Supporting young people and adults who present to A&E with self-harm or suicidal ideation

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and the ASSURED and SASH Teams

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Overview of ASSURED

- **ASSURED aims to reduce self-harm & reduce the risk of suicide**
- **We developed and are testing a brief, low cost, psychological intervention for routine contacts in the ED to reduce future self-harm**
- **The intervention was developed to be delivered by specialist mental health practitioners in existing psychiatric liaison teams**

WHY FOCUS ON SELF-HARM IN THE EMERGENCY DEPARTMENT?

- ~6,000 suicides in the UK per year (1)
- Self-harm (SH) is the most important risk factor (2-3)
- ~220,000 SH presentations a year to EDs (4)
- **Psychosocial assessments described as inadequate (5)**
- **Referrals to specialised mental health services - entry criteria, waitlists (6)**
- Risk of suicide greatest in initial week after discharge (7)

RATIONALE

- Brief psychological interventions in the ED reduce repeat SH and suicide (9)

- **Effective components are: Enhanced psychosocial assessment; safety planning; follow-up contact (10-12)**

- NICE states ‘engaging the service user is a pre-requisite’ (2)

- Therapeutic alliance linked to fewer suicide attempts in ASSIP intervention (10)

Conversation Analysis: Videos of ED psychosocial assessments

ELSEVIER

Social Science & Medicine
Volume 290, December 2021, 114082

Negative stance towards treatment in psychosocial assessments: The role of personalised recommendations in promoting acceptance

Clara Bergen, Rose McCabe

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frontiers in Psychiatry

Front Psychiatry. 2023; 14: 1197512.
Published online 2023 Aug 30. doi: 10.3389/fpsyt.2023.1197512

PMCID: PMC10499316
PMID: 37711424

Implying implausibility and undermining versus accepting peoples' experiences of suicidal ideation and self-harm in Emergency Department psychosocial assessments

Clara Bergen,[1,*] Lisa Bortolotti,[2] Rachel Kimberley Temple,[3] Catherine Fadashe,[3] Carmen Lee,[4] Michele Lim,[5] and Rose McCabe[1,*]

BJPsych Open

Asking about self-harm during risk assessment in psychosocial assessments in the emergency department: questions that facilitate and deter disclosure of self-harm

Published online by Cambridge University Press: 25 May 2023

Rose McCabe, Clara Bergen, Matthew Lomas, Mary Ryan and Rikke Albert

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Article Figures eLetters Metrics

ELSEVIER

SSM - Qualitative Research in Health
Volume 4, December 2023, 100249

Gatekeeping and factors underlying decisions not to refer to mental health services after self-harm: Triangulating video-recordings of consultations, interviews, medical records and discharge letters

Clara Bergen [a b], Matthew Lomas [c], Mary Ryan [d], Rose McCabe [a]

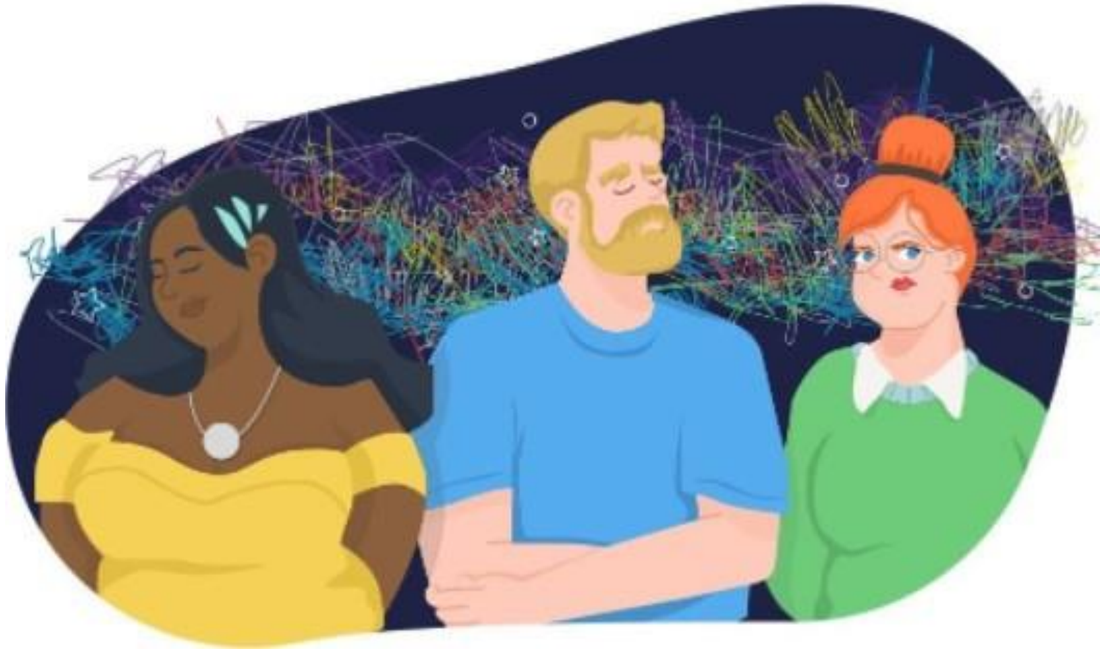
WHAT DO PRACTITIONERS & PEOPLE ATTENDING ED SAY?

1. People who SH are excluded from services leading to unhelpful cycles of attending ED

2. Practitioners feel powerless & patients feel judged

3. Patients need a human connection which practitioners underestimate

4. Risk assessments make staff feel safer but patients find them formulaic and not helpful (8)



Perspectives of people with lived experience

I mean liaison with that is to discourage people from going to A&E, I've been told, you know, we're not going to make it too comfortable for you to come here or enabling you… you know, you don't to A&E for a holiday, you'll go, I'm going for treatment of wounds

I heard them talking behind my back, like should we, should they call, erm, liaison team or something one person said, and the other responded like, no, it's okay, just let her go and self-destruct.

With repetition you get a reputation, you get quite badly treated

Perspectives of young people with lived experience

‘But actually, you know, it should be like an environment where like being open and honest in that way is kind of “praised”. Like as in praised with kind of, you know, a proper response and listening and talking, and not, not like then passing
onto someone else, or disengaging and saying like oh you’re too much of a risk or whatever.’

I’m here because I’ve almost put myself here, when there could be someone who’s having a heart attack or has done something not, and they just, and you’re like, I, I feel bad, because I feel like I’m taking up their time(young person)

Perspectives of practitioners: Concerns about the intervention

- Encourage attendance

> We're trying to work with avoiding A&E attendances so we try not to encourage the patients to come in and see us… y'know there's a word of mouth isn't it it spreads quite quickly that this this thing is going on, it's very nice…

- Dependence

> What we would be offering them? So would they be phoning up? They could potentially be phoning up each day going oh can I speak to [practitioner] please, oh you know, I'm struggling at the moment. And so I think how do you hold those boundaries with uh what you're offering?

- Increased responsibility

> Whose neck is on the line if something goes wrong?

Developing the intervention

- **Systematic review (McCabe et al. 2018)**
- **RELATE study – conversation analysis of 45 video recorded ED psychosocial assessments**
- **Lived Experience Advisory Panel (LEAP)**
- **Working with stakeholders**

ASSURED INTERVENTION

ED/Post ED meeting – 1 week
Narrative interview
(Psychosocial assessment)
Enhanced safety plan

72-hour check-in call

3 solution focused
follow up sessions
at 2, 4 and 8 weeks

3 letters
at 3, 6 and 9 months

ASSURED Training: https://training.assuredstudy.co.uk

Narrative Interview, Validation & Hope

- Welcome to Assured
- Introduction to Assured
- The Assured intervention
- Narrative interview
  - How do you do a narrative interview?
  - Allowing space for quiet
  - Example of a narrative interview
  - Narrative interviewing is about encouraging elaboration on each part of their story
  - How do you encourage elaboration?
  - How important is it to use validation in your practice?
  - Why is it important to validate?
  - How do you validate distress?
  - Seeking help in A&E
  - How do you validate help-seeking?
  - How can you give people hope?
  - What you can say to give people hope
  - What might get in the way of good communication?
  - Before moving onto the safety plan
  - Narrative interview: Exercise
  - What techniques should be used in a narrative interview?
- Enhanced and personalised Safety Plan
- Signposting resources
- Solution-focused sessions
- Assured intervention handover letter
- Assured follow-up letters
- Bank session
- Supervision
- What's next?
- Frequently Asked Questions
- Further reading

Brown & Stanley Safety Plan

MY SAFETY PLAN

You have been seen by: _____

From the Liaison Psychiatry Team at _____

on_____ /_____/ _____

MY WARNING SIGNS

What do I start to experience when I start to think about suicide or feel extremely distressed:

How will I know when the safety plan should be used:

DISTRACTIONS

What can I do on my own to distract myself :

How likely is it that I will be able to do this:

What might stop me from turning to these distractions:

What small steps can help me overcome these barriers:

CHANGING MY ENVIRONMENT

Where can I go to distract me from my thoughts:

How likely is it that I will be able to go there:

What might stop me from going to these places:

What small steps can help me overcome these barriers:

PEOPLE I TRUST

Who can I contact when I feel overwhelmed:

How likely is it that I will contact them:

What might stop me from contacting them:

What small steps can I take to help me overcome these barriers:

PROFESSIONALS

Which professionals can I contact:

How likely is it that I will contact them:

What might stop me from contacting them:

What small steps can I take to help me overcome these barriers:

Solution Focused Sessions

•Strengths-focused approach, helping people find ways to move forward from challenges (Ajmal & Ratner, 2019)

•Looking for resources rather than deficits

•Exploring the future the person wants

•Doing more of ‘what already works’

•Not the same as problem-solving, giving advice or telling people what to do: asking questions that enable people to build their own solutions

"Problem talk creates problems and solution talk creates solutions”

Steve de Shazer

Participants:

- **Practitioners:** NHS practitioners working in psychiatric liaison teams, who routinely conduct ED assessments
- **Patients:**
    - ≥16 years of age
    - presenting to ED
    - presenting with self-harm (i.e., self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act)
    - OR suicidal thoughts/behaviour

Assured Programme

Work Package 1: Developing the intervention (2019)

Work Package 2: Piloting the intervention across 4 sites in England

Work Package 3: Developing a training package for practitioners

Work Package 4: Data Extraction - primary outcome

Work Package 5: Randomised Controlled Trial

Work Package 6: Dissemination (2025)

AIMS: ASSURED RCT

- **To test the clinical and cost-effectiveness of the Assured intervention in reducing repeat attendance to the ED (resulting in a referral to psychiatric liaison team)**
- **The trial is taking place in 10+ hospitals in England**
- **Sample: 92 practitioners and 620 patient participants**

Primary Outcome

- Number of people who re-attend the ED and are referred to liaison psychiatry over 18 months following the index episode

Secondary Outcomes: 3, 9 & 18 months

- **Suicidality - Beck Scale for Suicide Ideation**
- **Self-reported self-harm – text survey**
- **Quality of life – EQ-5D-5L**
- **Psychological distress – CORE-OM**
- **Psychological wellbeing - Warwick-Edinburgh Mental Wellbeing Scale**
- **Social outcomes - SIX**
- **Suicide**
- **All cause mortality**

RCT (Re)design

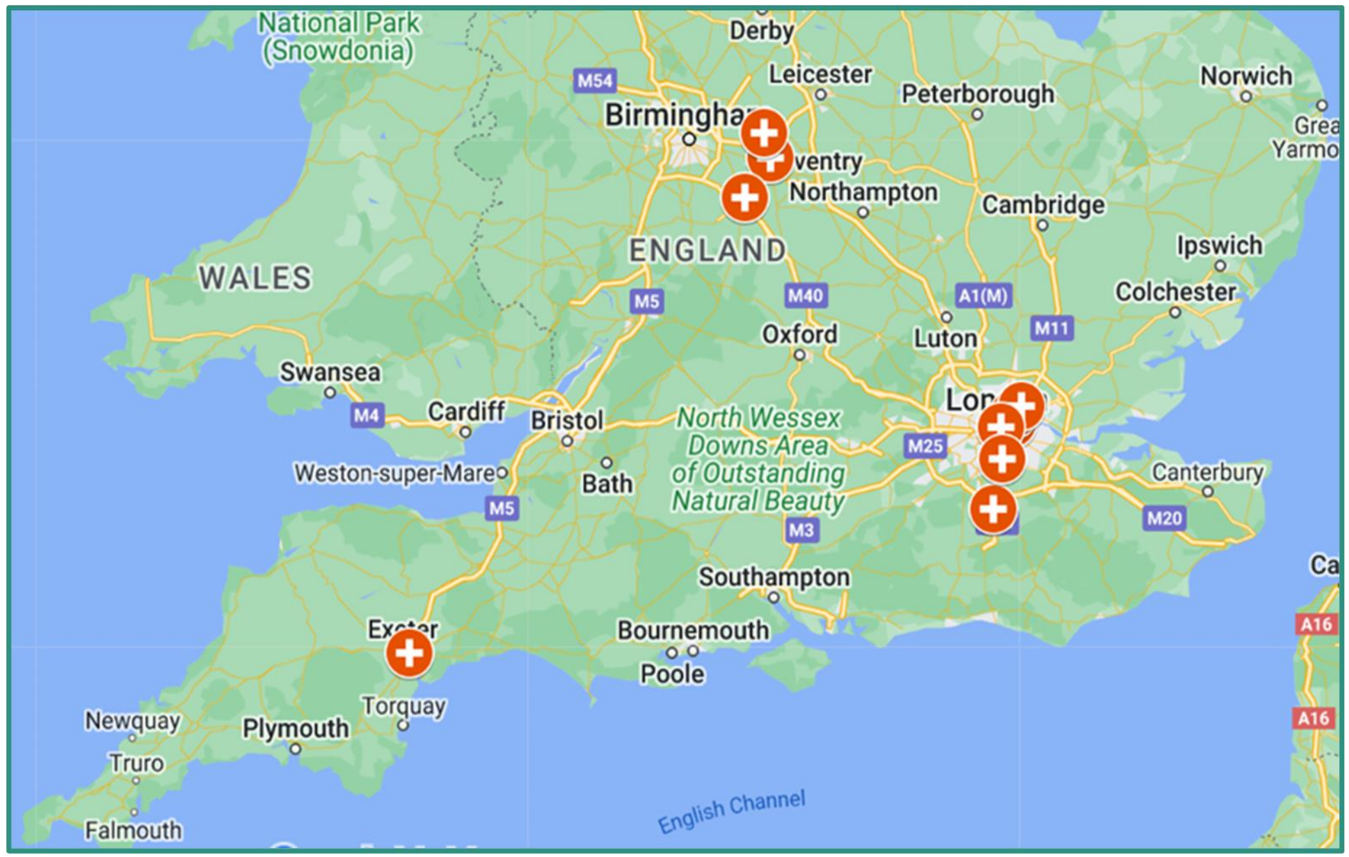
- **We started with a cluster randomised controlled trial, where practitioners were randomised to deliver:**
  - **Assured approach (& receive 3 days training)**
  - **Treatment as usual**

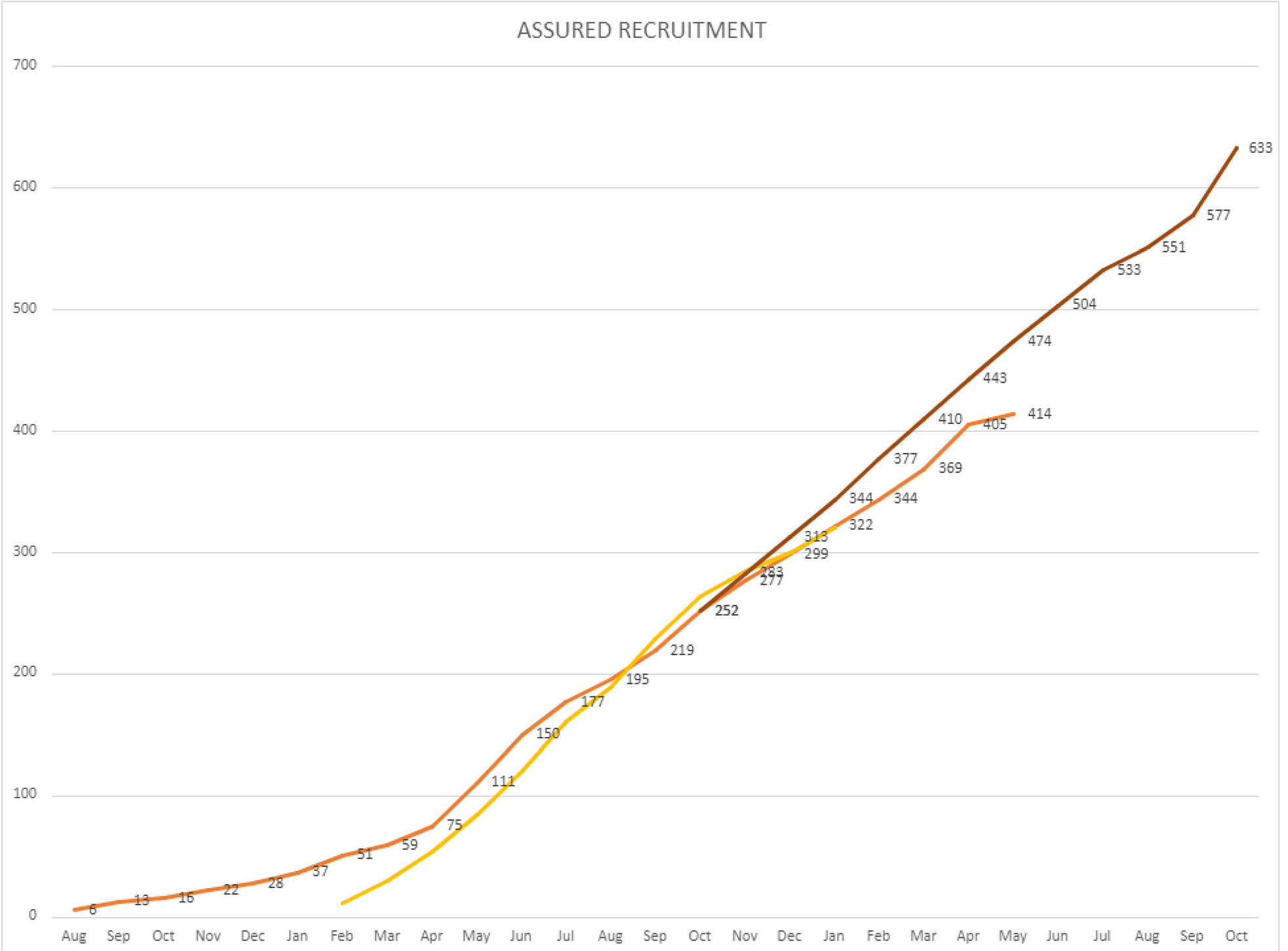
  Then COVID……

  We moved to an individually randomised controlled trial

Assured Sites

Royal Devon and Exeter Hospital	**OPEN FOR PATIENT RECRUITMENT**
Torbay	**OPEN FOR PATIENT RECRUITMENT**
Homerton University Hospital	**OPEN FOR PATIENT RECRUITMENT**
East Surrey Hospital	**OPEN FOR PATIENT RECRUITMENT**
Royal London Hospital	**OPEN FOR PATIENT RECRUITMENT**
Whipps Cross Hospital	**OPEN FOR PATIENT RECRUITMENT**
University Hospital Coventry and Warwickshire	**OPEN FOR PATIENT RECRUITMENT**
George Eliot Hospital	**OPEN FOR PATIENT RECRUITMENT**
Warwick Hospital	**OPEN FOR PATIENT RECRUITMENT**
University College London Hospital	**OPEN FOR PATIENT RECRUITMENT**
Newham University Hospital	**OPEN FOR PATIENT RECRUITMENT**




ASSURED RECRUITMENT
700
600
500
400
300
200
100
0
Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct
6
13
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219
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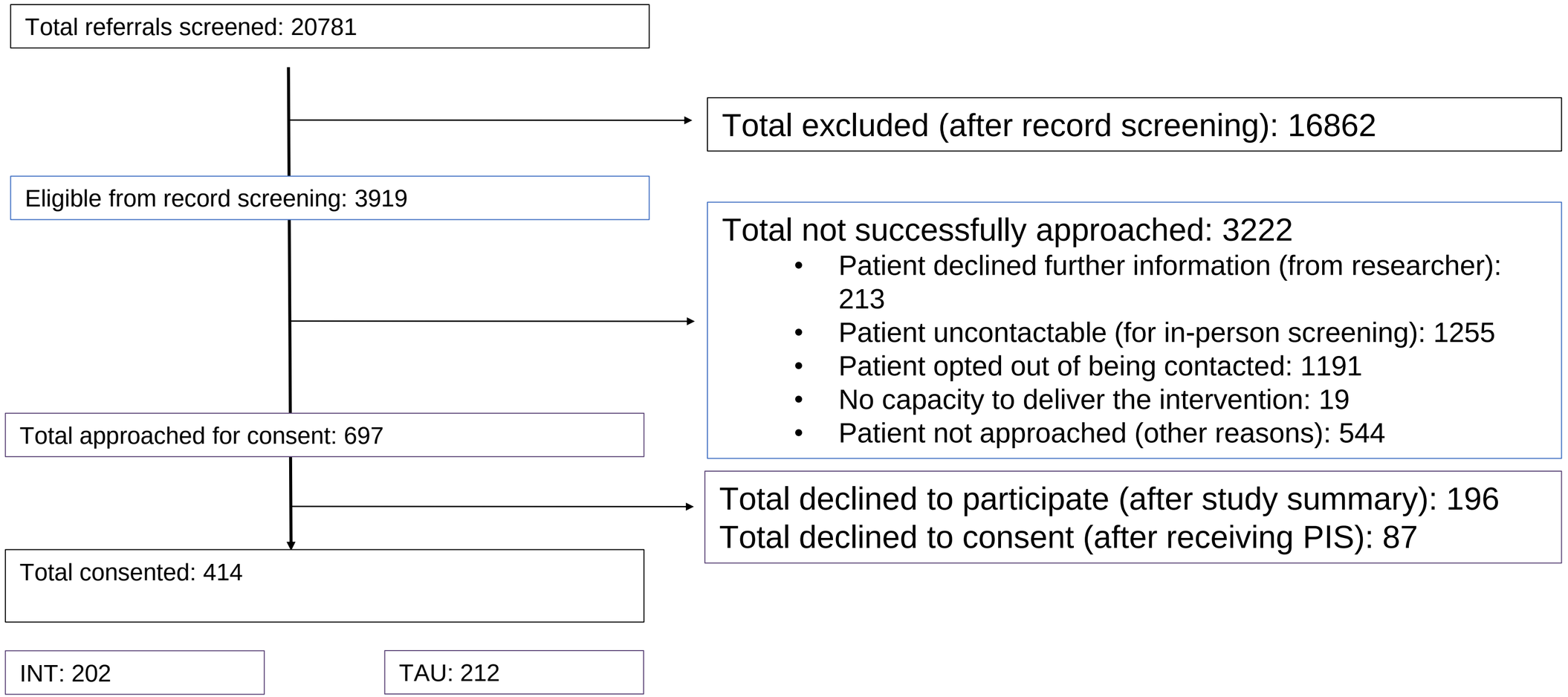
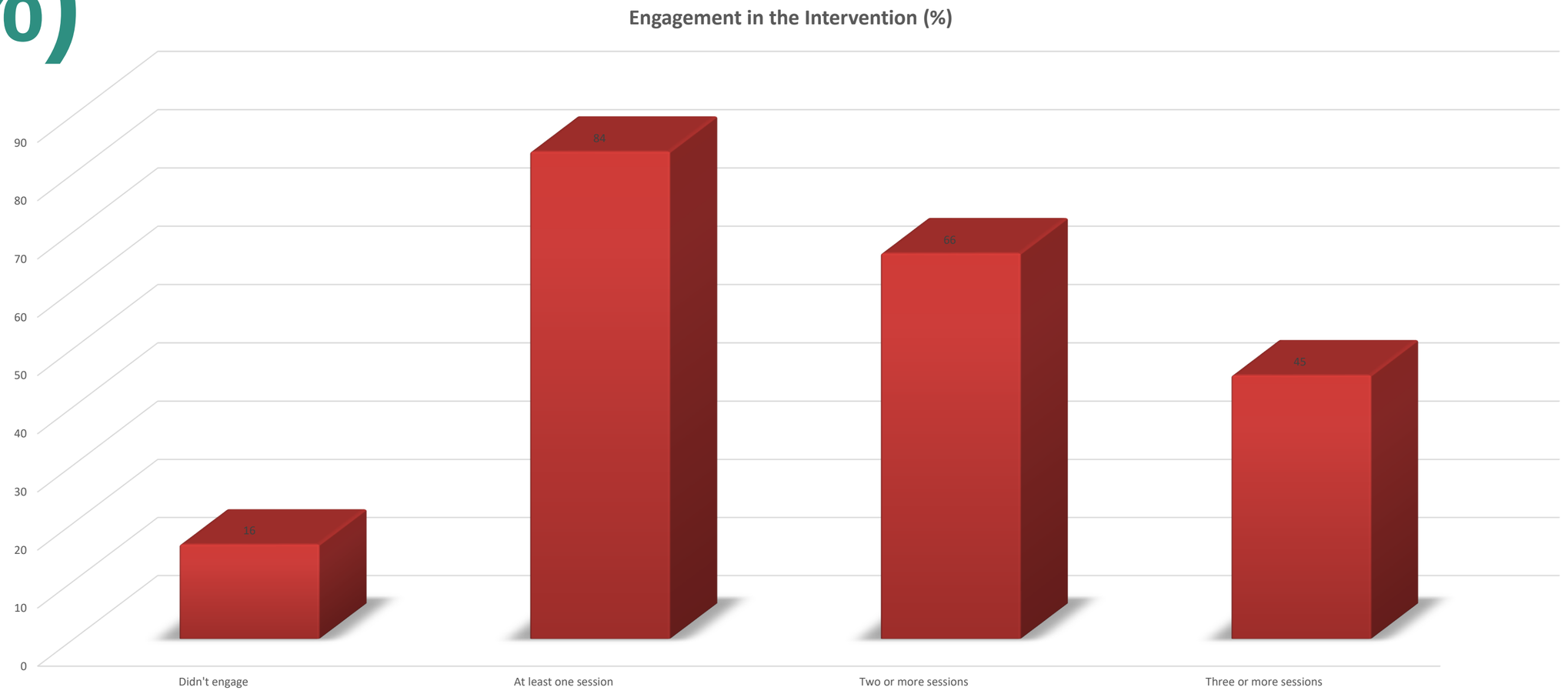
533
551
577
633
414

ASSURED Consort Diagram



Engagement in the Intervention (%)



Patients’ views (pilot study & RCT) on the narrative interview in ED: supportive, caring, non-judgmental

"It was **like a conversation** rather than her sat there taking notes and me just talking. So **I enjoyed that**." (Patient)

“[They **just went through everything with me**, talking about the mental health and all that, he actually made me feel a lot better and feel like I actually wanted to come home…..it was just the way he was, genuine, kind, helpful”

Patients’ views on safety plan

Patients found it helpful if it resonated with them

“The safety plan was **easy to use** and meant when you were in crisis, when it’s already difficult to think or make decisions, **I had something to use which I trusted**” (Patient)

"... it was really useful and it was probably the first time that I’ve not immediately thrown it away after leaving a session. So yeah. It was **one that I did that actually resonated with me**." (Patient)

Patients found the safety plan less helpful if it didn’t feel acessible or realistic to follow

"But the only thing was because it was on a piece of paper… **I don’t even know where the piece of paper is now**. I’ve lost it." (Patient)

"[The strategy] is like 'you should call a friend when you feel like that'. Things like that just seemed **aggravating for me** because I would love to just pick up the phone and be like “hey I’m not feeling great”, **but it is just not that easy in the moment.** " (Patient)

Practitioners’ views on safety plan

Practitioners had positive experiences of delivering the safety plan:

"I felt **the safety plan was really more than a safety plan**. Once people started to think about reaching out to other people and getting support from other people, they did so much more generally than just at times of crisis... They did make good use of the safety plan in other ways.”

“The conversation was good because she wasn’t in crisis. She was able to identify a lot more techniques of how she would calm herself down and things like that.”

Patients’ experiences of follow-up contacts

“Follow-up sessions gave me tools to work with, and **helped me to not re-attend A&E**. I looked forward to the sessions - it creates a set of expectations that you then want to fulfil”

"She gave me like a tool that I can you know... **I'm resilient enough to go and you know, continue to fight for my health.** And so yeah, she gave me this tool that it's really, really, really positive"

"It’s nice to be able to **see yourself changing throughout the sessions**, especially when you start off by thinking you’re never going to feel better again"

Practitioners’ view on the Narrative Interview in ED

"[The narrative interview] opened up more angles. So, instead of me just asking direct questions, with a narrative interview, **they would open new ‘lines of enquiry’**. It opens up all the different pockets of the conversation to try and explore"

"So to have that opportunity to **just express herself which is therapeutic in itself.** And [I did] gather a lot of information even just through her own narrative of what of what was going on for her"

"It felt like her **emotional needs were met during the assessment**."

AIMS: SASH RCT

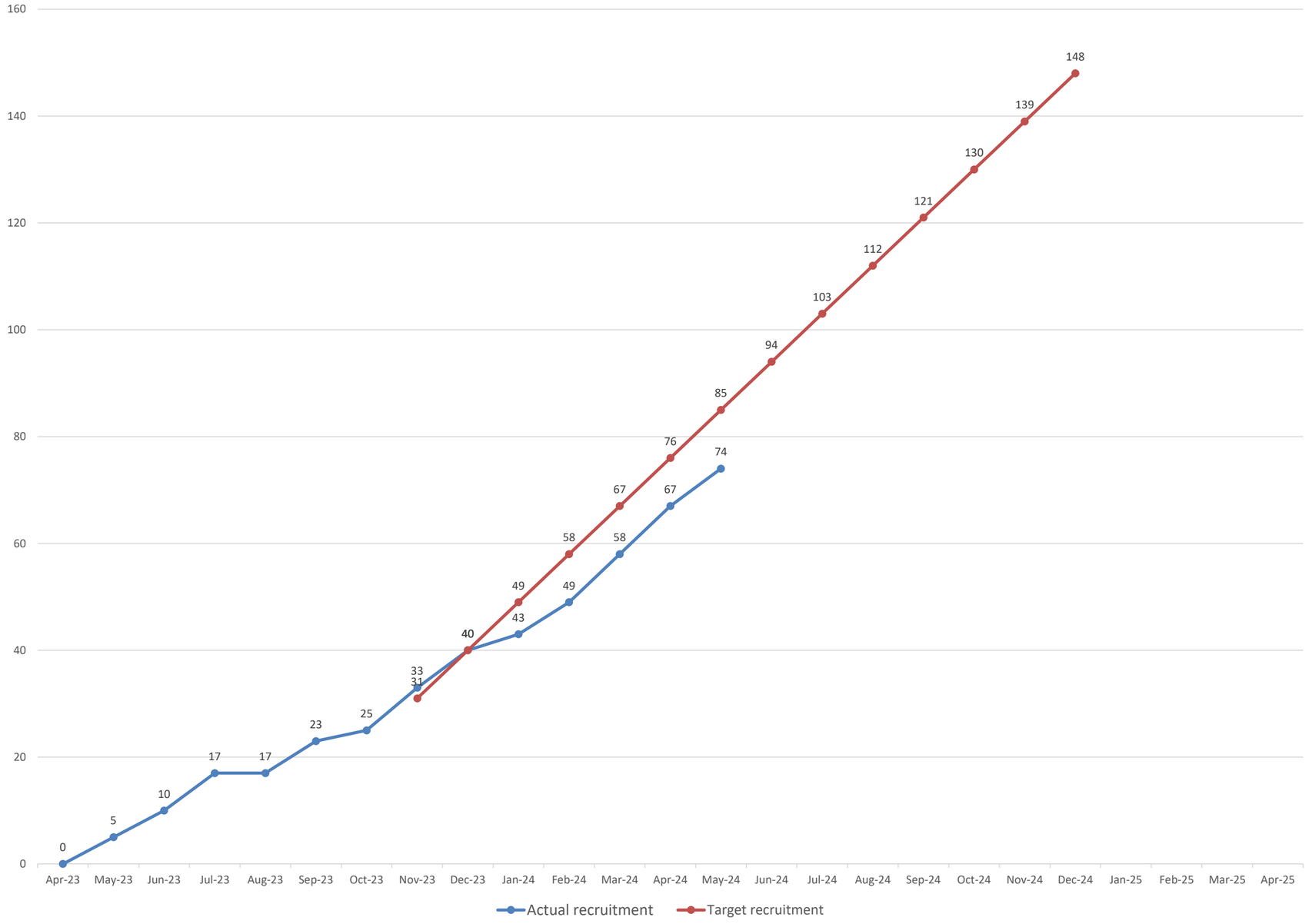
- **To test the clinical and cost-effectiveness of the SASH approach in reducing self-reported repeat self-harm**
- **The trial is taking place in 5 CAMHS crisis teams covering 8 A&Es in England**
- **Sample: X practitioners and 144 patient participants**

Secondary outcomes (2 weeks, ~2 months, 6 months)

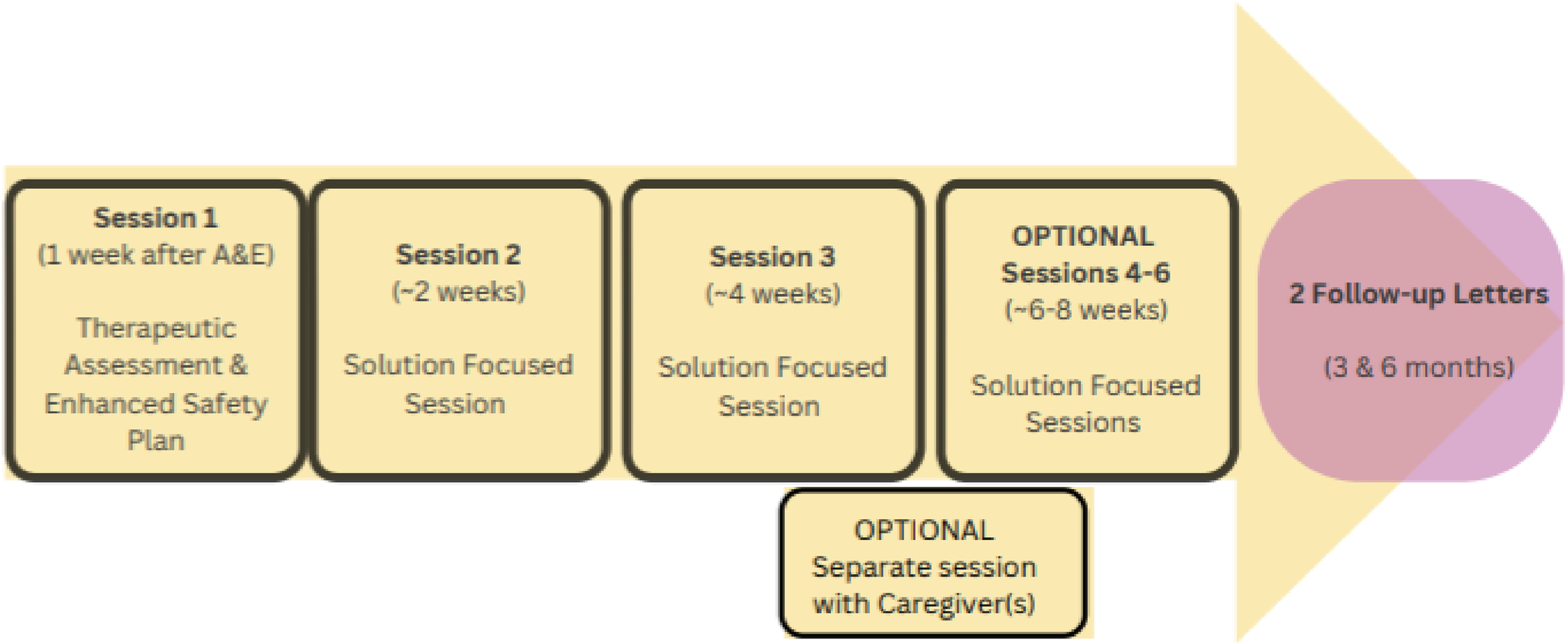
- **Self-report self-harm – two weekly text survey**
- **ED reattendance for self-harm or suicidal ideation**
- **Therapeutic alliance – helping alliance scale**
- **Depressive symptoms – MFQ**
- **Anxiety symptoms – GAD7**
- **Wellbeing – Edinburgh-Warwick**
- **Health related quality of life – CHU9D**
- **Health service use**
- **School attendance**

- **Carers: costs to carer, quality of life**

SASH recruitment



The SASH approach



Solution focused follow-ups: a paradigm shift for practitioners

“get to a place where you can be hopeful...even if you do self- harm, **celebrate the times in between when you managed not to do it and focus on whatever it was that you were doing during those times’ and tap into that"**

“...encouraging people to make most of the resources that are around them **works, seems to do something**… highlighting what people are doing already, who they have, what supports they have, the kind of things they do that help themselves"

“A lot of the time we do focus on the problems of the world instead of what's right, and **that shift is refreshing** because it helps people to recognise their own strengths, their own coping mechanisms and strategies”

Practitioners’ experiences of doing follow-ups

“It has been really **rewarding** doing the follow ups and getting to do therapeutic work with people”

"**This whole intervention has taught me, to really explore self-harm and suicidal thoughts**. Because what often happens in an A&E setting, we have patients that frequently attend with self- harm [and] you stop asking those questions [so] self-harm becomes a generic term. And **it's not generic, it's individual to each person**
- the intention behind it is different and it can be different each time. **Even if you've seen the same person, it could be different each time, it could be triggered by something different it could be more severe**"

"With a single point of contact that we might have with someone…it sometimes feels like you don’t know what happened with that patient and y’know, you feel there’s no sense of closure or there’s no sense of knowing and **learning from that experience** of what could have been more or less helpful”

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ANY QUESTIONS?

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