Evaluation of Sussex A&E follow-up by compassionate care call, after assessment after an episode of self-harm or suicidal distress: a pilot project

Final report : October 2021

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1. Executive Summary

1.1 Scope of the report

This is the final report of the evaluation of the pilot project, funded by Integrated Care systems (ICS) Sussex Suicide Prevention programme, to introduce a compassionate care call for adults who have attended at A&E Departments in seven Sussex hospitals following an episode of self-harm and/or in distress with suicidal ideation. The report describes and evaluates the introduction and delivery of this project over a twelve month period between October 2020 and October 2021. The aims of the project were to improve the quality of interventions for adults people presenting following an episode of self-harm/distress and reduce the risk of further self-harm by:

- Providing a compassionate timely and effective brief follow-up response to Adults and Older Adults who present at A&E where self-harm and suicide attempts are recorded
- Supporting the outcome of the A&E psychosocial assessment, through supporting engagement with the individual's care plan including further signposting.

The evaluation, undertaken between October 2020 and October 2021, assessed the following key areas: setting up; referrals; experiences and outcomes of the compassionate call. This report presents the findings and recommendations.

1.2 Key findings

1. The compassionate call intervention was successfully initiated and delivered by a team of mental health support workers (MHSW), supported and supervised by senior managers
2. Appropriate referrals of people following an episode of self-harm or suicidal distress were obtained from clinical teams, in seven hospitals, though the numbers of referrals was less than anticipated and varied across hospitals
3. Once established, clinical teams found the intervention and the contributions of the MHSWs helpful
4. All compassionate calls were made within the required timescale of 72 hours after referral, and a very high proportion (87.2%) successfully contacted the person referred.
5. The compassionate calls had a primary focus of supporting people through clarifying care plans and encouraging attendance at follow up appointments
6. The calls helped some people overcome distress and disorientation that can accompany the experience of presenting at A&E after an episode of self-harm or in suicidal distress
7. The calls involved the MHSWs in assessing risks, being open to new information, and recognising fluctuations in people's situations. In a few cases (2.4%), MHSWs initiated actions to support the person's safety.

8. There is initial indicative evidence that most people (76%) kept their next appointment with services after the compassionate call
9. The MHSWs and service users, the latter with limited evidence, emphasised that most people were appreciative of the calls
10. Though there is no direct evidence that the calls reduced repeated self-harm and suicide it is likely that they contributed to this through promoting continuity of service delivery, and the communication of compassionate recognition of people's emotional experiences
11. The scope of the evaluation is restricted by the brevity of the intervention, difficulties in accessing routinely collected data, follow up for individuals with a wide range of care plans, within and outside SPFT, and limited service user feedback

1.3 Recommendations

1. The compassionate call intervention is a successful innovation, and should continue to be delivered for people after an episode of self-harm or suicidal distress. Future commissioning could consider the following recommendations
2. Consideration needs to be given to finding the most suitable format and structure for the next phase of the intervention, as best fitting the needs of the service in the Trust as a whole.
3. The focus of the next phase of the intervention should be its sustainability and embedding within the service.
4. These considerations could include and emphasise the importance of retaining the reflective practice, meaning holistic focus on the individual, and team support aspects of the pilot project, and retaining the connections that have been built up with the social care and charitable sector as well as mental health organisations.
5. Consideration could be given to improving referral rates into this project, and ensuring full cooperation in the intervention of all clinical teams in all the hospital settings
6. Evaluation of the next phase of the project can be considered, particularly if this can be designed to include assessing longer-term effects in terms of reducing repeated self-harm and suicide, and the various trajectories involved in care plans, within and outside SPFT
7. Consideration could be given to the task of improving meaningful service user feedback in Liaison Psychiatry in order to improve and enhance ways of monitoring and facilitating audit
8. The benefits of the intervention could be shared nationally, including with policy makers and NICE as an example of good practice for people who presenting at A&E after an episode of self-harm or in suicidal distress.

2. Aims and objectives of the evaluation

The evaluation aims to assess the impacts and effectiveness of an innovative intervention, as a pilot project over 12 months for people attending A&E after an episode of self-harm (including suicide attempts) and in suicidal distress (including suicidal ideation). The intervention consists of a follow-up compassionate phone call, within 3 days of the psychosocial assessment, to support the person's engagement with their care plan. The rationale for the project is that the immediate period after an initial assessment has been identified as a critical time, and engaging people in services is a key strategy to reduce risks, and thus to prevent repeated self-harm (including suicide attempts) and prevent suicide. The objectives for the project were:

- To improve upon the quality of interventions for people presenting following an episode of self-harm/distress
- Reduce A&E admissions
- Reduce and prevent further acts of self-harm
- Reduce the risk of completed suicide in patients who self-harm

The evaluation aimed to apply both process and outcome evaluation methods to assess how, and to what extent, the project met its objectives, in order to make recommendations about future provision.

3. Background and contexts

3.1. National contexts

Preventing suicide is a social and health policy priority worldwide; studies show that most suicides are preventable (WHO 2014). The National Suicide Prevention Strategy (NSPS), *Preventing suicide in England: A cross-government outcomes strategy to save lives* (HMG/DH 2012) provides an overarching strategic approach with the intention of achieving a reduction in the suicide rate in the general population in England. It focuses on:

- reducing the risk of suicide in high-risk groups
- improving mental health in specific groups
- reducing access to the means of suicide
- providing better information and support to those bereaved or affected by suicide.

The fifth progress report of the strategy (DHSC 2021), in March 2021, identified developments, and addresses the impacts of Covid-19. Increases in suicide recorded in 2018 and 2019 did not continue into 2020, including through lockdowns, and there is uncertainty about how the pandemic will continue to impact on suicide rates in the recovery period. In 2019 the suicide rate was 10.8 deaths per 100,000 population; for males the rate was 16.7 per 100,000 and for females it was 5.2 per 100,000. The fifth Progress Report evidences the continuing concern about suicide amongst young people and that the highest rates of suicide are for males between 45 and 49 years. The by now long-established link between an episode of self-harm and suicide completion shows that around 50% of people who die by suicide have previously self-harmed. Here, the term self-harm is used in the way defined by the National Institute for Clinical Excellence

(NICE) to include any method, regardless of intention, and thus to include suicide attempts. Of particular importance for this project is the evidence that the risk of suicide is particularly heightened in the first month after an episode of self-harm. For those people who have been admitted to inpatient care, the highest risks are in the first week after leaving inpatient care, with the highest frequency on the third day after discharge, before their first follow-up appointment (HQIP 2021). These findings apply to people who have been inpatients, rather than those who presented at A&E but were not admitted.

Evidence from recent studies also shows that suicidal ideation increases risks for subsequent suicidal completion (Hubers et al 2018) and NICE recognise the importance of attending to and talking about suicidal thoughts (NICE NG105). Around 200,000 hospital attendances for self-harm are estimated each year in England, though most episodes of self-harm are not presented at A&E, but remain in the community. These figures do not include those presenting at hospital in distress or in crisis with suicidal ideation.

NICE guidance for attendances at A&E after an episode of self-harm (CG16 2004; CG133 2011) emphasise the importance of providing a comprehensive psychosocial assessment, in collaboration with the patient, and initiating a therapeutic relationship. The NICE Quality Standard (QS34 2013) adds that collaborative risk management plans and monitoring should be in place, that access to psychological interventions is available, and that transition plans are available when a patient moves between services. Crucial to all interventions is that people are treated with compassion, respect and dignity, and there is evidence in the literature, synthesised by NICE CG133, that this has not always been achieved. A recent systematic review of patients' experiences following self-harm (MacDonald et al 2020) notes the variability of experiences of care and concludes that compassionate care is particularly important in reducing the risks of future self-harm. Secondly, and of equal importance to these authors, is the finding of this systematic review that experiences of care at the points of admission and discharge can be disorientating and require 'navigation'. These findings are clearly highly relevant to this project.

3.2 Local contexts

Sussex Partnership NHS Foundation Trust (SPPFT) is a large provider with 7 A&E departments across the county in Brighton, Eastbourne, Worthing, Hastings, Haywards Heath, Crawley, and Chichester, receiving between 50,000 and 65,000 attendances each month. During the winter months of 2020 between 850 and 1031 of these presentations each month were related to self-harm and suicidal distress. A&E self-harm and suicidal distress presentations are assessed through liaison psychiatry teams in each hospital, and the clinical standard is to provide for each presentation a psychosocial assessment, an assessment of risks and an individualised care plan. Clinical outcomes - care and safety plans - for these presentations include inpatient admissions, referral to specialist mental

health services in Crisis and Home Treatment Teams, referrals to Urgent Care Lounges, to GPs and to other NHS and non-NHS partner organisations.

It has been recognised for some time that suicide rates in the county are higher than the national average, increased by factors such as Beachy Head and the wide range of urban and rural population in the county. A series of innovative interventions have addressed training for staff and community working with suicidal people, providing psychological therapies and counselling, and support for those bereaved by suicide.

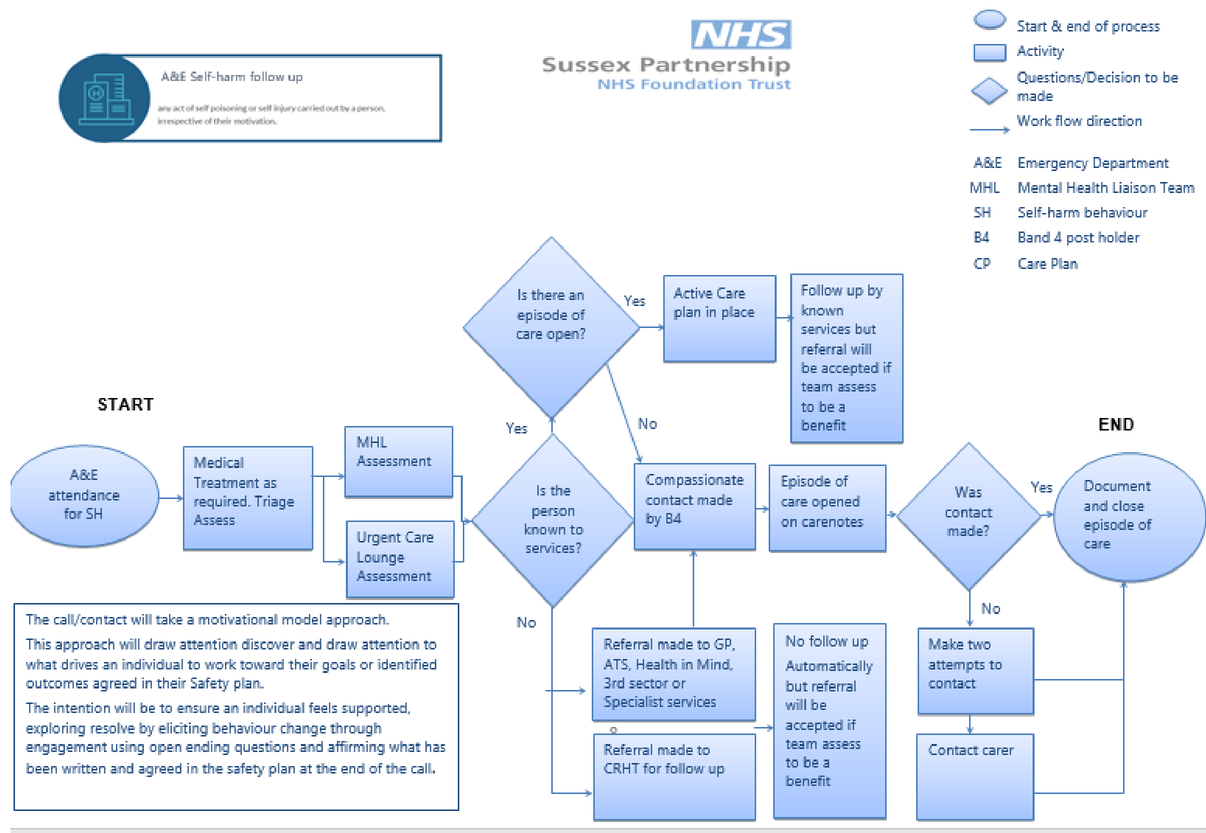
SPFT is committed to suicide prevention, a programme of continual quality improvement for staff, and a strategic objective of Towards Zero Suicide (SPFT 2020), launched in 2018, aligned with the Sussex STP Suicide Prevention Working Group. The strategy includes 10 ways to improve safety, including linking with partner organisations, training for staff in working with suicidal people, safer wards, early 3-day follow-up on discharge. A suicide prevention lead was appointed to coordinate the strategy.

3.3 The compassionate call project

The project was conceived as a contribution towards reducing suicide and repeated self-harm through providing a follow-up compassionate phone call, within 3 days of the psychosocial assessment, to support the person's engagement with their care plan. Three appointments were made of Mental Health Support Workers (MHSW), working together as a team (working remotely in the pandemic conditions) and supervised by the Deputy Director Adult Services and the Towards Zero Suicide Programme Lead. Each MHSW related initially to one of the A&E Departments in Brighton, Eastbourne and Worthing. To these other A&Es were subsequently added in Hastings, Haywards Heath, Crawley and Chichester. The MHSWs worked with the Liaison Psychiatry teams in each hospital to generate relevant referrals to whom a compassionate call was made within 72 hours of the referral.

The calls were designed to be relevant for people presenting at A&E after an episode of self-harm or with suicidal ideation, and who were not admitted to inpatient care. People who already had an ongoing, active engagement, or care plan, with a SPFT team were also excluded from the compassionate call project; they would continue with the care unless the treating service thought a call could be helpful. The pathway to receiving a compassionate call within the services was illustrated by a flow chart designed by the Project Lead (figure 1)

Figure 1: Flowchart showing pathways to receiving a compassionate call



The project thus aimed to provide an early one-off follow-up for people after an A&E presentation, to ascertain and clarify their engagement with the care plan formed through the psychosocial assessment during the A&E presentation. The method to be applied for the compassionate call was described as the motivational model approach involving active focus on working to the goal of recognising and agreeing the care/safety plan (see box in Figure 1). Clarifying and agreeing the care plan was expected to improve the person's engagement with services, and thus to contribute to reduction of self-harm, repeated self-harm and re-presentation to A&E.

4.Evaluation methods

The evaluation methodology and methods are based on experiences of evaluating services, projects and innovations, including a number of evaluations relating to self-harm and suicide. In essence, the evaluation methodology combines quantitative and qualitative methods to generate both overview and in-depth or 'practice-near' evidence.

The evaluation was undertaken between October 2020 and October 2021. The approach taken was to assess processes and outcomes, through robustly and sensitively capturing the available evidence, and using this to reach informed findings and recommendations for future development. For this project a working group was formed consisting of the Associate Director and QI Lead, Suicide Prevention Project Manager and the external evaluator, which facilitated access to staff and data regular monitoring of progress.

4.1 Data collection and analysis

The primary source of data for the project was routinely gathered information about all referrals for a compassionate call. A table was developed for completion by the MHSWs for each referral. It captured:

- Referrals: source, date, gender and age of patient, presentation (self-harm method; suicidal ideation) outcome of psychosocial assessment (hospital admission; physical treatment; psychological treatment; none); mental health diagnosis or issues.
- Calls: timing (when within 72 hours); outcome, stated as risks, (emergency; immediate risk of harm; serious concerns; possible risks; none); outcome stated as action taken (emergency; referred immediately; liaison with A&E assessing teams; encouraged to follow care plan; following care plan); signposting to services

This data was analysed numerically, and monthly summaries were produced, to identify numbers of referrals, by hospital, age and gender; calls made including percentage of referrals contacted, and the timing of contact (within the 72 hours target); reason for referrals; outcomes, as actions taken. The number of repeat referrals was recorded, i.e. a referral following the person presenting again at A&E, with these first appearing from March 2021. It was explored whether data from A&E might be accessed to facilitate comparisons with the data generated by the MHSWs, but this was not possible. Some A&E data was accessed to provide information about repeated presentations and to assess whether follow-up appointments were kept after the call.

These routine data were supplemented by interviews with MHSWs and clinical staff in Liaison Psychiatry teams. Interviews were conducted remotely using video calls. A sample of these was audio-recorded, and notes were taken during the interviews. Interviews were analysed using qualitative reflexive thematic analysis (Braun and Clarke 2019).

Interviews with the MHSWs were quarterly (in December 2020, February/March 2021, July 2021 and October 2021). These semi-structured interviews invited the MHSWs to discuss their experiences, including regarding referrals and calls, and experiences with the referring teams. The MHSWs were invited to provide illustrative examples and to discuss any unusual (positive and negative) experiences.

Interviews with liaison psychiatry managers and staff: interviews were conducted with clinical staff based in different locations (Eastbourne, Brighton and Worthing). The interviews asked for views of the project, aspects that were working well and those which were or are problematic, with illustrative examples. Additionally, interviews were conducted with the project managers, and with the Expert by Experience lead.

Data was collected relating to service user feedback. The initial intention was to ask service users to complete a service satisfaction survey but this proved impractical, primarily through the brevity of contact with the MHSW. It was also aimed to introduce an online service satisfaction survey, but again this was not possible, partly because the technology required information about the service user (mobile phone or email) which was not necessarily available). It was also explored if A&E or Liaison Psychiatry service feedback could be used, but this was also not available. From around the midpoint of the project, MHSWs asked 3 questions at the end of the compassionate call, if this seemed practical and appropriate:

- How supportive have you found the caller?
- How useful was it to go through the safety plan?
- Would you recommend the service?

Additionally, an email survey produced 6 responses to the three questions. The service user feedback produced a number of *ad hoc* comments, which were analysed by content analysis, and simple counting.

5. Findings

The findings are discussed in the following headings:

- Setting up: making the project operational and establishing working links with clinical teams
- MHSWs experiences of making the compassionate calls.
- Outcomes

5.1 Setting up

Setting up the project was accomplished efficiently, so that by the end of November 2020 the project was operational. This phase included successfully developing role descriptions for the three MHSWs, their appointments, induction and training. Highly competent staff were appointed to all three roles, and the team - working remotely - established working practices. These include daily support within the team – a daily 'huddle' - and regular, weekly supervision with the project lead.

5.2 Establishing working links with clinical teams

Senior staff/managers undertook effective preparatory work with clinical teams, and the three MHSWs displayed very facilitating skills in establishing working relationships with the clinical teams across Sussex. In discussing this phase, the MHSWs said they were *'doing promotional work*", undertaking a *"trust building mission with the teams"* and *"selling the service"*. Some teams raised questions about the project. One suggested it was duplicating responsibilities for risk assessment, whilst another team questioned whether the project would increase their workload. Another view was that the compassionate call might *"open up old wounds".* The MHSWs thought these resistances stemmed from the fact that *"teams don't like change"* and they experienced – overall - good levels of cooperation from early on in the project.

Clinical teams understood they would refer all patients meeting the criteria, though the rates of referrals varied between hospitals; some were quicker and more comprehensive in making referrals. From the perspective of the teams in the hospitals, it was frequently expressed that the qualities of the three MHSWs made a significant difference in establishing the process of referrals. They were experienced as helpful, skilled and available, attending and contributing to team meetings. Managers thought that the staff made use of the project more once they found it relevant and helpful; it contributed to the work of the team as *"a good resource",* and "*in a lively way*". MHSWs commented that when they noticed a new name of a clinician on a referral, this indicated widening of the recognition of the project's presence and task. MHSWs also commented that the clinical teams "*really appreciate your input*". The clinical team's manager's role was important in facilitating the referral process to the project; fewer referrals have been received to date from some hospitals, where there was a less engaged response (see 5.4.1 below). Managers and staff in the clinical teams also had to ascertain which referrals were

relevant, that is, meeting the criteria of A&E presentation and outcome; those admitted or having an existing service were not expected to receive a compassionate call. Relevance continued to be an issue throughout the project; a recent question has been raised about when to make the compassionate call to older adults whose discharge from hospital plans are unclear.

5.3 Mental Health Support Workers experiences of making the compassionate calls

Referrals for compassionate calls began to be made in December 2020. Initially, the project included referrals from three A&E Departments: Royal Sussex County Hospital (Brighton); Eastbourne District General Hospital; Worthing Hospital. In January 2021 further hospitals were added: Conquest Hospital, Hastings; Princess Royal Hospital, Haywards Heath; Crawley Hospital; St Richards, Chichester.

The MHSWs developed a method for the call that focused on the primary task of assessing whether the recipient of the call had a clear sense of the care plan that was provided in the psychosocial assessment during their A&E presentation. The timing of the call, within the 72 hour 'window' was important, and the MHSWs aimed to ensure they left some time to call again if the initial call was not answered. Though the clinical teams talked with the patients about a follow up call at the time of the A&E presentation, these calls are effectively blind, and the MHSWs are very skilled in responding sensitively to the service user's response; this necessitated judging how the person was feeling at the time. For example, one of the Support Workers spoke about one male service user who had been *"overwhelmed with calls from so many services, he has had so many calls"*. For most, however, this was their first call after the A&E presentation, and the experience was that most service users were pleased to hear from someone regarding their A&E presentation. The call gave service users the opportunity to reflect on the experience of attending A&E, to feel noticed, and to gather a sense of perspective, after what can often be an intense experience. The MHSWs found that either the service user was aware of their care plan, and it was helpful to talk over how to access help in a crisis, or, on the other hand, there was a sense of disorientation and confusion after the A&E presentation, for example "*some have lost their care plan before the call*". Others have *"forgotten the name of the [worker or service]* with whom they would be in contact. The call provided the opportunity to clarify and go through the plan on the phone. Encouragement to follow the care plan could involve helping the service user feel more optimistic and overcome doubts: in one example, the service user *"feels let down by services and feels nothing will change, I had to help them feel more hopeful".* Other service users said "things haven't changed", and they are "feeling low", but the MHSWs thought that talking through the care plan and listening *"puts them in a better state of mind".*

Understandably, there can be a sense of uncertainty about what the call will reveal, and the MHSWs have a complex task of engagement, and decisions to make within the call. The MHSWs described how difficult it could feel not having further contact after the call, and not being sure what would happen next, whether they would keep their next

appointment, or how the service users would respond to their distress and difficulties; they felt they could encourage, and then it was "*over to the services in the care plan*". It was not a "*quick fix*", and they were aware of the complexities of the kind of relatedness that can lead to self-harm and suicidal feelings. Serious incidents, repeated self-harm and suicide are always possibilities in the future.

New information could emerge during the call: for example, one MHSW recalled how she *"asked one more question*" rather than ending one call, and this led to her hearing some new information about the person's circumstances, information that had not been shared at the A&E presentation. The support worker was able then to signpost and to inform the relevant service. The complexities of the service users' psychosocial circumstances came centrally into the calls, including, for example, raising questions about safeguarding matters, including domestic abuse. Social vulnerabilities were also evident, and the MHSWs were alert to these, including homelessness. Thus the role of signposting became an important part of the compassionate call, including online resources and websites, and a range of the local charitable organisations. The MHSWs became extremely knowledgeable about and linked in with local resources, in health and social care and the charitable sector.

Whilst the MHSWs said that most calls are '*straightforward*', in the sense that clarifications about the care plan are usually sufficient, there were some calls where the adequacy of the plan is brought into question. In these cases, the MHSW's felt able to escalate, to refer back to the clinical team or to contact other services. One example was a service user taking double the prescribed medication (anti-depressants); this service user did not feel able to talk to his GP about this but was agreeable that the MHSW informed the GP on their behalf. The MHSWs said that they always reviewed the risks in the call, checking the current presentation against the care plan. In most cases the sense they gained from this was that the care plan was appropriate, and in some instances the person's situation seemed to have improved since the A&E presentation. In a small number of cases concerns were increased, and the compassionate call led to the MHSW informing the clinical team. In rare cases the MHSW intervened in a current crisis, identifying immediate risks of harm, for example, supporting a service user who was on the point of self-harm to go to A&E. One case involved this intervention when the MHSW learned the service user had taken an overdose (these interventions are further discussed below, section 5.4.3). The compassionate calls therefore present a complex situation to assess. The MHSWs had to be alert to possible risks, to receiving new information, and finding appropriate ways of responding to these. The MHSWs individually and as a team demonstrated high levels of skills in engaging the service users, and in assessing and responding. The structure of the team working together and the supervision framework provided a setting in which this work could be undertaken well and safely. All the MHSWs referred to the demands of this work, the need to have time to extend a call if necessary and if the person needed more time to talk, and the need to process the call, and take actions agreed during the call. Overall, as they reflected on the project, the MHSWs felt

"proud of what we have achieved". Service users expressed appreciation for the call, and they also *"express a lot of gratitude to clinical teams"*.

5.4 Outcomes:

Evaluating outcomes of the project involve addressing four areas:

1. the levels of success in engaging teams and service users to receive referrals
2. characteristics of people referred
3. the levels of success in making calls
4. the impact on engagement with services

5.4.1 Referrals

The number of referrals made by clinical teams for a compassionate call increased month by month between December 2020 and June 2021. In December 2020 there were 43 referrals, and in June 2021 there were 145. The referrals then fluctuated between 114 in July 2021, 141 in August 2021 and 132 in September 2021. In total 992 referrals were made for compassionate calls in these 10 months, so an average of 99.2 per month (see Table 1).

Table 1: Number of referrals for a compassionate call by month

Total number of referrals										
Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	**Sept**	**Total**
43	58	68	92	98	101	145	114	141	**132**	**992**

From June 2021, the criteria for referral were extended to include low mood and anxiety, and 'other'. This was explained as occurring through the number of referrals being lower than was anticipated before the project began, and it was upon these anticipated figures of 7-10 referrals per day that three MHSWs were recruited. There were some referrals in these categories (76 in all), therefore the total number of referrals between December 2020 and September 2021 following a presentation of self-harm or suicidal ideation was 916.

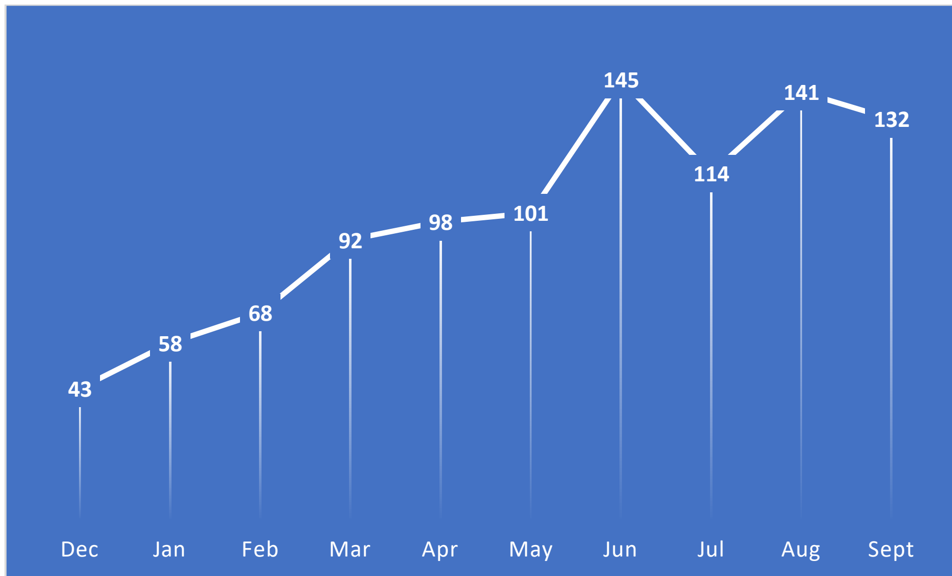
Referrals from the 7 hospitals ranged from a maximum of 46 in one month (Conquest Hospital, Hastings, September 2021) to 0 (St Richards' Hospital, Chichester, March 2021). The average number of referrals per hospital per month was 15.03. Three hospitals (Royal Sussex, Brighton; Eastbourne District General; Conquest Hospital, Hastings). St Richard's Hospital Chichester provided very few referrals (22 over 9 months, average 2.44 per month), which was explained by project leads and MHSWs as a consequence of managers within the hospital not engaging with the project (Table 2).

Table 2: Referrals from each hospital by month

Hospital	Number of referrals										
	Dec	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	Sept	**Total**
Royal Sussex County Hospital - Brighton	9	15	14	17	28	23	31	31	23	13	**204**
Eastbourne District General Hospital - Eastbourne	16	12	20	25	16	14	34	18	23	23	**201**
Worthing Hospital - Worthing	18	12	14	11	9	15	12	14	29	15	**149**
Conquest Hospital - Hastings		14	9	18	26	28	33	17	33	46	**224**
Princess Royal Hospital - Haywards Heath		0	3	12	10	4	12	15	14	11	**81**
Crawley Hospital - Crawley		3	8	7	8	15	17	16	16	21	**111**
St Richards - Chichester		2	0	2	1	2	6	3	3	3	**22**
Total	**43**	**58**	**68**	**92**	**98**	**101**	**145**	**114**	**141**	**132**	**992**

The raw referral figures illustrate trends rather than explaining levels of referrals, as the number of relevant cases was determined by whether the cases met the criteria of not requiring inpatient care, and not having a currently active, known service (see Figure 1, section 3.3 above). Liaison psychiatry managers have indicated referral to the project is also made on judgement by the clinical teams, which can be affected by attitudes to the project, and these developed and changed over time. Ensuring referrals were made was enhanced by MHSWs access to A&E data, from which they were able to screen presentations and notified teams if they identified potential suitable referrals. However, the variability of referrals across hospitals, and the evidence from St Richard's Chichester, indicate the service did not reach full capacity. Increasing numbers of referrals indicate, on the other hand, that there was a gradual but sustained increase in then take up of the service, which seemed to have begun to plateau by June 2021 (Figure 2).

Figure 2: Referrals by month, all hospitals



5.4.2 Characteristics of referrals

The referrals consisted of cases that followed an episode of self-harm and suicidal ideation. Of the 916 referrals in these categories, 510 (55%) were for self-harm and 45% were for suicidal ideation. As described above (section 5.41), referrals for low mood, anxiety, and 'other' were included from April 2021, and this accounted for 76 (7.6%) of the total referrals. The self-harm[1] referrals were categories by method, showing that the majority were for self-poisoning, 362/510 (71%). Self-injury accounted for 18% (94/510) and a smaller number were for hanging/asphyxiation (19/510; 3.7%) (see Table 3). The low numbers for methods of jumping and for firearm, as well as the low numbers for hanging/asphyxiation reflect the likely more serious injuries and clinical responses, including inpatient admission. The prevalence of self-poisoning and self-injury in these referrals similarly reflects likely immediate clinical responses.

[1] The NICE definition of self-harm was used (see section 3.1, above)

Table 3: Referrals by clinical presentation

Reason for referral	Number of referrals										
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Total
Self-harm: self-poisoning	17	18	29	31	43	35	46	42	47	54	**362**
Self-harm: self-injury (including self-cutting)	4	7	7	10	6	11	16	11	11	11	**94**
Self-harm: jumping from a building	0	0	0	0	1	0	0	0	2	0	**3**
Self-harm: jumping in front of moving object (vehicle)	0	0	0	0	1	1	0	1	1	0	**4**
Self-harm: hanging/asphyxiation	3	3	2	0	2	3	1	1	4	0	**19**
Self-harm: firearm	0	0	0	0	0	0	0	0	0	0	**0**
Self-harm: other	7	5	1	3	2	1	2	3	1	3	**28**
Suicidal ideation	12	25	29	48	42	33	62	48	61	46	**406**
Low mood					1	5	10	7	4	10	**37**
Anxiety					0	8	7	0	5	4	**24**
Other						4	1	1	5	4	**15**

A majority of people referred were in the 18-29 age group; 458/989 (46%), and a further 19.9% (197/989) were in the 29-39 age group. Numbers of referrals reduced with greater age (Table 4). The age groups were consistently represented in the referrals each month. This does reflect the concerns about young people and self-harm, but not the preponderance of middle aged men in current suicide statistics (DHSC 2021).

Table 4: Referrals by age group

Age	Number of referrals											
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Total	Mean
18-29	20	31	29	49	44	48	68	54	65	50	458	45.8
30-39	3	14	15	18	20	19	31	23	28	26	197	19.7
40-49	9	6	10	9	9	14	24	14	21	24	140	14
50-59	6	3	7	9	13	14	17	12	17	24	122	12.2
60-69	1	1	4	5	7	6	4	7	4	7	46	4.6
70-79	4	2	0	2	2	0	1	4	6	0	21	2.1
80-89	0	0	3	0	0	0	0	0	**0**	1	4	0.4
90-99	0	0	0	0	0	0	0	0	**0**	0	0	0
100-109	0	1	0	0	0	0	0	0	**0**	0	1	0.1
Total											989	
No data											3	

By gender, a majority of referrals were for females (55.9%), with 43.7% for males and 0.3% for non-binary/other specific. (Table 5).

Table 5 Referrals by gender

Gender	number	%
Female	555	**55.9**
Male	433	**43.7**
Other specific	3	**0.3**
Not known	0	**0**
Not specified	1	**0.1**
Total	992	**100**

5.4.3 The calls and their outcomes

As described above (section 5.3) the MHSWs were able to engage referred service users in compassionate calls that focused on clarifying and agreeing care plans, and the calls adapted to the circumstances of the service user; some were more complex than others. The MHSWs aimed to meet the timescales for the project, of a call within 72 hours. Overall, the MHSWs made calls to 866/992 people (87.2%) during the 10 months from December 2020 to September 2021, an average of 86.6 calls per month. Thus each MHSW, on average made 29 calls per month (Table 6). Calls were made on average just within the 3 day limit (mean = 2.938 days), reflecting the often complicated process of making telephone contact, and finding a time the service user could speak for at least 20 minutes, the minimum length the MHSWs felt was helpful for the calls, which might, and could, last longer than this (Table 6).

Table 6: Calls made: % referrals contacted, and time from referral to call

	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Mean
% referrals with contact made	80	86	94	86	87	94	89	83	87	86	87.2
Average time from referral to call (days)	2.67	4.1	3	3	2	2.76	2.48	2.75	3.9	2.72	2.938

The outcomes of the calls were coded using a 5 point scale, A-E, from higher to lower risk; codes B and C were subdivided to account for different outcomes reflecting similar risk levels. The descriptors for the codes are shown in Table 7. By far the most used category was 'D', where the outcome of the call was clarification and agreement that the service user would continue with the safety/care plan as established by psychiatry liaison during the A&E presentation. The risk assessment at the end of a call resulting in a 'D' code was that good support was needed to reduce possible risks of harm. In total, 828/866 (95.6%) calls resulted in this outcome. Much more rarely, the outcome was an

'E' coding, which identified a simpler solution, that no further action was needed as the person was able to follow their care plan without needing further encouragement or clarification. This was recorded after 18/866 (2%) calls. For a similar number of cases (17/866; 1.96%), a 'C' code indicated that the MHSW identified serious concerns and took some form of action to alert the clinical teams, such as advising the service user to attend A&E, or liaising with ATS duty, or making a referral for an appointment with Haven/UCL. On 2 occasions, the MHSW advised immediate attendance at A&E. There was one instance of a case where the highest level of action was initiated, where the MHSW directly involved emergency services to attend to the immediate risk, when the service user had taken an overdose. This is described in section 5.3 above. Therefore, the overall picture of these outcomes is that the MHSWs operated mainly within the category of clarifying the care plan, encouraging the service user to follow through with the plan, identifying the next step. This does collapse the range of interventions needed to achieve this outcome, as discussed in section 5.3 above. The relative rarity of more serious risks implies that on the whole, people leave the Liaison Psychiatry assessment with a viable plan and manageable risks.

Table 7: Outcomes of compassionate calls

Outcome of referral	Number										
	Dec	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Total**
A - Emergency/ Immediate referral - Due to physical medical emergency or danger to self or others	0	0	0	0	0	0	1	0	0	0	**1**
B - To emergency services if no family/friend present	0	0	0	1	0	0	0	0	1	0	**2**
B - Advised to attend A&E for face to face assessment	0	0	0	0	0	0	0	0	0	0	**0**
C - Liaise with ATS duty	0	2	2	1	2	0	1	1	3	0	**12**
C - Face to face Haven/UCL	0	0	0	1	0	0	1	0	1	1	**4**
C - Advised to attend A&E for face to face assessment	0	0	0	0	0	1	0	0	0	0	**1**
C - Living Well/Crisis Café referral	0	0	0	0	0	0	0	0	0	0	**0**
D - Encouraged to follow safety plan as agreed by liaison	34	47	60	76	85	91	123	95	108	109	**828**
E - Following through their safety plan	0	1	2	1	0	3	3	0	5	3	**18**
Total											**867**

5.4.4. Impacts of the calls on engagement with care plans

The effectiveness of the compassionate calls in increasing engagement with care plans is a crucial aspect of this project; it is a key indicator of success and indicates how the compassionate calls may influence suicide and self-harm. However, as described in the method section above, there is limited data available to make this assessment. Not only are there no comparison groups, but also the care plans themselves are varied and involve a range of possibilities, including SPFT services and teams, primary care, charitable organisations, to suggesting ways of improving wellbeing, including self-help and physical activities. Three ways have been identified to generate some initial findings; attendance at next appointment; re-presentation at A&E leading to re-referral for a compassionate call; and service user feedback.

Attendance at next appointment: One indication of the impact of the calls on engagement with care plans was possible through assessing a subsample of cases that were open to services, and therefore appointment records were available on clinical records (Carenotes). Taking referrals for 5 of the months during the period December to June (no data for January and April were included) and tracking which of these were open to SPFT services, it was found that 125/450 (27.8%) were open to services. 95 (76%) of these attended the next appointment after the compassionate call, 15 (12%) did not attend and attendance could not be verified for 15 (12%) (Table 8). Without available comparisons, over time and with/without a compassionate call, the finding has to be treated tentatively, but it does suggest that a large majority of referrals, in the group open to services, do go from the call to their next appointment. It does therefore suggest that the MHSWs have some success in clarifying and encouraging engagement with the care plan.

Table 8: Referrals open to services attending next appointment after receiving a compassionate call

Month	Referrals	Attended next appt.	Did not attend	Attendance not known
Dec	15	13	1	1
Feb	10	10	0	0
Mar	32	20	7	5
May	29	18	4	7
June	39	34	3	2
Total	**125**	**95**	**15**	**15**
%	**100**	**76**	**12**	**12**

Repeat referrals: A second avenue towards evidencing the effectiveness of the compassionate call is to examine representations at A&E. This is inherently ambiguous, as attendance at A&E indicates engagement. It is, on the other hand, an often used measure for assessing reduction of self-harm episodes. During the project, to date, between March and September, 11 referrals have been identified as being repeat referrals for a compassionate call, indicating they have represented at A&E (Table 9). All

of these received a second compassionate call. The increase in numbers since June 2021 may be indicating this could become a more prevalent feature as the project continues.

Table 9: Repeat referrals for a compassionate call

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept
0	0	0	2	2	1	5	8	7	**11**

Service User feedback: A further route to understanding the impact of the compassionate calls is through service user feedback. As discussed above (section 4) data collection has also proved problematic, and the evidence relies on *ad hoc* comments provided by some service users. Many comments (20) expressed gratitude and appreciation for the follow up call. Some (5) specified that the call had been helpful in going through the safety plan (2), the call left them feeling better after talking (2), that they felt more likely to contact services after the call (1), and that that signposting was helpful (6). Comments about the care in A&E and Liaison were more mixed. A good number (17) commented on these being helpful, with some specifically commenting on positive experiences with staff. Others (7) commented on negative experiences in A&E and/or Liaison, including finding it distressing and not being treated with respect. The email survey produced only 6 responses, which identified the call as useful and the caller as supportive. Although there is not much available data, the trends within it suggest that service users felt the call was useful and helpful in ways that were intended.

6 Discussion of findings

The findings will be discussed by evaluating to what extent the compassionate call pilot project met its aims and objectives (section 2, above). Through providing a compassionate call, the project aimed

- To improve upon the quality of interventions for people presenting following an episode of self-harm/distress
- Reduce A&E admissions
- Reduce and prevent further acts of self-harm
- Reduce the risk of completed suicide in patients who self-harm

These initial aims and objectives became more specific during the project, and the emphasis was placed on the first bulleted point above, the aim of improving the quality of interventions for people presenting with self-harm and suicidal ideation. The compassionate call had the immediate objective of clarifying and supporting the person to follow the care plan, with an emphasis on sustaining their engagement with services. To meet these objectives the task was to introduce a new service within SPFT, and for this to effectively take referrals and provide compassionate calls. This evaluation has focused on this primary task of the project, evidences how the service was set up and delivered, and how it was experienced by those within the service and linked with it. The discussion of findings will therefore focus on, firstly, the how the outcomes evidence the objective of improving the quality of care for people after an A&E presentation for self-harm or suicidal ideation, and, secondly, on how the intervention may contribute to the

reduction of repeated self-harm and suicide.

<u>The intervention:</u> The compassionate call project was delivered through the establishment of a team of three MHSWs, who worked closely as a team with clear support and supervision structures. The MHSWs made good connections with, and their contributions were highly valued by the clinical teams. There were some initial resistances to the project from within the team, and whilst these were mainly overcome, there remained some variability of referrals across the 7 hospitals. The actual rates of referrals were lower than was anticipated; this was due to several factors. Partly the actual referral are explained by the criteria for a compassionate call, which excluded the more severe cases requiring inpatient care, and those who had a current open service, but it also reflects not all potential cases being referred. The MHSWs were not therefore working at full capacity, though the time and emotional labour involved in this work may have been underestimated.

The MHSWs were successful in making calls to a very high proportion of the referrals. Through the experiences of the calls, the MHSWs worked out ways, using their diverse skills and experiences to focus on clarifying the service users understanding of their care plans, and supporting and encouraging them to follow-up with their next appointments. Making the calls involved working with a considerable sense of uncertainty; though in most cases a conversation about the care plan, clarifying what this meant and encouraging follow up was the outcome of the calls, to reach this point required engaging with feelings of disorientation and distress. Whilst the MHSWs felt that most people were perhaps improved from the time of their A&E presentation, some continued to be in distress, and a few required intervention to prevent harm. The calls therefore required assessments of risks and openness to hearing new information about difficulties. The MHSWs were in this sense able to continue the process of assessment and responding with appropriate signposting and direct interventions, including contacting services. The strong team working ethos and structured supervision in place is essential for work of this kind; the MHSWs work was well supported by senior managers. The calls demonstrate that people who present at A&E after an episode of self-harm or with suicidal ideation contend with complex psychosocial predicaments, requiring attention to social and mental health needs. MHSWs were able to identify ways in which support could be signposted, for example with safeguarding issues, such as situations of domestic abuse, and social needs such as homelessness.

It appears that for a sample of the people called, those open to services in SPFT, the next appointment was kept by three quarters of those called. Both the MHSWs and the small sample of service users who commented, felt the service was highly appreciated and there are some indications that the calls did help to clarify and orient service users to the care plan, and to provide them with an experience of emotionally processing the experience of presenting at A&E. The intervention was highly successful, therefore, according to several key criteria.

Does the intervention contribute to reducing suicide and repeated self-harm?

This evaluation is limited by the absence of direct evidence as to whether the compassionate call has an impact on reducing suicide and repeated self-harm. There is limited data about what happened after the call for most recipients, especially as many of the people called did not continue to access SPFT services, but were helped by a wide range of organisations and interventions, including online. There is also limited service user feedback; A&E and Liaison Psychiatry also informed the evaluator of the limits to the quality of feedback that was available. This is a broader issue; MacDonald et al's (2020) recent systematic review of patients' experiences comments that: "progress is required to capture this patient experience and translate it into the direct improvement of treatment. Previous recommendations have included the development of standardized service user interview schedules that can be used for routine auditing purposes" (p. 481). The question of monitoring and reviewing the quality of self-harming and suicidal patients experiences across A&E and Liaison maybe an area for development.

In this evaluation the focus was placed on the patient's experience of care. Though the feedback from service users is limited it does indicate the importance, for them, of the experience of being heard, recognised and respected. This demonstrates that the patients are engaged and emotionally affected by their interactions with professionals. As described above (section 3.1), there has been growing awareness of the importance of patient experience, and of reducing negative experience, since the NICE self-harm longer term management guideline CG133 (2011) highlighted service-users' experiences. The NICE quality standard QS34 (2013) itemises that people should be treated with compassion, respect and dignity. MacDonald et al (2020) show that what they call 'gentle' treatment, may encourage help-seeking, disclosure and reduce the risk of recurrent self-harm. The compassionate call project provided examples of how the call could lead to new disclosures of predicaments the service users experienced, and thus elicit plans for seeking help for these. The calls recognised the emotional experiences of the A&E presentation after self-harm or in suicidal distress and provided continuity and reduced the sense of abruptness and disorientation. Therefore, it is likely that the calls contributed to reducing repeated self-harm through promoting continuity and the communication of the sense of compassionate recognition of emotional experiences. Thus the compassionate call project can be thought of as providing an improvement in patient experience and meeting the project's aim of improving the quality of interventions for people presenting at A&E after an episode of self-harm or in suicidal distress.

Future developments. There is clearly sufficient encouraging evidence from this evaluation to continue to have a compassionate call for people presenting at A&E after an episode of self-harm or in suicidal distress, and to extend this - as has begun to happen – for other presentations. The aims of the compassionate call for other presentations need to be articulated to differentiate from the specific objectives of the call for cases where

the overarching aim is the reduction of suicide. Senior management have considered different options for future provision, and these have advantages and disadvantages. One option, as was initially envisaged, is to structure the calls within Liaison Psychiatry teams, with the advantage of integrating the call as part of the process of the psychosocial assessment. On the other hand, the risk may be that the call could become diluted as workload pressures influence priorities. The reflective space needed for making reflecting and following up on the calls is to an extent counter cultural. The second option of retaining a separate, discrete team with the task of making these calls would retain the team ethos, but leave the work separate from the mainstream. As has been discussed above (section 5.4.1) the team may be under capacity if sufficient referrals are not forthcoming, and dependent upon the quality of relationships with the clinical teams. It may be that a further period of piloting could be used to further explore these options, or developing a hybrid format.

Recommendations

1. The compassionate call intervention is a successful innovation, and should continue to be delivered for people after an episode of self-harm or suicidal distress. Future commissioning could consider the following recommendations
2. Consideration needs to be given to finding the most suitable format and structure for the next phase of the intervention, as best fitting the needs of the service in the Trust as a whole.
3. The focus of the next phase of the intervention should be its sustainability and embedding within the service.
4. These considerations could include and emphasise the importance of retaining the reflective practice, meaning holistic focus on the individual, and team support aspects of the pilot project, and retaining the connections that have been built up with the social care and charitable sector as well as mental health organisations.
5. Consideration could be given to improving referral rates into this project, and ensuring full cooperation in the intervention of all clinical teams in all the hospital settings
6. Evaluation of the next phase of the project can be considered, particularly if this can be designed to include assessing longer-term effects in terms of reducing repeated self-harm and suicide, and the various trajectories involved in care plans, within and outside SPFT
7. Consideration could be given to the task of improving meaningful service user feedback in Liaison Psychiatry in order to improve and enhance ways of monitoring and facilitating audit
8. The benefits of the intervention could be shared nationally, including with policy makers and NICE as an example of good practice for people who presenting at A&E after an episode of self-harm or in suicidal distress.

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