

Services & Trusts Integrating To improve Care in self-Harm

STITCH

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Bristol
Avon and Wiltshire Mental Health Partnership NHS Trust
North Bristol NHS Trust
University Hospitals Bristol NHS Foundation Trust

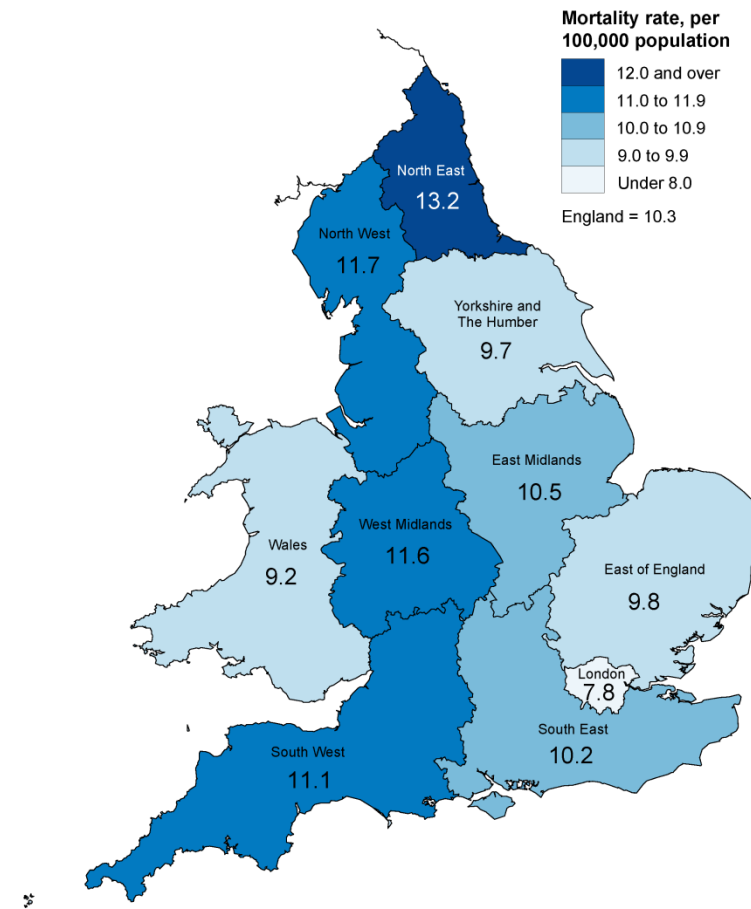


University of the
West of England



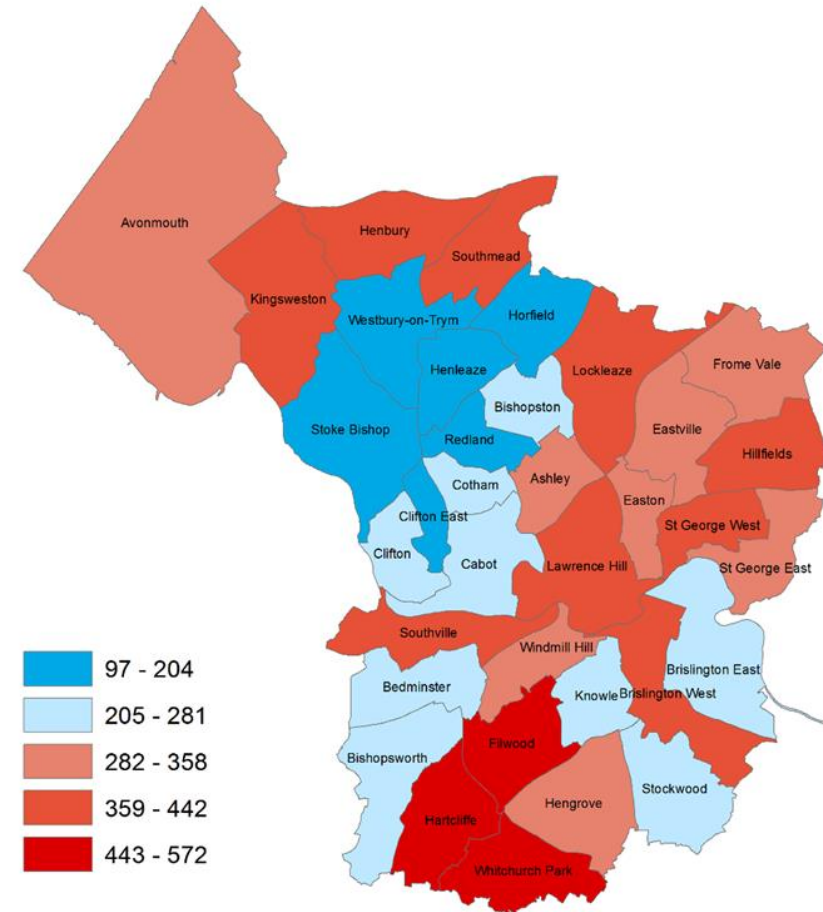
Background

- 4880 suicides in England in 2014 – half are in contact with health services in the month before death
- Approx. 200,000 hospital attendances every year for suicide attempt / self-harm
- Previous suicide attempt / self harm is the strongest risk factor for suicide
- 15-20% suicides treated in A&E in the year before their death
- Suicide attempt / self-harm care is a key opportunity for suicide prevention
- Butthere are huge variations in practice, underfunding of services, evidence gaps and slow uptake of research findings



In Bristol

- 20,000 young people self harming (ALSPAC)
- Suicide rate higher than national average:
12.8 vs 10.1/100,000
- middle aged men: 28.2/100,000
- In 2015 46 suicides:
1/3 in contact with psych service
40% saw their GP beforehand
60% previous self harm



Aims of

STITCH

Treatment and care is equitable across the health system, fully evidence based and non-stigmatising for all people who self harm and to reduce suicides in Bristol

- Monitor self harm in Bristol
- Improve service user engagement
- Provide a psychosocial assessment following self harm
- Reduce the 'the science to service' gap
- Reduce repetition, LOS, admission to hospital and suicide following self harm
- Improve self-harm training: ED, SWAS, GP
- Targeting improved pathways especially in deprived areas



How has STITCH impacted?



Spreading innovations nationally and internationally:

- Part of Government Strategy
- Prescription change raised in Parliament
- Solihull and South West Suicide Prevention
- Innovation to service:
- Translational research: BNSSG, Avon area, South West
- Teaching – GPs across BNSSG
- Teaching – SWAS Ambulance
- Internet research now part of assessment

National Suicide Prevention Alliance

CLINICAL

Establishing a self-harm surveillance register to improve care in a general hospital

Salena Williams

Self-harm is increasingly defined as self-poisoning or self-injury, irrespective of the apparent purpose of the act. (National Institute for Clinical Excellence, 2014)

The most common methods are self-cutting and self-poisoning, other methods include self-hypnosis, self-burning and a range of other behaviours. Self-harm is one of the most common reasons for presentation to hospital emergency departments (EDs), with an estimated one million attendances in England annually (Hawton et al., 2010). Hospital admission rates for the South West of England indicate that there was a 21% increase in admissions between 2002/3 and 2010/11 (Covk, 2012). The incidence of self-harm is higher in females than males, peaks at age 16-19 years and is relatively more among people aged over 65 (Hawton et al., 2010).

Self-harm is important, not only as it is a common cause for hospital admission, but also as a result of the strongest predictors of completed suicide. Up to 25% of patients presenting to general hospital following self-harm repeat in the next 12 months, and one percent more than that (Chen et al., 2010; Carroll et al., 2011), accounting for up to one in five of all suicides. Half of completed suicides have previously self-harmed at some point in their lives (Eaton et al., 2004). The Suicide Prevention Strategy for England (2011) states:

ABSTRACT

Self-harm is a common reason for admission to general hospitals, accounting for 200,000 admissions in the UK annually. To discover who these patients were, why they were attending and what was their care pathway we set up a self-harm surveillance register, which now collects data across two general hospitals and a children's hospital for a UK city. Here, we describe the method of setting up the register, and show what is collected and how it can be used to understand self-harm presentations to the general hospital and how it can be used to improve care. Key findings were that paracetamol was the most common medication used in overdose, and that 80% of patients had previously self-harmed. One of the important findings was that only 30% of patients were receiving a mental health assessment in the emergency department, despite the risk of repeat self-harm and rate of completed suicide being higher than the general population. This information led to funding for a seven-day psychiatric service.

Following self-harm are males, older individuals, those who have previously self-harmed, and those using high lethality methods, such as hanging or jumping in their self-harm episode.

This article describes the establishment and use of a self-harm surveillance register in a general hospital in South West England. The aim of the Self-Harm Surveillance Register was to provide timely information on the incidence, demographics and clinical characteristics of people who attend hospital after a self-harm episode, describe how they are managed and review patient outcomes in relation to the care they receive and changes to service provision.

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“The Self-Harm Study Day was one of the very best eye opening opportunities to learn I have had in my whole plastic surgery career”.

House of Commons
Health Committee

Suicide prevention: interim report

Fourth Report of Session 2016-17

Report, together with formal minutes relating to the report

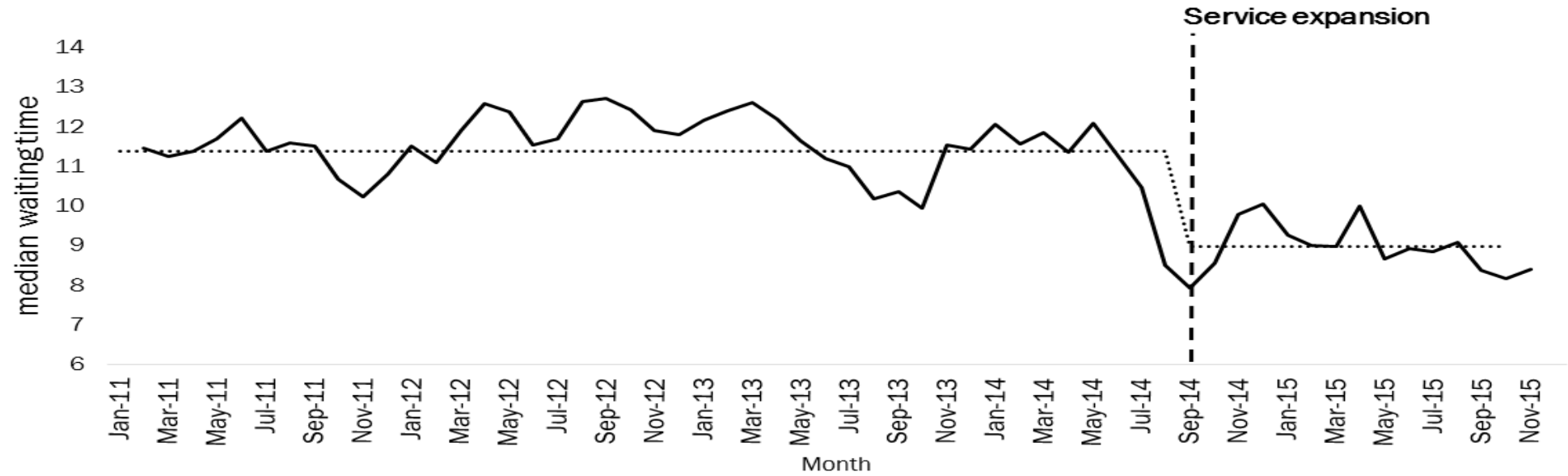
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We have improved self harm care and saved money:

- Reduced the mean cost of care per patient
- Significantly reduced self discharges 20%-13%
- Reduced wait time between medic to psych by 2 1/2 hrs
- Significantly increased psychosocial assessments: 57%-68%
- Reduced length of stay: 3.06 to 2.09 days
- Reduced ITU admission 2.5% to 0.5%
- Reduced total admission: 4.1 to 2.8
- Reduced cost of attendance: £1178 to £1001 (-15% per patient)
- Repeat self harm reduced by 27%

Psychosocial assessment wait time

Figure 6. Median time from medic to being seen by a mental health professional per month (3-month moving average with pre/post liaison psychiatry expansion average).



STITCH Research

- **Gunnell, Barnes - HOPE study: more care and help for people who have money worries (in progress)**
- **Benger, Gunnell – paracetamol in overdose**
- **Williams - Self Harm Surveillance Register: monitoring self harm and admission to hospital**
- **Opmeer (CLARHC) - Economic evaluation of Liaison Psychiatry**
- **Fox (CLARHC) – Involving patients in self harm research**
- **Carroll - Self injury (cutting) as a predictor of suicide**
- **Biddle Padamanathan – Internet use and self harm/suicide**
- **Gunnell – Psychosocial interventions following self harm and their efficacy**
- **Williams – LGBT and self harm (in progress)**

What you can do

- **Self Harm Surveillance Register funding at risk**
- Get involved: lobbying MPs, join in the research, steering group meets quarterly
- Public Health funding for PPI involvement in STITCH ending soon
- LGBT project
- DNW/self discharge project
- Hospital to GP pathway and supporting RMNs in GP surgeries
- GP generated Self Harm app