Building on Positive Experience: Developing, Implementing and Evaluating a Model for a Self Harm Clinic

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Location: Oxford Health NHS Foundation Trust

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Summary of the project

This project built on a positive experience within a self harm team, of providing increased support to a service user who was frequently self harming. In collaboration with wider professional and service users, a team of nurses in Oxford have developed, implemented and evaluated a clinic to provide preventative and proactive support to people who frequently present at A&E following self harm and who are not currently receiving support from any services. Using an action research approach enabled the team to conduct a 12 month pilot of the clinic, developing the clinic in an ongoing way in response to discussions within the regular group supervision meetings for team members and with the project steering group.

All service users who attended at least one session showed a significant reduction in presentations at A&E six months post clinic as compared with the six months pre clinic. Although presentations at A&E is only one measure of self harming behaviour, such a reduction will result in a considerable cost saving to the health services. The team had hoped to be able to evaluate other outcomes for service users and to gain feedback about their experience of attending the clinic but this was more difficult to achieve. As many service users did not attend all the sessions, they did not complete the selected self-reporting scales pre and post clinic and the response rate to the postal experience questionnaire was very poor. The team have drawn learning from this pilot and are using this to inform future developments within the clinic.

Background

The Barnes Unit self harm service is provided by a nurse-led team made up of 3.74 Band 7 psychiatric liaison nurses, managed by a Band 8A nurse. The team is currently working at full establishment. The core business of the team is the psychosocial assessment of service users between the ages of 13 and 65 who come to the accident and emergency department (A&E) following acts of self harm. Following assessment the team signposts and/or refers service users to statutory or voluntary services depending on need, and also offers brief outpatient work (generally around six sessions) to people who may benefit from problem solving interventions or who require further assessment or containment while awaiting formal referral elsewhere.

People who frequently self harm and present to hospital raise particular challenges for A&E, the Barnes Unit and wider mental health services. This population has a high level of psychological morbidity (Guthrie, 2001) and given the strong links between self harm and subsequent suicide (Kapur et al., 2008) are a high risk group. Many people in this service user group present with
indicators of borderline personality disorder and in the absence of noncomitant mental illness are not always appropriate for Community Mental Health Team (CMHT) caseloads. A significant minority of people who recurrently self harm do not want to engage with the Specialist Personality Disorder (Complex Needs) Service due to its group emphasis, or because work commitments make it difficult to access the groups, which are only available during the working day. Historically the Barnes Unit team has lacked the formal expertise, supervision and capacity to manage the care of this population on an outpatient basis. Thus there exists a vulnerable group of people who remain at high risk of self harm and suicide, whose needs are clearly not met and who frequently feel let down and uncared for by the Trust (this has been feedback by repeat attenders).

From a resource perspective this population is costly to both the mental and community health trust and also the general hospital’s trust. Regular presentations to A&E, often with overnight stays, involve administrative, clinical and bed costs. In line with the NICE Guideline on self harm (CG16) (2004), service users should receive an assessment by the Barnes Unit team or out of hours staff on each occasion, which can result in time consuming duplication if various professionals become involved. Service user feedback over time has suggested that whilst these assessments are helpful in the short term, ongoing input from the Barnes Unit team would be more so.

Based on this feedback, in 2010/2011 the Barnes Unit team worked with a service user who was presenting to A&E with increasing frequency. Both A&E and the self harm team were struggling to provide her with adequate care and support. The team concentrated on this individual because they felt that if they could help her to manage and reduce her self harming behaviour she would feel more stable, her use of A&E and mental health resources would reduce and staff would feel less helpless, which in turn might lead to a more positive attitude towards her and similar patients.

The psychiatrist from the Needs Service agreed to help the team develop a care package for this service user and also to provide supervision. Three team members were involved in this work and two out of the three saw the service user on a fortnightly basis.

Although the team members were not trained in specialist approaches for people with borderline personality disorder and had no additional resources, the expert supervision they received, which was based on concepts from transactional analysis, psychodynamic approaches and learning theory, guided them in their reflections, practice and planning of the work that was undertaken with the service user. Admissions to A&E were significantly reduced during this outpatient work. Other positive outcomes were that the service user reported that she felt supported and stabilised, the team established a robust collaborative relationship with the personality disorders service and they reported that their skills and confidence in working with this client group were much enhanced.

Whilst this work was demanding in terms of clinical time, the demand was offset by the reduction in A&E presentations, the associated psychosocial assessments and by reduced contact with the crisis team. Furthermore, the outpatient work was structured and consistent, which frequent assessments by different staff members would not have been.

Recent NICE guidance for longer term management of self harm (2011) (CG133) stresses the importance of establishing trusting and supportive relationships with service users over time to ensure their care is based on their needs and preferences. In line with this, the experience of both
the service user and the team outlined above suggests that such an approach should be offered to other service users who repeatedly self harm. This project was therefore initiated by two of the self harm nurses based on their experience of working with the particular service user as outlined above, and a humanistic need to provide something for this client group who frequently fall between the service parameters.

**Aims and objectives of the project**

Building on this positive experience, the following aims for this project were identified:

- To reduce the incidence of self harming behaviour within a client group known to regularly self harm by providing a preventative component to the Barnes Unit service
- To improve service users’ experiences of care in the context of self harm
- To reduce costs associated with A&E bed usage, crisis team utilisation and self harm assessments of repeat attendees

To achieve these aims, the following objectives were identified:

- To develop the Barnes Unit team’s skills and expertise with this client group and to enable them to work proactively with service users as well as being a response service
- To provide interventions that aim to facilitate self efficacy with regards to problem solving and managing self harm

**Methodology**

The project team used an action research process to inform this service development. Action research is: ‘a form of self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own practices, their understanding of these practices, and the situations in which the practices are carried out’ (Carr and Kemmis, 1986, p 162). This process has enabled a group of stakeholders to work together, to build on a positive experience from practice by drawing on and reviewing multiples forms of evidence, including research, service user experience and clinical experience (Rycroft-Malone et. al., 2004), and to use this to develop a clinic for service users who repeatedly self harm. Ongoing reflection during a 12 month pilot of the clinic has informed further refinements.

This action research process is summarised in the Figure 1 below.

![Figure 1: Action research cycle, adapted from Hart and Bond (1995) by Williamson, Bellman and Webster (2012, p 53)](image-url)
A number of activities have supported, informed and enabled the initial and ongoing development of the clinic. These are summarised in Table 1 below.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Dates</th>
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</thead>
<tbody>
<tr>
<td>Development of a steering group which met five times during the project</td>
<td>November 2012 – September 2014</td>
</tr>
<tr>
<td>Collection of positive narratives</td>
<td>September/October/November 2012</td>
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<tr>
<td>Retrospective audit of notes</td>
<td>February/March 2013</td>
</tr>
<tr>
<td>Initial planning of clinic structure and sessions</td>
<td>April - August 2013</td>
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<tr>
<td>Staff supervision sessions (n=6)</td>
<td>First – December 2013 Last – September 2014</td>
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**Development of a steering group**

At the outset of the project, the team decided that it would be beneficial to create a steering group to ensure the clinic had input from multiple sources. The purpose of this group was to offer expert advice and support to the project, as well as generating ideas and offering critique. The project team identified the key stakeholders and the following people were approached and agreed to be involved: Keith Hawton, Professor and Head of the Oxford University Centre for Suicide Research; Dr Steve Pearce, Consultant Psychiatrist and Head of the Complex Needs Service in Oxford; Karen Lascelles, Suicide Prevention Project Lead for the Strategic Health Authority; Nigel Wellman, Senior Lecturer at Brookes University on the Nursing Course; Linda Whitehead, Locum Lecturer and ex Self Harm Nurse; an ex Service User; Sarah Twine, Manager of Self Harm Team; and five Self Harm Nurses. The group met a total of five times during the project. The meetings were more frequent at the beginning of the project as the group was instrumental in the development of the clinic. Later in the project, the project leader kept the steering group members informed by email about the progress of the pilot of the clinic.

**Reflecting on a theme**

**Collecting positive narratives**

Initially, members of the steering group and also service users and carers who had utilised the Barnes Unit service, students who had been on placement with the service and staff members, were asked by the project team to share positive narratives about self harm care. The plan was to use these to start to generate ideas for developing the clinic, enabling the team to build on the best of self harm care. A total of seven stories were collected from three staff members, two service users and two nursing students. The stories were shared at the first steering group and themes were identified.

Positive engagement, time to talk, validation of feelings and feeling heard, were four themes that were identified more than once. By pulling themes from the feedback and looking at the positive themes from the work that the self harm service had done, the steering group was able to consider the best of what is and use this to inform the basics of an operational policy for the self harm clinic. It was from this that the group was able to think about the best way to tailor the sessions, the main focus being to give the responsibility back to the service user while ensuring they felt validated and heard. In this way, it was agreed that the first session would focus upon what the service user
would like to get from the intervention, so that we were involving them from the beginning in planning their care.

**Retrospective audit of notes**

A retrospective audit of notes was undertaken in April 2013 by a member of the project team for three reasons:

- To inform the development of inclusion criteria by determining the level of presentations of this client group
- To identify common themes for presentation and to use these to create ‘core sessions’ for the clinic
- Inform the inclusion criteria regarding anticipated numbers

During the audit, all the notes of service users who had presented at A&E more than once over the last six months were reviewed (n=18). The number of presentations by each service user was recorded (range was from 2 to 16), and the assessment paperwork was reviewed to identify common themes for presentation. These included alcohol problems, learning disability, poor coping skills/problem solving and drug misuse, anger management and depression.

**Planning action**

**Initial planning of clinic structure and sessions**

Using the information collected to date and in discussion with the steering group, the project team began to develop the clinic structure and sessions.

**Inclusion/exclusion criteria**

Service user inclusion criteria for the clinic were developed by the steering group, informed by the frequency of attendances at A&E as identified in the audit of the notes, as well as discussions about the capacity of the Barnes Unit team, alongside the needs of this service user group. The final inclusion criteria were: at least three presentations to A&E following self harm in 12 months or five presentations in 24 months. The clinic would be offered to people aged 13 years and over, thereby making it available to both younger and older service users.

A number of exclusion criteria were also discussed and agreed by the steering group. Service users that were currently engaged with psychological services or the Complex Needs Services were to be excluded from the clinic. It was not considered to be appropriate to engage them in another ‘therapy’ because it was felt that this could be counterproductive. Service users who met the inclusion criteria but who were currently under the care of the Community Mental Health Team would be discussed with their care co-ordinator to determine if it was appropriate that they should have the opportunity to engage with the clinic.

**Creating the clinic structure**

There were lengthy discussions in the steering group meetings to formulate the structure of the clinic. These discussions along with the key structures are summarised below:

- After much deliberation, it was decided that the clinic should be called BIRSH: Brief Interventions in Repeat Self Harm
- It was decided that the style of work should be 1:1 (Royal College of Psychiatrists, 2010), with the person who assessed the service user when they presented in A&E
• Because of the difficulty of securing appropriate accommodation on a set day, it was agreed that the dates and times of the ‘clinic’ sessions should be negotiated between the clinician and service user at the first session and the clinician should then take responsibility for booking appropriate rooms for these sessions. The self harm team are not based in a clinical area so it was agreed that the sessions should be held at the general hospital in the social work department where the team have access to rooms. There was discussion around having the session at the Warne Ford site (a psychiatric hospital with big outpatient department owned by the trust), as space can be difficult to come by at the general hospital, however it was felt this might stigmatise service users further and the team believed that service users were more likely to re attend an area they are familiar with

• To manage caseload numbers, it was decided that each clinician would work with a maximum of three BIRSH clinic services users at any one time

• Each clinic session was planned to be 45 minutes long, and each service user would be offered six sessions over 12 weeks with all the session dates being agreed at the first session. The sessions were planned in this way taking two main factors into account; firstly, evidence shows that six sessions is enough to form a therapeutic relationship and secondly, that a dependency is unlikely to develop in this period of time (Royal College of Psychiatrists, 2010)

• It was anticipated that there would be three to four ‘core sessions’, probably focussed around self harm and minimisation, problem solving and coping strategies. Then two to three specific sessions based on the particular needs of the individual service user; for example, alcohol, personality difficulties, bereavement, etc. There would obviously be a strong preventative theme, aiming to focus upon the alternatives to self harm behaviours. Initially the ‘core sessions’ were delegated to the self harm nurses to devise guidelines and identify resources for each particular need that could be used by all the team

• The process for admission to the clinic was agreed as follows: when a service user was seen and assessed in A&E by a member of the Barnes Unit team following self harm, they would be considered for the BIRSH clinic. If they met the inclusion criteria then they would be given an information leaflet and the BIRSH clinic would be offered; the clinician would be able to answer any questions about the clinic. If the service user wanted to attend, they would be given their first appointment date and time. The DNA (Did Not Attend) policy would be explained and the option of travel reimbursement would also be offered. If a service user currently engaged with the BIRSH clinic presented to A&E with self harm, a different clinician would carry out the self harm assessment wherever possible (so that the service user does not utilise self harm as a way of accessing their BIRSH clinician)

• It was agreed that the boundaries around non-attendance for appointments should be within the trust DNA policy and should be further outlined at the first session. There was no obligation for service users to attend the clinic, but an expectation that they would let the clinician know if they could not or did not want to attend. Service users would be reminded about their appointment by text the day before their session to enhance engagement. If the clinician was sick the service user would be contacted and the offer of seeing another clinician would be made

Identifying outcome measures
The project team and steering group members acknowledged that a number of outcome measures needed to be identified to determine the effectiveness of the clinic. Several suggestions were offered, including: Alcohol Use Disorders Identification Test (AUDIT); Patient Health Questionnaire
(PHQ-9), a tool that can be used to screen for depression; EQ-5D, which is a quality of life measure; CORE-OM; and the Subjective Units of Distress Scale (SUDS). The suggested outcome measures were reviewed by two members of the stakeholder group.

There were differing opinions within the steering group regarding which of the outcome measures should be used; some members felt that it is very important to collect a variety of data however, the clinical staff were reluctant to use anything too lengthy and onerous as this would impact greatly on the amount of time available for discussion with the service user during the session.

Eventually it was agreed that the service user would complete the Beck’s Depression Inventory (Beck et al., 1961) at every session, along with the trust’s self harm scale. At sessions one and six, the Edinburgh and Warwick Wellbeing Scale (Tennant et al., 2007) would be completed, in addition to a self-concept scale that is used in Oxfordshire. There would also be a service user satisfaction feedback form for the final session.

Data on presentations at A&E during the year prior to attending the clinic and during the year following the intervention would also be reviewed where possible, in addition to self report data regarding acts of self harm.

**Supervision**

The steering group agreed that all the clinicians involved in the BIRSH clinic should receive monthly group supervision to provide an opportunity to discuss cases and share learning. Group supervision would enable the team to ensure that the same approaches were being adopted and provide an opportunity to discuss the efficacy of the intervention (Hawkins and Shohet, 1992). This supervision was to be provided by Karen Lascelles, Suicide Prevention Lead for Oxford Health. In addition to this supervision, all clinicians would also be involved in supervision every eight weeks with Dr S Pearce, the Consultant Psychiatrist with the Complex Needs Service; the purpose of this was to focus upon disengagement (ending the sessions without the patient feeling abandoned) of this difficult group.

Eventually, six supervision sessions were held during the year-long clinic pilot, five facilitated by Karen Lascelles and one by Dr Pearce. Although it was originally agreed to discuss every new case in supervision, it was found that this was not practical, largely due to changes within the team structure and working hours. The team moved to a shift system four months into the project which meant that it became more challenging to have everyone attending the supervision. The supervision sessions were used to discuss cases that were particularly challenging or interesting, giving all the team the opportunity to be involved and to give feedback regarding the different cases. It also provided an opportunity to discuss the structure of the clinic and to implement changes where appropriate.

In between formal supervision, all the staff involved with the clinic also sought peer supervision, for reassurance that cases were appropriate for the service and, at times, as a way of sharing risk.

**Taking action - commencement of clinic**

The details of the clinic were finalised and an operational policy was drafted and agreed by the steering group. The clinic commenced on 1st September 2013.
Ongoing development – observe, evaluate and reflect
The supervision sessions in particular provided an opportunity for the team to reflect on aspects of the clinic that they believed could be improved. Through discussion, areas for improvement were identified, suggestions offered and new plans made, creating a number of smaller action research cycles as indicated by the inner arrow in Figure 2 below. This relates to the ‘tiny cycles’ identified by Wadsworth (1998) as ‘reflection on action, learning about action and then new informed action which is in turn the subject of further reflection.’ Using this approach meant that improvements could be made to the clinic at any time, rather than waiting until the end of the clinic pilot. These improvements/developments are outlined below.

Figure 2: Action research cycle showing smaller cycles

Session outlines
Early into the pilot of the clinic, discussions in supervision led the team to decide that sessions would be more therapeutic if they were service user led, rather than following a pre-decided preventative theme. The team recognised that they had access to a central, specific information database on a computer hard drive and therefore felt able to respond to the needs of the service user using these resources to support the session. The team decided that the main focus should be on encouraging the service user to think about what they would like to get from the sessions. Two examples that have been identified by service users are a reduction in self harming behaviours and the ability to get through the day. The team agreed that they could respond to these needs using their knowledge and skills and the resources mentioned, discussing interventions that would be most helpful to the service user.

Inclusion criteria
During the first supervision session, current cases were discussed. At that time, the clinic had been running for one month and seven service users had been offered appointments (two of these were for a future date). Of the five service users that had been offered appointments on past dates, only one had turned up. The team was disappointed about this but recognised that this was a risk when working with this particular service user group. During discussions, the team considered broadening the inclusion criteria to offer the service to a wider group of service users. The rationale was that the team wanted the service to be fully utilised and there was a group of service users who did not
fit into any other service who could benefit from the support offered by the BIRSH clinic, particularly following the introduction of service changes in March 2013 which meant that the team were no longer able to offer outpatient follow up to any service users who did not meet the BIRSH criteria. The inclusion criteria were therefore extended so that service users who did not meet the original inclusion criteria (i.e. three self harm presentations in 12 months or five in 24 months) but who would benefit from some further intervention following their self harm presentation would be offered the BIRSH clinic under the same operational policy. The team agreed that this arrangement would be reviewed in three months and if the workload became unmanageable, it would be reconsidered.

**Non-attendance**
An aspect of the project that required adjustment was managing non-attendance. It was initially decided that the Oxford Health Trust DNA policy would be followed. This would mean that the clinician would provide a telephone call and a letter following any DNA. However it became clear that often the service user would then re-present at A&E with a further episode of self harm in a short space of time and it was felt important that the door was kept open for them to utilise the clinic, thereby allowing for the person to move through stages of readiness to change (Prochaska and Diclemente, 1983).

Following discussion, the team decided that on re-presenting at A&E, a further opportunity to engage with the clinic would be offered. It was acknowledged that this group of service users may have chaotic communications and behaviours which may interfere with attending appointments, but that this should not prevent them accessing the service. It was also accepted that individuals’ readiness to engage may fluctuate and so a service such as this needed to be flexible in order to tailor the intervention and service provision to the needs of the individual and to ensure collaboration (NICE, 2011).

Service users that did not attend appointments but then re-presented at A&E, were offered further opportunities to engage with the clinic. This resulted in some service users starting to attend on the second or third offer of appointments. One service user was also given the option of contacting the service if she changed her mind and decided she wanted to take up the offer at some point. Three of the service users who have engaged with the clinic are people that have been given repeated opportunities to attend. The service user that was offered open access very quickly decided to take advantage of this and did attend once, although did not return after this. However, the success in engaging with some service users that the change in approach has achieved has demonstrated the importance and significance of flexibility with this client group.

**Evaluation**

**Outcome measures**
A number of outcome measures were used to evaluate the effectiveness of the clinic. The BDI was used at every session attended and the EWWBS and self-concept scales were used at the first and last sessions. In addition to this, the number of presentations at A&E was monitored in the six months pre and post attendance at the clinic. A brief questionnaire was posted to service users who attended the clinic, asking them for feedback. This consisted of four questions regarding the service they had received.
We received feedback from those who had attended all six sessions of the BIRSH clinic (n=5), but despite posting out feedback forms with a stamped addressed envelope to all patients who had attended one or more sessions, we only had one response posted back. Table 1 provides a summary of these measures.
### Table 1: Summary of outcome measures for service users who were offered the BIRSH clinic

<table>
<thead>
<tr>
<th>Attendee</th>
<th>Number of sessions attended</th>
<th>A&amp;E attendance six months pre-clinic</th>
<th>A&amp;E attendance six months post-clinic</th>
<th>BDI start/finish</th>
<th>Posted feedback/received feedback?</th>
<th>EWWBS first/last session</th>
<th>Self-concept scale first/last session</th>
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<tr>
<td>1</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>29/26</td>
<td>Y - N</td>
<td>23</td>
<td>24</td>
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<td>5</td>
<td>7</td>
<td>1</td>
<td>27/34</td>
<td>Y - N</td>
<td>28</td>
<td>14</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>11</td>
<td>5</td>
<td>36/14</td>
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<td>19/20</td>
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<td>4</td>
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<td>8</td>
<td>1</td>
<td>12</td>
<td>3 (but in prison for 12 weeks)</td>
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<td>Y – N</td>
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NB: Where there is only one score, this was collected at the first session. Final scores are not available for many service users as they did not attend all the sessions.
Summary of outcomes

- 38 service users were offered the BIRSH clinic
- 26 service users attended one session or more (mean number of sessions per service user = 2.45)
- Five service users attended all six sessions. 3 had a increase in their EWWBS and self-concept scores (increased scores reflects increases in self-reported well-being and self-concept)
- All service users who attended one or more sessions have had a reduction in A&E presentations post clinic. The mean number of attendances in the six month period pre and post clinic are 3.5 and 0.75. These figures have been calculated using 23 service users (the three service users who were in hospital or prison services were excluded)
- There does not appear to be a clear link between the number of BIRSH clinic sessions attended and the extent to which A&E presentations were reduced
- Most of the service users that attended two or more sessions (n=14) had a reduction in their BDI score (n=12) (a reduction in scores indicates a reduction in self-reported depression)
- All service users that attended one or more sessions, but not all six, were posted the feedback form and scales to assess outcome measures with a stamped addressed envelope – only one was returned
- Six service users completed feedback forms and one narrative was received (in the form of a handwritten thank you card describing what had worked about the intervention). A theme in the feedback is ‘too many forms’

Discussion

The project had three aims:

- To reduce the incidence of self harming behaviour within a client group known to regularly self harm by providing a preventative component to the Barnes Unit service
- To improve service users’ experiences of care in the context of self harm
- To reduce costs associated with A&E bed usage, crisis team utilisation and self harm assessments of repeat attendees

These aims will be briefly discussed below in light of the project outcomes and relevant literature.

Reducing self harming behaviours

As is stated in the outcomes, there has been a significant reduction in presentations at A&E with self harm for every service user that attended one or more BIRSH sessions; although there doesn’t seem to be a clear link between the number of sessions attended and the extent of the reduction in self harm presentations.

Whilst these reductions are positive, the limitation of the use of attendance at A&E alone as a measure of self harming behaviour is recognised. Because self harm is often a hidden and secretive behaviour, most acts of self harm will never come to the attention of health care services (Mental Health Foundation, 2006). It is therefore not possible to say definitively if self harm reduced as a result of the BIRSH clinic, as the service users mays have attended their GP surgery or self-managed their self harm.

Overall, the scores that were used to measure outcomes in relation to depression, well-being and self-concept were not particularly helpful. Outcomes suggest that service users who attended two
or more sessions experienced a reduction in self-reported depression. Outcomes from the other scales (EWWBS and self-concept scale) were variable and therefore no conclusions can be drawn.

**Improving service user experiences of care**

It was very difficult to evaluate whether or not service users’ experiences of care had improved, primarily due to the fact that very few service users attended all six sessions and only one service user returned the postal feedback form. However, of those service users who completed the scales/tools on more than one occasion, most reported some improvement (depression, well-being and self-concept). Whilst it could be suggested that this demonstrates that these service users were benefiting from service, supported by the reduction in A&E attendances, it does not specifically address the area of service user experience.

Six feedback forms were received from service users – the main theme to emerge was that there were too many forms to complete; however, a card was received from one service user which stated:

‘When I first came I couldn’t imagine a life away from overdosing and depression, you helped me find hope and I am able to cope with things I assumed I never would.’

**Reducing health service costs**

A considerable amount of NHS resources are used for the assessment and treatment of self harm (NICE, 2004). In a study of people who accessed services at a general hospital following self harm, Sinclair et al., (2010) found cumulative increases in health and social care costs, particularly for service users who experienced five or more self harm episodes in a six month period. As well as direct costs to health and social care services, there are many indirect costs related to attendance and productivity in work and education, long-term health issues and disabilities, and premature death (Deacon et al., 2011). With these issues in mind, some basic costings are provided below.

Locally the procurement team state that an average 12 hour stay on the Emergency Assessment Unit (EAU), which is part of A&E, costs around £500. This is a very rough estimate and it is acknowledged that there are a number of variables which would impact on this cost.

The cost of a 45 minute session in the BIRSH clinic could be based upon an hourly rate of the staff member who is delivering the session i.e. a Band 7 nurse. Costing for one hour allows for a small amount of administration time for each appointment (e.g. arranging room, sending reminder text etc.) An hourly mid-scale rate equates to approximately £25 per hour (including the organisational on-costs).

Although the cost of the room used could be seen as negligible, as these are outpatient rooms that are open whether they are used or not and can be booked by our team, there are obviously ongoing capital costs for the organisation.

During the pilot of this clinic, service users attended an average of 2.45 sessions, which equates to £61.25 per service user. In the six months post attendance at the BIRSH clinic, all of the service users had a reduction in their A&E presentations. If this is costed assuming a 12 hour stay, this represents a reduction in costs from £1750 (based on 3.5 attendances in the six months pre clinic) to £375 (based on 0.75 attendances in the six months post clinic). This is potentially a saving of in excess of £30,000 per year.
Staff experiences of BIRSH
In addition to service user experiences of the service, we also wanted to reflect on our own experiences of being involved in the clinic. To do this Karen Lascelles, who had run the group supervision facilitated a forum, which was an open speaking session that gave staff the opportunity to talk about what they felt was positive or negative about the BIRSH sessions from their perspective. The general consensus was that the BIRSH clinic was a very positive intervention and staff felt somewhat reassured to be able to invite service users back for further follow up once they had been assessed. Comments from staff included:

‘Empowering to be able to offer something that probably will reduce self harm’
‘Good to have something to offer other than referral on to other services, helps with validation and improves the patient journey as they are returning to see their assessor rather than another clinician’

Areas of development
The project team acknowledge that there is an element of inequitability due to the fact that service users seen out of the hours of the self harm team (5pm-9am) are not offered the service. However since the 1st January 2014 the self harm team have operated an extended service from 7.30am-9pm, thus increasing accessibility to the BIRSH clinic.

As of the 1st of May 2014 the Emergency Department Psychiatric Service (as our service has been renamed) began seeing service users at the Horton Hospital (another general hospital 30 miles away, but under the same trust). These service users can now also be offered the BIRSH clinic but they would need to attend the John Radcliffe hospital for their appointments.

The sessions will also be facilitated by different clinicians that may skew the outcome measures. As we all deliver sessions slightly differently and have different motivations and styles to how we work, although the overall motivation is the same for all of the team. The team will utilise the monthly group supervision to ensure we discuss the ways we are supporting service users, which will enhance efficacy and give a more streamlined approach.

Following an incident where half way through a BIRSH clinic appointment, a service user alleged that she had ingested an overdose and refused to attend A&E, the team developed a Standard Operational Policy for service users alleging self harm whilst in the BIRSH clinic sessions.

Moving forward
The BIRSH clinic has now moved beyond the 12 month pilot phase and it has been agreed within the team that it should continue, but with a number of minor changes:

• Reduce the number of sessions to three, with the understanding that more can be offered if appropriate
• Investigate the use of alternative outcome measures, for example Patient Health Questionnaire-9 (Kroenke et al., 2001)
• Consider use of the True Colours online self management system alongside the sessions (see https://www.truecolours.nhs.uk/wwy/)

The operational policy is being amended to incorporate the above.

References


