97% of attendees rated the event speakers as 'Good' or 'Excellent' and 95% indicated that the event had met or exceeded their expectations.

The overall conclusion was that the symposium achieved (or exceeded) the original objectives in terms of content, learning, organisation and delivery. Ultimately, the goal to actively promote discussion amongst key professionals and those working in the field was achieved with learning stretching beyond the immediate event to inform and influence the wider policy and commissioning of services in order to ensure better outcomes for those who self-harm in the future.

Summary of Key Learning Points and Questions for the Future

The key discussion/learning points from the event were:

- How do we ensure that self-harm remains a key focus for the new suicide prevention strategy
- How do we promote the surveillance work in NI as part of the Self-Harm Registry within the rest of the United Kingdom and further afield as best practice
- How do we use the data being reported from the self-harm Registry
- How can we effectively address training in the ED setting

- Longitudinal data provides a broad spectrum of information and this needs to be translated into meaningful reports.
- The use of supplement reports needs to be used as a channel to continue to raise awareness of the prevalence of self-harm
- Service users need to remain at the heart of service design and research
- There are many models of intervention operating, how should they be quality assured and delivered in a consistent and equitable manner.
- How do we promote awareness and use of effective models of risk assessment that will bring about positive outcomes for service users.
- Collaboration is critical if as a society we are to address self-harm and therefore the interface between the statutory, community and voluntary providers is critical.
- The need to address the link between substance misuse and self-harm, the evidence of the correlation is strong but often solutions to address the issues are dealt with in isolation from each other.
- How do we as professionals develop NI as a research and learning base on self-harm, what partnerships need to be developed and how can these be exploited to bring about a cultural and service change to address self-harm

1.0 Context

1.1 Background

The context for the symposium arose from discussions following the publication of the first annual Self-Harm Registry report 2012/13 and the discussion of the Self Harm Registry Steering group and the regional Self-harm Working Group. It was clear that professionals working in Health & Social Care and those working in the community & voluntary sector were keen to explore their understanding of self-harm and effective interventions to address the needs of those who self harm.

At the same time, there was an increasing desire to find ways to support families and carers' understanding about what they could do to support someone who was self-harming and, most importantly, play a part in their recovery.

To address both these challenges two events were commissioned, one was specifically tailored to meet the needs of families and carers and was commissioned through the Self-harm Service User Reference Group. This event sought to examine real life experiences and practical interventions and is reported on separately. The second event was aimed specifically for professionals and those working in the field of self harm and was developed by the Public Health Agency (PHA). The intention was to create an environment for learning and discussion which focused on the key issues of concern alongside highlighting best practice. The planning of the events was designed to coincide with Self-Harm Awareness Week from 1- 8 March 2015.

The chair of the morning session was Dr Carolyn Harper, Executive Medical Director and Director of Public Health in the PHA. Dr Harper outlined the content of the event, including the primary aims and baseline awareness data collected, and its relevance to public health in Northern Ireland.

1.2 Symposium Aim:

The aim of the event was to facilitate a learning event for professionals from the statutory, community and voluntary sectors working in the field of self-harm to examine best practice locally, nationally and internationally and consider the challenges in the context of future commissioning and service redesign.

1.3 Symposium Objectives:

In order to achieve the aim of the symposium 11 high level objectives were identified, they were:

1. To outline how self-harm is to be addressed in the context of the new Suicide Prevention Strategy for Northern Ireland
2. To hear the service user experience and how it can impact on service re-design
3. To launch the second annual report of self-presentations in Northern Ireland
4. To present evidence on the rates of repetition of self-harm, the associated factors and care pathways

5. To highlight models of intervention at community level and the role of families and carers
6. To examine models of training for staff on self-harm awareness and how to develop empathy with service users
7. To examine the challenge of addressing self-harm in a primary care setting and the link to wider commissioning of services
8. To outline existing and emerging opportunities for research in self-harm and developing collaborations
9. To examine the impact of self-harm on acute services and understanding the patient pathway
10. To assess how Northern Ireland is addressing the challenge of self-harm in a national and international context
11. To actively promote discussion amongst key professionals in a multi-disciplinary setting in terms of developing better care pathways for service users

The initial aim was to attract an audience of between 100-120 delegates and bring together a diverse range of speakers from all five health and social care trust areas, statutory and community providers and from other parts of the UK and Ireland that could provide learning, stimulate discussion and stimulate new ideas. The programme for the event is attached in appendix 1

1.4 Pre-event Questionnaire

In order to ascertain the impact of the symposium a pre-event questionnaire was developed. During registration, participants were invited to complete the short pre-event questionnaire. The purpose of the survey was to gauge the current understanding on self-harm behaviour in Northern Ireland (NI). These questions were linked directly with the objectives of the event with the aim of increasing people's understanding of self-harm behaviour and care pathways throughout NI.
In total, there were **112** responses which equates to almost **70%** response rate of those who pre-registered, a full summary of the questions and responses is provided in appendix 2.

Key points:

- **40%** of respondents indicated that their current understanding of the prevalence of self-harm in NI is 'very little' or 'average'
- Over two thirds (**69%**) indicated that their understanding of the service user perspective on self-harm services is 'very little' or 'average'
- **82%** of respondents highlighted the importance of training for front-line staff as 'important' or 'essential'
- The majority (**56%**) of respondents indicated that the level of self-harm research is 'very little' or 'average'
- Two thirds (**67%**) indicated that their understanding of services in the C&V sector as 'average' or 'good'

2.0 Addressing self-harm in a Strategic Context

Presenter: Jim Wells MLA, Minister of Health, Social Services & Public Safety

Statistics on suicide and self-harm provide key indicators of the mental health status of any country. These statistics are determined by a broad spectrum of different factors which are individual to each country. The key issue is how we use that data to improve services. Data on suicide and self-harm are widely used to inform research, planning and policy-making, enabling government agencies and support services to target their resources most effectively.

In 2013 the Northern Ireland Statistics and Research Agency (NISRA) reported 303 suicides, the second highest number on record in Northern Ireland. Just over three quarters (n=229) of these suicides were by males. The Minister drew attention to the extent of the incidence of self-harm and suicidal ideation in Northern Ireland. In particular, the challenges to wider society in addressing the impact associated with self-harm on the individual patients, their family and/or carer and the health and social care system. There are 12000 annual Emergency Department attendances due to self-harm and suicidal ideation in Northern Ireland. The true figure is higher with many others attending their GP or a community based organisation, and others not seeking any help. Research has indicated that 10% of our 16 year olds have self-harmed at some stage.

The symposium highlighted the need for interface protocols between mental health services, addiction services, emergency departments within the Trust areas and the development of appropriate management plans for those who present to Emergency Departments following self-harm and suicidal ideation across Northern Ireland.

Minister Wells drew attention to the association between alcohol and self-harm. Alcohol is involved in around 50% of self-harm presentations at Emergency Departments. This underlines the need to both reduce alcohol misuse in our society and improve on the good co-ordination between alcohol services and services addressing mental health and self-harm.

The recent World Health Organisation (WHO) publication *Preventing Suicide – A Global Imperative*[3] highlighted the importance of adopting a Public Health approach to addressing suicide prevention, one which is underpinned by surveillance, ie defining the problem of suicidal behaviour through systematic data collection. The report highlights the need for standardisation of information and recording of self-harm episodes attending emergency departments as one of the basic tasks needed in all countries, in an effort to understand more fully the issue and eventually reduce deaths by suicide. The publication specifically references the model of data collection developed by the National Suicide Research Foundation (NSRF) in Cork

[3] World Health Organisation (2014). Preventing Suicide – A Global Imperative. WHO: Luxembourg.

as a model of best practice. It is this model of data collection and recording that is used for the Northern Ireland Registry of Self-Harm.

3.0 Surveillance of Self-harm

Presenter: Dr. Eddie Rooney, Chief Executive, Public Health Agency

The Self-Harm Registry began as a pilot project in the Western Health & Social Care Trust area in 2007 as part of the All-Island Action Plan on Suicide Prevention. The pilot programme reflected the experience of the National Registry of Self-Harm, led by the National Suicide Research Foundation in Cork, which monitors self-harm attendances to ED in all acute hospitals in Republic of Ireland. Following the initial pilot stage, the expansion of the Registry became a Programme for Government target in 2011/12 to include the Belfast Health & Social Care Trust area, and following evaluations the Registry, has further been extended to cover all acute hospitals across NI. The first of its kind, the Island of Ireland now has full coverage of self-harm recorded at ED settings and has been recognised locally, nationally and internationally as a model of best practice.

The second annual report from the Self-Harm Registry was launched at the Symposium. The key findings of this report are that between April 2013 and March 2014:

- There were 8,453 self-harm presentations to Emergency Departments (ED) in Northern Ireland, involving 5,983 persons.
- Almost a third of presentations occurred in the Belfast Health and Social Care (HSC) Trust (30%), 18% in the South Eastern and Northern HSC Trusts, and 17% in the Western and Southern HSC Trusts.
- In Belfast, the Royal Victoria Hospital dealt with 16% of self-harm presentations, followed by the Ulster Hospital with 14% and the Mater Hospital with 13%.
- Overall, there was an even balance of male and female presentations. However, females were marginally overrepresented in the northern (55%), western (54%) and southern eastern (52%) trust areas.
- The majority of people presented on just one occasion (80%).
- One fifth (20%) of people presented with self-harm on more than one occasion during the twelve month period, with 17% presenting between 2-4 times in the year, and 3% between 5 and 9 presentations. In total, 127 people accounted for 1,160 presentations during 2013/14, each presenting 5 or more times.
- The rate of repetition of self-harm was 20% for males and 19% for females.
- Persons aged 15-29 years accounted for almost half (44%) of all self-harm presentations, with 16% of presentations being made by 20-24 year olds, followed by 15-19 year olds (15%) and 25-29 year olds (13%).
- Those under 18 years of age accounted for 10% of all presentations. The ratio of females to males was 2.2:1 for this age group.
- Drug overdose was the most common method of self-harm accounting for almost three quarters of presentations (74%), followed by self-cutting which was involved in 24% of presentations.

- Although rare as a sole method of self-harm, alcohol was involved in almost half of the total presentations (49%), the proportion varying from 39% in the South Eastern HSC Trust area to 57% in the Western HSC Trust area.
- Based on the European Age Standardised Rate (EASR), the rate of self-harm for Northern Ireland was 327 per 100,000 (males: 333; females: 321). This rate ranged from 254 per 100,000 in the Southern HSC Trust area to 502 per 100,000 in the Belfast HSC Trust.
- The EASR of self-harm was highest among 20-24 year olds (789 per 100,000). In particular, the highest female rate was observed among 15-19 year olds (935 per 100,000) and the highest male rate occurred among 20-24 year olds (908 per 100,000).
- The EASR of self-harm in Northern Ireland was over two-thirds (64%) higher than that for the Republic of Ireland. However it should be noted that there are different heath care systems in operation in each country. Under the Health and Personal Social Services in Northern Ireland, there is free access to healthcare for all residents, while there is a fee for each visit to the ED in the Republic of Ireland for non-medical card holders.
- Comparing the incidence of hospital treated self-harm for those aged over 15 years in Northern Ireland to the Republic of Ireland and a number of study areas in England, Belfast City had the highest incidence rate of 632 per 100,000, followed by Derry City (622), Limerick City (610) and Derby with a rate of 435 per 100,000.
- Some 4% (n=376) of self-harm presentations were made by persons who were homeless, many of these male (72%; n=271), aged between 15-24 years (46%) and residing in the Belfast Trust area (56%; n=212).
- Less than 2% (1.7%; n=147) self-ham presentations were made by persons in prison, the majority of whom were male (95%; n=139) and aged between 20-29 years (69%).
- In addition to self-harm, data was also collated on suicidal ideation. There were 3,623 cases recorded in 2013/14.
- Almost two thirds of cases presenting with suicidal ideation were males (65%; n=2,371).
- Approximately 5% (4.8%; n=173) of presentations of suicidal ideation involved people under 18 years of age, with persons under 16 years old accounting for 2% of these cases.
- Approximately 6% (228) of presentations involving suicidal ideation were made by persons who were homeless, the majority of which were male (81%; n=185) and residing within the Belfast HSC Trust area (47%; n=106).
- The total numbers of presentations in Northern Ireland for self-harm and suicidal ideation for the financial year 2013/14 was 12,076.

The full report can be downloaded from:
http://www.publichealth.hscni.net/publications/northern-ireland-registry-self-harm-annual-report-201314

4.0 Addressing Self-Harm in ED: Up skilling Professionals

Presenter: Professor Ella Arensman, Adjunct Professor with the Department of Epidemiology and Public Health University College Cork & President of the International Association for Suicide Prevention and the European Alliance Against Depression.

The need for skilling and resourcing Emergency Department (ED) staff who have contact with individuals who self-harm has increasingly been recognised as a vital requirement[4] to help to understand self-harm behaviour and provide the necessary care[5].

The American Association of Suicidology strongly promotes the roll-out of pilot interventions in EDs regarding self-harm and suicide and advocates for staff training on suicide risk, assessment and management.

There is growing evidence which supports the effectiveness of self-harm and suicide awareness training for ED staff in improving knowledge, attitudes towards self-harm and suicide.[6]

Professor Arensman presented the findings from a systematic review by Saunders et al (2011) which looked at attitudes and knowledge of clinical staff regarding people who self-harm:

- Majority of ED staff had negative attitudes towards people who had engaged in self-harm
- Non ED staff had more empathetic and compassionate attitude than ED staff

Prof Arensman also referred to a report compiled by Hunter et al (2012) which looked at service user perspectives on psychosocial assessment following self-harm and its impact on further help seeking. This report highlighted:

- Most people felt judged by ED staff for their acts of self-harm
- This compounded existing feelings of shame, guilt and isolation as well as resulting in dissatisfaction with care and issues with treatment compliance
- Non-judgemental treatment inspired confidence in future care opportunities.

[4] HSE (2005). Reach Out – National Strategy for Action on Suicide Prevention 2005/2014

5 National Institute for Health and Clinical Excellence, NICE Guidelines, 2011

[6] Knesper, D. J. "American Association of Suicidology. 2010." *Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit*.

There are a number of initiatives in RoI which aim to address these issues including training on awareness of self-harm and suicide for ED staff in HSE South. The aim of this this training is to 'improve ED staff's management, assessment and treatment of people who present to the ED following self-harm'. The objectives of this training are:

- To increase knowledge and understanding of self-harm and suicide
- To promote a positive attitude regarding self-harm and suicide prevention
- To improve clinical confidence in the management of self-harm

The training is delivered over three levels:

Level 1: Development and delivery of 2-3 hour self-harm and suicide awareness, skills-based training
Objectives:
a) To increase knowledge and understanding of self-harm and suicide
b) To promote a positive attitude regarding self-harm and suicide prevention
c) To improve clinical confidence in the management of self-harm

Level 2: Development and delivery of one-day training in the management and assessment of self-harm and suicidal behaviour
Objective:
To enhance the patient assessment procedure and crisis management of self-harm patients

Level 3: Development and roll-out of a structured electronic self-harm assessment and information system
Objective:
To facilitate data collection, the assessment and follow-up of patients and the early identification of those with a pattern of repeat self-harm presentations

Four key aspects covered in the training include:

1) The extent of self-harm and suicide in Ireland
2) Staff attitudes towards depression, self-harm and suicide
3) The direct and indirect effects of alcohol in relation to self-harm and suicide
4) The identification of risk and responding to a person who has engaged in self-harm

The training delivery employs the Train-the-Trainer model (TTT): One day (8hr) TTT workshop involving five senior hospital staff. Subsequently ED staff from Cork & Kerry hospitals in the HSE South were invited to partake in this 2-hour training. Staff invited included ED nurses, doctors, clerical staff, porter staff, paramedic staff, security staff etc. Each training session including a maximum of 15 staff members took place onsite, within the ED setting and was facilitated by 2 trained trainers.

Evaluation: Participants receive a matched pre/post-training and 6-month follow-up evaluation. Information collated included basic demographics; previous training experience and Pre & post-training measures of staff knowledge, attitudes and confidence regarding self-harm and suicide. Participants also reported on their satisfaction with the training in a brief 1-page evaluation.

Results:

- So far, 102 ED staff have been trained and 87 are included in this analysis
- The majority of the ED staff included in this analysis were female (67.8%)
- The mean age of these ED staff was 37 years (SD: 9.3)
- The mean years spent in education was 17 years (SD: 4.3)
- The mean years' experience in their current position was 10 years (8.9)
- Significant improvements were recorded in changes in attitude, knowledge and confidence. These improvements continued to be recorded in the 6-month follow-up review on confidence.

Recommendations:

- The evidence obtained in the current study supports the wider implementation of the 2-hour awareness training programme on self-harm and suicide among Emergency Department staff in Ireland
- In order to enhance the sustainability of training effects, it would be recommended to consider implementing refresher courses.
- The efficacy of the training could be enhanced by extending the 2-hour programme to 3 hours and including more elements of skills-based learning.
- In order to ensure safety and optimal learning for the trainers involved in delivering the suicide and self-harm awareness training programme, it would be recommended to develop a formal structure for support and debriefing for trainers.
- It is recommended that the evidence base obtained in the current study be integrated in the national guidelines for the management and assessment of self-harm patients presenting to Emergency Departments as part of the National Clinical Programme.

Prof Arensman's presentation can be viewed in Appendix 3

5.0 Longitudinal Analysis of self-harm: 6 Year Review of Data from WHSCT

Presenters: Dr Eve Griffin, National Suicide Research Foundation & Brendan Bonner, PHA

Data has now been collected for the WHSCT area for six full calendar years, which provides sufficient data over a significant period of time to begin analysis of trends and highlight key issues in respect of self-harm prevalence in the WHSCT area. PHA launched the *'Northern Ireland Registry of Self-Harm Western Area Six Year Summary Report 2007–2012'* at the Symposium.

The purpose of the report is to demonstrate how the Registry can be used to define trends in Northern Ireland and allow comparable analysis with data collected in the Republic of Ireland. Given the extensive amount of data that is now available, the Public Health Agency in partnership with NSRF, will be publishing a number of supplementary reports that will focus on specific issues relating to self-harm.

This first publication gives an overview of the total numbers of presentations in the western area for the six years from 2007–2012. Perhaps more significantly, the focus for this first report is on the issue of repetition. It is acknowledged that those who repeat the act of self-harm are at higher risk of taking their own lives by suicide, therefore, understanding the patterns associated with the acts of repetition can help service planners better meet the needs of those populations at increased risk.

Key Outcomes

- **Number of attendances**
  During 2007–2012, there were 8,175 self-harm presentations to hospital, involving 4,733 individuals. Residents of the catchment area accounted for 8,024 (98.2%) of the presentations and 4,618 (97.6%) of the individuals. Female residents accounted for 53.6% (n=4,298) of these presentations and 53.7% (n=2,479) of the individual patients.

- **Incidence rates**
  Respectively, the total, male and female age-standardised incidence rate was 342, 320 and 366 per 100,000 of the population. Derry City Council residents had a much higher self-harm rate than other Local Government Districts (LGDs). The peak rate for women was among 15–19 year olds (837 per 100,000). This rate implies that one in every 119 girls in this age-group presented to hospital with self-harm. The peak rate among men was among 20–24 year olds (809 per 100,000, or one in every 124). The rate of self-harm in 2012 was 6% higher than that in 2007, an increase that was more pronounced for males than females (9% and 3% respectively).

- **Methods of self-harm**

The most common method of self-harm was intentional drug overdose, which was involved in over two thirds of all presentations and more common among men than women (79% v 70%). Self-cutting was the next most common method of self-harm, used in almost one fifth of all episodes. While rare as a method of self-harm, alcohol was involved in 60% of all presentations.

- **Repetition of self-harm**
  During the period 2007–2012, 4,733 individuals engaged in 8,175 self-harm presentations. Considering the period 2007–2011, which allows for a one-year follow-up, there were 6,706 self-harm presentations by 4,041 patients. The rate of repetition within 12 months was 33.8% based on presentations (2,266 of 6,706) and 18.0% based on persons (726 of 4,041). This implies that over one-third of all presentations were due to repeat acts.

There was variation in the rates of repetition by Local Government District (LGD). The highest rates of repetition were for Derry LGD (19.8%) and Limavady LGD (18.6%). The lowest rate of repetition was recorded in Omagh LGD (13.5%) and this did not appear to vary across the study period.

The majority of self-harm patients presented to hospital just once during the six-year study period (n=3,455, 73.0%). However, a percentage of individuals repeated self-harm multiple times during this period. In total, 58 individuals repeated 10 or more times. While this is a relatively small group of people, they account for a significant proportion of presentations (12.6%).

Almost one in five individuals (18%) treated for self-harm made at least one repeat presentation to hospital with self-harm within 12 months. Having a previous history of attending the ED with self-harm increased the likelihood of repeating and the risk increased with each subsequent presentation of self-harm.

Self-cutting was associated with an increased level of repetition, with 26% of those who engaged in self-cutting at the time of the initial episode making at least one subsequent presentation within 12 months. Risk of repetition was greatest in the days and weeks following a self-harm presentation to hospital. Rates of repetition were highest among those who left the ED without seeing the doctor.

The report highlights the incidence of self-harm in the western area of Northern Ireland, with the highest rates being observed among females and young people. In addition, rates were higher in urban areas, which is consistent with international findings. While the rates reported here are higher than those recorded in the Republic of Ireland[7] or England[8], the profile and pattern of self-harm presentations is consistent.

[7] Griffin, E. Arensman, E. Wall, A. Corcoran, P. Perry, IJ. (2013) National Registry of Deliberate Self Harm Annual Report 2012. Cork: National Suicide Research Foundation.
[8] Hawton, K. Bergen, H. Casey, D. Simkin, S. et al (2007). Self-harm in England: a tale of three cities. Multicentre study of self-harm. *Social Psychiatry and Psychiatric Epidemiology*. 42(7):513-21

The impact of the recent economic recession on rates of suicide observed in the European Union (EU)[9,10] and US[11,12] has not been reflected to the same extent in the western area. Between 2007–2012, there was a 6% increase in rates of self-harm in the western area. Rates of suicide in the western area showed some evidence of a downward trend during this time. This evidence, that changes in rates of self-harm and suicide in the western area were less pronounced than in other European countries, may reflect a possible buffering effect of protective factors, which would be important to explore in further detail.

One such protective factor may have been high levels of public sector spending across Northern Ireland, which may have buffered the impact of the recession, potentially reducing the impact on construction and other industries. However, there has been a reduction in public spending in more recent years with capital spending reduced by 37% between 2010 and 2014[13]. A further protective factor may have been the implementation of self-harm and suicide prevention initiatives as part of the *Protect Life* strategy. During the period covered by this report, there was investment in two self-harm specific services in the Western HSC Trust area, namely a pilot community-based service known as the Self-Harm Interagency Network (SHINE) and the resourcing of additional staff within the Trust Mental Health services to address the issue of self-harm.

The association between non-fatal self-harm and risk of future suicide has been established internationally and there is also growing evidence that increasing rates of self-harm, particularly among men, are likely to be followed by increasing rates of suicide. This highlights the importance of further research using data linkage studies of self-harm data with suicide mortality data, in order to better understand the predictors of suicide risk in Northern Ireland.

The report incorporates Supplement 1, which examines the issue of repetition among self-harm patients in the western area. This information will be of value both to EDs and mental health departments, helping to inform risk assessment and also future service developments. The findings reveal that 18% of all patients who attended EDs in the western area with self-harm had a repeat episode of self-harm within 12 months. Overall, 34% of self-harm presentations were due to a repeat act. These figures are within the range of repetition rates reported in the international literature. This highlights the need to address the issue of repeated self-harm in order to improve the lives of people who self-harm as well as minimising the impact on hospital services.

[9] Reeves, A. McKee, M. Stuckler, D. (2014) The Great Recession, unemployment and suicide. J. Epidemiol. Community Health, 05(3):246-7

[10] Stuckler, D. Basu, S. Suhrcke, M. Coutts, A.et al (2011) Effects of the 2008 recession on health: a first look at European data. *Lancet.* 9;378:124-5

[11] Kaplan, MS. Huguet, N. Caetano, R. Giesbrecht, et al (2014) Economic contraction, alcohol intoxication and suicide: analysis of the National Violent Death Reporting System. *Injury Prevention.* doi:10.1136/injuryprev-2014-041215

[12] Reeves, A. Stuckler, D. McKee, M. Gunnell, D. et al (2012). Increase in state suicide rates in the USA during economic recession. *Lancet*. 380:1813-4.

[13] Chancellor George Osbourne – Budget Statement 2012: http://www.politics.co.uk/reference/public-spending

The findings show that risk of repetition was greatest in the first three months following an index episode of self-harm. A number of factors associated with increased risk of repetition were identified in this analysis, in particular self-harm involving self-cutting. Previous research has highlighted increased risk of non-fatal repeated episodes of self-cutting where less extensive medical treatment was required.[14] Future work should focus on establishing the risk of fatal suicide among those who engage in self-cutting.

The factor most strongly associated with risk of repetition was the number of self-harm presentations a person had made, further illustrating the 'dose-response relationship' between number of presentations and risk of repetition.[15] In addition, the findings highlight that a small number of individuals account for a significant proportion of all presentations. Frequent repetition of self-harm has previously been associated with a high prevalence of personality disorders and there is some evidence on the benefit of interventions such as Dialectical Behavioural Therapy for such patients.[16]

The report has also identified that a relatively large proportion of those who left the ED without being seen were more likely to repeat again within 12 months (26.5%). This underlines the need for uniform assessment and management of self-harm patients in the ED, in line with international best practice. It also highlights the need to implement measures that minimise the risk of patients leaving the ED without being seen and ensure appropriate follow-up for those who do leave without being seen.[17]

Additionally, the findings emphasise the importance of implementing and evaluating self-harm awareness training for all ED staff. There is evidence that having a psychosocial assessment following self-harm is associated with lower rates of non-fatal repetition, highlighting the importance of having appropriate services in place to offer psychosocial assessment.[18,19] The second supplement of the six-year summary report will specifically focus on aftercare of self-harm, and will further explore the outcomes of self-harm patients in terms of the care pathway for those attending the ED with self-harm.

The full report is available to download on
http://www.publichealth.hscni.net/publications/northern-ireland-registry-self-harm-western-area-six-year-summary-report-2007%E2%80%932012

[14] Larkin, C. Corcoran, P. Perry, IJ. Arensman, E. (2013). Severity of hospital-treated self-cutting and risk of future self-harm: a national registry study. *Journal of Mental Health.* DOI: 10.3109/09638237.2013.841867.
[15] Perry, IJ. Corcoran, P. Fitzgerald, AP. Keeley, HS. et al (2012). The incidence and repetition of hospital-treated deliberate self harm: findings from the world's first national registry. *PLoS One.* 7(2):e31663. doi: 10.1371/journal.pone.0031663.
[16] O'Connell, B. Dowling, M. (2014). Dialectical behaviour therapy (DBT) in the treatment of borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing.* 21(6):518-25.
[17] National Institute for Health and Clinical Excellence. (2011). Self-harm-The short term physical and psychological management and secondary prevention of self-harm in primary and secondary care. http://www.nice.org.uk/guidance/cg16
[18] Bergen, H. Hawton, K. Waters, K. Cooper, J. Kapur, N. (2010). Psychosocial assessment and repetition of self-harm: the significance of single and multiple repeat episode analyses. *Journal of Affective Disorders.* 127(1-3):257-65.
[19] Kapur, N. Steeg, S. Webb, R. Haigh, M. Bergen, H. Hawton, K. Ness, J. Waters, K. Cooper, J. (2013). Does clinical management improve outcomes following self-harm? Results from the multicentre study of self-harm in England. *PLoS One*. 8(8):e70434. doi: 10.1371/journal.pone.0070434.

Dr Griffin & Mr Bonner's presentation can be viewed in Appendix 4

6.0 A View from Inside: Service User Perspective

Presenter: Ms Grainne McAnee

The purpose of this presentation at the symposium was to provide insight from a user perspective and to emphasise the importance of seeking help and talking to someone you trust, if you are feeling low and unable to cope.

Grainne has experienced mental health problems since her early teens and has attempted suicide. Grainne believes that people may cover up their problems as they are afraid to ask for help, but she stresses that talking to someone about how you are feeling can have a very positive impact.

For a number of years, the 43-year-old and mother of two, tried to cope with her low moods and anxiety herself and says that the image she portrayed to the outside world was very different to how she was feeling inside.

> *"I tried various methods of coping, spending too much money and using alcohol. I did try to make changes but they never worked,"*

Grainne outlined how on she appeared to have everything in life, a great career in IT, she travelled, had her own house and sports car. On paper my life looked brilliant, but she hated herself and her job, she was completely false in what she presented.

In 2007 she had a breakdown and lost her job, her home and her car. She described how depression affected her.

"I wasn't feeling anything there was just numbness, I was just going through the motions."

In 2010 she was feeling extremely low and had suicidal thoughts. When she confided how she was feeling to a friend, it was the first step towards recovery.

"I was so exhausted it was a relief to stop pretending,"

Grainne referred to how she had spoken to a close friend, who was very supportive, and she encouraged her to go to her GP. The role of the GP was important as she reassured Grainne. She described her as very practical and reassuring."

Grainne was referred to her local Primary Care Liaison team and started to receive counselling. As well as receiving medical help, Grainne was also supported greatly by her parents and her friends.

She was out for lunch with two of her closest friends when she had something she describes as a “light bulb moment”.

> *“A friend said to me, I know how you feel and you can do something about it.”*

Grainne says that at that point she started to take care of herself, seriously embracing her counselling. She was careful about her alcohol intake, ate more healthily and started exercising. These things have been instrumental in her recovery and she has built them into her daily life.

Grainne’s life has changed greatly since 2010. She now feels better able to care for her daughters and she has a job she loves at Aware Defeat Depression. Last year she graduated with a degree in Psychology and is now working towards a PhD.

Looking back, she says

> *“It was the worst time in my life, I lost everything and I started over again. What happened to me has made me the person I am today.”*

Speaking about stigma at the symposium, Grainne said

> ‘*If we feel that we will be judged if we reach out to ask for help then we won’t do it. The heart of stigma. This can be internalised, about what we think other people are going to think, and unfortunately, it is also alive and well and not just a perception. Layers and layers of stigma. Layers and layers of barriers to accessing help. Stigma is born from lack of understanding of the facts or from an inability to remove our own judgement from the facts even when we know them. People who self-harm are not strange creatures from another planet. They are not lesser people. They don’t benefit from judgement or from a lack of kindness being shown to them. They pretty much tend to have that covered all by themselves. They look like this. Like me. They have feelings like mine. Like yours.’*

7.0 Learning from Others: The Scottish Experience

Presenter: Mr Niall Kearney, Scottish Government

Mr Kearney presented information on a potential model being developed in response to commitments outlined within the Scottish Suicide Prevention Strategy.

This model includes Distress Brief Intervention (DBI). DBI is a time limited, assertive, supportive and problem solving contact between an individual in distress and a service provider. Components of it would include:

- Empathetic problem focused assessment – physical, psychological and social.
- Risk assessment.
- Identification of existing supports and assets.
- Exploration of strategies to help resolve problems.
- Information and supported signposting to specialist services and other community resources.
- Creation of a future plan – how to identify and avoid triggers, what to do.
- Exploration of the possibility of local connection of the individual with a peer support worker.

DBI could potentially be targeted for:

- People in the community presenting to any front line service - including Primary Care, A&E, Police, Local Authority and Third Sector services - in distress that fulfils the above definition.
- All presentations of self-harm that do not require emergency specialist referral or admission.
- Repeat attenders to A&E where the reason for attendances is not primarily due to physical health problems. More than 4 such presentations in a month would trigger a DBI referral.
- People already attending specialist mental health services, including substance misuse teams. Communication would be essential to ensure the services and the DBI service were aware, to allow them to coordinate their support.

The model is still under consideration by the Implementation Group and local focus groups and will be developed over the coming months with a view to reviewing impact and informing future direction.

8.0 Clinical Assessment: Is Risk Assessment after Self-Harm a Waste of Time?

Presenter: Professor Nav Kapur from Centre of Suicide Prevention at Manchester University

Professor Kapur considered the impact of risk assessment after an act of self-harm during his presentation. Referring to a large suicide study which found that the majority of individuals who were assessed were categorised as 'low risk', he set out a number of concerns about relying on such assessments alone.

Risk assessment tools and scales are usually checklists that can be completed and scored by a clinician, or sometimes the service user depending on the nature of the tool or scale. They are designed to give a crude indication of the level of risk (for example, high or low) of a particular outcome, most often suicide.

There is increasing emphasis on the assessment of risk in clinical services. Risk assessment in mental health is a broad concept which covers a judgement of the likelihood of an adverse outcome such as suicide or self-harm but also of violence, risk to children, risk of exploitation and environmental risks such as safety in the home. Risk assessment in the UK is carried out by undertaking a clinical interview and this often includes a checklist of risk factors derived from an assessment scale. In the UK there is no consistency in the risk assessment tools used by different mental health services. Despite the widespread use of these instruments, there is no clear evidence that their use makes any difference to patient outcome. The usefulness of any particular risk assessment scale for repeated self-harm depends on the ability to correctly distinguish all those who do go on to self-harm from those who do not. Whilst the risk of repeated self-harm is important, healthcare professionals will be most concerned about the risk of suicide. This is more difficult to predict, given the relative rarity of suicide, even in a population at high risk such as those who have self-harmed.

Professor Kapur recommended offering an integrated and comprehensive psychosocial assessment of needs and risks to understand and engage people who self-harm and to initiate a therapeutic relationship. During assessment, it is important to explore the meaning of self-harm for the person and take into account that each person self-harms for individual reasons. Each episode of self-harm should be treated in its own right.

NICE quality standards are a set of specific, concise statements[20]. They set out markers of high-quality, cost-effective patient care. Quality standards will be reflected in the new Commissioning Outcomes Framework and will inform payment mechanisms and incentive schemes. The standards recommend:

1. People are treated with compassion, respect and dignity

[20] http://publications.nice.org.uk/quality-standard-for-selfharm-qs34

2 They receive an initial assessment of physical health, mental state, social circumstances and risk of suicide.
3 They receive a comprehensive psychosocial assessment
4 They receive the monitoring they need to keep them safe
5 They are cared for in a safe physical environment
6 Collaborative risk management plan are in place.
7 They have access to psychological interventions.
8 There is a transition plan when moving between services.

Other areas that were suggested included:

- Do the simple things well
- Timely access to interventions
- Develop and use guidelines
- Support families

Professor Kapur's presentation can be viewed in Appendix 5

9.0 Workshops

As part of the Symposium Programme, there were two sessions of workshops. Each session comprised of five parallel workshops. The first session was held in the morning of the event and these were then repeated in the afternoon, allowing participants to attend two workshops of their choice.

	Workshop title	Presenters	Chairperson
1	Self-Harm in a Community setting *(Appendix 6)*	Anne Bill, FASA Conor McCafferty, Zest	Madeline Heaney, PHA
2	Addressing Training Needs *(Appendix 7)*	Dr Denise O'Hagan, PHA Damien McAleer, CEC Marie Dunne, WHSCT	Fiona Teague, PHA
3	Self-Harm and Substance Misuse *(Appendix 8)*	Dr Bob Boggs, BHSCT Richard Grant , WHSCT	Seamus Mullan, PHA
4	Self-Harm and Research *(Appendix 9)*	Prof Siobhan O'Neill, UU Dr Maggie Long, UU	Eithne Darragh, HSCB
5	Self-Harm and Long-term Management within Mental Health Services *(Appendix 10)*	Dr Edward Noble, HSCNI Dr Tracy Millar, SEHSCT Bryan Rhodes, SEHSCT	Owen O'Neill, PHA

Each workshop had a chairperson and a scribe to record a note of discussion. A template was provided to each scribe and details of discussion points are outlined below. Presentations can be viewed in appendices 6-10:

9.1 Self-Harm in a Community Setting workshop

The key discussion points that were raised included:

- There are different models/approaches and this would require greater evaluation and evidence of effectiveness
- How the original Zest model offering befriending did not work but 24 hour referral model was more effective
- Ethically it was not appropriate to keep people on waiting lists when they needed immediate support, how could this be addressed
- It was reported that feedback found that people did need support/ a holding service in the community while waiting for and after counselling.
- There was a challenge around the issue of safety first and that it was important this is more than opening the door for individual and family
- The safety of an individual and family is paramount – services at the right and in the right place at the right time were highlighted
- The initial response to individuals and family is important. The atmosphere/ environment must be supportive, compassionate, warm and with acceptance.

- Collaboration was important and an example given was that Lighthouse is having meetings with BHSCT, NIAS and Lifeline working towards developing a MoU / a process for working together and agreeing the arrangements. These meetings have included discussions on signposting vs. referral.
- Zest and Lighthouse /FASA are well known at this stage – they signpost a significant number of individuals to other services as many have a number of interconnecting/ complex issues i.e. Citizens Advice.
- Zest uses a problem solving approach / model – teaching how to solve problems so individuals can take away and use in later life, providing the skills for individuals to be empowered to move on with their lives.
- The work with family members has been shown to be very effective in supporting the person who is self-harm or having suicidal ideation
- Alcohol misuse is a significant issue – Zest does not accept individuals who require detox.
- There is evidence of a lower repeat rate with Zest and Lighthouse clients.
- Lighthouse pilot with BHSCT is until the end of this year they want to roll out this model; they will be approaching the SEHSCT.
- The SHINE model can only accept referrals from the Mental Health Team, the care pathway was very clear
- Communication very important coming out of both presentations – question asked on what sort of hurdles are faced in setting up and keeping communication going.
- Both contributors highlighted importance of communication between their service and the statutory sector as critical
- There was s discussion about the use of proformas, having agreed pathways and referral guidelines and having written referrals that were followed up with telephone calls back to the referrer.
- With regard to clients it was essential that they come from a place of caring. Essential to go over the clients expectations from the outset.
- There was a question around the access to similar services such as SHINT and on-going SHIP tendering was explained.
-

9.2 Addressing Training Needs workshop

The key discussion points from this workshop were included:

- Knowledge and Understanding Framework was discussed and in particular how clients are referred. It was noted that the programme was open to everyone but it was £100 approximately to attend.
- ED – Educational trainers being trained up for sustainability.
- Addressing self-harm for those people on the autistic spectrum and people with other learning disabilities needs to be considered.
- Integrating NIAS and PSNI into training of ED modules looking at module 1 would be an important development
- Continuity of care when multiple services are involved needs addressed

- On the presentation of the training underway it was acknowledged that in the ROI training for ED staff on self-harm had also included the police and ambulance staff as first responders. It was suggested that this is something that could be considered for NI. Currently the training is rolled out to staff within the ED only.
- The concept of diagnosing someone with a personality disorder was discussed and highlighted that this can take a considerable time to diagnose. It was noted that the Knowledge and Understanding Framework outlined in the presentation could be accessed up to Masters Level. The information within the framework can be easily transferred and used to support those individuals that display certain characteristics that may fit with Personality Disorder traits.
- STORM Training was also highlighted as an example that could be accessed and in particular the 3rd day of this training focused on Self Harm.

9.3 Self-Harm and Substance Misuse workshop

The key discussion points from this workshop included:

- The need for better coordination and planning at pre-entry stage for this client group was discussed.
- Alcohol Liaison Nurse is the 'lynchpin' on which all of this works (takes on a lot in terms of admin and follow up) but a critical role
- Groups of GPs now wanting input from this group on re-attenders known to them and how they can be supported
- Perseverance is key with this client group – even if faced with persistent non-engagement
- There has been a big improvement in communication and awareness of 'who's who' and 'who can offer what' – this was important as service develops
- At the minute defining success is by headline numbers only (e.g. the decline in repeat attendances) however need plan to do a more intense audit in the future
- For some re-attenders loneliness is a key factor, they come to ED for comfort, and social support
- Patients are identified that meet the criteria for access to the service, the aim is to provide options for care and improve quality of life.
- A holistic approach which includes meeting physical needs of the patient is important.
- GPs invited to patient meetings and the alcohol liaison nurse outreaches to GPs in community – the outreach approach has increased awareness of the service.
- Cohorts of individuals do not engage – it is important to continue to keep the door open and find ways of working with this group

- Harm reduction approach was discussed in particular the aim to reduce self-harm not necessarily stopping.
- One example of a holistic approach was to organised dentist appointments for street drinkers – extended opening hours. Outcome has been a reduction in street drinkers presenting to ED with acute dental problems.
- Education about alcohol with young people is important as early as key stage II.
- The workshop was advised that the alcohol strategy includes education in schools.
- Public Health England survey - the trend appears to indicate a reduction of young people misusing alcohol in England – are there lessons relevant to NI.
- Increased pricing for alcohol was noted and the impact it may have
- Issue of transition for young people from CAMH services to adult mental health (MH) Trust services were discussed. Support services for young people who have transferred from CAMHs to adult MH services are mixed. There are good examples of collaboration between CAMHs, Adult and community and voluntary sector to support young people transition.
- It was noted that a lot of young people mature and do not go down the road of addiction and there are positive lessons from their experience
- It was noted that there is a strong link between alcohol dependence and depression.

9.4 Self-Harm and Research workshop

The key discussion points from this workshop included:

- A discussion on the methodology and findings of the evidence presented.
- The importance of research in developing and piloting interventions was noted including the Samaritans Radar App was quoted as an example where this would have been beneficial, it was noted that this has since been deleted. This also led to discussion on the new Facebook button.
- There was a question on PTSD- 'as PTSD has a generational effect do we know if it is it something that is impacting on our population?' It was agreed that the issue warrants investigation. A report due on transgenerational impact* showing that people exposed to conflict have higher rates of ideation but not any more likely to support this finding. Joiners model – habitation of violence increases capacity.

  *(The Commission for Victims and Survivors (NI) in partnership with Ulster University launching report 'Towards a Better Future: an examination of the trans-generational consequences of the Troubles' legacy in Northern Ireland 5th March 2015)

- Discussion on counselling – and NICE guidelines: i.e. as counselling is widely used, what do we actually know about the efficacy of counselling in Self Harm?
- Meta-analysis of counselling has shown no empirical evidence but certain therapies have an evidence base such as DBT. However DBT has not been

tested against other therapies just Treatment as Usual so this needs to be addressed.

- There was regular reference around the need for evidence off what works with men - needs attention as many studies are biased towards females.
- Another participant commented on the difficulty of finding evidence based treatments for self-harm as if self-harm was an entity in itself when SH is a behaviour/symptom… one form of treatment may not be the answer when there is such a variety of reasons for the behaviour.
- There was a discussion on how to get local statistics and make them relevant to the community
- Need for local figures to support GPs' understanding of prevelance
- Social networks – putting moods on Facebook status and feedback received has been good to instigate discussion with and for those you don't know. This suggestion has also received criticism.

9.5 Self-harm and Long-term management within Mental Health Services workshop

The discussion points from this workshop included:

- It was acknowledged the need to offer timely and effective support to these individuals at risk.
- There was considerable interest in the Dialectical Behaviour Therapy Service currently being delivered in the SEHSCT. It was acknowledged that this service has the resources to work intensively with patients and that similar services that work intensively with patients should be available in each HSCT area.
- The need for good communication and clear protocols across disciplines was highlighted by some practitioners at the workshop as these patients regularly attend in crisis. One respondent stated that these patients can be 'passed' from professional to professional leading to poor outcomes for the patient.
- The case was made for the targeting of those who are frequent attenders at ED as the outcome of such an approach seems to be working, leading to reduced admissions in the SEHSCT area.
- Need for Person centred Partnership Approach (between all services, e.g. Ambulance, Security, PSNI) plus therapeutic intervention required in order to change behaviour of frequent attenders.
- Close working across HSCTs is important particularly in the greater Belfast area given that patients attend EDs managed by both HSCTs.

10.0 Plenary Discussion

To complete the event there was a plenary discussion to allow participants to bring together their views and question the speakers in terms of the content, learning and emerging opportunities.

The panel was chaired by Mary Black CBE, Assistant Director of Public Health (Health Improvement) and the panel members were:

- Professor Nav Kapur, University of Manchester
- Professor Ella Arensman, NSRF/WHO
- Mr Niall Kearney, Scottish Government
- Dr Denise O'Hagan, PHA
- Ms Eithne Darragh, HSCB
- Mr Brendan Bonner, PHA

Discussion points and questions were welcomed from participants.

A question was asked about the initiatives currently in place to address the needs of those who self-harm. The following services were identified as examples:

- SHINE Project (Western pilot)
- Protect life services, including the work with FASA in Belfast
- HSCTs Mental Health teams and work around personality disorders
- ED staff training
- Funding through HSCB for mental health services (in progress)
- DBT/CBT

In addition, participants were reminded about the Regional Self Harm service which is currently being procured by the PHA.

There was discussion on the need for comprehensive services and a systematic whole system approach.

It was noted that following clinical assessment a menu of evidence informed/based interventions was required and that there is a need to up-skill all first responders, beyond health and social care staff.

The panel discussed the care and the use of new technology, reference was made to ensuring that the pathway reflected the NICE guidelines.

The use of "Schematherapy" was raised by a participant from the Northern trust, the value of such an approach which, although intensive, was part of therapy which was deemed to be effective for more for complex cases.

The issue of recurrent/chronic depression and the importance of this condition when accompanied with a self-harm presentation was discussed. It was acknowledged there is no 'quick fix', and that this issue will require on-going treatment.

The panel discussed the role of risk assessment and what drives the system, which focuses attention on the clinician and their assessment of risk, rather than a whole

systems approach. Attending an SAI (which would focus on what is helpful, including better supervision of staff and honing of skills) – highlights the importance of health and social care and other staff in the workplace and the need to provide training and support for those staff.

The session also highlighted what is working well and the importance of giving positive messages about the work on suicide prevention and self-harm. The Donaldson report has highlighted the value of intervening early and the approach outlined with cardiac care could also have application to mental health and suicide prevention. Scotland has also led good work in health awareness raising for population groupings and the tailoring of messages to meet the specific needs of those at greater risk.

There was general discussion about the importance of suicide postvention and the links with alcohol and drugs. It was agreed that new services should consider the link between suicide, self-harm and addiction as core elements, equally important was the need for evaluation of such services.

Mary concluded the plenary discussion by summarising the key points which will be taken forward into service development.

11.0 Post evaluation feedback and Media Awareness

Participants were asked to complete an evaluation form which was included in event packs. In total, 60 forms were returned:

- 97% rated speakers as 'Excellent' or 'Good'
- 98% rated the organisation of the event as 'Excellent' or 'Good'
- 97% rated the venue as 'Excellent' or 'Good'
- 95% rated the food/catering as 'Excellent' or 'Good'

When asked how the day met their expectations in relation to the provision of information:

- The prevalence of self-harm in NI - 95% stated that the event 'met' or 'exceeded' expectations
- The pattern of repetition of self-harm attendances to ED – 93% stated that the event 'met' or 'exceeded' expectations
- The importance of service user input to service redesign – 63% stated that the event 'met' or 'exceeded' expectations. Some 10% of respondents were 'unsure'
- How self-harm can be addressed in the context of the new suicide prevention strategy – 58% stated that the event 'met' or 'exceeded' expectations. Some 22% stated they were 'unsure'
- Understanding patient pathways – 60% stated the event 'met' or 'exceeded' expectations. Some 22% stated that they were 'unsure'
- How NI is addressing self-harm in comparison to counterparts across UK – 73% stated that the event 'met' or 'exceeded' expectations
- Provide an opportunity for discussion amongst professionals – 72% stated that the event 'met' or 'exceeded' expectations.

Participants were asked to rate the workshops they attended:

1. Self-Harm in a Community Setting – 59% rated 'Excellent', 33% rated 'Good'
2. Addressing Training Needs – 67% rated 'Excellent', 33% rated 'Good'
3. Self-Harm and Long Term Management in MH services - 50% rated 'Excellent', 28% rated 'Good'
4. Self-Harm and Research – 50% rated 'Excellent', 43% rated 'Good'
5. Self-Harm and Substance Misuse – 32% rated 'Excellent', 47% rated 'Good'

Participants were provided with a free-text box to provide any additional comments. The majority of these comments were very positive. A full list of responses can be found in Appendix 11.

A further measure of the effectiveness of the symposium was the level of media coverage of the event. The PR element was managed by Roisin McManus from the PHA and a full summary of the coverage can be found in Appendix 3.

The general coverage was excellent, it included:

Pre-event radio coverage commenced two weeks before the symposium on the NI Regional station U105. Coverage on the morning of the event included a TV interview on BBC Breakfast, interview on BBC Radio Ulster, BBC Radio Foyle, Q Network (covers 11 channels) and U105. There was also an extensive lunch-time debate on BBC Talkback programme (for 50 minutes) and coverage on the BBC, evening news, including an extended version of the interview broadcast that morning.

In addition to the coverage on radio, there were also a number of articles covered in the print and on-line media at a regional and local level and these are listed in appendix 3.

12.0 Conclusions

The level of interest in the subject of Self-harm in terms of those who attended the symposium and the span of media coverage demonstrates the desire to examine the issue of self-harm and, importantly, determine what can be done to support individuals who self-harm and their carers.

The primary objectives of the symposium were achieved and were reflected in how the Minister of Health, Social Services and Public Safety, Jim Wells MLA, set the issue of self-harm in the context of the Protect Life strategy and the wider challenges for society of addressing emotional health and wellbeing. This issue was also picked up in the extensive media coverage of the event.

The service user experience was one of the highlights of the event and the warmth of response in the hall following the presentation by Grainne McAnee, reflected the empathy and support that staff working in the field have for service users, and the importance of embracing a recovery model with the vital support that can be provided to an individual and their carer. The user experience was also a highlight of a major radio debate on the popular BBC Radio Ulster's "Talkback" when 45 minutes was set aside for discussion. Before the event over two-thirds indicated that their perspective of the issue was either 'average' or 'very little' awareness. The post evaluation indicated that over 60% suggested that the presentation had met or exceeded their expectations on learning in this area.

The launch of the two reports at the conference was an ideal opportunity to highlight the extent of self-harm, the importance of surveillance and how the data can be used in both academic and policy settings. In both cases, over 90% of respondents stated the presentations had met or exceeded their learning objectives.

Whereas a separate event was held the following day for carers and families, the inclusion of a workshop on Self-harm in a community setting ensured that the issue was addressed and it was worth noting that this workshop was the most popular of the 5 workshops hosted on the day.

The two key note presentations by Professor Ella Arensman and Professor Nav Kapur highlighted awareness of the importance of skilling up ED professionals and also the challenge of providing the appropriate skills for staff to undertake meaningful risk assessments that in turn, could reduce risk and repetition. Almost 100% of those who completed the post event questionnaire indicated that their learning on addressing training needs as either 'Good' or 'Excellent'.

The keynote speakers highlighted the need to ensure that self -harm awareness was more than an issue for the hospital setting and that it had to be addressed within a primary care setting. The workshops also highlighted the links with substance misuse and long-term management within mental health services and the challenge on how this should be addressed. These discussions addressed the challenge of understanding the patient pathway and models of best practice, with 60% of

participants who completed the post evaluation stating that the event had met or exceeded their expectations of learning on this particular issue.

Whereas the launch of the two reports, including the supplement on the 6-Year review of Repetition in the WHSCT, helped highlight the potential for further research in the subject, the workshop with presentations on current and future areas provoked further interest and resulted in an approach from the University of Manchester to discuss further collaboration with the database and wider health & social care data sources.

The input from Niall Kearney, Professors Arensman and Kapur added significantly to the understanding of self-harm within health and social care in Northern Ireland and how this compared to benchmarking nationally and internationally. In many aspects Northern Ireland appears to be ahead, in terms of understanding and addressing the issue, and in other respects it is clear that there is much more room for development. Almost three quarters of those who completed the post evaluation indicated that the presentations had met or exceeded their expectations in terms of understanding how Northern Ireland compared to other areas.

The initial goal was to attract between 100-120 delegates to the event. On the day, over 200 registered and participated in the symposium. Before the event 40% of pre-registered delegates had indicated that their understanding about the prevalence of self-harm was ‘very little’ or ‘average’, post the event, 97% rated the event speakers as ‘Good’ or ‘Excellent’ and 95% indicated that the event had met or exceed their expectations.

In terms of wider awareness, there was extensive media coverage on all the primary television and radio stations throughout the day, as well as coverage across the print media and associated social media outlets.

The overall conclusion was that the symposium achieved or exceeded the original objectives in terms of content, learning, organisation and delivery.

13.0 Key Discussions and Learning Points

One of the ultimate objectives of the symposium was to actively promote discussion amongst key professionals in terms of developing better care pathways for service users. It was anticipated that this would go beyond the immediate event and that the learning from the process would be feed into the wider policy and commissioning frameworks in order to ensure better outcomes for those who self-harm in the future.

The key questions/learning points for the future were:

- How do we ensure that self-harm remains a key focus for the new suicide prevention strategy
- How do we promote the surveillance work that is done in NI as part of the Self-Harm Registry within the rest of the United Kingdom and further afield as best practice
- How do we use the data being reported from the self-harm Registry and how can we make the information more meaningful for policy makers, commissioners and service providers
- How can we effectively address training in the ED setting, against the serious pressures that are already present yet ensure self-harm awareness is embedded in all ED staff core training and spread out to other services within the acute setting
- Longitudinal data provides a broad spectrum of information but needs to be translated into meaningful reports that can, influence learning and policy direction
- The use of supplement reports needs to be used as a channel to continue to raise awareness of the prevalence of self-harm and the interventions available to encourage help seeking behaviour
- Service users need to remain at the heart of service design and research but how can service users become beacons of hope to encourage more of those self harming to seek help and recovery. How can service users become part of the training and awareness process for professionals
- There are many models of intervention operating, how should they be quality assured and delivered in a consistent and equitable manner. How do we provide scope for innovation and continued learning in the self-harm spectrum
- How do we promote awareness and use of effective models of risk assessment that will bring about positive outcomes for service users. In this process how do we ensure balance between following the technical process and making a difference for the patient? Linked to this issue is the need to ensure timely access to appropriate interventions, and support for families
- Collaboration is critical if as a society we are to address self-harm. The interface between the statutory and community & voluntary providers is critical. How do we explore the shared learning and building of trust between both sectors for the betterment of the patient

- As a society we need to address the link between substance misuse and self-harm, the evidence of the correlation is strong but often solutions to address the issues are dealt with in isolation. This is critical, especially in terms of the long term management of patients and early recognition of people at risk.
- Finally, how we develop NI as a research and learning base on self-harm, what partnerships need to be developed and how can these be exploited to bring about a cultural and service change to address self-harm.

Acknowledgements

The PHA would like to acknowledge the support and contribution of all those who assisted with the event, including:

Event Chairpersons:
Dr Carolyn Harper, Medical Director / Director of Public Health, PHA
Mrs Mary Black CBE, Assistant Director of Public Health, PHA

Keynote Speakers:
Mr Jim Wells MLA, Minister for Health, Social Services and Public Safety
Dr Eddie Rooney, Chief Executive, PHA
Professor Ella Arensman, NSRF
Dr Eve Griffin, NSRF
Mr Brendan Bonner, PHA
Ms Grainne McAnee
Mr Niall Kearney, Scottish Government
Professor Navneet Kapur, University of Manchester

Workshop Chairpersons:
Ms Madeline Heaney, PHA
Ms Fiona Teague, PHA
Mr Seamus Mullan, PHA
Ms Eithne Darragh, HSCB
Mr Owen O'Neill, PHA

Workshop Speakers:
Ms Anne Bill, FASA
Mr Conor McCafferty, Zest
Dr Denise O'Hagan, PHA
Mr Damian McAleer, CEC
Ms Marie Dunne, WHSCT
Dr Bob Boggs, BHSCT
Mr Richard Grant, WHSCT
Mr John Mullan, WHSCT
Professor Siobhan O'Neill, UU
Dr Maggie Long, UU
Dr Ed Noble, HSCNI
Dr Tracy Millar, SEHSCT
Mr Bryan Rhodes, SEHSCT

Note takers:
Ms Naomi McCay, PHA
Ms Helen Gibson, PHA
Ms Hilary Parke, PHA
Ms Elizabeth McGrath, PHA
Ms Amy Pepper, PHA
Ms Kelly Gilliland, PHA
Ms Nuala Quinn, SHSCT

Media/PR
Ms Roisin McManus

Staff from HSC Leadership Centre
Ms Hilary Coleman
Ms Susan Lewis
Ms Anne Hamill
Mr Terry Lavery

Staff from PHA Health Improvement
Ms Amanda O'Carroll
Ms Frances McAuley
Ms Maria Dulson

All staff and management from Riddel Hall, QUB

Appendices

Appendix 1

Programme

	Morning Session	**Chair: Dr Harper**
8:45	Registration Tea/coffee & Scones	
9:30	Welcome	Dr C Harper
9:45	Self-Harm in a Strategic Context	Minister for Health
10:00	Launch of the 2014 Self Harm Annual Report	Dr E Rooney
10:15	Training of Healthcare Staff – Outcomes of the review on training in the ROI	Prof. E Arensman
10:40	Repetition Rates – A 6 Year Review	Dr E Griffin & Brendan Bonner
11.00	Seeing from the Service User Perspective	Grainne Mc Anee
11:15	Tea/Coffee	
11:30	Workshop session (1)	
12:20	LUNCH	
13:15	**Afternoon Session**	**Chair: Mary Black**
13:20	Self-Harm in a UK Context – A Scottish Approach	Niall Kearney
13:40	Is Risk Assessment After Self-Harm a Waste of Time?	Prof. Nav Kapur
14:10	Workshop Session (2)	
15:00	Tea/Coffee	
15:15	Panel Discussion Topic: Opportunities for Applied Learning • Prof. Nav Kapur • Niall Kearney • Ella Arensman • Dr Denise O Hagan • Eithne Darragh • Brendan Bonner	
15:45	Close	Mary Black

Appendix: 2

The questions that were asked that the responses provided:

Please rate:

1. Your Understanding of the prevalence of self-harm in NI

	Frequency	Percentage
No answer	0	0%
Nil / Not	0	0%
Very little / Few	11	10%
Some/Average	35	31%
Good/Important	52	46%
Extensive/Essential	13	12%
None	1	1%
Total	112	100

2. Your Understanding of the service user perspective on self-harm services

	Frequency	Percentage
No answer	0	0%
Nil / Not	3	3%
Very little / Few	35	31%
Some/Average	43	38%
Good/Important	25	22%
Extensive/Essential	6	5%
Total	112	100%

3. The importance of self-harm training for frontline staff

	Frequency	Percentage
No answer	2	2%
Nil / Not	0	0%
Very little / Few	4	4%
Some/Average	14	13%
Good/Important	24	21%
Extensive/Essential	68	61%
Total	112	100%

4. The level of research on self-harm

	Frequency	Percentage
No answer	1	1%
Nil / Not	2	2%
Very little / Few	21	19%
Some/Average	41	37%
Good/Important	32	29%
Extensive/Essential	15	13%
Total	112	100%

5. Your understanding of self-harm services for people within a mental health setting

	Frequency	Percentage
No answer	0	0%
Nil / Not	1	1%
Very little / Few	18	16%
Some/Average	50	45%
Good/Important	28	25%
Extensive/Essential	15	13%
Total	112	100%

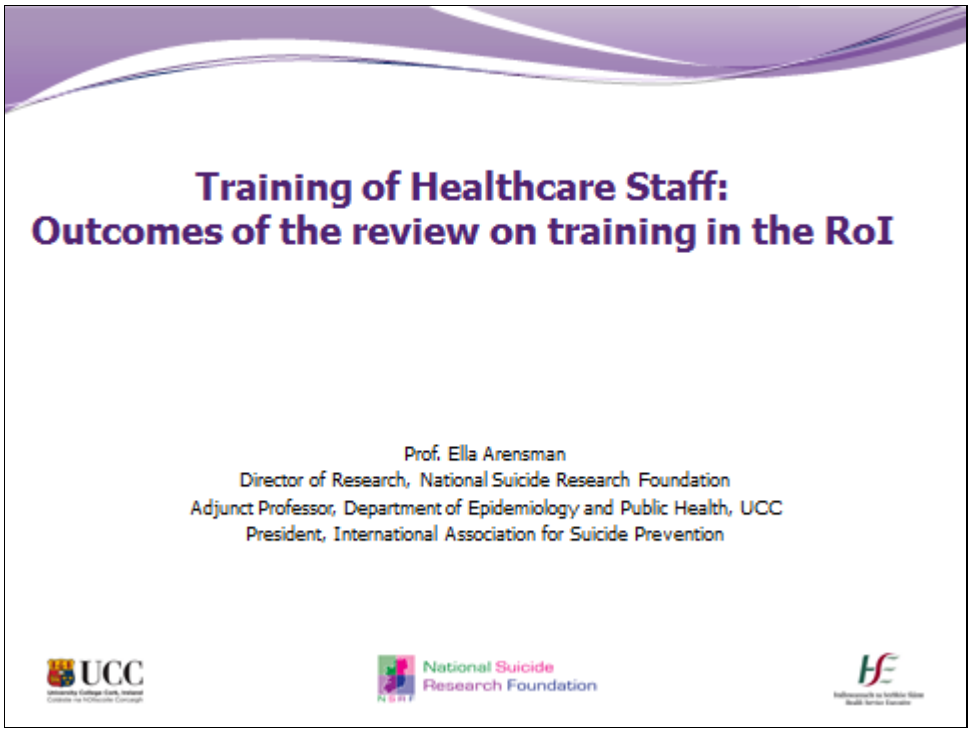
6. Your understanding of the link between self-harm and substance misuse

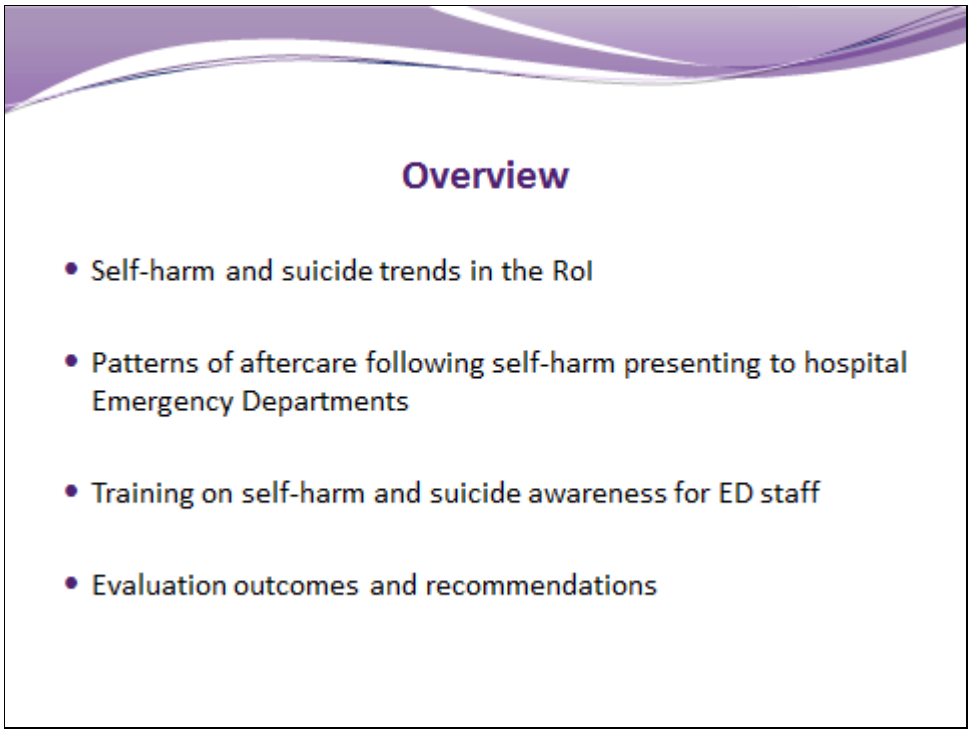
	Frequency	Percentage
No answer	2	2%
Nil / Not	1	1%
Very little / Few	8	7%
Some/Average	33	29%
Good/Important	50	45%
Extensive/Essential	18	16%
Total	112	100%

7. Your understanding of services in the Community and Voluntary sector

	Frequency	Percentage
No answer	0	0%
Nil / Not	0	0%
Very little / Few	23	21%
Some/Average	33	29%
Good/Important	42	38%
Extensive/Essential	14	13%
Total	112	100%

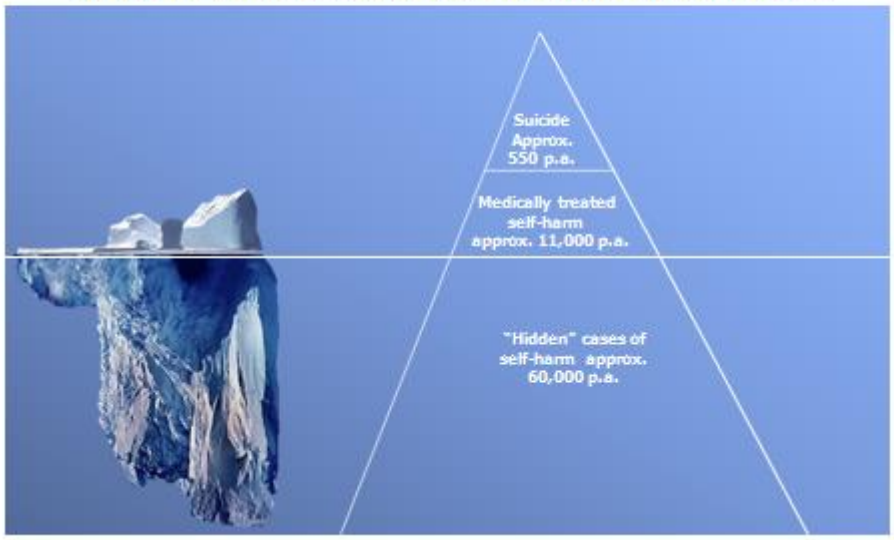
Presentation from Prof. Ella Arensman



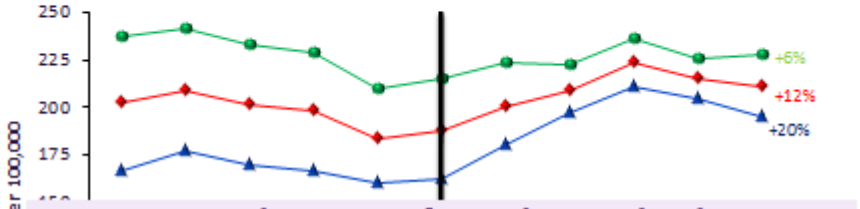


Context

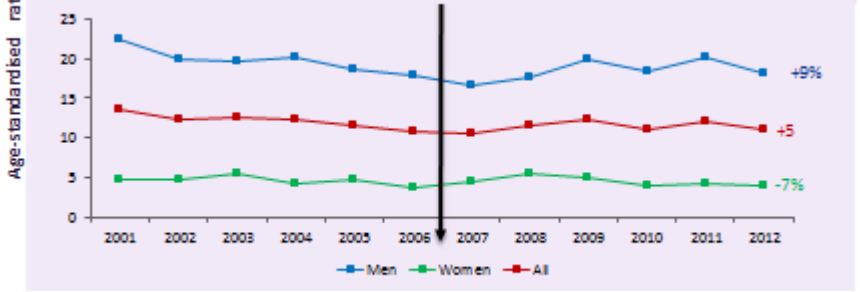
Suicide and medically treated self-harm in Ireland: The tip of the iceberg



Trends in rates of self-harm in Ireland



Trends in rate of suicide in Ireland



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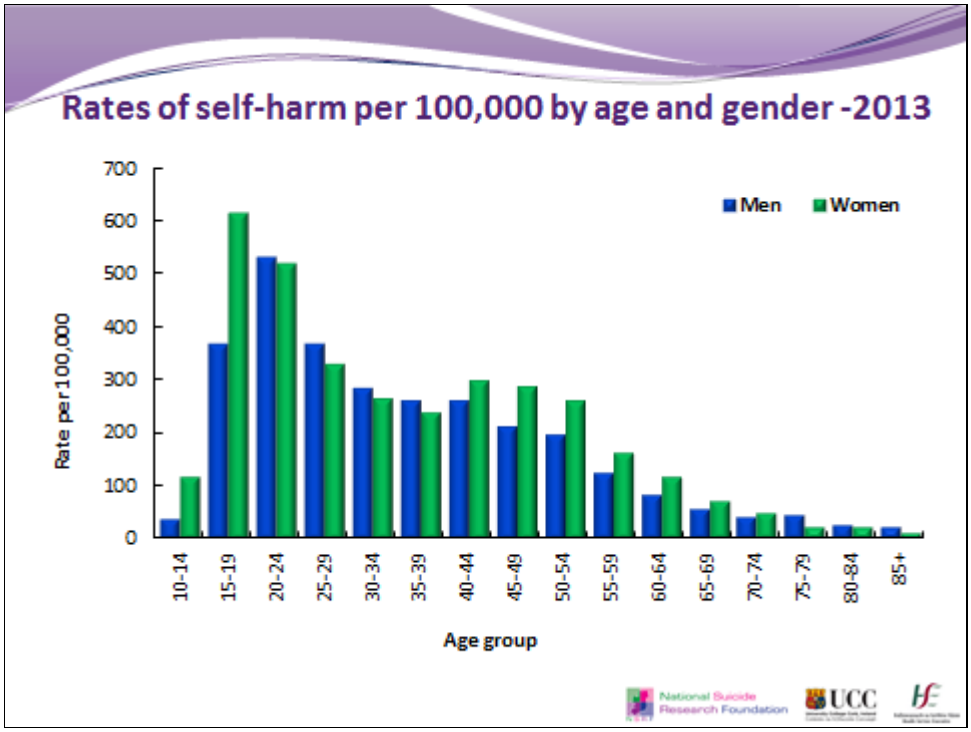
Rates of self-harm per 100,000 by age and gender -2013
Rate per100,000
700
600
500
400
300
200
100
0
Men
Women
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85+
Age group
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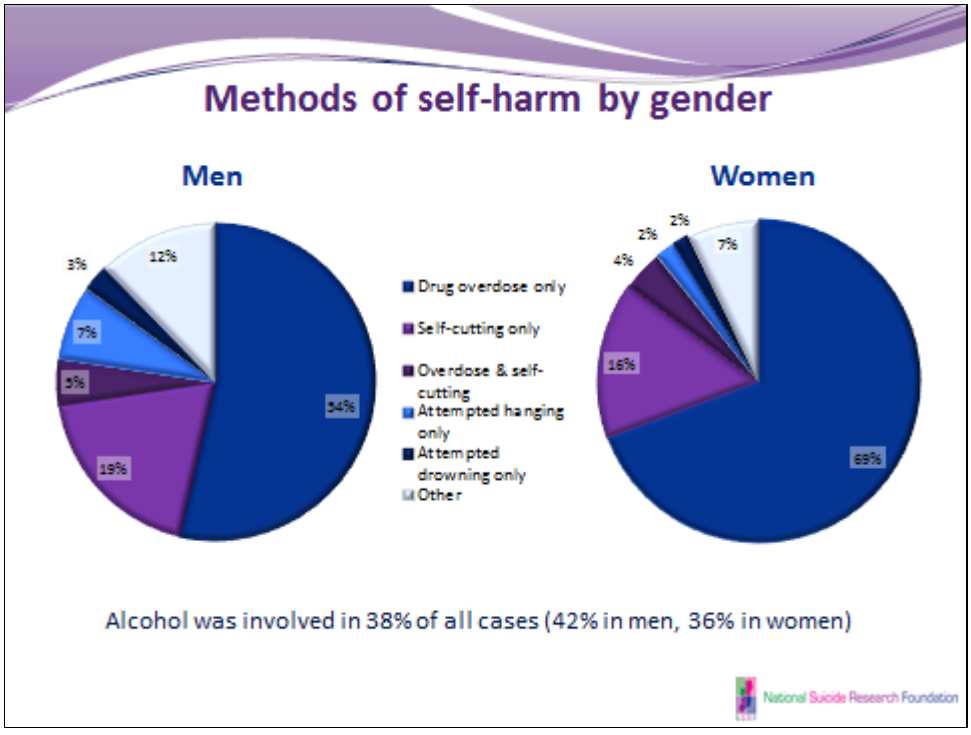
Methods of self-harm by gender
Men
Women
12%
3%
7%
5%
34%
19%
Drug overdose only
Self-cutting only
Overdose & self-cutting
Attempted hanging only
Attempted drowning only
Other
2%
2%
4%
7%
16%
69%
Alcohol was involved in 38% of all cases (42% in men, 36% in women)
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The extent of repeated self-harm presentations

No. of self-harm acts in 2004-2012	Persons (n=63,457)		Presentations (n=101,904)	
	Number	(%)	Number	(%)
One	48,702	76.7	48,702	47.8
Two	8,159	12.9	16,318	16.0
Three	2,809	4.4	8,427	8.3
Four	1,305	2.1	5,220	5.1
Five - Nine	1,854	2.9	11,620	11.4
10 or more	628	1.0	11,617	11.4

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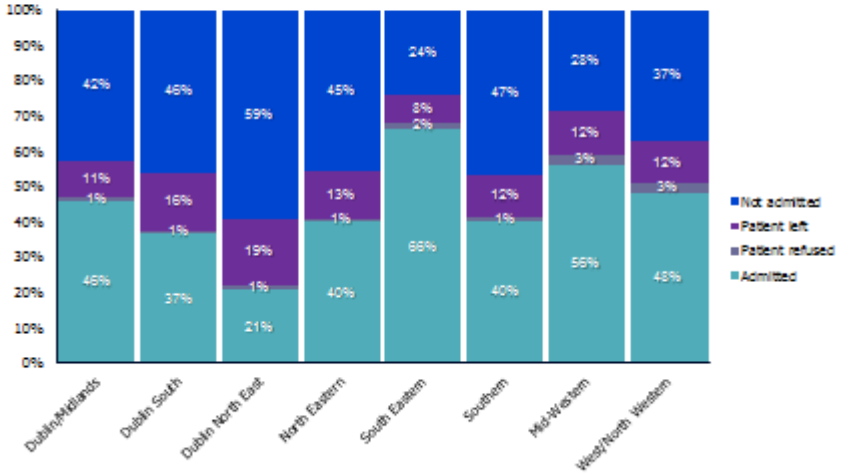
Variation in recommended aftercare following ED presentation due to self-harm by HSE Hospitals Group (Average percentage 2004-2013)



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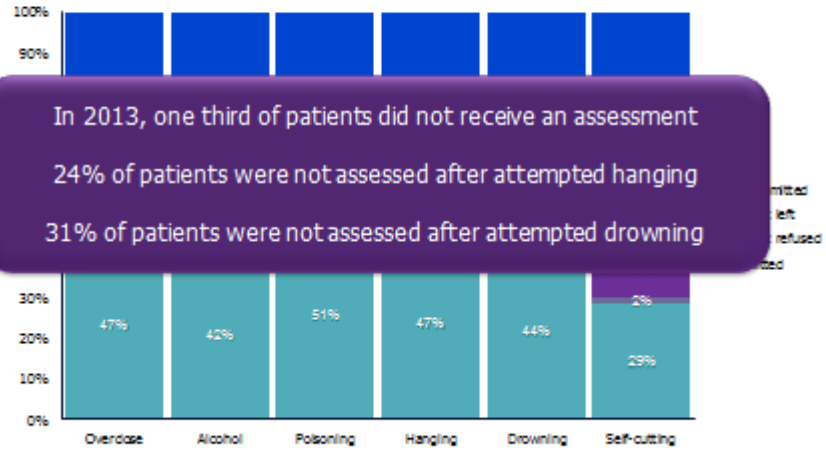
Variation in recommended aftercare following ED presentation due to self-harm by method of self-harm (Average percentage 2004-2013)



In 2013, one third of patients did not receive an assessment

24% of patients were not assessed after attempted hanging

31% of patients were not assessed after attempted drowning

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Background: Policy Context of Training

- *Reach Out*, the National strategy for Action on Suicide Prevention 2005-2014 (HSE, 2005) argues the need to *"develop and resource an effective response in the health services for people who present to services having engaged in self-harm"*

- The National Institute for Health and Clinical Excellence (NICE, 2011) further asserts that all *"clinical and non-clinical staff who have contact with people who self-harm should be provided with appropriate training to equip them to understand and care for people who self-harm"*

- The American Association of Suicidology strongly promotes the roll-out of pilot interventions in EDs regarding self-harm and suicide and advocates for staff training on suicide risk, assessment and management

- There is growing evidence which supports the effectiveness of self-harm and suicide awareness training for ED staff in improving knowledge, attitudes towards self-harm and suicide *(Knesper et al, 2010; WHO, 2014)*

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Background: Staff Attitude, Knowledge and Confidence The Evidence so far

Staff perspective

Saunders et al (2011) Systematic Review

Attitudes and knowledge of clinical staff regarding people who self-harm

- Majority of ED staff had negative attitudes towards people who had engaged in self-harm
- Non ED staff had more empathetic and compassionate attitude than ED staff

"Dealing with patients who self-harm can hurt staff emotionally, simply because we feel there is NOTHING that we can do to improve their situations, we don't know how to speak to patients"

"When you've got a department or ward take full of severe asthma, meningitis...etc, and then you've got a couple of young girls who have taken a cocktail of things... They cannot... with our current resources... be looked after in the same way...which I am not saying I am proud of feeling"

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Background: Staff Attitude, Knowledge and Confidence - The Evidence so far

Hunter et al (2012) Research Report

Service user perspectives on psychosocial assessment following self-harm and its impact on further help-seeking

Service user perspective

- Most people felt judged by ED staff for their acts of self-harm
- This compounded existing feelings of shame, guilt and isolation as well as resulting in dissatisfaction with care and issues with treatment compliance
- Non-judgemental treatment inspired confidence in future care opportunities.

"The main thing was that he (ED staff member) did look as if he actually cared, and he really wanted to help me, and so that was a very positive thing"

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Training on awareness of self-harm and suicide for ED staff in the HSE South: Aim and Objectives
To improve ED staff's management, assessment and treatment of people who present to the ED following self-harm
To increase knowledge and understanding of self-harm and suicide
To promote a positive attitude regarding self-harm and suicide prevention
To improve clinical confidence in the management of self-harm
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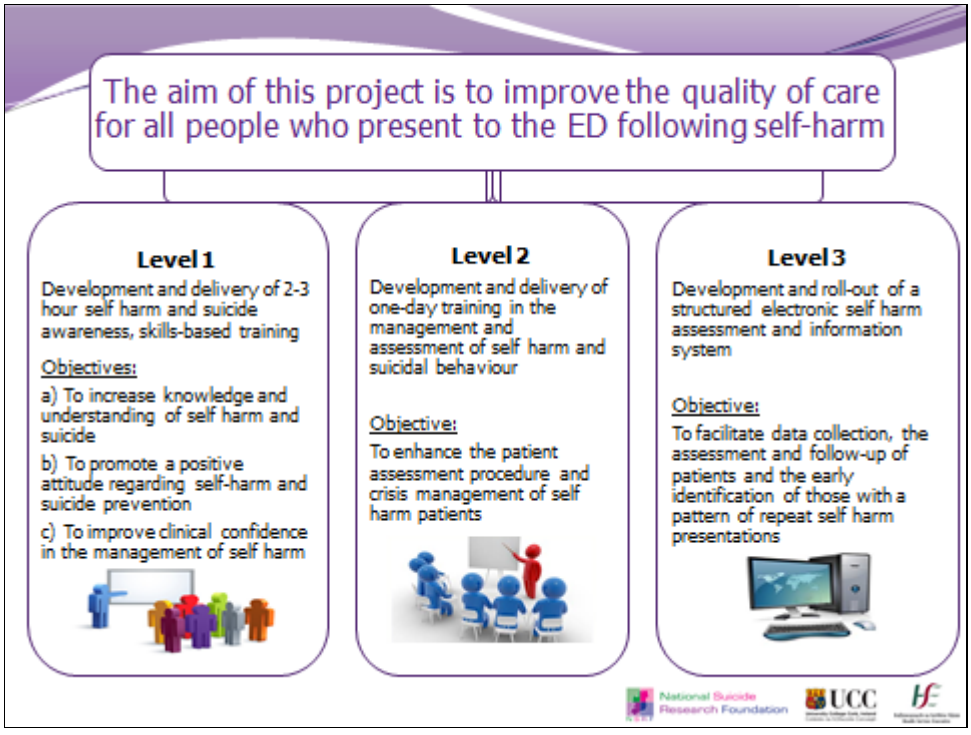
The aim of this project is to improve the quality of care for all people who present to the ED following self-harm
Level 1
Development and delivery of 2-3 hour self harm and suicide awareness, skills-based training
Objectives:
a) To increase knowledge and understanding of self harm and suicide
b) To promote a positive attitude regarding self-harm and suicide prevention
c) To improve clinical confidence in the management of self harm
Level 2
Development and delivery of one-day training in the management and assessment of self harm and suicidal behaviour
Objective:
To enhance the patient assessment procedure and crisis management of self harm patients
Level 3
Development and roll-out of a structured electronic self harm assessment and information system
Objective:
To facilitate data collection, the assessment and follow-up of patients and the early identification of those with a pattern of repeat self harm presentations
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Methodology: Training Content

Four key aspects covered in the training include:

1) The extent of self-harm and suicide in Ireland
2) Staff attitudes towards depression, self-harm and suicide
3) The direct and indirect effects of alcohol in relation to self-harm and suicide
4) The identification of risk and responding to a person who has engaged in self-harm

Detailed training content:

- Interactive exploration of self-harm and suicide and the associated risk/protective factors
- Discursive exploration of staff attitudes, understanding and knowledge of self-harm
- Discussion on the direct and indirect effects of alcohol and the implications for assessment
- Detailed explanation of how to identify risk, respond and provide support
- Group role plays

➢ The training programme has received accreditation from the Royal College of Surgeons Ireland and An Bord Altranis

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Training Delivery

- Employs the Train-the-Trainer model : One day (8hr) TTT workshop involving five senior hospital staff
- Subsequently ED staff from Cork & Kerry hospitals in the HSE South were invited to partake in this 2-hour training
- Staff invited included ED nurses, doctors, clerical staff, porter staff, paramedic staff, security staff etc.
- Each training session including max. 15 staff members took place onsite, within the ED setting and was facilitated by 2 trained trainers

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Training Evaluation

- Participants receive a matched pre/post-training and 6-month follow-up evaluation
- Information collated detail:

  Basic demographics; Previous training experience and Pre & post-training measures of staff knowledge, attitudes and confidence regarding DSH and suicide
- Participants also reported on their satisfaction with the training in a brief 1-page evaluation

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Measurement Scales

Training Aspect Measured	Scale
1) Knowledge and understanding of self harm and suicide	Jeffery & Warm 2002 (20 items)
2) Attitude towards deliberate self harm	Attitude Towards Deliberate Self Harm Questionnaire (ATDSHQ) McAllister et al, 2002 (19 items)
3) Attitudes towards suicide prevention	Attitudes towards suicide prevention scale (ATSPS) Herron *et al*, 2001 (14 items)
4) Confidence in management of patients presenting with self harm or suicidal behaviour	Morriss *et al*, 1999 (2 items)

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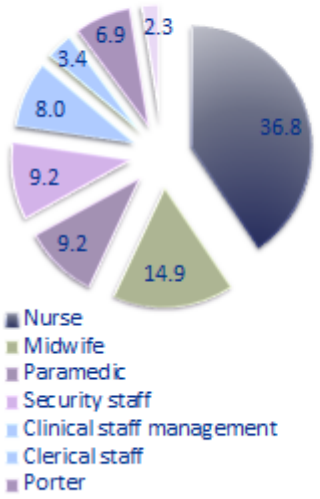
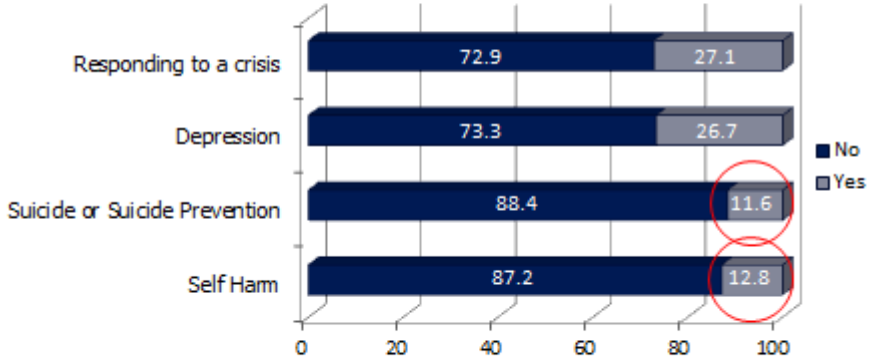
Results: Baseline characteristics



- So far 102 ED staff have been trained and 87 are included in this analysis
- The majority of the ED staff included in this analysis were female (67.8%)
- The mean age of these ED staff was 37 years (SD: 9.3)
- The mean years spent in education was 17 years (SD: 4.3)
- The mean years experience in their current position was 10 years (8.9)

Results: Previous training experience

Have you had any previous training relating to...



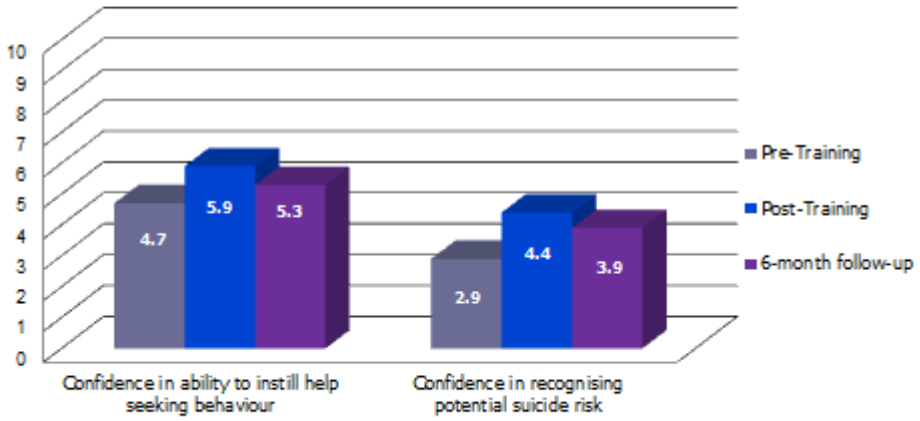
Approximately one third dealt with self-harm or suicide on a weekly basis in the ED setting

Results: Pre & post-training changes in attitude, knowledge and confidence

Scale	Pre-training Mean (SD)	Post-training Mean (SD)	P value	Cohen's d	Mag. of change
Attitude Towards Deliberate Self Harm (ATDSHQ) Total (Range: 19-95)	53.6 (4.0) →	55.5 (3.6)	<.000	0.498	+1.9
Confidence					
-In instilling help seeking	4.7 (2.3) →	5.7 (2.0)	<.000	0.452	+1.0
-In recognising potential risk (Range: 1-10)	3.8 (2.4) →	4.7 (2.3)	<.000	0.328	+1.1
Attitude Toward Suicide Prevention (ATSP) (Range: 14-70)	49.8 (5.4) →	50.8 (5.1)	.058	0.178	+1.0
Knowledge (Range: 20-100)	70.9 (6.2) →	71.9 (6.3)	.059	0.157	+1.0

6-month follow-up

Pre, post-training and 6-month follow-up changes in confidence among staff



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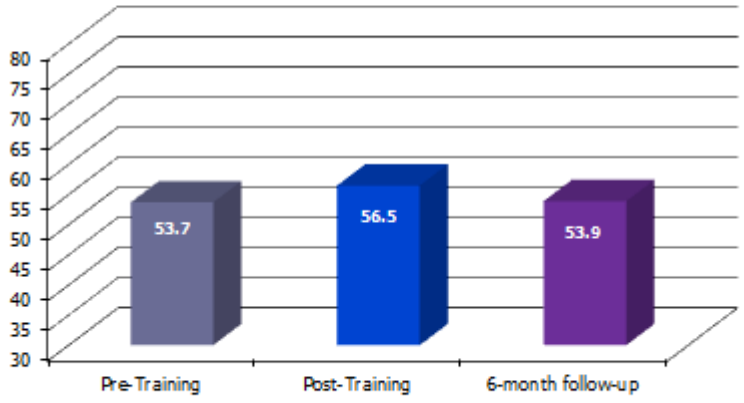
6-month follow-up

Pre, post-training and 6 month follow-up changes in attitudes towards self-harm (%)



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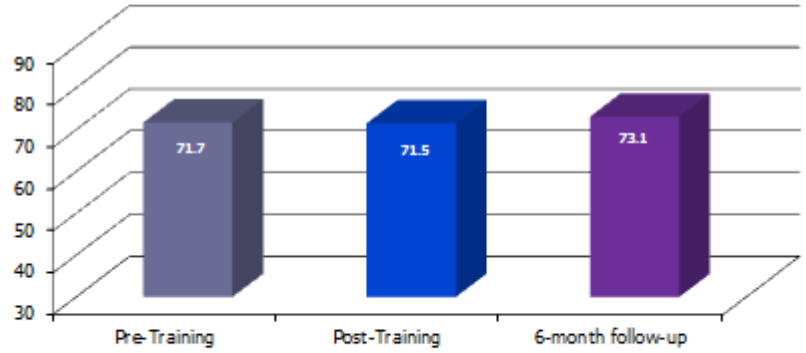
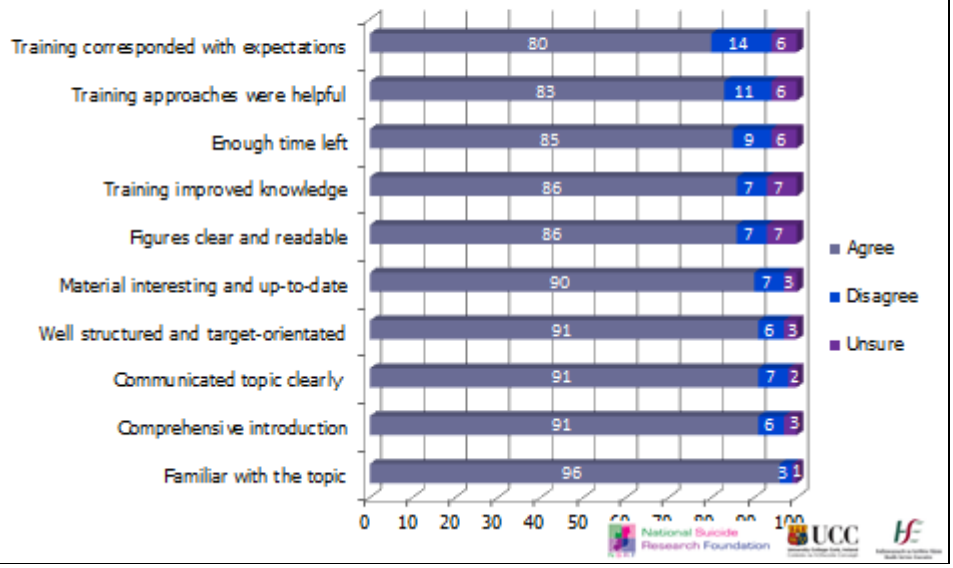
6-month follow-up

Pre, post-training and 6 month follow-up changes in knowledge and understanding of self harm (%)



National Suicide Research Foundation UCC

Participant satisfaction feedback



National Suicide Research Foundation UCC

Participant Satisfaction Feedback contd.

"Good insight given to present trends and good information given on speaking/managing a client who self harms"

"Role plays were helpful…(they) certainly helped how I would approach someone who self harmed"

"Very informative and I have a better understanding of self-harm, which I will find useful in my workplace"

" The crisis nurses in the ED provide a vital role for improving mental health services and as an ED nurse I would welcome expansion of services. Also further training courses for us would be very welcome"

National Suicide Research Foundation UCC

Recommendations

- The evidence obtained in the current study supports the wider implementation of the 2-hour awareness training programme on self-harm and suicide among Emergency Department staff in Ireland
- In order to enhance the sustainability of training effects, it would be recommended to consider implementing refresher courses.
- The efficacy of the training could be enhanced by extending the 2-hour programme to 3 hours and including more elements of skills-based learning.
- In order to ensure safety and optimal learning for the trainers involved in delivering the suicide and self-harm awareness training programme, it would be recommended to develop a formal structure for support and debriefing for trainers.
- It is recommended that the evidence base obtained in the current study be integrated in the national guidelines for the management and assessment of self-harm patients presenting to Emergency Departments as part of the National Clinical Programme.

"People who attempt suicide never want to die, what they want is a different life"

(R. Wieg, 2003)

Acknowledgements

Dr Eugene Cassidy
Department of Psychiatry, Cork University Hospital
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National Suicide Research Foundation, University College Cork

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the National Office for Suicide Prevention

Thank you!

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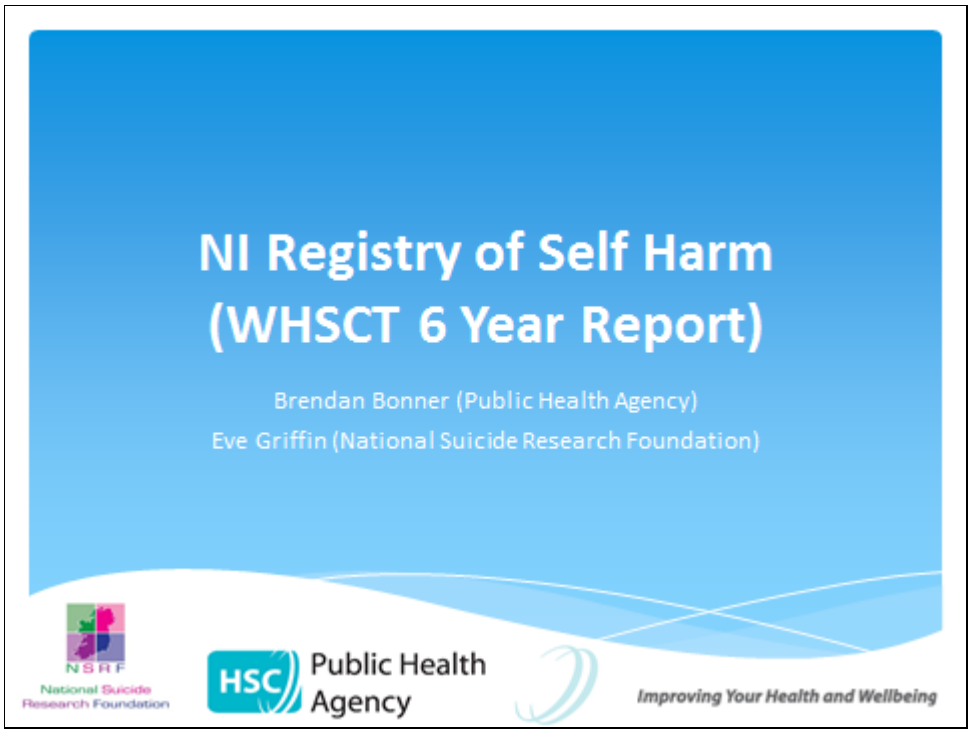
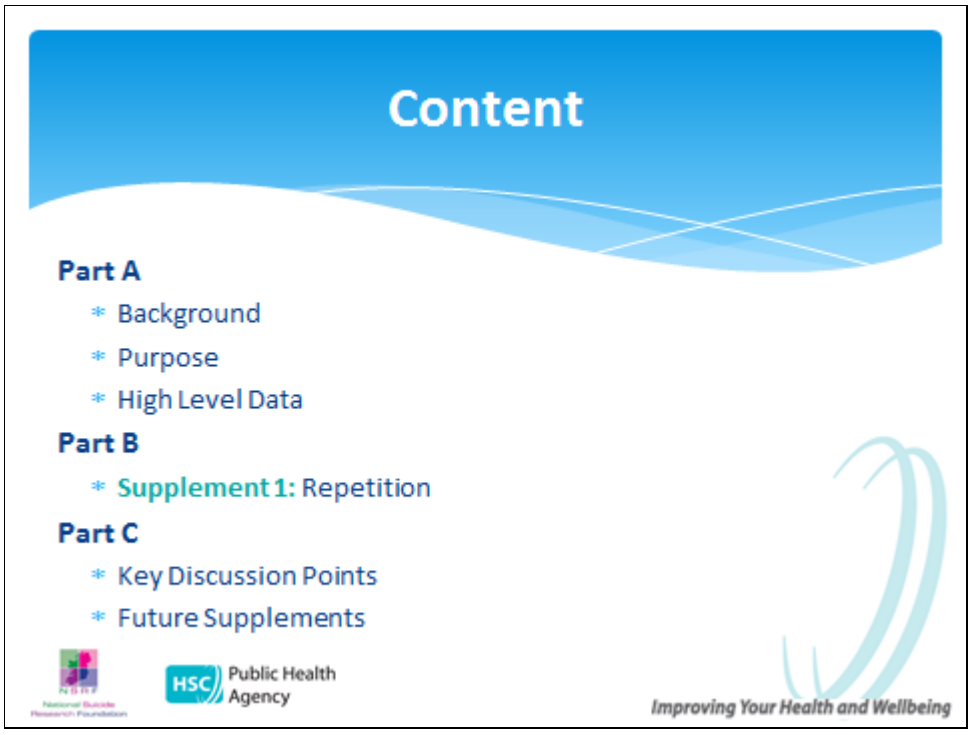
Presentation by Dr Eve Griffin and Mr Brendan Bonner





Background to the Registry

* Operational In ROI since 2002
* Cross Border initiative under Protect Life
* Pilot in the West from 2007
* Partnership with NSRF (Cork)
* Regionalised from 2012
* First Annual Report 2014
* 6 Years Data for WHSCT

HSC Public Health Agency

Improving Your Health and Wellbeing

Purpose

* Understanding of Self-Harm/Suicidal Ideation
* Impact of Self-Harm/Suicidal Ideation on HSC
* Inform Service (re)Design
* Inform Policy
* Inform Communities/Stakeholders
* Stimulate Research and Peer Reviews

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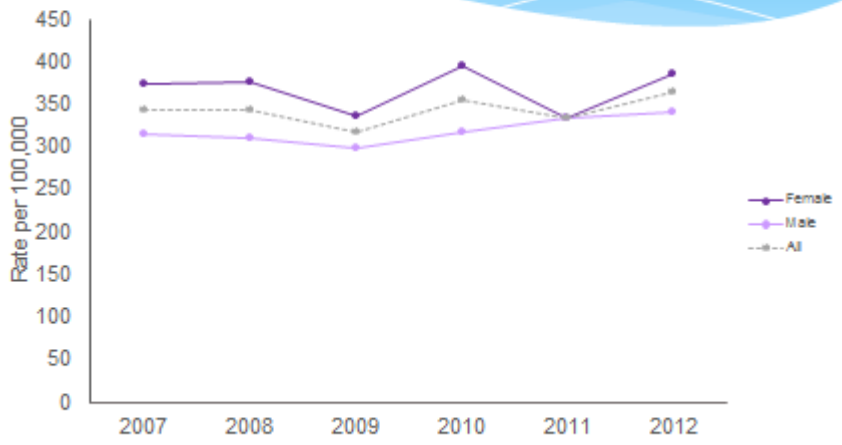
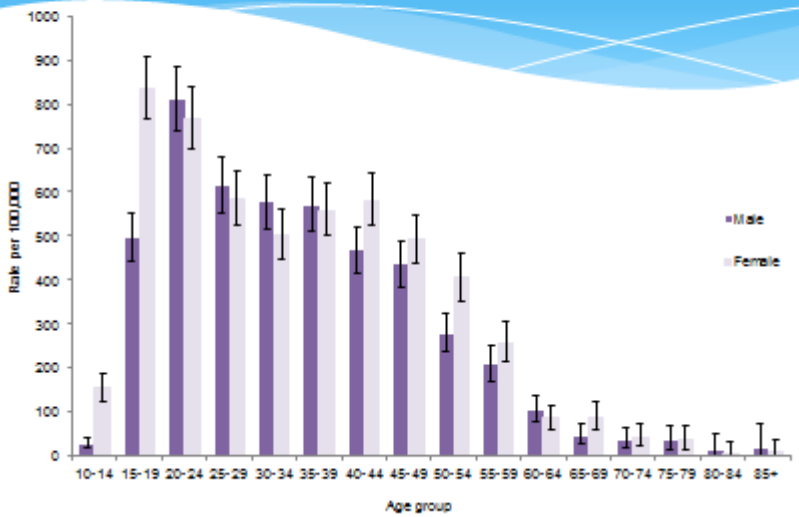
Improving Your Health and Wellbeing

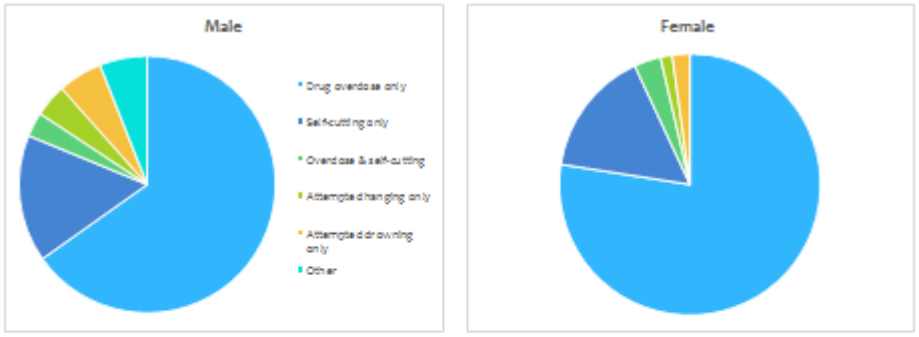
Person-based age-standardised rate (EASR) of self-harm, by gender, per 100,000, 2007–2012



EASR per 100,000 of self-harm, by age and gender 2007–2012

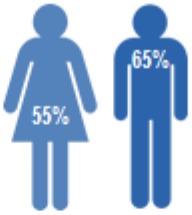


Method of self-harm used by gender, 2007–2012



Influence of Alcohol

* Alcohol involved in 60% presentations
* Males 65% Females 55%
* 45-64 year olds 65%
* 25-44 year olds 64%
* In attempted drowning's 68%
* In attempted hangings 67%



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Improving Your Health and Wellbeing

EASR (15+)of self-harm for cities in Northern Ireland, ROI and England

Incidence rate per 100,000	Males	Females	Total
Limerick	596	671	634
Derry	609	627	623
Belfast	584	545	563
Cork	484	399	442
Derby	322	552	435
Manchester	355	446	398
Waterford	350	406	377
Dublin	338	378	358
Galway	358	381	344
Oxford	248	358	301

Supplement 1: Repetition of Self-Harm

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Improving Your Health and Wellbeing

Extent of repeated self-harm, 2007-2012

Frequency of attendances with self-harm	Persons (n=4,733)		Presentations (n=8,175)	
	Number of persons	% of total persons	Number of presentations	% of total presentations
1	3,455	73.0	3,455	42.3
2	670	14.2	1,340	16.4
3	232	4.9	696	8.5
4	142	3.0	568	6.9
5–9	176	3.7	1,084	13.3
10 or more	58	1.2	1,032	12.6

Repetition by method of self-harm

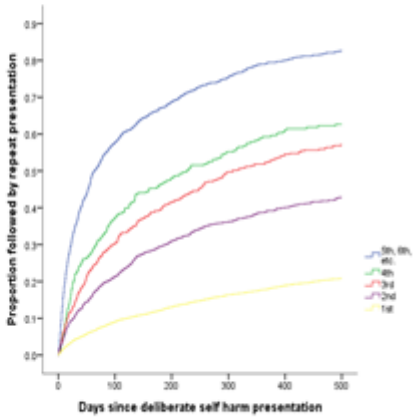
	Overdose	Cutting	Drowning	Hanging	Other	Poisoning	Total
No. of individuals	3,196	544	198	144	77	45	4,041
No. who repeated	544	143	47	21	17	<5	726
% who repeated	17.0%	26.3%	23.7%	14.6%	22.1%	8.9%	18.0%

Repetition by aftercare

	General admission	Psychiatric admission	Refused to be admitted	Left without being seen by ED doctor	Not admitted	Total
No. of individuals	2,271	282	121	219	1,148	4,041
No. who repeated	406	61	23	58	178	726
% who repeated	17.9%	21.6%	19.0%	26.5%	15.5%	18.0%

Factors associated with repetition

* 8,175 presentations by 4,733 individuals
  * 18% of people represented more than once
* Risk of repetition was greatest in the short term
  * 20% of presentations were followed by a repeated act within 3 months
* Rate of repetition varied by:
  * Age
  * Method of self-harm
  * Recommended next care
  * Number of previous self-harm presentations



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Summary: Repetition

* Person-based repetition rates consistent with findings in Ireland and England, as well as in Northern Ireland
  * Repetition patterns and risk factors consistent with international findings

(Perry et al, 2012; Carroll et al, 2014; PHA, 2015)

* Relatively high proportion (24%) of cases involving attempted drowning were followed by a repeat act
* Association between aftercare and repetition not well established and requires further exploration

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Key Discussion Points (1)

* Highest rates: Women/young people/urban areas
* Profile and pattern of hospital-treated self-harm consistent with ROI and England
* Impact of economic recession
  * Implementation of Protect Life / Investment as potential protective factors
* Like between non-fatal self-harm and risk of future suicide

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Improving Your Health and Wellbeing

Key Discussion Points (2)

- Patterns of repetition informing risk assessment and service developments
  - Short-term risk of repetition
  - Dose-response relationship with repeaters
  - Risk of repetition among those leaving the ED without being seen
- Results emphasise the importance of implementing and evaluating self-harm awareness training for all ED staff
- Evidence that a psychosocial assessment following self-harm is associated with lower rates of non-fatal repetition

(Bergen et al, 2010; Kapur et al, 2013)

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Improving Your Health and Wellbeing

Future supplements

- **Supplement 1** – Repetition
- **Supplement 2** – Aftercare of self-harm
- **Supplement 3** – Methods of self-harm and alcohol involvement
- **Supplement 4** - Socioeconomic factors associated with self-harm

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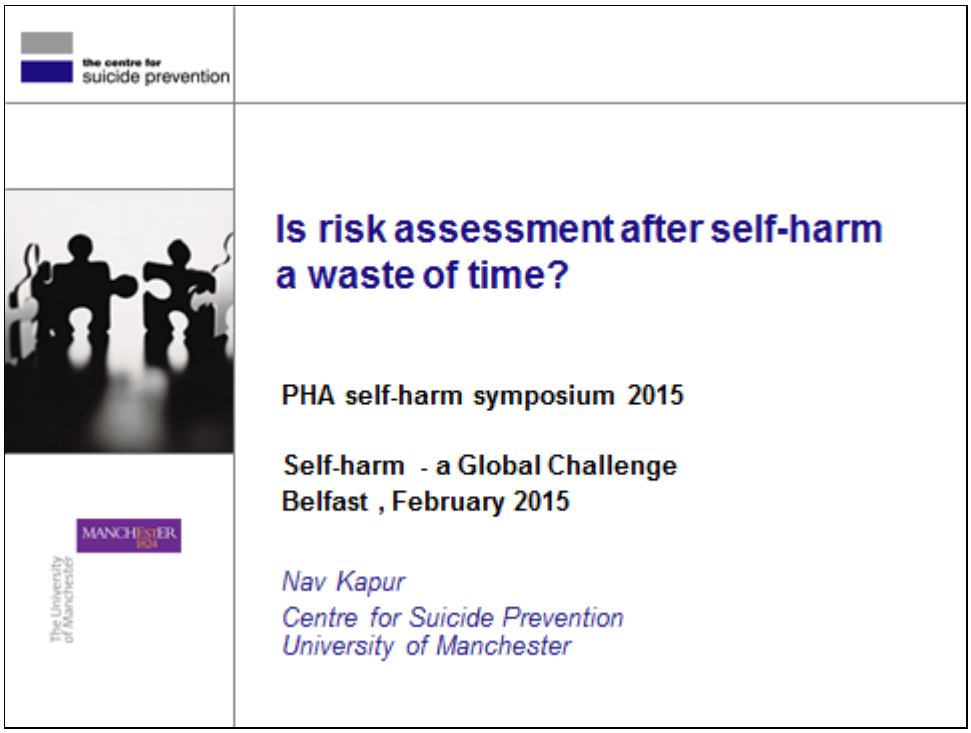
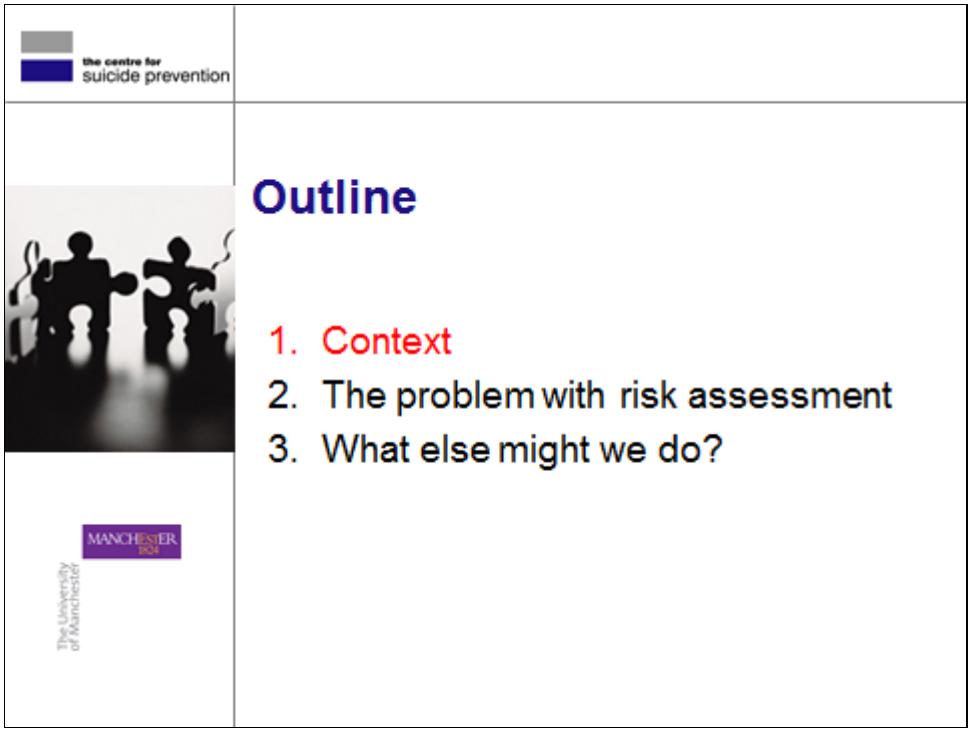
Presentation by Professor Nav Kapur





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Global context

Global rate of 'suicide attempts' 400 per 100 000 per year

28 000 000 episodes per year

.....or just about one every second

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Self-harm in England

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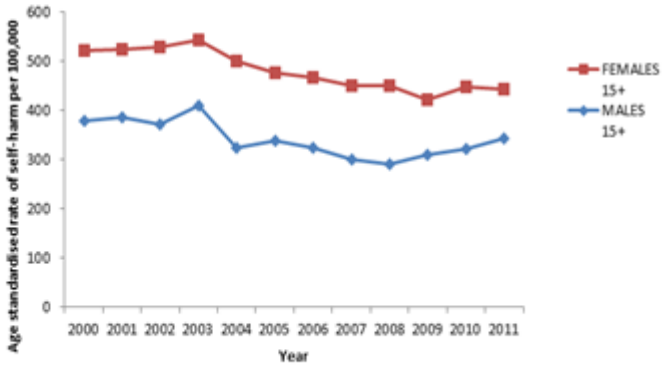
Self-harm in England

Figure 15.2 Age-standardised rates of self-harm in people aged 15 years and over in three centres (Oxford, Manchester and Derby), combined



Hawton, Gunnell, Kapur CMO Annual Report 2013

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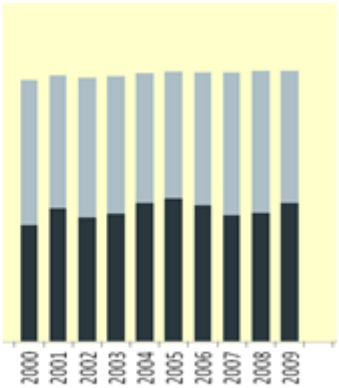
Self-harm and suicide

- 50%+ of those who die by suicide have a history of self-harm
- Risk of suicide increased 30-50 fold in the year after self-harm

Life expectancy in men who self-harm vs the general population



Bergen et al 2012, Lancet

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Service user experience

`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...'

`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...'

(Taylor et al 2009, BJPsych)

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Outline

1. Context
2. The problem with risk assessment
3. What else might we do?

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Risk

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The problem with risk assessment: Assessment of risk prior to suicide

Table 2: Social and clinical characteristics of Inquiry suicide cases (continued)

	Number (6,203)	%
Behavioural features		
History of self-harm	4,124	68
History of violence	1,291	22
History of alcohol misuse	2,631	44
History of drug misuse	1,789	30
Contact with services		
Last contact within 7 days of death	2,955	49
Symptoms at last contact	3,759	61
Estimate of immediate risk: low or none	4,984	86
Estimate of long-term risk: low or none	3,368	59
Suicide thought to be preventable	1,017	19

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Risk assessment following self-harm

Risk (N)	n(%) repeating
Low (1721)	165(9.6)
Moderate(1738)	548 (16.6)
High (369)	95(25.7)

(Kapur et al BMJ 2005)

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Risk tools and scales

SAD PERSONS
(10 items)

S Sex
A Age
D Depression
P Previous Attempts
E Ethanol Abuse
R Rational Thinking Loss
S Social Support Lacking
O Organised Plan
N No Spouse
S Sickness

Risk tools and scales

Risk tools and scales to predict suicide after self-harm:

- Positive Predictive Value less than 5%
- So they are wrong 95% of the time
- And they miss suicide deaths in the large 'low risk' group

Risk tools and scales

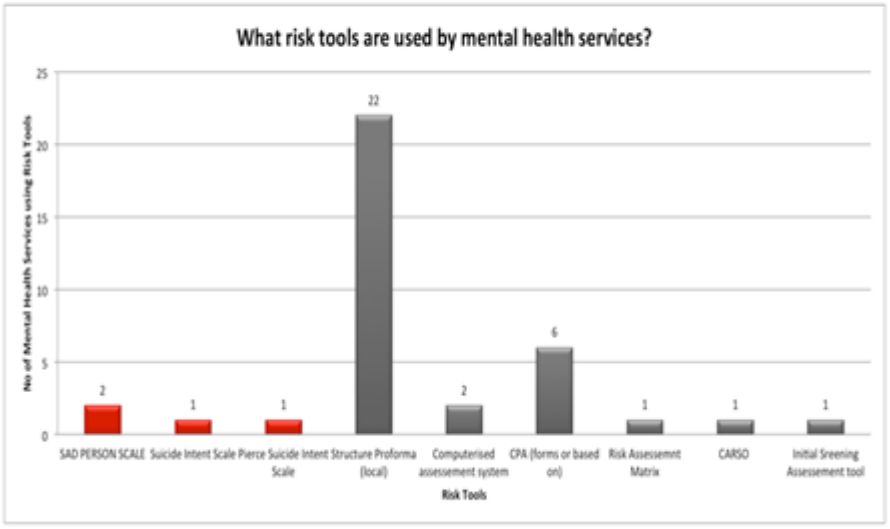
NICE Guidelines:

Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.

Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.

Risk assessment tools may be considered to help structure, prompt, or add detail to assessment.

What are we doing?



Quinlivan et al BMJ Open 2014

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Outline

1. Context
2. The problem with risk assessment
3. What else might we do?

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What else might we do?

- Do the simple things well

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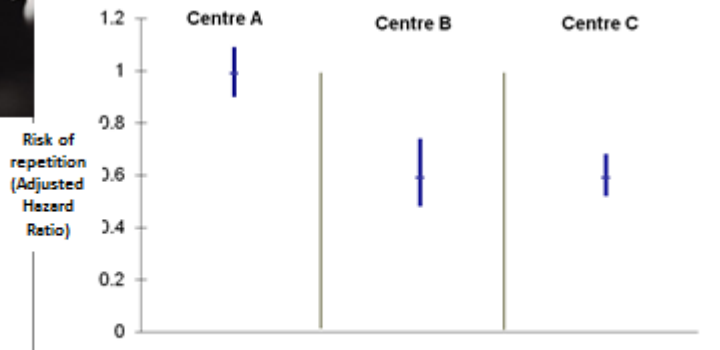
the national confidential inquiry into suicide and homicide by people with mental illness

What works?

Psychosocial assessment

Observational data on 35,938 individuals presenting with self-harm to 3 centres in England, comparing repetition in those receiving vs not receiving specialist assessment (adjusted for baseline characteristics)



(Kapur et al 2013)

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How does it work?

The assessment itself

The main thing was that [psychiatrist] did look as if he actually cared, that's it, and he wanted, he really wanted to help me, and so that was a very positive thing" (P4)

Access to aftercare

[I'm] hugely grateful that I've got the help, it's made a whole world of difference [yeah], I'm getting regular phonecalls, people are phoning me, keeping me informed, my care people are coming, I know that within the next couple of weeks, I will have the support I need" (P10).

(Hunter et al 2013)

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What else might we do?

- Do the simple things well
- Timely access to intervention

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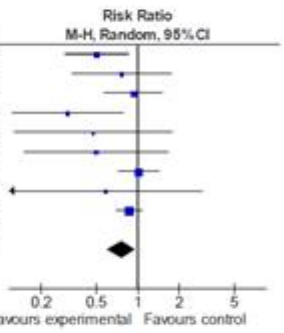
What works?

Psychological interventions and repeat self-harm

1.4 Per protocol repetition (last follow up)

Study or Subgroup	Experimental Events	Experimental Total	Control Events	Control Total	Weight	Risk Ratio M-H, Random, 95% CI
BROWN2005	13	45	23	40	13.0%	0.50 [0.30, 0.85]
DUBOIS1999	8	43	10	41	6.5%	0.76 [0.33, 1.74]
GIBBONS1978	27	200	29	200	14.6%	0.93 [0.57, 1.51]
GUTHRIE2001	5	58	17	61	5.3%	0.31 [0.12, 0.78]
HAWTON1987	3	41	6	39	2.8%	0.48 [0.13, 1.77]
SALKOVSKIS1990	3	12	4	8	3.3%	0.50 [0.15, 1.66]
SLEE2008	26	40	21	33	21.8%	1.02 [0.72, 1.44]
STEWART2009	3	23	2	9	1.9%	0.59 [0.12, 2.95]
TYRER2003a	84	213	99	217	30.9%	0.86 [0.69, 1.08]
Total (95% CI)		**675**		**648**	**100.0%**	**0.76 [0.61, 0.96]**
Total events	172		211			

Heterogeneity: Tau² = 0.03; Chi² = 11.36, df = 8 (P = 0.18); I² = 30%
Test for overall effect: Z = 2.35 (P = 0.02)



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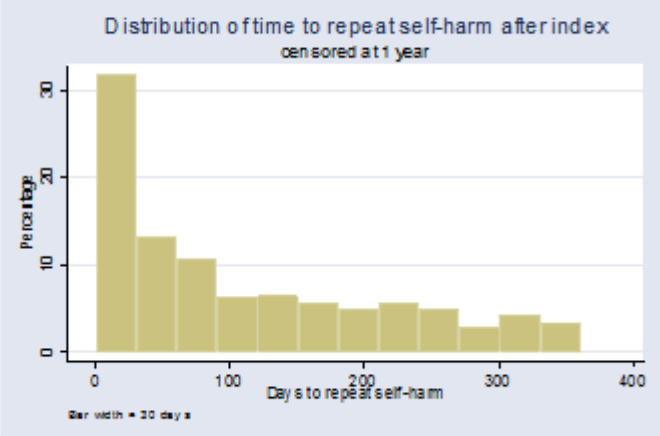
Interventions for self-harm



(Kapur et al J Clin Psychiatry 2006)

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What else might we do?

- Do the simple things well
- Timely access to interventions
- Develop and use guidelines

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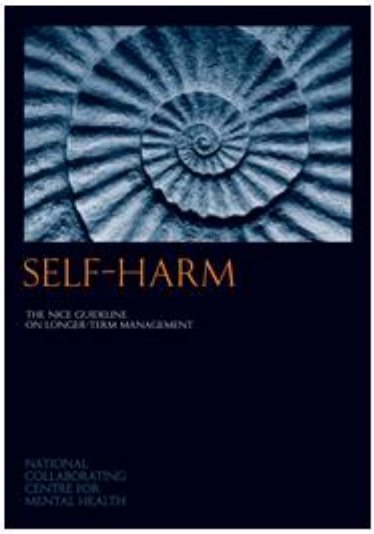
NICE guidelines 2012



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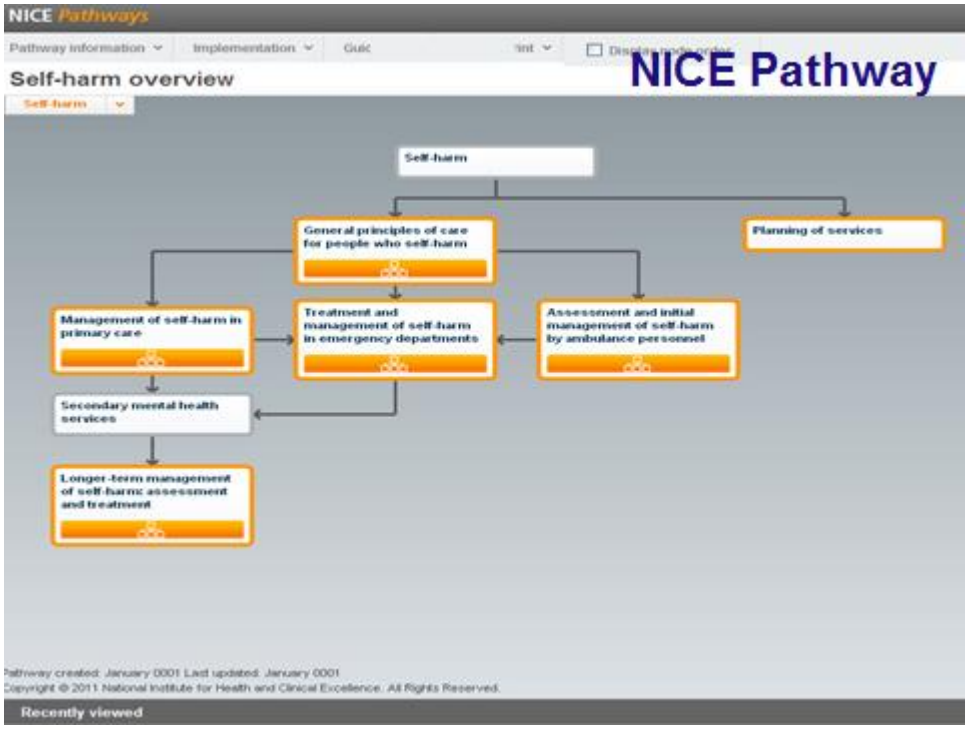
Psychosocial assessment

Offer an integrated and comprehensive psychosocial assessment of needs and risks to understand and engage people who self-harm and to initiate a therapeutic relationship.

During assessment, explore the meaning of self-harm for the person and take into account that each person self-harms for individual reasons. Each episode of self-harm should be treated in its own right.



NICE quality standards

NICE quality standards are a set of specific, concise statements

They set out markers of high-quality, cost-effective patient care.

Quality standards will be reflected in the new Commissioning Outcomes Framework and will inform payment mechanisms and incentive schemes.

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NICE self-harm Quality Standards – June 2013

1. People are treated with compassion, respect and dignity
2. They receive an initial assessment of physical health, mental state, social circumstances and risk of suicide.
3. They receive a comprehensive psychosocial assessment
4. They receive the monitoring they need to keep them safe
5. They are cared for in a safe physical environment
6. Collaborative risk management plan are in place.
7. They have access to psychological interventions.
8. There is a transition plan when moving between services.

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http://publications.nice.org.uk/quality-standard-for-selfharm-qs34

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Implementing guidance

Department of Health

Improving outcomes and supporting transparency

Part 2: Summary technical specifications of public health indicators

Updated November 2013

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Indicator definition	The indicator will have two elements: **2.10i Attendances at A&E for self-harm per 100,000 population** **2.10ii Percentage of attendances at A&E for self-harm that received a psychosocial assessment**

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What else might we do?

- Do the simple things well
- Timely access to interventions
- Develop and use guidelines
- Support families

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Self-harm – helping young people and parents

healthtalk.org OXFORD

Self-harm: experiences of parents

Watch parents and carers share their experiences of having a child who self-harms, on the award-winning website healthtalk.org. Research by The University of Oxford.

"I'm just thinking 'why is my little girl doing this? What did I do?'"

"Just remain hopeful and strong and realise that nothing stays the same"

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Acknowledgements

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Presentations from Workshop 1 – Self-Harm in a Community Setting

Anne Bill, FASA

Conor McCafferty, Zest

FASA Believe
Meaningful Engagement is Essential and Recovery is Possible

"Everyday Engagement" with our Service Users and other Stakeholders

Meaningful Service User involvement takes time and effort to develop and needs constant monitoring and improvement to meet the changing needs of the client group we are working with

SEEING IS BELIEVING

FASA

Self Harm Project # 1
Unscheduled Care Pilot
Belfast

What did we do?

- Working from the Psychological First Aid Model

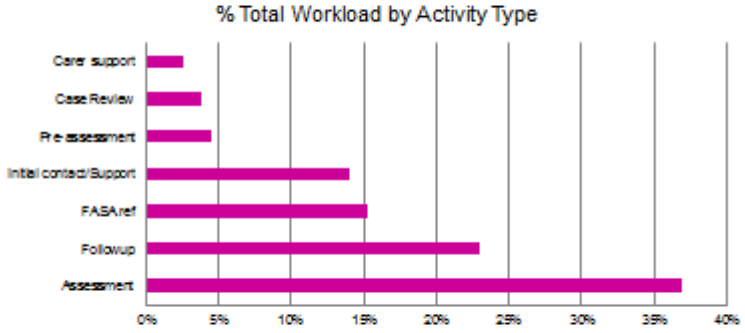
Safety . Security . Shelter . Basic Needs . Soothing human contact . Validation that reactions are "normal" . Social supports . Supporting loved ones . Connection to Recovery services

- 2 FASA Workers as First Responders with Emergency Departments
- Embedded within the Unscheduled Care Team, BHSCT
- Built key Referral Pathways to a wide range of Organisations
- 1:1 Counselling and Mental Health Recovery Coaching Support

SEEING IS BELIEVING

FASA

Self Harm Project # 1
Unscheduled Care Pilot
Belfast



SEEING IS BELIEVING

FASA

Self Harm Project # 1
Unscheduled Care Pilot
Belfast

What has been the Learning & Outcomes?

- Excellent Collaborative Working Model – FASA/USC/ED
- Relationships across Trust and FASA Staff
- Ensured those presenting with issues of Self Harm are signposted to most appropriate service – Statutory or VCS
- Provided a SafetyNet to individuals who would not meet the threshold of Statutory Mental Health Services but do need support
- Engagement has reduced returners
- Engaged those who have presented as Hard to Engage
- Positive Service User Stories

SEEING IS BELIEVING

FASA

Service User Experience
Ann's Story
Collaborative Working for Better Outcomes

- Presented at Emergency Dept. – Mater Hospital
- Engaged with Unscheduled Care and assessment completed
- Engaged with Mental Health and Psychiatry
- Referred by Psychiatrist to FASA for additional support
- Engaged in FASA Counselling and Holistic Therapy Services
- On holiday used FASA EDEN Village Services – Recovery Support and Crafts etc.
- Applied and secured a Back to Work Placement at FASA EDEN Village
- Recruited as a Peer Support Worker

SEEING IS BELIEVING

FASA

CRISIS SUPPORT CENTRE

THE NIGHTINGALE

'Help when you need it'

SEEING IS BELIEVING

FASA

Self Harm Project # 2
Nightingale 24/7 Crisis Centre

- Modelled on 'The Sanctuary' in Manchester
- Development of Protocols, Operational Handbook
- MOUs with both Statutory and VCS Organisations
- Professional Staff Recruited – Social Work, Nursing, Counselling
- Peer Support Volunteers and Peer Support Staff Recruited
- Additional training for Staff and Peer Support Volunteers via Clinical Education Centre – KUF, Storm 3, Motivational Interviewing,
- Operating 'Out of Hours' but not yet 'Through the Night'

SEEING IS BELIEVING

FASA

Self Harm Project # 2
Nightingale 24/7 Crisis Centre

- 16 Week Self Harm Groupwork Programme
- 'CALM' Anxiety Clinics
- Sleep Clinics – (New)
- WRAP – 1:1 and Groups
- 'Inspirations' Self Harm Support Group
- 'Empathy' Family & Carers Support Group (Self Harm)

SEEING IS BELIEVING

FASA

FASA Perspective on Workshop Questions

Why is a community setting seen as more accessible for some client

- Perceptions – Easily Accessible – Self Referral
- Publicity, PR and Word of Mouth - Use of a wide variety of Mediums
- Relationships through local people, community/youth workers etc.

How does the community sector provide the clinical and social care governance assurances to the Commissioners

- Robust Training of Staff – E.g. FASA SLA with Clinical Education Centre
- Registration with relevant bodies – NISCC, BACP Etc.
- Robust Operational Protocols/Risk Management
- Adherence to agreed Frameworks i.e. PHA Framework for Counselling
- Services Quality Assured in accordance with NICE Guidance

SEEING IS BELIEVING

FASA

FASA Perspective on Workshop Questions

How best can the C&V sector and Statutory sector collaborate

- Robust meaningful relationships – Client Focussed
- Appreciation of each other's role and thresholds
- Both Sectors Play to Strengths
- Recognise limitations of both Sectors
- Memorandum of Understanding

How best is the C&V sector valued

- Seen as equals regarding professional Services
- Recognised for its strengths i.e. Engagement, Innovation, Local Knowledge

How can the community sector be used as a setting for R&D

- Embrace best practice, develop and share regionally and beyond

SEEING IS BELIEVING

FASA

SHINE: The Self-harm Interagency network

Conor McCafferty
Zest: Healing the Hurt Ltd

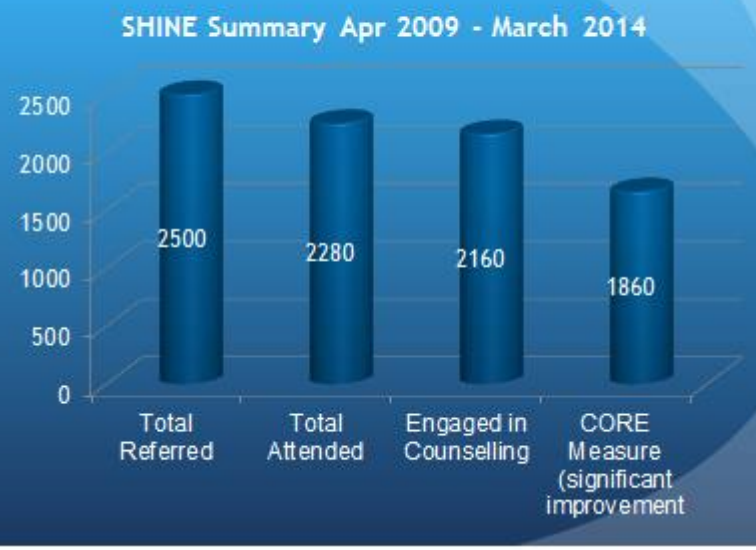
The 'Mentoring' Pilot

- 2007: Mentoring Pilot 'Protect Life' strategy
- Direct referral pathway to Community sector from the CMHT's for patients after a serious episode of self-harm
- WHSCT: Limavady, L'Derry, Strabane, Omagh and Enniskillen
- N.I. Ethics Committee
- An exercise in 'Trust'
- 198 referrals over 18 months

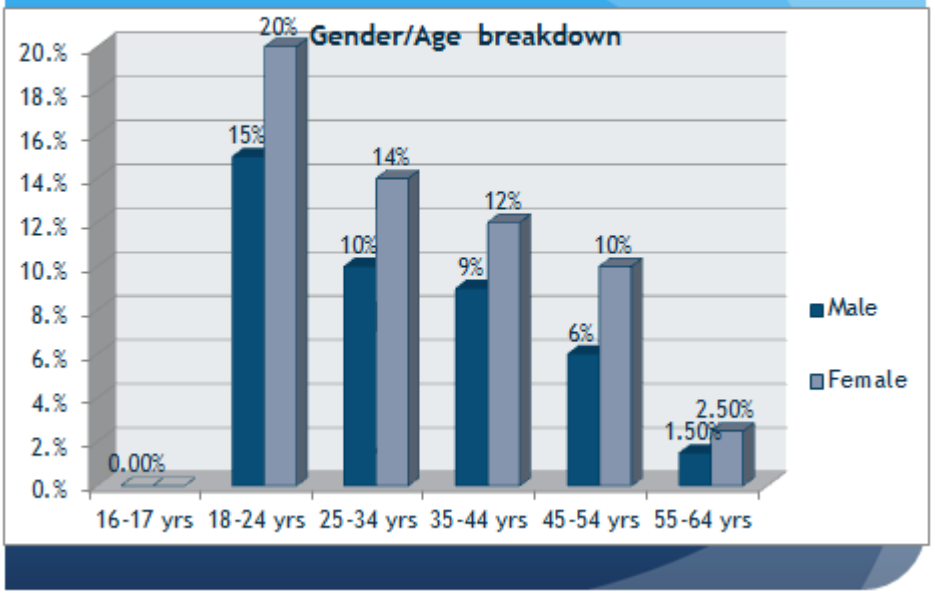
The Self-harm Interagency Network

- 2009: Counselling element was continued as a pilot re-named SHINE:
- Referrals:
- Year 1: 2009/10: projected 220 v actual 280
- Year 2: 2010/11: projected 320 v actual 400
- Year 3: 2011/12: projected 320 v actual 420
- Year 4: 2012/13: projected 320 v actual 520
- Year 5: 2013/14: projected 320 v actual 560

SHINE: Outcomes



SHINE: Referrals



Issues associated with SH

- Depression
- Personal/Family Alcohol Misuse/Abuse
- Other drug use
- Personal/Family Relationships
- Sexual Abuse
- Emotional Abuse
- Physical abuse
- Neglect
- Financial problems
- Gambling
- Low self-esteem

SHINE: Family Support

SHINE: Partnership

- Impacting positively to reduce self-harm and promote resilience against suicide
- CORE measures of mental health and well-being
- Service-user recovery measures
- Referring service-manager evaluations

SHINE: Partnership

- Social and interpersonal benefits

Reaching specified at-risk groups:

- Young males
- Young women
- Those with a history of self-harm
- Those who have problems with alcohol or other drugs
- LGBT

SHINE: Partnership

- Providing a comprehensive, integrated therapeutic approach which includes support for family members
- Developing and disseminating practice-based evidence across a variety of sectors and stakeholders, most notably in the area of intoxication, self-harm and suicide

WHSCT/PHA and Zest

- Embedded referral pathway between psychiatric/psychological services and C&V counselling
- Regular communication and feedback between Zest, GPs and CMHTs
- Agreed risk management protocols
- Open, professional and effective collaboration

Statutory & C&V: Lesson learned

Neither sector can address these problems on their own.

The way forward lies in the partnership and collaboration.

Each sector is equally important!

Zest: Healing the hurt Ltd.
15 Queen Street
L'Derry
BT48 6ST
Email: zestni@yahoo.co.uk
Website: www.zestni.org
Tel: (028) 71 266999

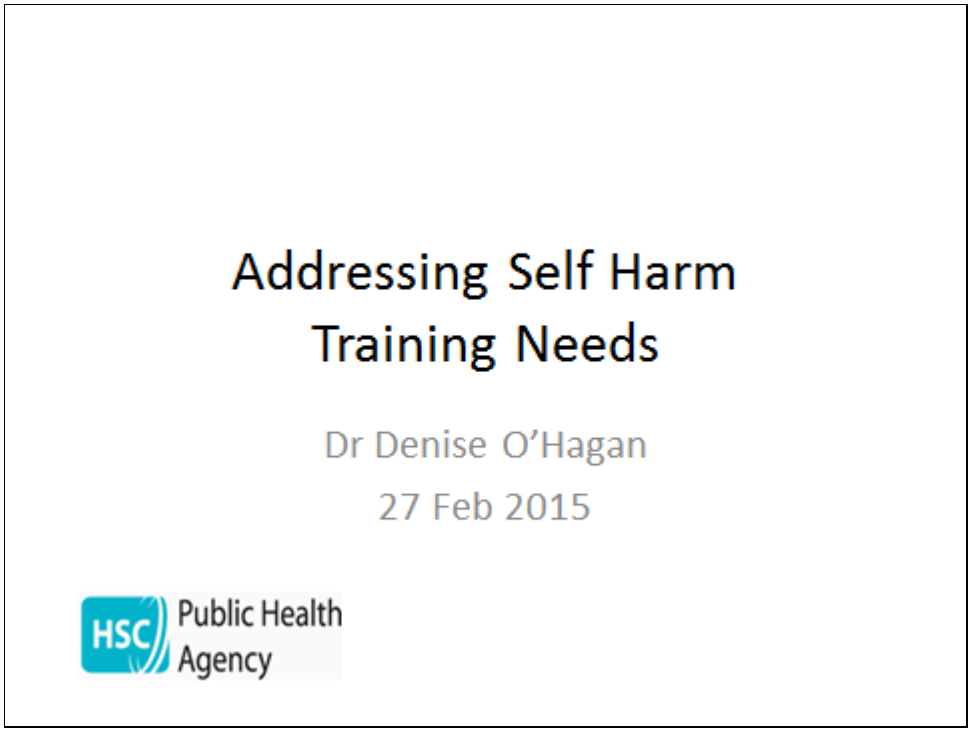
Thank-you!

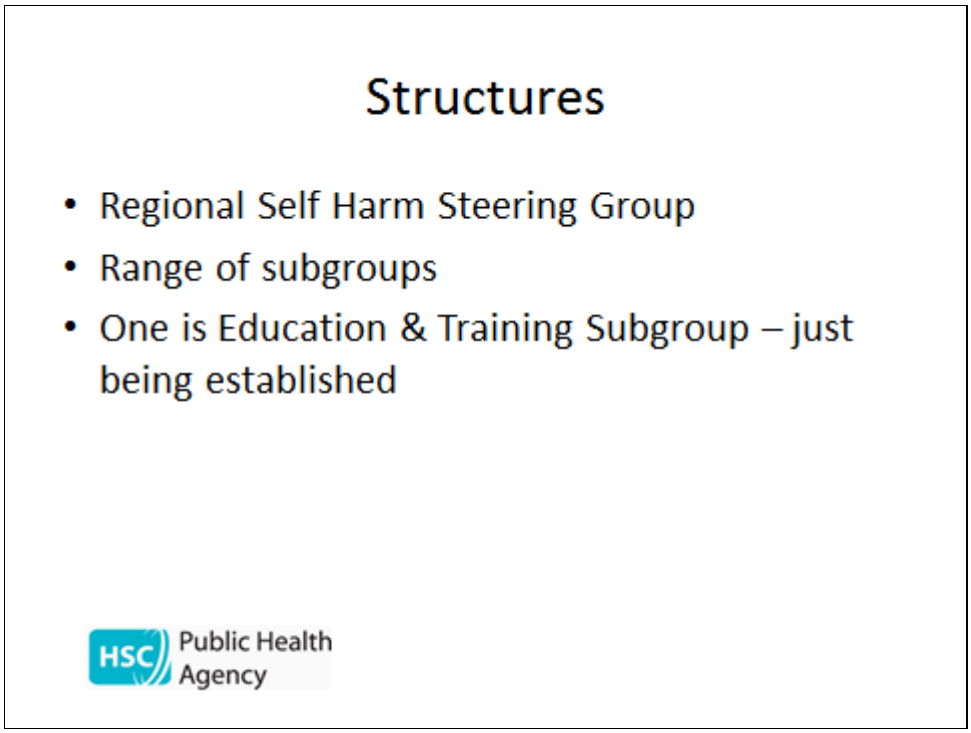
Presentation from Workshop 2 – Addressing Training Needs

Dr Denise O'Hagan, PHA

Damian McAleer, CEC

Marie Dunne, WHSCT





What training opportunities are there?

Level 1: Basic awareness of self harm, appropriate attitudes

- Suicide Talk; Introduction to Self Harm, Module 1 of the ED programme, Leaflets for carers

Level 2: Training for those supporting people who self harm

- Safe Talk; Understanding Self Harm; Mental Health First Aid , Applied Suicide Intervention skills Training (ASIST); Skills Based Training on Risk Management (STORM), ED staff training programmes, Keeping the intoxicated person safe, Ad-hoc events with GPs, Supporting the Family, KUF.

Level 3: Training for mental health practitioners

- ASIST; STORM; KUF; Other CPD

Level 4: Training for Trainers including Safe Talk, Suicide talk, ASIST, Mental Health First Aid, ED training programme, Supporting the Family, KUF

HSC Public Health Agency

ED Training Programme

- CEC - iteratively developed with ED staff
- Modular Programme 6 x 30 mins
- Flexible delivery in ED
- Format: Presentations, Scenarios, DVD
- Co-delivery by MH and ED staff
- Strengthen existing relationships
- Raising profile of mental health issues in ED
- Promoting use of leaflets etc

Content of ED Programme

1. Exploring our communication & attitudes
2. Overview of Care Pathway with Focus on Triage
3. Legal & Professional Issues
4. Exploration of Mental Illness
5. Risk Assessment
6. Formulation, Referral, Safety Planning.

GP training- Self Harm

- 399 GPs attended training, 69% of practices
- Update on NICE guidance
- Understanding & Attitudes
- Raising Awareness of Lifeline
- Networking with CV sector

GP Training: Depression

- On-going programme several years
- Via Board Practice Based Learning Events
- 2014-15
  - 5 evening events : 3 hr programme
  - 4 Trust areas plus 1 targeting GP locums and GP trainees
  - 100% of GPs said met their needs

Content of GP Programme

- Setting the Scene
- NICE guidance on Depression
- Suicide Risk Assessment
- Accessing Trust services & Referral Processes
- Psychological & Psychosocial Interventions incl Hubs
- Networking with CV sector & Trust staff
- Recovery
- Case Studies incl Self Harm case / Suicidal case

Trust staff & Ambulance Service

NIAS –

PHA offered NIAS Training for Trainers – Safe Talk & In discussion around other needs

Trusts-

Ward staff, Children's Residential Units

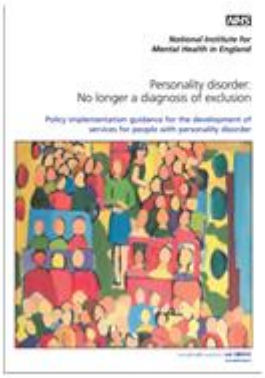
Future Direction

- Enhance availability of training around substance misuse/ self harm links
- Work with HSCB/ Trusts to identify staff groups requiring training and promote training opportunities
- Work with NIAS and PSNI to determine their needs
- Bamford Sub-Group and Self Harm Community Reference Group will consider needs of the CV sector

Working Effectively with Personality Disorder: KUF Awareness Level Training

Damian McAleer

Personality Disorder gets noticed 2003



The Key Purpose of the KUF

Is to…

Improve the quality of service user experience by developing practitioner attitudes, skills and behaviours

KUF Development

- Commenced 2007- developed by a collaborative partnership including:
  - Institute of Mental Health
  - The Tavistock & Portman NHS Trust
  - Emergence (largest P.D service user and carer support group in U.K)
  - The Open University

KUF Standard Awareness Level Modules (3 contact days and 20hrs VLE reflection)

Module 1

- **What is Personality Disorder?**

Module 2

- **Labelling, Myths and Beliefs about Personality Disorder**

Module 3

- **Recognising Personality Disorder: different perspectives**

Module 4

- **Equipping the Organisation to Work with Personality Disorder**

Module 5

- **Understanding Different Perspectives about Personality disorder**

Module 6

- **Positive outcomes**

KUF-New Developments

- Prison KUF- 2 Days
- Women in secure settings (WKUF)- 1/3/4 Days
- Probation/G.P reception staff- 1 Day

Some definitions

- 'The essential features of a personality disorder are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits. The impairments are relatively stable across time and consistent across situations; are not better understood as normative for the individual's developmental stage or socio-cultural environment and not solely due to the direct physiological effects of a substance (e.g. drug of abuse, medication) or a general medical condition (e.g. severe head trauma).' **DSM-5**

Some definitions

- '"Personality disorder" is the term used within mental health services to describe longstanding difficulties in how an individual thinks and feels about themselves and others, and consequently how they behave in relation to other people.'

Meeting the Challenge, Making a Difference: *Working effectively to support people with personality disorder in the community* (2014)

What is Personality Disorder?

The 3 Ps

It's not personality disorder unless the symptoms are:

- **Persistent –** starting in adolescence and continuing into adulthood
- **Pervasive** – affecting a number of different areas of a person's life
- **Problematic** – unusual and causing distress to self or others

Current trends in Personality, Self-Harm and Suicidality

- Self Harm and Suicidality improve with time and suicide is an exception, usually occurring in middle age in those who fail to remit from symptoms.
- Emotional regulation and relief- Dysphoric inner states (affective and cognitive) best distinguished those with extensive from those with less intensive history of self-harm.

(Simonsen et al 2014)

Suicidal or Non-deliberate self-harm?

- 'A BPD patient seeking help or medical attention , using any method other than superficial injury to the skin or reporting a failure to effectively resolve the reasons for the DSH event should be considered as likely to have had a S-DSH event (greater suicidal intention)'

(Gillian et al 2010)

New for 2014

- Working effectively to support people with personality disorder in the community.
- This is an essential guide for everyone involved in frontline work with individuals who might be seen to have a personality disorder
- The guide can be downloaded from the Emergence website:

www.emergenceplus.org.uk

References

- Gillian, R (2010). *Distinguishing suicidal from non-suicidal deliberate self-harm events in women with Borderline Personality Disorder.* Australian and New Zealand Journal of Psychiatry; 44: 574-582
- Simonsen, E , Sorensen, P, Pederson, L (2014). *Current Trends In Research And Clinical Issues In The Study Of Personality And Its Disorders: A survey Of The Presentations At The ISSPD Anniversary Congress.* Journal of Personality Disorders, 28(5), 629-636.
- www.personalitydisorderkuf.org.uk

Self-Harm: Supporting The Family

Marie Dunne
Health Improvement Service
WHSCT

Western Health and Social Care Trust

Health Improvement

1

RATIONALE

- Local needs
- Self harm impacts on the family unit
- Healing and recovery needs family involvement
- Those supporting families need empathy and care
- Evidence based
- Quality assurance and Standards
- Right trainers with skills, knowledge and empathy
- Home grown product – based on our own expertise

2

JOURNEY

- Funding allocated to HID WHSCT from the PHA to develop a Training For Trainers in the area of self harm 2013 (Home grown product)
- Brief -

- ✓ Develop an evidenced based Training For Trainers
- ✓ Sources experts in the field to design and deliver the Training
- ✓ Adhere to PHA training standards
- ✓ Quality Assurance
- ✓ Equip facilitators with knowledge and skills to deliver a one day training programme that could be targeted at individuals and groups supporting families where a family member maybe self-harming.
- ✓ Facilitators would represent the statutory ,voluntary and community sector.
- ✓ Facilitators would committee to delivery of training and contribute to the pilot both in terms of the Training For Trainers and the delivery of the programme
- ✓ Complete the pre and post evaluations .

3

CONTENTS

Training is divided on the 3 modules

- Module 1 – WHAT IS SELF- HARM
- Module 2 - THE PERSON BEHIND THE BEHAVIOUR
- Module 3 - THE IMPACT ON THE FAMILY
  HOW TO HELP AND SUPPORT

- Delivered in a way that supports the range of learning styles

4

EVALUATIONS

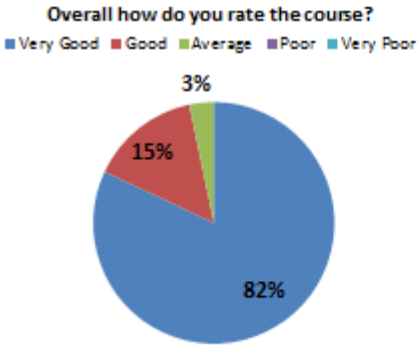
- TRAINING FOR TRAINERS

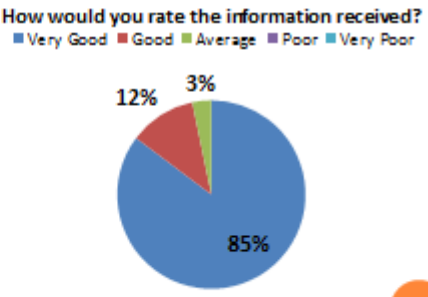
- 9 participants were successful in securing a place on the 3 day training for trainers
- Representing statutory and community sector
- One day delivery- two days for peer supported assessment
- Assessments completed

5

DELIVERY OF TRAINING

- Five one day programmes delivered
- Total of 61 participants attended





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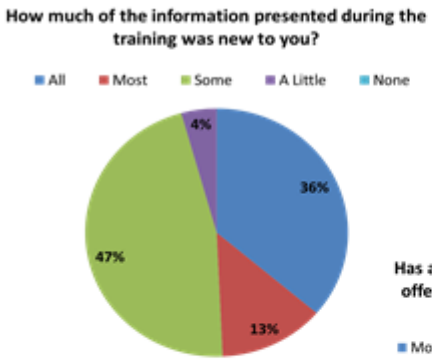

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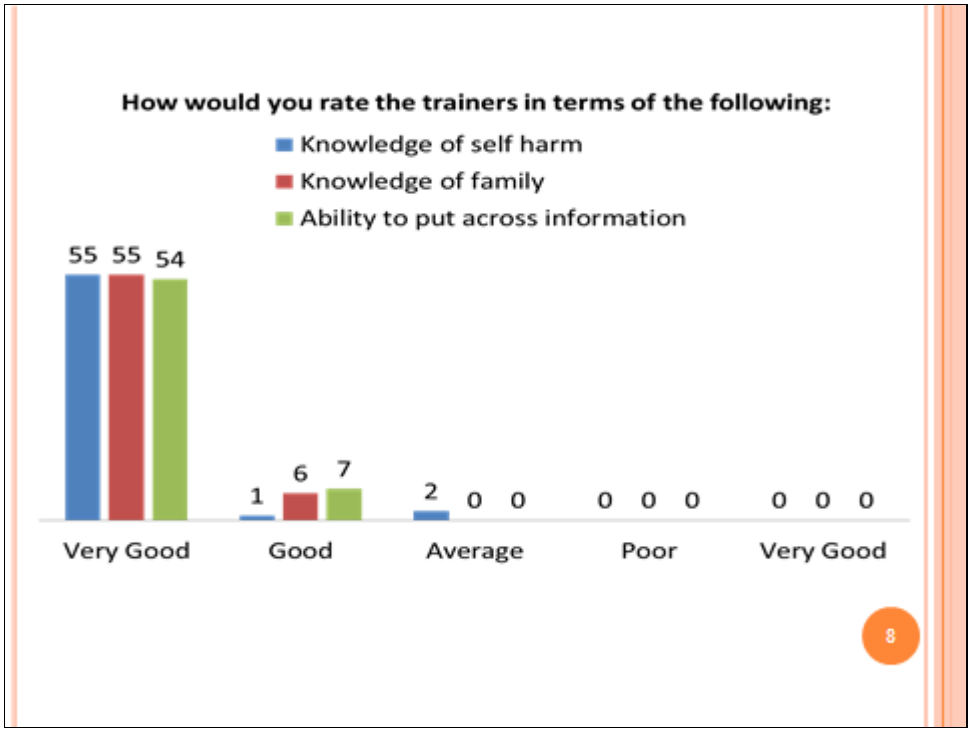
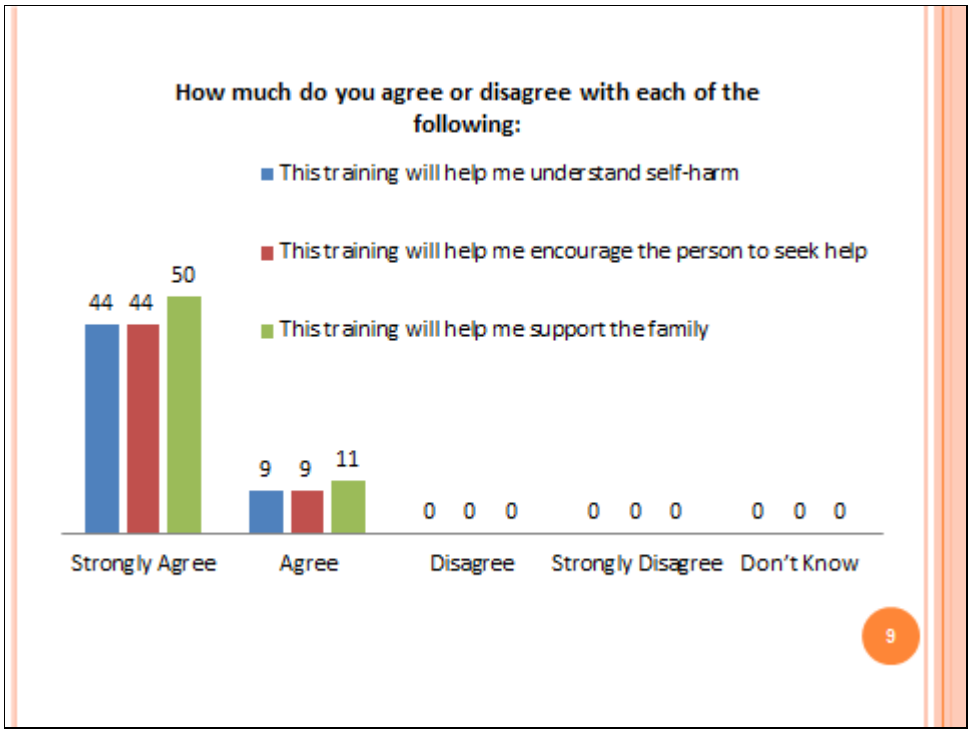
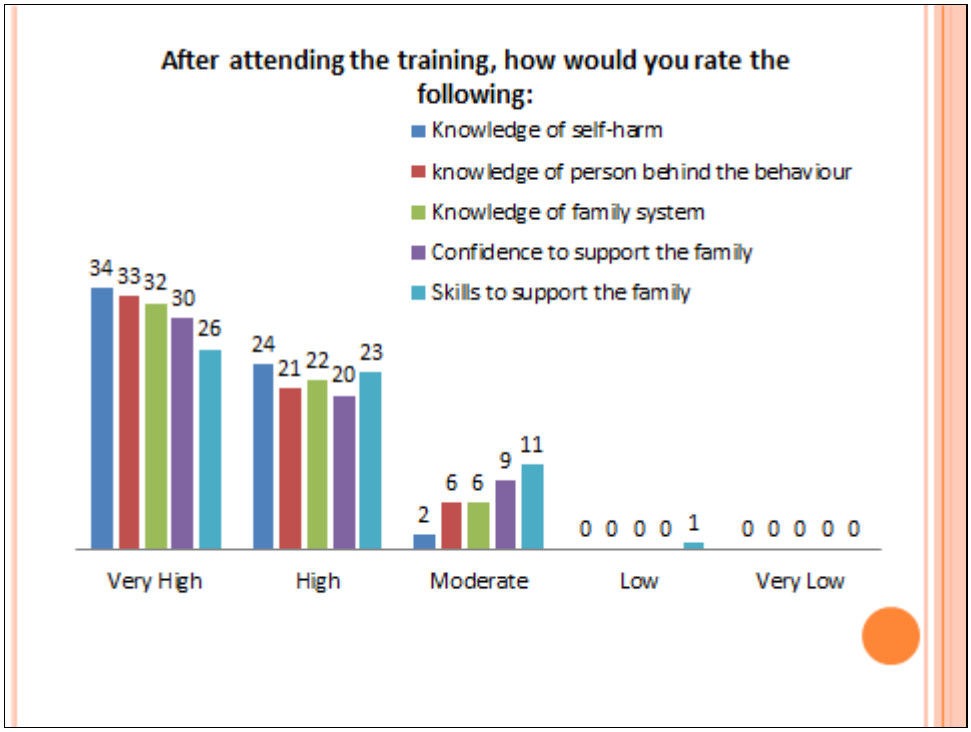

How would you rate the trainers in terms of the following:
Knowledge of self harm
Knowledge of family
Ability to put across information
55 55 54
1 6 7
2 0 0
0 0 0
0 0 0
Very Good
Good
Average
Poor
Very Good
8


How much do you agree or disagree with each of the following:
This training will help me understand self-harm
This training will help me encourage the person to seek help
This training will help me support the family
44 44 50
9 9 11
0 0 0
0 0 0
0 0 0
Strongly Agree
Agree
Disagree
Strongly Disagree
Don't Know
9



GENERAL COMMENTS

- I feel there was too much theory involved in the training
- Knowing that there is people and places to help people that self-harm.
- Knowing how to talk to people that self-harm -more group work would be beneficial
- I thought that personal experiences and group work were most relevant
- This has prompted me to take this area to a further level, I will take on more courses that gives me a wider insight into mental health.
- How to deal with someone who self-harms - compassion and kindness
- The day has given me more tools to work with.
- The language and perceptions we use must ,always be reflected and to promote compassion and kindness in my work.
- Great to get an understanding into self-harm as a way of survival and looking at the person as a whole and their background.
- Being able to understand why some people self-harm
- The training has given me more confidence to work in this area
- A very valuable learning course
- I feel more confident now to talk with the family and the person – before I would have avoided the topic.

11

- A lot to take in over one day
- Some modules had far too many slides
- Would like to see more practical skills- through role play , case studies
- Would like to focus more on how to help
- The subject matter was uncomfortable , but in saying that the facilitators were excellent in providing support and delivered it with such empathy and compassion

- **'Need to encourage more people to attend , I have my own personal experience with a family member – it was such a lonely and scary journey – like walking on egg shells most of the time. Thank you for bringing this subject out in to the open'**

12

A PLEA ON BEHALF OF THOSE WHO SELF - HARM

This person's known great suffering
This person's in great pain
She needs words of reassurance, not telling to refrain

She doesn't need rejecting;
Punishment to calm her down.
She needs your respect and your acceptance
A smile – not a frown.

She may struggle to communicate
What's hurting her within.
But if you're prepared to listen,
Her healing will begin

I appreciate your time is precious
And understanding her is hard,
But I make no plea on her behalf,
Look beyond the scars.

You don't need to know the answers;
Tell her what she should do
Some warmth and reassurance
Are all she asks of you.

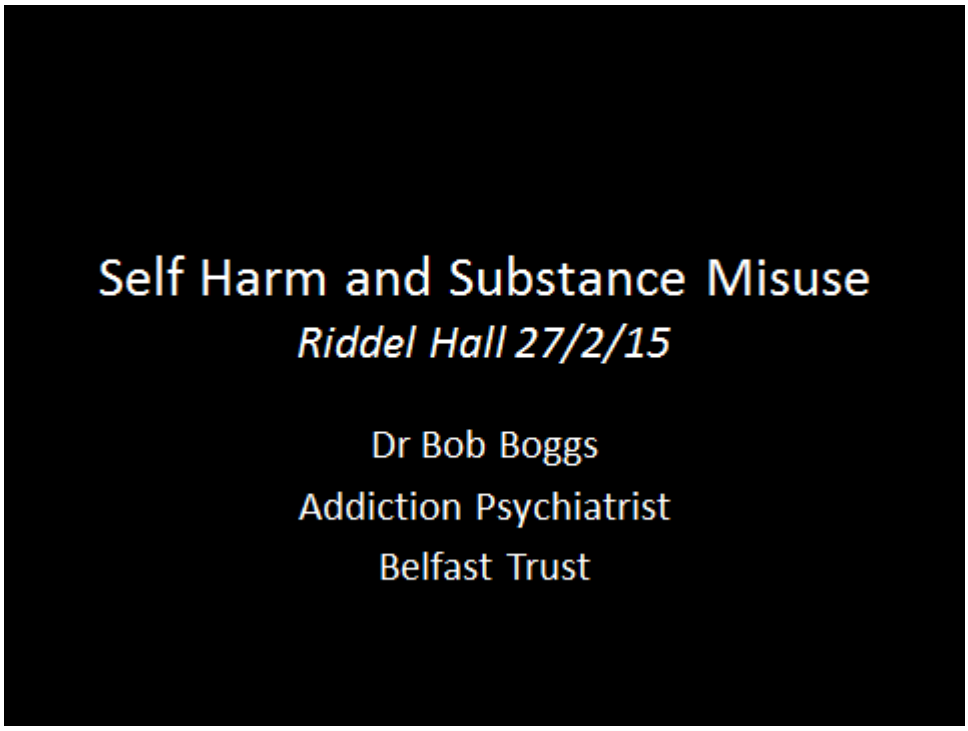
She is fighting a great battle;
Her wounds are deep and raw,
So please treat her with tenderness,
And help her win the war

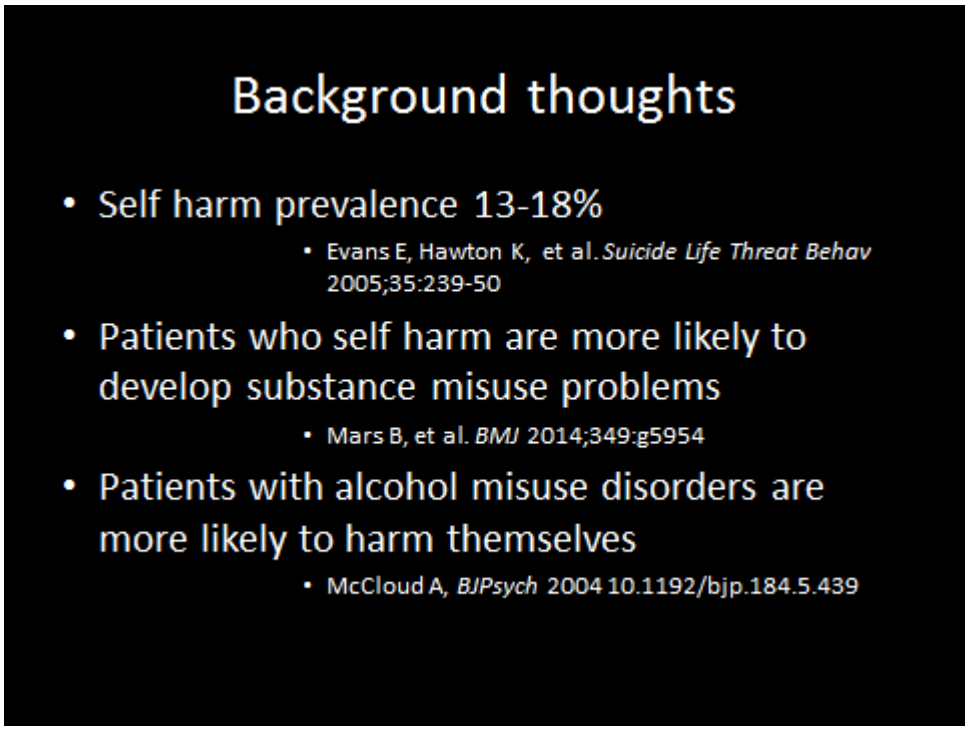
Thank-you!

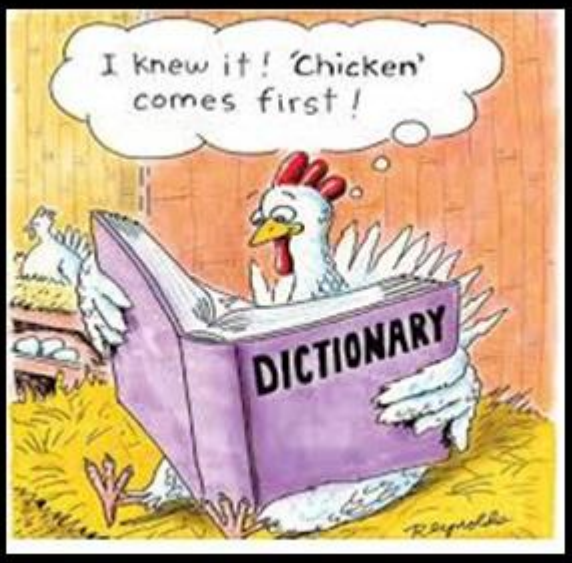
Presentations from Workshop 3 – Self-Harm and Substance Misuse

Dr Bob Boggs, BHSCT

Richard Grant, WHSCT







Belfast Figures

- Alcohol Liaison Audit March-Sept 14
  - 639 referrals
  - 120 of which had self harmed
  - 44 were referred on to Unscheduled Care
    - Thanks to Dr R Cherry
- Hope to increase complement of Substance Misuse Liaison Nurses soon

How to support/integrate?

- Small project with Self Harm/Personality Disorder Services and;
  - USC
  - ED
  - Addictions
- Education and awareness raising with the current patients in group work in SH/PD service

Format

- Small group work on common types of addiction
- How you know you are addicted
- Personal experiences of addiction
- Signposting to appropriate services

Outcomes

- Problematic engagement…
- Feedback that it was valuable
- Intent to roll out to wider audience

Psychotherapy view

- Why cut?
- Why use?

Rat Park

Deprivation- a common root?

- When I talk to addicted people, whether they are addicted to alcohol, drugs, gambling, Internet use, sex, or anything else, I encounter human beings who really do not have a viable social or cultural life. They use their addictions as a way of coping with their dislocation: as an escape, a pain killer, or a kind of substitute for a full life.

» Bruce K Alexander, The View from Rat Park

Self Harm and Substance Misuse

Riddel Hall 27/2/15

Dr Bob Boggs
Addiction Psychiatrist
Belfast Trust

ALCOHOL / SELF HARM
RE-ATTENDERS GROUP

WHSCT

FEB 2015.

Western Health and Social Care Trust

BACKGROUND

- DURING 2010 INCREASE IN ATTENDANCES OF 11% IN SELF-HARM PRESENTATIONS ACROSS WHSCT COMPARED WITH 2009
- REPEAT ATTENDANCE ACCOUNT FOR 1 IN 5 OF ALL SELF-HARM ATTENDANCES IN 2010 (SIMILAR TO PREVIOUS YEARS)
- ALCOHOL INVOLVED IN 55.8% OF SELF-HARM PRESENTATIONS.
- OVERLAP WITH CPN & ALN

Western Health and Social Care Trust

AIM

- TO FOCUS ON THOSE WHO HAVE FREQUENT ATTENDANCES WITH SELF-HARM AND / OR ALCOHOL ABUSE. IDENTIFY THEIR NEEDS AND WORK COLLABORATIVELY TO REDUCE RE-ATTENDANCES IN A&E
- IMPROVE COMMUNICATIONS BETWEEN ALL CARE PROVIDERS INVOLVED

HSC Western Health and Social Care Trust

MEMBERSHIP OF GROUP

- ALCOHOL LIAISON NURSE (ALN)
- A&E CONSULTANT
- A&E TEAM LEADER / SENIOR NURSE
- PRIMARY CARE LIAISON MENTAL HEALTH LEAD
- ALCOHOL & DRUG TEAM LEAD
- MENTAL HEALTH CRISIS TEAM LEAD
- OTHER CARE PROVIDER SPECIFIC TO INDIVIDUAL CASE DISCUSSION

HSC Western Health and Social Care Trust

PATIENTS IDENTIFIED

- REGULAR ATTENDERS
- HIGH RISK
- ESCALATING BEHAVIOUR
- ALCOHOL & PSYCHIATRIC PROBLEMS
- VULNERABLE

HSC Western Health and Social Care Trust

PATIENT EXPERIENCE

	2010	2011	2012	2013	2014
PT1	-	-	23	5	14
PT2	-	-	-	23	0
PT3	-	26	45	8	7
PT4	45	36	23	2	5

HSC Western Health and Social Care Trust

OUTCOMES

- TOTAL PATIENTS DISCUSSED TO DATE – 56.
- IMPROVED COMMUNICATIONS
- STAFF UNDERSTANDING OF PATIENT GROUP IMPROVED.

HSC Western Health and Social Care Trust

ONGOING CHALLENGES

- IDENTIFICATION OF HAZARDOUS DRINKING IS KEY
- NOT ALL PATIENTS RESPOND TO INTERVENTION
- COMMUNICATION ACROSS SERVICE PROVIDERS
- MORE POLY DRUG / ALCOHOL ABUSE / SELF-HARM
- PERSEVERE WITH CARE-PLAN
- TIME COMMITMENT & ADMIN

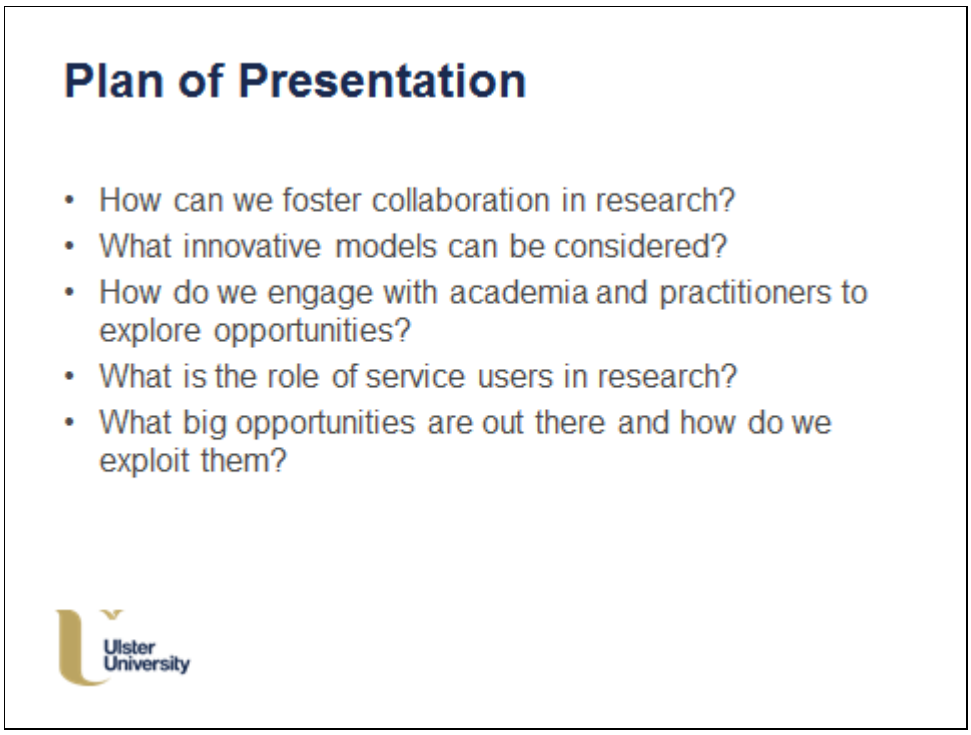
HSC Western Health and Social Care Trust


NEXT STEPS AND NEEDS
MAINTAIN REGULAR ATTENDERS GROUP
INCREASE ALCOHOL LIAISION PROVISION
AUDIT & REVIEW GROUPS WORK
HSC
Western Health
and Social Care Trust

Presentations from Workshop 4 – Self-Harm and Research

Prof Siobhan O'Neill

Dr Maggie Long



Fostering Collaboration

- Identifying clinically relevant research questions.
- Identifying existing networks and research groups.
- Research training and awareness of expertise required.

Types of Research Studies

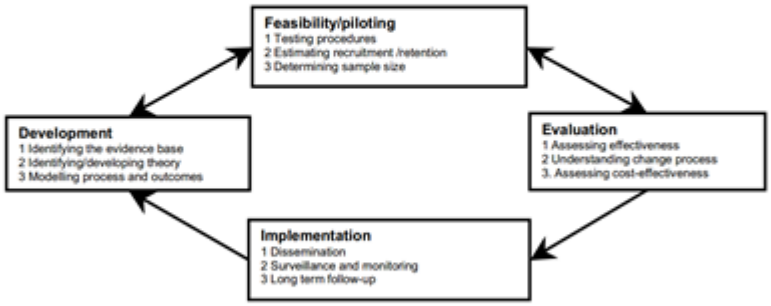
- Constructivist approaches: qualitative methods, phenomenology, Interpretative Phenomenological Analysis, Grounded Theory, ethnography.
- Positivist approaches: population based, surveys, epidemiology, evaluation of interventions and services.

Designing a Research Study

- Methodological expertise.
- Developing a research team.
- Review of the evidence/ literature.
- Study design.
- Sample size calculation.
- Ethical and governance requirements.
- Preparation of research proposal.
- Apply for funding.

Models of Evaluation Research

Figure 1 Key elements of the development and evaluation process



Developing a Service or Intervention

1. Identify the evidence base.
2. Identify the theory underlying the intervention- the mechanism of effect.
3. Model the processes or outcomes.
4. Develop the intervention.
5. Feasibility testing (testing study protocols, sample size calculation etc).

Why an RCT?

- Suitable for testing an intervention (drug, therapy, info package).
- Two groups- equal in all other (important) respects.
- Except for the intervention of interest.
- Equality is best achieved through randomisation.
- Outcomes in the two groups are measured and the difference is purported to be as a result of the intervention.

Variations on the RCT

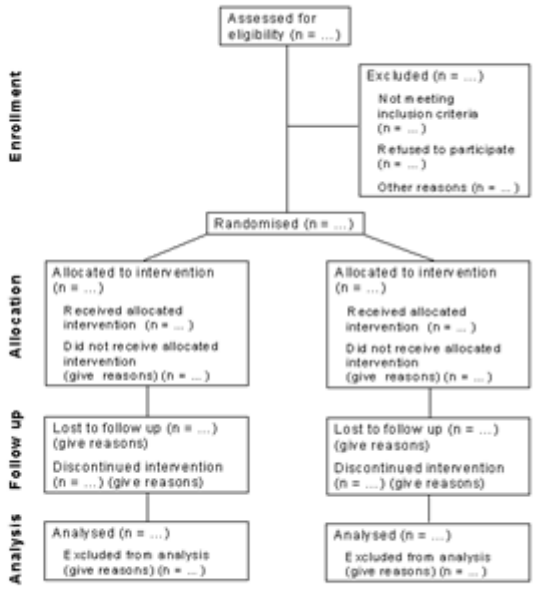
- Controlled trial: a control group but participants are not randomised (should be 'equal').
- Cohort study: participants are followed over time.
- Placebo controlled trial: control group given placebo (dummy pill or inert intervention).

The Evaluation Process

- Feasibility testing (testing study protocols, sample size calculation etc).
- Assessing effectiveness --- ideally a Randomised Controlled Trial.
- Understanding change processes/ mechanism of effect (incl. qualitative methods).
- Assessing cost effectiveness.
- Long-term follow up.

Flow Diagram

data collection:
pre and post intervention



Designing Your RCT

- **Who** will be in the study?
  The study population
  - Inclusion / Exclusion criteria.
- **What** will be studied?
  - What is your hypothesis/ research question?
  - Intervention X will produce at X least an X difference in X (outcome).
  - Keep it CLEAR and SIMPLE.
  - Confounding variables also need to be assessed.
- **How** will they be measured?
  - Method, timing, personnel.

Planning an RCT

- Develop research question based on literature review.
- Id key stakeholders.
- Secure funding.
- Convene steering group.
- Employ researcher.
- Obtain ethical approval.
- Trial registration.
- Identification of sample.

- Invitation to participate.
- Recruitment packs.
- Getting informed consent (24hrs).
- Recruitment procedure.
- Randomisation.
- Intervention.
- Data collection.
- Data monitoring.
- Steering group meetings (new developments).
- Completion, publication, dissemination.

Trial Registration

- Necessary prior to commencement of the trial.
- Helps balance effects of publication bias.
- Usually a fee (plan in costing the study).
- We use www.clinicaltrials.gov (US National Institutes for Health).
- Not difficult- descriptions of elements of the study.

A Note on Psychosocial Interventions

- Interventions do always not come as a neat little pill!
- The effects of psychosocial interventions (e.g. exercise prescription, counselling therapy etc…) can be a product of:
  - participant concordance,
  - aspects of the delivery of the intervention or
  - extraneous (confounding) variables (e.g. media campaigns, soap opera story lines).
- All these factors need to be considered.
- Produce intervention 'manual' so others can replicate every detail of the intervention.
- Consider mixed method approaches.

Mixed Methods

- Suitable for complex interventions.
- Use of qualitative data to evaluate:
  - Success of intervention.
  - Successful aspects of intervention.
  - Other effects not previously considered.
- Appropriate where concordance (adherence) may be an issue.
- Important in understanding the causes of changes (or no changes) between the groups.

Ethical Issues

- Ensure correct approval obtained.
- NHS staff or patients: ORECNI (need sponsors from university/ hospital- requires pre-approval).
- University ethical approval e.g. UUREC (vulnerable groups require additional approval).
- Need to obtain appropriate permission from all groups involved.
- Trial registration.

Ethical Issues Specific to RCTs

- Participants' understanding of randomisation.
- Procedures for terminating early.
- Waiting list control? (can effect outcomes- not usual care).
- Require 24 hours to consider participation.
- Use of incentives.
- Informed consent.
- Consent to participate in mixed methods studies.
- Vulnerable groups (older people, children, power relationships, terminal diagnosis).

CONSORT

- Stands for: Consolidated Standards of Reporting Trials.
- Initiatives developed by the CONSORT Group to alleviate the problems arising from inadequate reporting of randomized controlled trials (RCTs).
- The CONSORT Statement: an evidence-based, minimum set of recommendations for reporting RCTs.
- Offers a standard way for authors to prepare reports of trial findings, facilitating their complete and transparent reporting, and aiding critical appraisal and interpretation.
- The statement comprises a 22-item checklist and a flow diagram.
- Items focus on reporting how the trial was designed, analyzed, and interpreted.
- Flow diagram displays the progress of all participants through the trial.

Main points of the checklist

1. Scientific background to the study and rationale.
   - Needs to be 'worthwhile' (ethical)
   - Needs to have a sufficient sample to show effect or no effect (sample size calculation)
   - Should have obtained ethics and governance approval.
   - Specific research questions and hypotheses

Entry into the study

1. Clear eligibility criteria
2. Clear exhaustive exclusion criteria
3. Information about the locations where the data was collected and by whom (can be a source of bias).

How are participant allocated to interventions?

1. Random allocation, randomized, or randomly assigned.
2. How? (*e.g.*, numbered containers or central telephone), was sequence concealed until interventions were assigned?
3. Not all 'random' allocation is actually random…
   - E.g. Seasonal effects
   - Alternate groups
   - 'random' numbers.
4. Roles of the research team members in randomisation.

Interventions

1. Need precise details of the interventions for each group
2. How administered?
3. By whom- training?
4. When?
5. Complex interventions may require a 'manual'.

Outcome Measures

1. Primary/ secondary
2. Need to be clearly defined
3. Outline methods of enhancing the quality of measurements (*e.g.*, multiple observations, training of assessors).
4. Statistical methods used to assess primary and secondary outcomes (including effect size and precision (*e.g.*, 95% confidence interval) and subgroup analyses).
5. Use of 'intention to treat analysis'.

Blinding

1. Were participants blinded (could they be?)
2. Were those administering the intervention blinded?
3. Were outcome assessors blinded?
4. How was the success of blinding evaluated?

Reporting the Study

1. Flow of participants through ecah stage of the study (a diagram is strongly recommended). Specifically, for each group report the numbers of participants randomly assigned, receiving intended treatment, completing the study protocol, and analyzed for the primary outcome.
2. Description of deviations from protocol and reasons.
3. Adverse events.
4. Baseline characteristics of each group, number in each group.

Discussing the Results

1. Interpreting the results, taking into account study hypotheses, sources of potential bias or imprecision and the dangers associated with multiplicity of analyses and outcomes.
2. Generalisability of the findings (representativeness of samples).
3. Interpreting the results in the light of current evidence.

The role of service users in research

- At all stages of the process.
- Shaping the research questions.
- Commenting on proposals.
- Designing materials.
- As participants.
- As advisors.
- Role in dissemination.

What big opportunities are out there and how do we exploit them?

- Data linkage: Honest Broker Service.
- Horizon 2020 and other funding programmes.
- Funding for clinicians.
- Northern Ireland's USP.
- Multi-site trials.
- Innovative technologies.

Self-harm and Research

Dr Maggie Long
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Institute for Research in Social Sciences (IRiSS)
Ulster University

Definitions

- Self-harm refers to a wide range of behaviours, including self-poisoning with or without suicidal intent, and self-injury.
- Self-injury is defined as, "the intentional and direct injuring of one's body tissue without suicidal intent and for purposes not socially sanctioned" (Klonsky, May & Glen, 2013, p. 231).

Existing Research

- Northern Ireland based research
  - (Cousins, McGowan & Milner, 2008; Long, Manktelow & Tracey, 2014; O'Connor, Rasmussen & Hawton, 2014; Schubotz, 2009)
- Self-harm demographics & characteristics
  - (Hawton et al., 2001; 2004; 2006; 2007; 2014; Hawton & Harriss, 2008)
- Young people
  - (De Leo & Heller, 2004; Evans, Hawton & Rodham, 2005; Fisher et al. 2012; Hawton, Harriss, & Rodham, 2010; McAndrew & Warne, 2014; Mojtabai & Olfson, 2008; Ystegaard et al., 2009)
- Internet
  - (Adams, Robin & Gavin, 2005; Adler & Adler, 2011; Baker & Fortune, 2008)

Existing Research

- Service-user perspectives of self-harm & self-injury (qualitative)
  - (Harris, 2000; Huband & Tantam, 2004; Hume & Platt, 2007; McAndrew & Warne, 2005; Sinclair & Green, 2005)
- Counselling
  - (Fleet & Mintz, 2013; Fox, 2011; Long & Jenkins, 2010)
- Functions of & risk factors for self-injury
  - (Gratz, 2003; Gratz, Conrad & Roemer, 2002; Klonsky, 2007; Nock, 2009; Smith, Kouros & Meuret, 2014)
- Social context: "psychiatric survivor"; feminist discourse; sociological
  - (Adler & Adler, 2005; 2007; 2011; Chandler, 2012; 2013; Chandler, Myers & Platt, 2011; Harrison, 1997; Hodgson, 2004; Inckle, 2010; 2011; Pembroke, 1996; Shaw, 2002)

Relevance of Recent International Evidence for NI Context

- Self-injury is an "especially important" risk factor for suicide (Klonsky et al, 2013; Klonsky, Victor & Saffer, 2014)
- Coping with trauma symptoms is an important function of self-injury (Smith, Kouros & Meuret, 2014)
- Relevance to NI Context:
  - Suicide (Jordan et al., 2012; O'Neill et al. 2014; Tomlinson, 2012)
  - PTSD (Ferry et al., 2013)

Research Project

SELF-INJURY & HELP-SEEKING: CLIENT & HELPER PERSPECTIVES

Rationale

- Discrepancy between self-injury at a community level and self-harm hospital presentations
- Dearth of research on self-injury in Northern Ireland (NI)
- Beyond NI – limited qualitative research from perspectives of people with a history of self-injury
- Help-seeking is recognised to be difficult for people who self-injure due to feelings of shame and unworthiness
- Existing research from perspectives of counsellors: to understand client and counsellor experiences of counselling
- Role of community level gatekeepers in suicide prevention (Mann et al., 2005)
- Triangulate three perspectives: client, gatekeeper (first responder) and counsellors: All encompassing understanding of help-seeking process from initial point of contact to use of therapeutic interventions

Research Aim & Objectives

Aim:

- To understand the experiences of self-injury and the process of seeking and accessing help for self-injury from the perspectives of counselling clients, gatekeepers and counsellors.

Objectives:

- To explore and examine clients', gatekeepers' and counsellors' perceptions of the phenomenon of self-injury.
- To explore and examine the helping process for self-injury from the perspectives of clients, gatekeepers and counsellors.
- To conceptualise the helping process from the perspectives of clients, gatekeepers and counsellors.

Research Methods

- Qualitative
- Retrospective
- Community level
  - Clients/service users (n = 10)
  - Community level gatekeepers (n = 10)
  - Counsellors (n = 10)
- 1:1 face-to-face interviews
- Grounded Theory analysis
- Ethical approval – University of Ulster Research Ethics Committee (UUREC)

Summary of Key Findings 1

- Age of onset: childhood & adolescence
- Life experiences: trauma, abuse, victimisation, isolation
- Self-injury: coping, control, release, communication, private
- Intensity of self-injury often increased as time progressed
- The journey of self-injury:

  coping and control _____ feeling out of control
- No significant resolution of distress & lack of appropriate support could lead to suicidal crisis

Summary of Key Findings

- Help-seeking: a complex process involving informal social networks & formal services
- Barriers to help-seeking: stigma – prejudicial attitudes & discriminatory practice; fear & confusion; functions of self-injury
- Overcoming barriers: turning point/crisis, role of informal support, empathic responses in formal services
- Counselling: trust, relationship, underlying issues, option to provide more than six sessions, degree of flexibility in counselling approach, reluctance to engage/disclose to school counsellors, mixed reports on group therapy

Limitations

- Small scale
- Ratio of women: men
- People currently engaging in self-injury
- People who have not sought help/accessed counselling

Implications

- Need to involve service-users in research
- Improving access to ED and uptake of follow-up services: e.g. ED pastoral support, cross-sector, interdisciplinary
- Reduce stigma (social & self) – major barrier to help-seeking
- Earlier intervention
- Support for practitioners working in the field e.g. dedicated training, therapeutic supervision

Suggestions for Future Research

- Population prevalence of self-injury & risk factors in clinical and non-clinical populations (Klonsky et al., 2013)
- Qualitative/exploratory: Service users; young people; men; women aged 40 + years
- Hidden self-injury: Access to people who self-injure (not necessarily service users) – all demographics – pathway prior to the Registry
- Young people in general
- Vulnerable populations – young people in care, in-patient settings, prisons
- Use of social media

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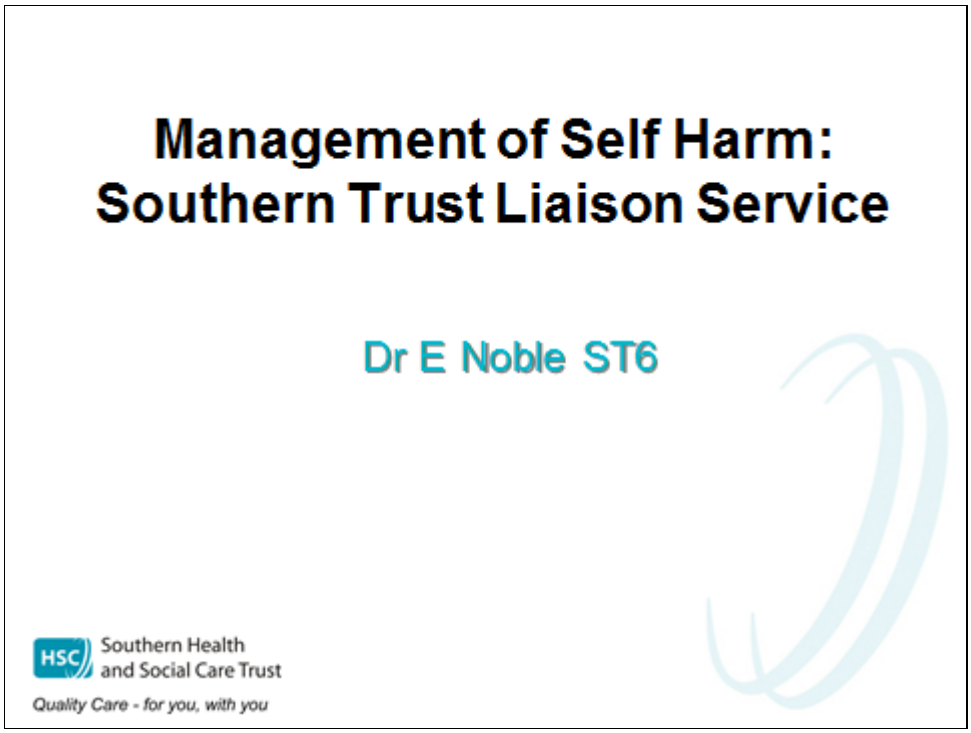
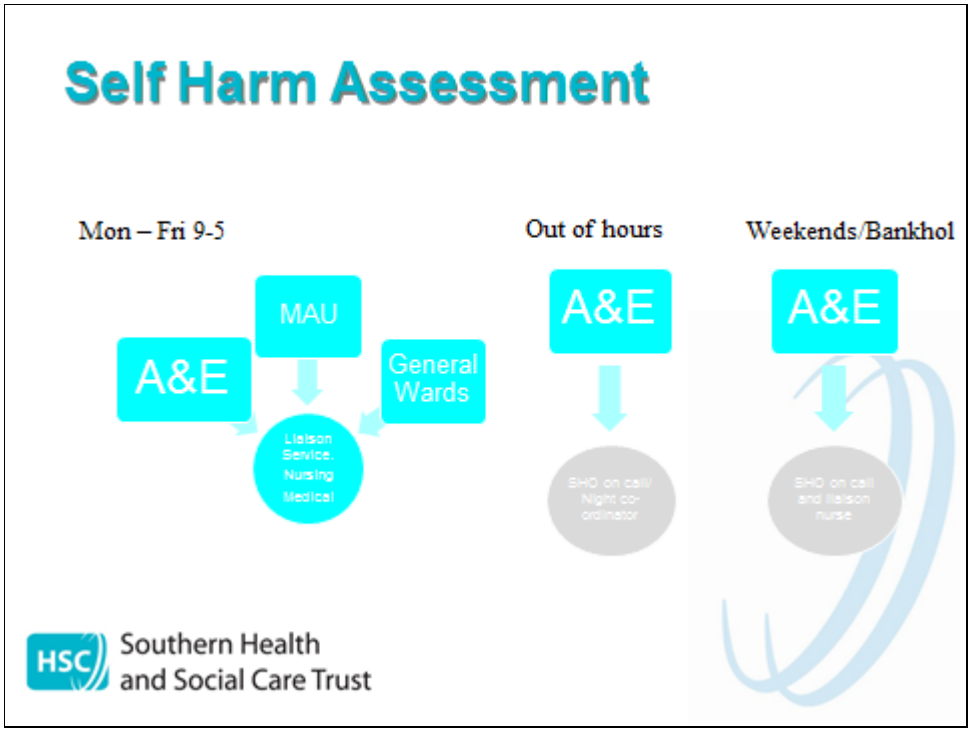
Presentations from Workshop 5 – Self-Harm and Long Term Management within Mental Health Services

Dr Ed Noble, HSCNI
Dr Tracy Millar, SEHSCT
Bryan Rhodes, SEHSCT





Nice guidelines

- 'Self-harm: short-term treatment and management' (NICE clinical guideline 16) covers the treatment of self-harm within the first 48 hours of an incident.
- Self-harm: longer-term management, clinical guideline 133 , deals with the longer-term psychological treatment and management of both single and recurrent episodes of self-harm.

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Interventions for self-harm

- Do not offer drug treatment as a specific intervention to reduce self-harm.

- Consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm. This should be tailored to individual need.

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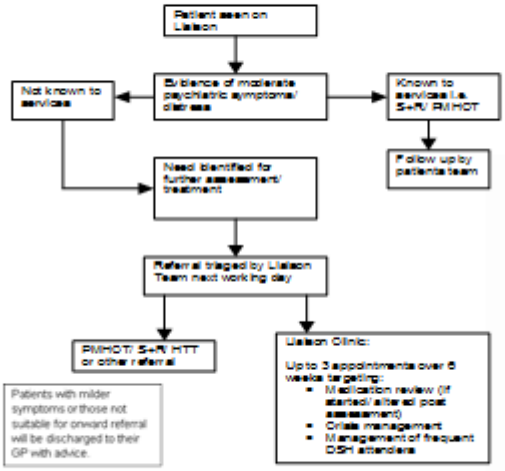
SHSCT Liaison Clinic



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Rationale

- Provide crisis support and encourage engagement with non-statutory services.
  - To reduce development of the 'sick role'
  - Reduce demand on Primary Mental Health
- Bridge from liaison to Primary mental health
  - Prevent the need to engage HTT in crisis role
  - Begin treatment and monitor progress
- To begin to address NICE133

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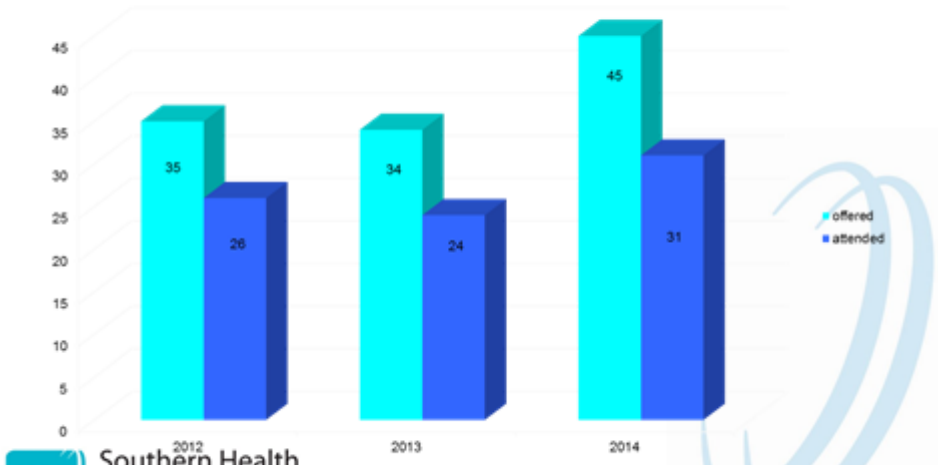
Usage



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Outcome

- …

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Working with self harm – a DBT model

Dr Tracy Millar
Consultant Clinical Psychologist

South Eastern Health and Social Care Trust

- We have been established for 2 years.
- Opted for a Comprehensive Dialectical Behaviour Therapy approach because it is NICE guidelines recommended and due to the pre-existing evidence base
- 13 RCTs / 9 completed by researchers independent of the treatment developer

The DBT Team

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Dialectical Behaviour Therapy was named as one of the **best 100 new scientific discoveries** by Time.

Referred to as a treatment that is successful with patients who were once considered incurable.

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Do we work with self harm?

- Currently referral to our service is based on a diagnosis of Borderline Personality Disorder /Emotionally Unstable Personality Disorder

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What is BPD?

- Out-of-control emotions
- Impulsive and dangerous actions
- Troubled relationships
- Problematic thinking
- Poor of sense of self

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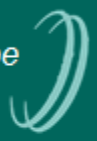
CONSEQUENCES OF BPD

- Enduring mental health problems and misery
- Extensive use of services – 10% of community mental health patients and 20% of psychiatric inpatients; in excess of 12,000 presentations of non-suicidal self-injury to Irish A&Es in 2010
- Extended disability
- Lifetime completed suicide rate of 10%
- Lifetime attempted suicide rate of 75%
- 80%+ have a history of self-mutilation

What is DBT?

- It is a psychological intervention designed primarily for highly suicidal and self harming people.
- Seeks a synthesis between the dialectics that the person needs to change and that the person needs to accept themselves.
- It is a RECOVERY FOCUSED
- It is based on the here and now
- It is a stablisation model.

'It might not help you feel better but it will help you be better at feeling ….' SU



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The Biosocial Model

A model of emotional dysregulation

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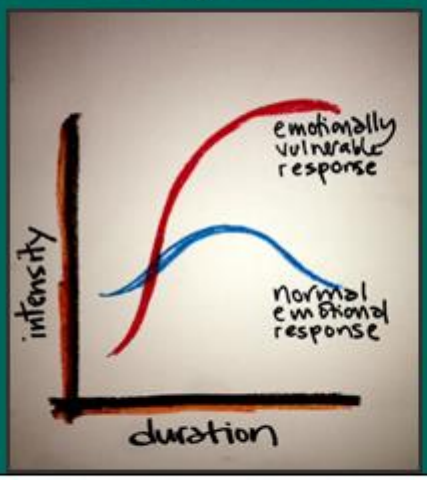
Biological vulnerability



- High sensitivity to emotional stimuli
- Intense emotional responses
- Slow return to baseline

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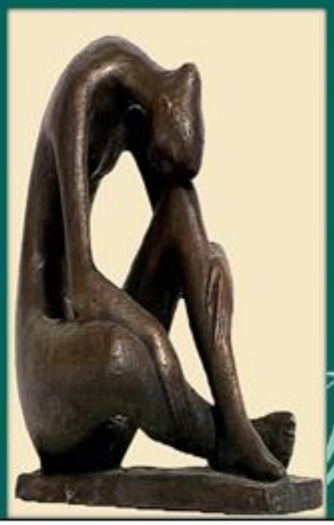
Invalidating environments

- Place a value on controlled emotion
- Oversimplify problem solving
- Dismiss expression of painful or difficult emotions (attributed to lack of motivation or effort)
- Punishment used to control behaviour



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Emotion vulnerability + biological vulnerability =

- The person has not been able to learn how to label or regulate emotional arousal
- Has not learned how to tolerate emotional distress
- Doesn't know when to trust his or her own emotional responses as reflections of valid interpretations of events

Solutions that are problems

- 'Out of control' behaviours are often ways of attempting to solve a crisis situation: they are also solutions that become a problem!
- In the short-term these actions make sense - in the medium or long term they make a bad situation even worse.

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STRUCTURE OF Dialectical Behaviour Therapy

FUNCTION	MODE
1. Enhancing capabilities	1. Skills-training group
2. Enhancing motivation	2. Individual psychotherapy
3. Ensuring generalisation	3. Telephone / between-session consultation
4. Structuring the environment	4. Treating the environment (consultation to the patient)
5. Ensuring therapist motivation and ability to treat	5. Therapist group consultation

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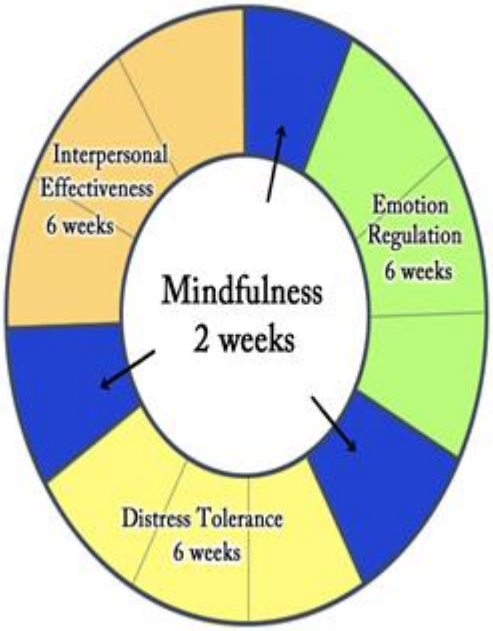

Research

- Service evaluation focused on:
  - Service usage: i.e. bed days/contacts
  - Self harm incidents
  - 3 monthly self report measures
    - BPD symptomology
    - Hopelessness
    - Suicidality
    - General health
    - Positive ways of coping
    - Difficulties in emotional regulation

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Contact

- 72 people have been seen in total for pre-treatment assessment
- 16% (24) decline the service during pre-treatment (generally felt it was too much)
- 49% (37) are in treatment/completed
- 8% (11) dropped out during treatment (compared with 44% in English studies)
  - ***We have hardly any DNAs****

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Service usage

Service usage for first 15 completers

	Year previous	Year during	Year after (incomplete)
Inpatient days	439	39	78
A&E	57	7	Not collated
Crisis contacts	194	9	Not collated

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QOL

"Above all you have given me a life worth living – I can see a future – not sure what, but at least there is one and not blank numbness."

"I rarely look back and if I do it's in Wisemind, I take more time, think and focus. I'm much more aware of me."

"My life has done a 360, I want to live."

"It was tough at first but I had the greatest support from all staff involved."

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Number of suicide attempts/self harming incidents

- Haven't analysed the data
- Anecdotally: dramatic reduction in self harming incidents and eventually

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Self report measures

- Only looked at BPD symptomology (BSL-23) and Ways of Coping (The Ways of Coping Checklist).
- Initial analysis of those questionnaires complete by our first graduates indicate significant results (although this is rudimentary statistical methods on a small sample).
- Analyses of differences between scores at week 1 and week 52 of DBT were conducted on 8 completers using the the Wilcoxon Signed Rank method for non-parametric data.

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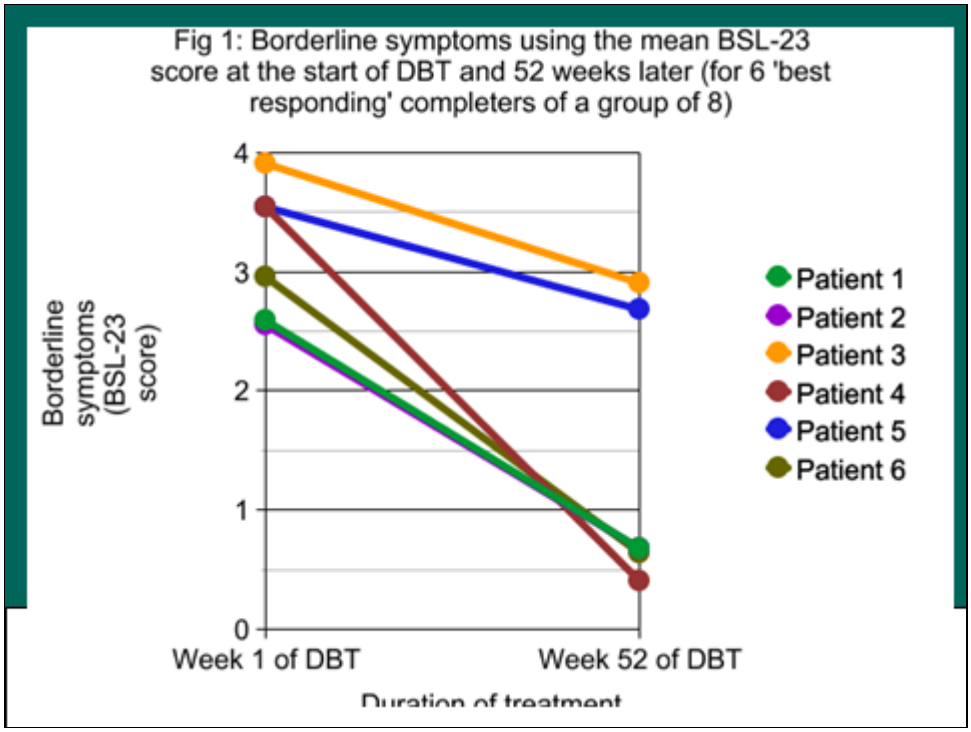
Fig 1: Borderline symptoms using the mean BSL-23 score at the start of DBT and 52 weeks later (for 6 'best responding' completers of a group of 8)
Borderline symptoms (BSL-23 score)
4
3
2
1
0
Week 1 of DBT
Week 52 of DBT
Duration of treatment
Patient 1
Patient 2
Patient 3
Patient 4
Patient 5
Patient 6

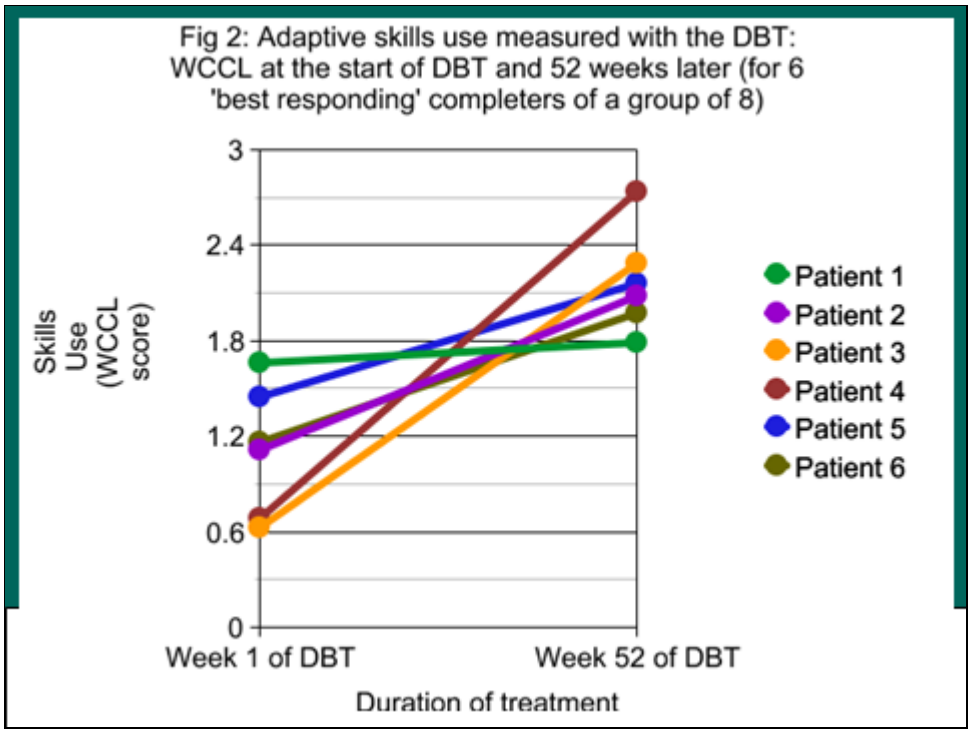
Fig 2: Adaptive skills use measured with the DBT: WCCL at the start of DBT and 52 weeks later (for 6 'best responding' completers of a group of 8)
Skills Use (WCCL score)
3
2.4
1.8
1.2
0.6
0
Week 1 of DBT
Week 52 of DBT
Duration of treatment
Patient 1
Patient 2
Patient 3
Patient 4
Patient 5
Patient 6

The goal in DBT is to build a life worth living

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Improving Quality, Consistency and Safety of Care for Frequent Attenders at Emergency Department with Self-harm/Self-harm Ideation

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We know from the Registry data that approximately 20% of individuals will present on more than 1 occasion within a year and that a smaller number of these individuals will present more frequently.

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The impact is not only on the Emergency Department

There are a number of ways to consider the issues of frequent attendance at ED (with self-harm/ideation). At one level this can be viewed in the context of increased traffic to an already overstretched services. This, however is too simplistic a view.

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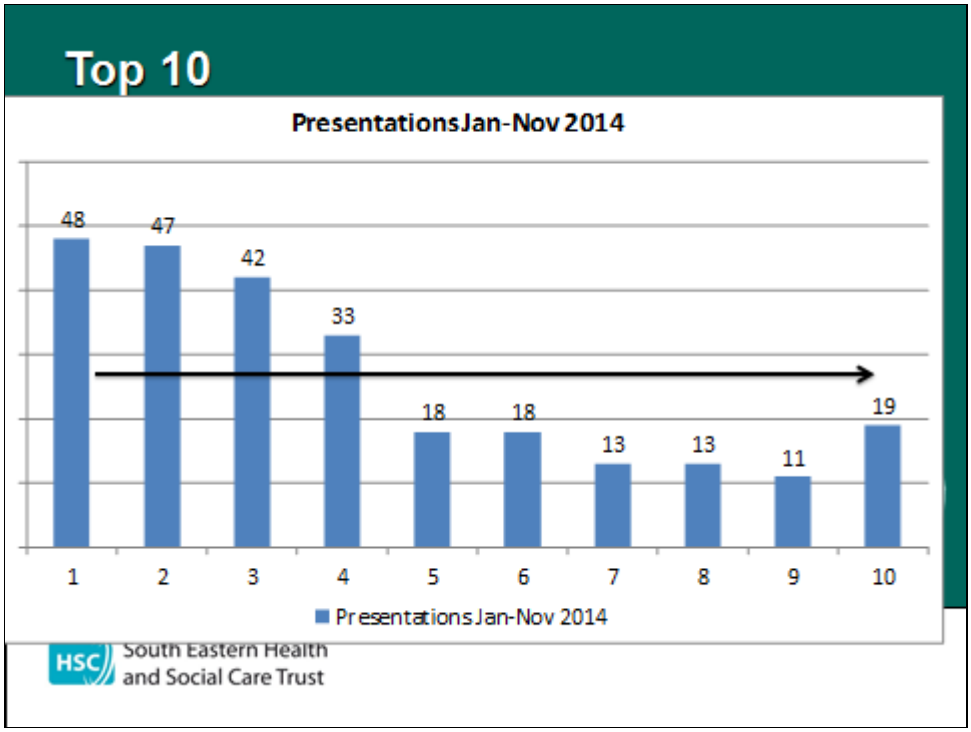
Top 10
Presentations Jan-Nov 2014
48
47
42
33
18
18
13
13
11
19
1
2
3
4
5
6
7
8
9
10
Presentations Jan-Nov 2014
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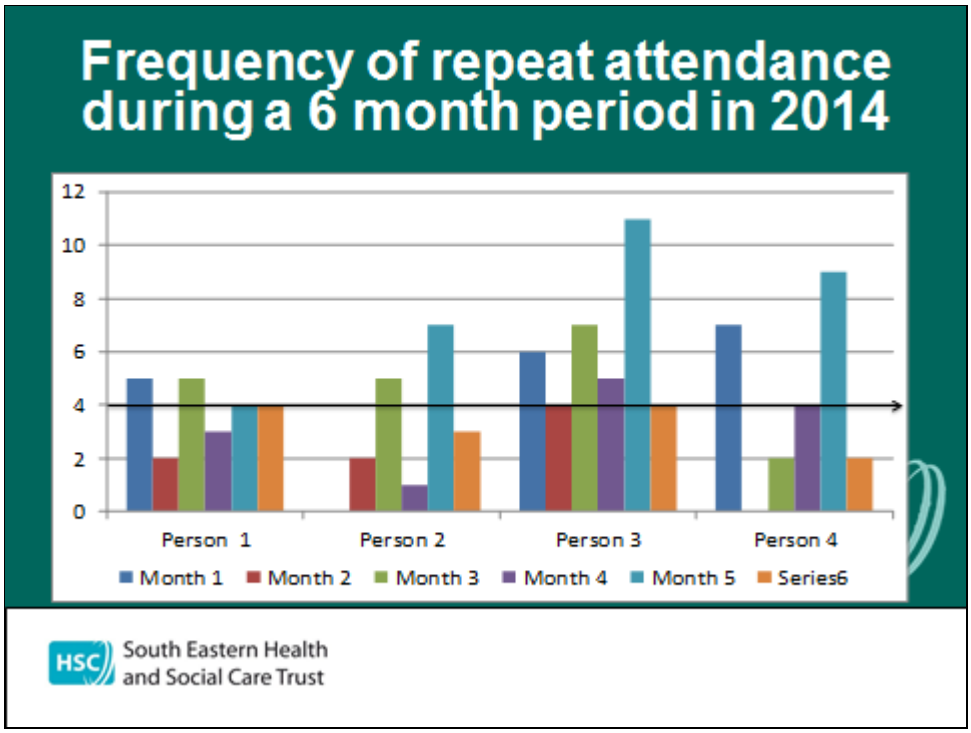
Frequency of repeat attendance during a 6 month period in 2014
12
10
8
6
4
2
0
Person 1
Person 2
Person 3
Person 4
Month 1
Month 2
Month 3
Month 4
Month 5
Series6
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Addressing the issue

- Mental Health and Emergency Department Services Interface Group
- This group has considered the issue of frequent attendance in the context of self-harm/ideation and identified this as an area where we could take forward work to improve the quality, safety and consistency of our services and the individuals experience.
- As a model we believe our services should be high quality, safe and consistent. The issue of consistency is particularly important in the context of experience and our approach to care.

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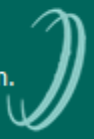
Aims & Objectives

- To identify the (system, process, resource) challenges faced by staff/services in managing individuals who present with a history of self-harm/mental health problems to the South Eastern Trust's Emergency Departments.
- To identify individuals with a history of frequent attendance associated with self-harm/mental health problems.
- To profile the top ten frequent attenders in respect of the clinical and management manifestations of these attendances.
- To meet individually with each of these persons and develop an agreed personalized multi-agency shared crisis care management plan.



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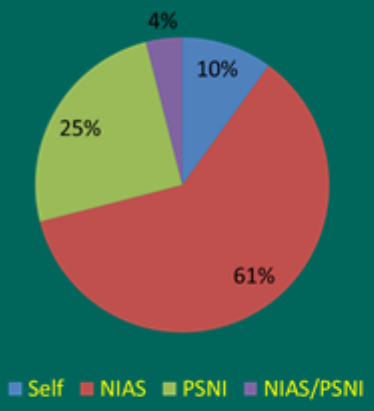
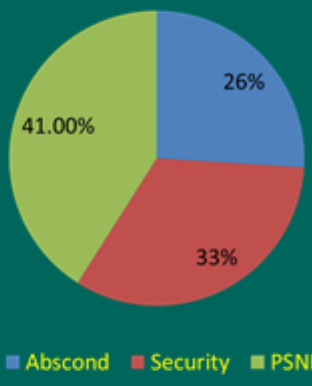
Impact on other services

- Method of arrival



- Challenges



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Desired Outcomes

- To reduce the incidence of self-harming behaviour within this service user group.
- To improve service users' experience..
- Reduce the impact on family/carers
- To reduce resource consumption associated with these frequent Emergency Department attendances.

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Crisis/Risk Management Plans

Critical to this process is the development of a customised person centred multiagency risk management plan.

Plan based on the model developed by Dr Rhona Morrison, NHS Forth Valley.

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Risk management Plan (based on work by Dr Rhona Morrison, NHS Forth Valley)

The risk management plan is based on a traffic light approach.

- Green describes the 'normal status or presentation.
- Amber & Red suggest increasing risk and the need for a different management strategy response to this presentation.
- Symptom and behaviour descriptions are required.
- Action plans should include guidance for partner agencies detailing how to manage the person on crisis as well as for health care staff

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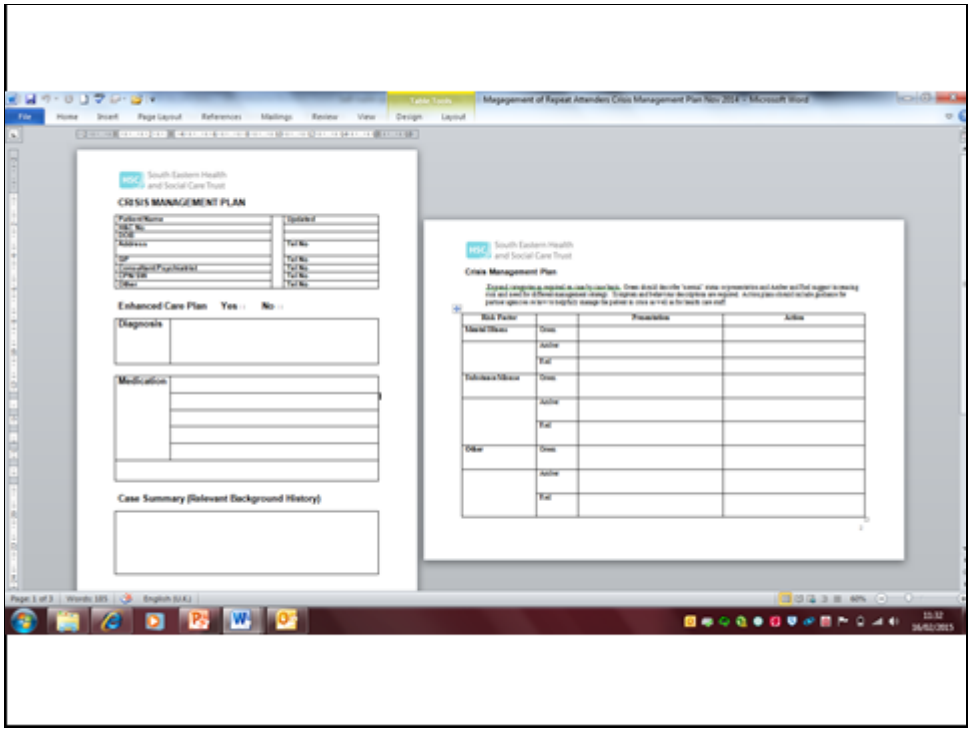

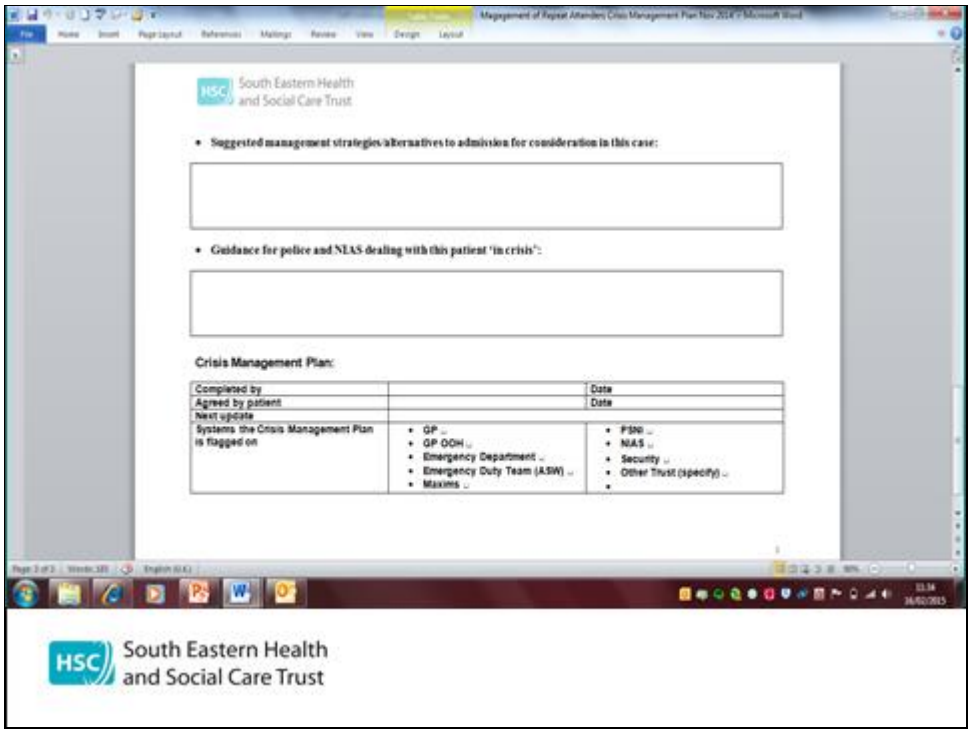

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The case for DBT

We know from Registry data that our repeat attendance rates have reduced. We believe that this is in part attributable to the impact of our DBT service, though we are only now beginning to analyse data to see if our assumptions can be validated.

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Additional comments provided in post-event evaluation form:

- All departments need to work together to address this issue from year 0 upwards. Mental Health should be compulsory part of the curriculum. Education about alcohol should be addressed in Primary schools P4-P7 as with smoking. ELB's Youth Service and PSNI should have been in attendance, our culture and attitudes need to change in general towards alcohol, Thank you
- Very informative and extremely useful, more needed on other external agencies voluntary, education and SS
- Good and worthwhile conference
- Very engaging presentations and speakers, sparked interest and desire to expand own knowledge. Could have included session on aftercare/therapies
- An excellent range of speakers, brilliantly organised in a great venue
- Excellent day, I would have liked a bit more on practical management
- Content overall very medical model focused – rather than on practice in the field/ how to support service users better and effective interventions
- Overall very good day, well planned with wide range of expertise – well done! One suggestion: x3 presentations too many in workshop so less time for engaging in discussion/questions
- Having programme and overview in advance would have been useful. Didn't know what to expect but was pleasantly surprised, excellent speakers and very useful day, thank you
- Location wasn't very accessible to motorway/those travelling distances. Would have been useful to include a 'commissioning direction' workshop to provide opportunity for clarity of commissioning (broadly) and importantly to influence re: longer term future of services (+ not just PHA, Lottery, LCGs + HSCB)
- I felt that young people were largely absent throughout the day. I was surprised of the lack of specific discussion in this regard and that CAMHS weren't present at MH service workshop. Also entire focus was on adults presenting at ED. I work with young people who largely keep their SH private and confidential
- Well-structured meeting with good high quality presentations. Follow up or extension of work in terms of discussion with key stake holders in light of conference would be vital
- One area of intervention given a lot of exposure, why the move from CBT and solution focused to DBT? This therapy has been present in the community setting for years but only when Trust engage in it do the powers that be take notice. Very informative day
- This is the best conference I have ever attended, excellent speakers, appropriate delegates generated good conversations
- Main concern was lack of evidence of effective intervention - stats were over used. This is important but actual effective intervention is vital, Nav Kapur has I.D problem solving treatment and possible impact lack of link between vol/comm effective services and outcomes. Poor link in terms of research the hidden

population who SH and do not attend ED but do not go on to take their lives, one dimensional approach.

- Thank you – service user reflection was excellent
- Excellent organisation by Amanda, many thanks for your hard work – brilliant day
- Excellent Conference – afternoon speakers talked about proposals and ideas that are actually here e.g. SHINE which exactly reflects the DBI Initiative in Scotland – We are ahead in many ways
- Enjoyable stimulating day. Across NI Services appear patchy
- The need to have a whole system approach was very evident today. In order for this to work we need to strengthen the 3rd sector organisations ability to meet the needs of clients/carers but it must fit with the governance and standards that is expected of stat services in order to increase confidence in their usage
- Thank you
- Fantastic Day, so informative, well organised and presented
- Would need more time in workshops
- Would liked to have heard more about intervention
- The entire day has been very informative around the issue of self-harm. The concept of compassion, respect and dignity for the individual behind the behaviour was very refreshing to hear and all of the speakers spoke about or addressed the importance of the person and how best to help them
- Found the talk on DBT the most useful part. Catering was very good, room was a bit squashed
- Very interesting day, of much more use to policy makers and practitioners than researchers
- DBT Tracy was very good but there wasn't enough time for discussion and it was badly chaired same people kept speaking
- Some slides, need to be said and not 'this'? It, those, these, they, them out, here is good? Q& A: I must be said? Help also for deaf/blind kids because they can't talk to GP etc.! Thank you for all your help! Appreciated!