RESPONDING TO SELF-HARM

AN EVALUATION OF THE SELF-HARM INTERVENTION PROGRAMME (SHIP)

Full Report

NATIONAL OFFICE for SUICIDE PREVENTION

ncs
The National Counselling Service

HSE
Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

This report has been assured by Social Value UK. The report shows a good understanding of, and is consistent with, the Social Value process and principles. Assurance here does not include verification of stakeholder engagement, data and calculations.

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Foreword

"*Responding to Self Harm*" was commissioned by the *National Office for Suicide Prevention, Mental Health Division* and I am pleased to have the opportunity of writing the Foreword. The report is an account of a comprehensive evaluation of the SHIP counselling service which was undertaken by *Quality Matters Ltd*. The report highlights the SHIP counselling service as a good example of the high quality standards of practice in service delivery and underpinned by an evaluation and research framework which is required by "Connecting for Life". The SHIP counselling service was first established in Wexford in 2004 and then expanded across the rest of the south east in 2012. It is fully aligned with Action 4.2 of "Connecting for Life" on "improving access to effective therapeutic interventions" and also fully aligned with Action 4.1 in "providing care pathways for people vulnerable to suicidal behaviour".

The clear message in the report based on feedback from service users and a broad range of other stakeholders is that the SHIP counselling service is both clinically effective and cost effective. Whilst the SHIP service is embedded in and integrated with other HSE Counselling services such as the National Counselling Service (NCS) and Counselling in Primary Care (CIPC) the report also highlights the importance of the SHIP service as part of a continuum of services in suicide prevention. It achieves this by complementing and providing onward care pathways to front line assessment services such as the Liaison Psychiatric Nurse Service in the Emergency Departments and the Suicide Crisis Assessment Nurse (SCAN) service.

The report also notes that whilst the day to day management of the service is provided by the Director of Counselling and the SHIP Counselling Coordinator the service also benefits from the support and expertise of an Interdisciplinary Steering Group consisting of the Suicide Resource Officer, Mental Health Services General Manager, Regional Coordinator for Social Inclusion & Substance Misuse and a Psychology Manager. This is another clear example of the collaborative partnerships which yields rich learning which is envisaged under *Connecting for Life*.

Anne O'Connor

National Director Mental Health

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The SHIP Steering Group overseeing the programme and this evaluation included:

- Jeanne Hendrick, General Manager, South East Mental Heatlth Service, HSE
- Dr. Sheila Kissane, Principal Psychology Manager, HSE South
- Dr. Derval Howley, Regional Coordinator for Social Inclusion & Substance Misuse, CHO Area 5
- Seán McCarthy, Regional Suicide Resource Officer, HSE
- Dr. Gerard O'Neill, Director of Counselling NCS South East, CHO Area 5
- Athol Henwick, Counselling Coordinator, Self Harm Intervention Programme

1 Introduction

1.1 Overview

This report outlines the process and findings of an evaluation of the Self-Harm Intervention Programme (SHIP). The SHIP service provides non-crisis time-limited specialist counselling support to people who are self-harming or at risk of suicide across the south east of Ireland. The SHIP service, which is a HSE provided service, is unique within Ireland in terms of its approach, its model and the structures that underpin how the service is run. A full description of the SHIP counselling service including both the therapeutic model and the service delivery model are included in Chapter Five of this report.

This evaluation of the whole SHIP service included the views of former and current clients, families of past and present clients, counsellors, management, and professionals in other organisations. Full ethical approval for the study was provided by the HSE University Hospital Waterford Research Ethics Committee in October 2014 prior to the commencement of the study (see Section 2.7). The SHIP evaluation consists of four facets:

1. A demographic profile of SHIP clients and their presenting issues
2. An evaluation of outcomes for clients of SHIP
3. An process evaluation of the SHIP service
4. A cost/benefit and impact evaluation of the service

1.2 Research Personnel

The steering group, eager to ensure that a comprehensive, detailed and robust evaluation was undertaken, tendered for independent researchers to lead the evaluation. Research charity Quality Matters, in partnership with Dr Ladislav Timulak, were successful in their tender. The research was overseen by a multi-agency steering group.

1.3 Guide to this Report

The steering group had identified a number of research aims and objectives which were refined with the research team. This resulted in a broad range of methodological approaches being used to meet these aims, which are described in considerable detail throughout the report. The research team's approach to the various facets of the evaluation is detailed in the methodology section, Chapter two. This chapter also examines how a number of issues in relation to participant well-being were anticipated and managed, and also details a number of limitations to this research that must be kept in mind when considering the findings and their implications.

The third chapter, 'Context for SHIP: Suicide, Self-harm and Policy', provides detail on the prevalence of the issues that SHIP seeks to provide support for (suicidality and self-harm), both within a national context, and more locally in the South Eastern Region. This chapter also includes an analysis of the relationship between self-harm and suicide. Chapter three also details the solutions to these problems as articulated in national strategy and international good practice literature.

Following the context in terms of the problem and its policy responses in Chapter three, Chapter four outlines evidence for the therapeutic approach adopted by the programme,

specifically providing evidence for the time-limited model and for psychosocial interventions for suicide and self-harm prevention.

The final chapter before the presentation of results, Chapter five, is a detailed history of the SHIP service, including a description of the programme, the target group and the staffing and governance structures. This chapter also details key lessons learned from the process to date.

Chapters six through nine present the findings of the primary research and secondary analysis. Chapter six provides a profile of SHIP clients gleaned from an audit of client files. This profile includes key demographic information as well as a profile of the issues and risks with which they presented to SHIP.

Chapter seven provides a detailed analysis of the short-term outcomes for clients in relation to well-being and risk as a result of engaging with SHIP, collected using the CORE-OM tool. This is followed by self-reported outcomes for clients as collected in client-satisfaction surveys. These chapters provide a robust picture of the changes experienced by clients who engaged with SHIP.

The final chapter of findings, Chapter nine, details the effectiveness of the SHIP service from the perspective of the counselling team. The chapter's key finding from the report combined with those from the impact evaluation will support the development of evidence-informed recommendations for the service into the future and implications for potential roll-out of the service as part of an effective national suicide prevention strategy.

2 Methodology

2.1 Overview

This chapter presents a detailed description of the methods used to undertake this evaluation: the research process from the identification of the study aims and objectives to study design, as well as execution of the research. This chapter also addresses some of the limitations of the research.

2.2 Study Aims and Objectives

The aims of the study developed by the steering group include:

- To analyse outcomes for clients of the SHIP counselling services across the domains of well-being, problems/symptoms, life functioning and risk to self and others
- To evaluate the social return on investment (cost-benefit analysis) of SHIP
- To analyse the experience of stakeholders involved in the provision or receipt of SHIP
- To evaluate the process of implementation of SHIP

In order to achieve the following objectives:

- To evaluate the effectiveness of the SHIP programme in line with its stated objectives
- To assess feasibility for roll out and provide an analysis of context and relevance of the programme in relation to regional service provision and national policy

A research company, Quality Matters, was selected to conduct the research through an open tender process.

2.3 Overview of Approach

To meet the multiple aims and objectives of the study, the evaluation of the SHIP service consisted of both a process evaluation and an impact evaluation. The evaluation included an overview of demographics of the client group undertaken through a file audit and an analysis of existing client satisfaction data, compiled though anonymised client satisfaction surveys collected over the previous two years from SHIP clients by the SHIP team.

The process evaluation involved primary research with key stakeholders, including referrers, clients, family members of clients, and counsellors, using surveys and semi-structured interviews. Through these surveys and interviews, the research sought an understanding of the experience of those involved with SHIP as well as the impact of SHIP on their work or life experienced.

The impact evaluation involved two different methods: the first was an analysis of anonymised pre and post outcomes data collected by SHIP counsellors from their clients using the CORE tool. This information alongside data from surveys and interviews was used as part of a social return on investment evaluation (SROI) (see part 2 of the research for additional details on the SROI process). An SROI is a cost benefit analysis undertaken using a specific methodology in order to assess the value of outcomes from the programme against the full costs associated with running the programme over a period of nine months.

2.4 Data Collection Methods Used

2.4.1 Overview of Methods

The study employed the collection of primary data from a range of different participant groups, using interview and online surveys as well as secondary analysis of data previously collected by the SHIP service in the preceding two years. This data had not been analysed prior to this evaluation.

2.4.2 Analysis of SHIP Data

The following table shows the outcomes data analysis and data mining used for the research. The table highlights the information source, how many individuals were included in the data, and the analysis undertaken with the data. The table also outlines the sampling method for each information source.

Table 1: Documentary Analysis and Data Mining

Information Source	No. of Clients	Sampling	Data Analysis
CORE-OM[1] Tool	80	Whole population of completed pre and/or post CORE-OM forms	- Analysis of up to 80 outcomes profiles for clients collected pre & post using CORE-OM outcomes tool using SPSS - Changes from baseline to follow up (pre and post intervention) were assessed using means and N of CORE-OM - A mix between-within subject analysis of variance was conducted to assess any impact of time of testing (pre/post) or gender on each CORE-OM sub-scale.
Client Counselling File Audit	85	Randomly stratified sample 25% of client files, gender and age.	- Build a demographic profile of SHIP clients
Client Satisfaction Evaluations	120	All completed forms analysed	- Assess level of satisfaction with service provision (waiting times, number of sessions and the ending of the counselling contract) - Assess self-reported outcomes at the end of the counselling contract

2.4.3 Data Collected Through Interviews and Surveys

There were eight unique stakeholder groups identified for the purposes of this evaluation. Stakeholders were defined as any group potentially affected, either negatively or positively, by the SHIP service. Stakeholder input was gained through either online survey or one-to-one interviews conducted by phone. The following table shows the stakeholder group, sampling summary and method used for each.

[1] For a detailed explanation of this validated tool, please see section xx

Table 2: Data Collection and Sampling Summary

Stakeholder Group	Sample Size	Response Rate	Method of Sampling	Method and details
SHIP clients	25	71%	Random: every second client was selected from the SHIP client database	Semi-structured phone interviews included SROI[2] questions, averaging approximately 45 minutes. 78 letters were sent out to SHIP clients. 37 people agreed to participate and 14 declined. There was no response from the rest.
Family members of SHIP clients	8/11	72%	Snowball sampling	Semi-structured phone interviews included SROI questions, averaging approximately 20 minutes. 17 service users were asked for permission to contact their family members. 10 service users gave consent to contact a family member and seven did not[3]. On contacting family members, one declined to participate [one interview pending].
Ship Counsellors	16/16	100%	Survey and Phone interview	The survey, using an adapted validated tool, the Mental Health Problems and Perceptions Questionnaire[4], as well as SROI-based questions was sent and completed by all counsellors. All counsellors also participated in the semi-structured phone interview, averaging approximately 35 minutes. Counsellors were able to log one hour's work time on their time sheets to account for this engagement.
National service providers	5/18[5]	27%	Survey – full population	A brief bespoke online survey was sent to Suicide Resource Officers and National Counselling Service Coordinators.
Service providers	8	100%	Purposive sampling	Phone interviews averaging 30 minutes using a bespoke semi-structured interview schedule were undertaken with a representative sample of service providers and referrers in youth, addiction and mental health services.

[2] For a detailed explanation of the SROI method and validation process, please see section xx
[3] Four service users explained that their family or partner did not know they attended the SHIP service or self-harm experience and three service users did not feel comfortable with their family member being interviewed.
[4] For detailed information on this validated tool, please see section xx
[5] All national service providers were invited to participate and five chose to complete the survey

Referring services including doctors	16/44	36%	Whole population	A brief bespoke online survey was sent to a list of referring agencies. Follow-up emails and phone calls were undertaken with individuals marked as frequent referrers to encourage participation in the survey.
Steering group	5/5	100%	Focus group and phone interviews	A three quarter day focus group was held with members of the steering group with follow up phone calls for those that were able to attend the focus group.

2.5 Additional information on Participant Selection and Recruitment

Clients were selected for interview from two groups: all clients who had received and completed their SHIP counselling contract within the previous three months[6] and clients who had completed at least 11 of their 12 SHIP counselling sessions. Clients still in treatment were required to have at least 11 sessions completed in order to ensure that participants had sufficient experience with the service to provide an assessment of it. SHIP staff identified clients who progressed to this point as less likely to be vulnerable at the time of interview than those with fewer sessions completed.

Regarding selection of professionals, a representation of referring organisations and all SHIP counsellors and management were invited to interview and/or survey. Family members of clients who participated in interviews were invited to participate where the client and the family member gave.

Clients were recruited by invitation in a letter and follow-on phone-call from SHIP staff. Once consent was achieved, key contact details were passed on to the research team. Professional participants likewise were invited by letter/email from SHIP and follow on phone-call prior to information being provided to the researchers.

The main inclusion criteria for clients was that they must have completed a counselling programme with SHIP or had completed 11 of the 12 counselling sessions at the time of the interview. People were excluded from participating if they were not able to provide consent for engagement (or in the case of those under 18, parental consent was not provided) or did not meet the criteria described above.

2.6 Thematic Analysis of Interview Transcripts

Interview transcripts were thematically analysed. Coding was done initially by the researcher who conducted the interview and was subsequently reviewed by another member of the research team.

2.7 Ethical Considerations

2.7.1 Ethical Approval

A number of ethical considerations informed this research. The steering group were anxious to ensure that the risk of harm to participants in this study would be minimised or

[6] This meant that the service received had been provided within the SROI period

eliminated. Ethical approval was sought and achieved for this study from the University Hospital Waterford Research Ethics Committee in October 2014.

2.7.2 Consent

Achieving full and informed consent of clients or former clients of SHIP was a priority for this research and SHIP staff and the research team ensured that the implications of participation were clearly explained at multiple points in the process. Consent to participate in semi-structured interviews was obtained through invitation by letter and follow-on phone call. The letter contained detailed but accessible information on

- The purpose of the research
- The reason they were invited to participate
- Their right to refuse participation
- The implications of their participation
- The voluntary nature of participation and their capacity to withdraw at any point
- Issues around confidentiality and reassurance regarding implications of non-participation.

SHIP staff who made follow-on phone calls for the purposes of recruitment were fully briefed on these issues, had an information sheet detailing these considerations, and went through these issues on the phone with clients prior to the client agreeing to participate. At the beginning of each interview, the researcher discussed these points again on first contact and at the beginning of the interview to ensure the client fully understood the nature of consent and the implications of their participation.

As with child protection, no issues regarding capacity to consent arose. However, a number of precautions were agreed in advance should this situation have arisen, which included ensuring that data collection would be delayed until the researcher was confident that consent could be given when there was a concern about capacity to consent for any reason.

2.7.3 Confidentiality and Management of Data

All data was managed in line with relevant data protection legislation. All data retained was written in digitised files with no audio recording (all interviews were partially transcribed). A confidentiality policy in line with the HSE's and that of the research organisations was in place from the earliest point of the research. Identifying information from interviews was only available to the research team, and was pseudonymised prior to submission for review by the steering group or for publication. Identifying information from client files was anonymised by the SHIP team before being released to the research team.

2.7.4 Child Welfare

The safety and welfare of children was considered of paramount importance in undertaking this research. It was agreed in advance that if during the course of the research it came to the attention of the researcher that a minor was at risk from harm, any such reasonable concern or suspicion of abuse or neglect would elicit a response in line with national guidance on child protection and the child protection policies of the research organisation and the HSE. However, no child protection concerns manifested relating to this research. No 16 or 17 year olds were randomly selected to participate in the research, although it was agreed in advance that should someone in this age group

present for participation, explicit informed consent would be required both of the young person and their guardian in advance.

2.7.5 Risk of Emotional Upset

Given the potentially difficult subject matter under discussion, particularly for clients or their families, a number of steps were taken before, during and after interviews to ensure that harm or potential harm was minimised:

- Researchers checked in with participants at the beginning of interviews to ensure they were in a positive mental space and feeling safe to engage in the conversation.
- Interviews were conducted from a strengths-based approach, focussing on positive outcomes achieved as a result of engagement and encouraging constructive criticism where the service did not meet client needs or expectations. The role of clients as experts by experience was emphasised and the potential benefit of their participation to the improvement of the service and to better outcomes for others was also highlighted.
- Levels of distress were monitored during the interview by the researchers, who regularly checked in with clients asking questions such as 'I'm just going to pause there and check in, see how you are doing. Are you OK to go on?'
- All clients were offered a follow-on phone-call within two days of the interview
- All researchers had a working knowledge of ASIST, and a researcher trained in ASIST was available on standby at all times when research interviews were being conducted.
- Agreed-upon protocols for responding to clients who were actively suicidal were included in the research ethics application and approved by the steering committee for the evaluation.

2.8 Limitations to the Research

2.8.1 Self-Selection Bias

Although all participants who met the criteria outlined above were invited to participate in the evaluation, some individuals decided not to engage. It is possible that those who did not have a positive experience with SHIP chose not to be involved in the evaluation, thus skewing the data towards a more favourable outcome. Efforts made to address this potential limitation were unsuccessful. Clients who had dropped out of the service or did not progress past the initial referral stage were invited to be involved in the research, but these individuals chose not to be interviewed at either initial engagement from the SHIP Counselling Coordinator or, for those who gave initial consent for their information to be shared, declined subsequently when contacted by the researcher.

2.8.2 Lack of Comparable Research

In relation to a number of areas in this study, there is little or no comparable data, in particular, of a comparable cost-benefit analysis of a similar service, outcomes from other specialised self-harm counselling services, or in relation to the therapeutic commitment, role competency and role support of counsellors providing specialised services.

2.8.3 Short-Term Impact

This evaluation assessed impact at the end of a time-limited counselling contract, and does not provide information on longitudinal outcomes.

2.8.4 CORE-OM Reduced Number of Post Assessments

There are limitations in relation to the pre and post analysis of CORE-OM clinical data. In all of the sub-scales of the CORE-OM, the numbers of participants for whom there is CORE-OM data post-therapy is half that of those who supplied data pre-therapy. While there is participant attrition in all research, it is unclear in this case why there was such a high drop-off from pre to post therapy. This discrepancy between those completing pre and post assessments raise possible questions in relation to research bias, i.e. It is possible that only those participants who felt well following therapy took part, therefore giving disproportionately positive outcomes. This discrepancy between the number of completed pre and post assessments may also be a reflection of the newness of the support and tool to individual SHIP counsellors using the CORE-OM to inform their individual practice, leading to some inconsistencies and gaps in its usage. This limitation begs future repetition of this aspect of the research. A more consistent approach to the use of the CORE-OM would ensure that that the results are representative of the wider population of SHIP users and to further evidence the findings of this analysis.

3 Context for SHIP: Suicide, Self-Harm and Policy

3.1 Overview

The SHIP service is a unique, specialised counselling service provided to people who are self-harming in the South Eastern Region of Ireland. In acknowledgement of the key link between self-harm and suicide, the programme is part funded by the National Office for Suicide Prevention to support their objectives of reducing suicide in Ireland, nationally. Other funding sources have included HSE mental health services and counselling services. While Ireland has a rate of deaths by suicide that is lower than the average in the EU (1), we bear a disproportionate burden of youth suicide (2). The South Eastern Region of Ireland is home to a number of counties that carry a heavier burden of suicide deaths than other counties in Ireland (3) and higher than average rates of male self-harm, but promisingly have lower rates of repeat self-harming behaviour, which is a common factor preceding death by suicide (4). The purpose of this chapter of the report is to give a detailed backdrop of the context in which the SHIP service is provided. The first section of this chapter includes information on the prevalence of self-harm and suicide at a regional and national level. In this first section, the SHIP service is located in a continuum of regional service provision and contextualized in relation to key national strategic responses.

3.2 Suicide in Ireland

3.2.1 Defining and Recording Suicide Deaths

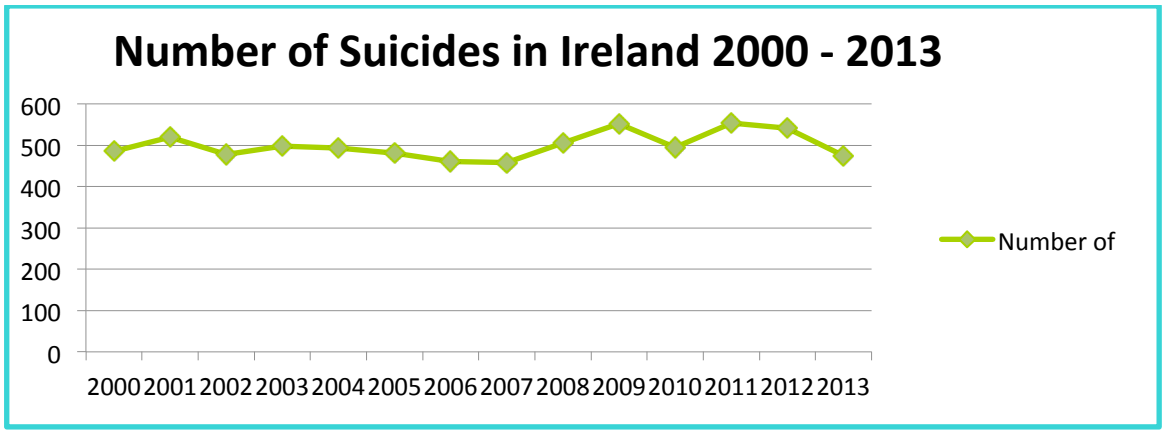
Suicide is defined as the act of intentionally killing oneself. The classification of a death as suicide is based on a coroner's report and, where necessary, a report from the Garda that attended the scene(3). Deaths by suicide in Ireland are recorded by the Central Statistics Office. The National Office for Suicide Prevention notes that a proportion of deaths by suicide are included in the category of deaths by external causes, along with deaths by accident, homicide and undetermined deaths, and highlight that it is likely that a proportion of the deaths classified as undetermined were actually deaths by suicide. However, it's also noted that it is not possible to calculate the proportion of undetermined deaths that are likely to be suicides, and it is not possible to say whether the proportion remains the same each year (2).

3.2.2 Change in Suicide Rates in Ireland

The most comprehensive and conclusive data[7] on suicide in Ireland is available most recently from 2013. This shows that for every 100,000 deaths registered in that year, 10.3 of them were deaths by suicide: a total of 475 in that year. This is a drop from 11.8 per 100,000 or 541 deaths in 2012 (5). The figures from 2012 and the preceding years show that the number of suicides fluctuated between a low of 458 in 2007 to 541 in 2012. The graph below, figure 1, illustrates the increase in suicide in the years since the onset of the economic recession (3). The National Office for Suicide Prevention notes that more recent data from 2013 indicates a levelling off of this rise, but advise caution in interpreting this pattern, as data for 2013 is still provisional (2).

[7] In this context, comprehensive means data completed on 'year of occurrence' as opposed to 'year of registration'

Figure 1: Number of Suicides in Ireland 2000 – 2013



3.2.3 Suicide Rate in Ireland Compared to EU

The most recent available comparable information from 2010 tells us that Ireland's rate of deaths by suicide, at 11 deaths per 100,000 was slightly below the EU34 average of 12.4 deaths per 100,0000 (1). Almost 83% of the deaths from suicide in Ireland in 2011 were men (2), reflecting similar patterns across Europe (1). While it may be reassuring, to an extent, that Ireland's suicide mortality rate falls below average levels, it remains a cause for concern that Ireland has the second highest rate of suicide mortality among young people aged 0 – 19 in the EU(6).

3.2.4 Age, Gender and Suicide in Ireland

Information on factors such as age and gender of people who die by suicide can help to promote effective targeting of prevention and response strategies for suicide and risk factors, including self-harm, towards those who are most likely to need them. The most significant factor associated with death by suicide in Ireland is gender: 83% of people who died by suicide in 2011 were male. This rate has fluctuated little over time(3). In terms of age, male suicide rates in 2011 were highest in among men in the 45-64 age-group (28 per 100,000) while female suicide rates were highest in women in the 25-44 age-group (almost seven per 100,000).

3.2.5 Methods of Suicide

Understanding the methods people use to end their lives can help to direct preventative policies that limit access to methods of suicide, while information on methods can also provide information on severity of self-harming behaviour and suicide risk in self-harming people. The methods most commonly used in suicide have followed a consistent pattern as far back as 2007 until 2011. In 2011, the most common method of suicide, accounting for 74% of deaths, was hanging, strangulation and suffocation. The second most common method was drowning and submersion, at 8.3%, with self-poisoning accounting for 7.9% of deaths (3).

3.2.6 Alcohol and Suicide

The connection between suicide and alcohol consumption is well-established: the World Health Organisation acknowledge harmful alcohol use as a key risk factor for suicide. Therefore, reducing harmful alcohol use is a universal prevention measure (7). There are various reports in Ireland that link alcohol consumption and suicide in Ireland. One study that compared suicide rates and alcohol consumption between 1968 and 2009 found that alcohol consumption had a significant effect on suicide mortality, particularly on the male

suicide rate up to age 64, although less so on the female suicide rate (8). Research with the families of over 100 young people who had ended their lives through suicide found that 50% of cases were identified as having abused alcohol in the year prior to death, although less than half of these cases had any alcohol in their system at death (9).

3.2.7 The Relationship between Suicide and Self Harm

There is a strong relationship between suicide and prior self-harm; people who are treated for self-harm are more likely to die by suicide compared to people in the general population. In one study involving 7,968 people who had presented to hospital with self-harm, there was a 30-fold increase in risk of suicide compared with the general population (10). A systematic review of self-harm and suicide research in the UK notes that the risk of suicide is 'hundreds' of times higher in people who self-harm (11).

In particular, repetition of deliberate self-harm may be one of the strongest risk factors for death by suicide, indicating that specific suicide prevention strategies should be targeted at this group (12). In research that involved over 4,000 repeat deliberate self-harmers over a 15 year period, people with repeated deliberate self-harm were over twice as likely to die by suicide as those with a single episode. Women who have repeat episodes of deliberate self-harm have an increased relative risk, which means that repetition may be particularly relevant when assessing risk in women. However, it is important to note that while self-harm is a relatively strong risk factor for suicide, it is not necessarily a strong indicator of subsequent suicide. In the research described previously, suicide occurred in only a small minority of cases: 4.7% of repeat self-harmers and 1.9% of single episode self-harmers (12).

3.3 Self-Harm in Ireland

3.3.1 Definition

Self-harm, as described by the National Office for Suicide Prevention (2), includes the various methods by which people deliberately harm themselves. Varying degrees of suicide intent can be present. Sometimes there may not be any suicidal intent, although an increased risk of further suicidal behaviour is associated with all self-harm. The National Suicide Research Foundation notes that deliberate self-harm includes acts involving *'varying levels of suicidal intent and various underlying motive such as loss of control, cry for help or self-punishment'* ((4)p15). Information on self-harm in Ireland is collected in the innovative National Registry of Deliberate Self-Harm by the National Suicide Research Foundation, funded by the National Office for Suicide Prevention.

3.3.2 Rate and Repetition

As is indicated with the national suicide rate in recent years, rates of self-harm in Ireland have decreased over the past three years (between 2010 and 2013), after a year-on-year increase between 2007 and 2010 – again similarly to the rate of suicide. However, the rate of self-harm in 2013 remained 6% higher than pre-recession rates (4). Although the number of incidents had reduced in 2013, the rate of repetition remained the same, accounting for 21% of all presenting incidents. Those who used cutting as a method were most likely to be repeat self-harmers, and repetition was most likely in the day and weeks following a self-harm presentation. The National Suicide Research Foundation notes that repetition continues to pose a major challenge for hospital staff as well as the families involved in supporting loved ones who are self-harming. As indicated in the previous chapter, repetition of self-harm is more concerning and a stronger risk factor for subsequent suicide. The National Suicide Research Foundation highlight the significant regional variation in

rates of repetition, and given that repetition of self-harm is a strong predictor of future suicide, this warrants further investigation and may provide valuable knowledge for providers and policy makers seeking to reduce incidence of suicide (4).

3.3.3 Self-Harm Methods

There is a different pattern in the methods used for self-harm compared to those used for suicide, as detailed in the previous section. The method of self-harm most commonly used during 2012 was drug overdose, in 67% of cases or 7,457 cases. This presented a 10% decrease on the previous year. Overdoses predominantly featured minor tranquilisers, paracetamol and anti-depressants or mood stabilisers. Also of note is that the proportion of presentations involving hanging increased by 7%, between 2007 and 2012. This is a concerning trend, considering that lethal self-harm methods are associated with higher suicidal intent (4) and that the most common method of suicide in Ireland is hanging or suffocation. Also of note is that during the recession there was a 'steep increase' in highly lethal self-harm presentations., Although this has declined since 2011, the National Suicide Research Foundation urge caution in interpreting this decrease as a lasting trend (4).

3.3.4 Alcohol and Self-Harm

There is a correlation between alcohol use and self-harm in Ireland. Alcohol was present in 37% of self-harm presentations (40% in men) in Irish hospitals in 2012. The National Suicide Research Foundation notes that the pattern of presentations for self-harm at hospitals, with more people presenting at night, on Sundays, Mondays and Public Holidays, could be associated with alcohol use and that this potential correlation warrants further investigation (4).

3.3.5 Gender, Age and Self Harm in Ireland

Women are more likely to present with self-harm than men. The rates for female presentations are 217 per 100,000 versus 182 per 100,000 for men, a 19% difference. This is down from a 37% difference in 2004 (4). The My World Survey on youth mental health found that young females were much more likely to report self-harm than males: 16% young men vs 24% young women (13). Young men are most likely to present to hospitals with self-harm at age 20-24, and young women 15-19. The NRSF note that this means one girl in every 162 between the ages of 15 and 19 presented to hospital with self-harm in 2013; one young man in every 196 between the ages of 20-24 presented to hospital as a result of self-harm in 2013 (4). The lifetime prevalence of deliberate self-harm in Irish adolescents is between 8 and 12%, so around one in every ten teenagers will engage in self harm behaviours, with significantly more young women than young men having lifetime experience of self-harm (14). Of note is that more than a fifth of the 8,200 young adults who participated in the My World Survey (21%) reported that they had deliberately hurt themselves without wanting to take their life, and 7% of them had attempted to take their own lives in the past (13). Over one-quarter of those who had harmed themselves previously said that they had self-harmed within the past year.

While it could be presumed that an explanation for the gender difference in self-harm may be explained by the fact that men are less likely to engage in help-seeking behaviour and going to hospital, research with young people in Ireland suggests that prevalence is indeed higher among females than males, which is in line with research internationally, particularly in relation to younger people (15).

3.3.6 Self-Harm and Help Seeking

When reviewing the rates of self-harm presentation referenced in this chapter, the hospital presentations of self-harm are very likely a minority of self-harming incidents that occur in the community. For example, research in Cork and Kerry comparing hospital presentation statistics with self-reported self-harm statistics revealed that only 5% of those who self-harm ever present at hospital for self-harm (16). Results from the My World survey support this finding that hospital presentation – indeed any help seeking – is the outcome in a minority of self-harming incidents; one fifth of the young people who participated[8] had self-harmed and many did not seek professional help, despite feeling they needed it after self-harming (3). For the young people who did seek help for their problems, doctors/GPs were the most likely source of formal support, at 46%, followed by psychologist, counsellor or therapist (37%), student counselling services (34%) and a relative (30%) (13).

3.3.7 Assessment and Follow on after Self Harm Interventions

Key national data reveals that 30% of patients discharged from the emergency department were discharged home without a referral. The NRSF notes variability in the assessment, management and follow-on care of self-harm presentations across the country. This serious issue may be caused primarily by variable resources as well as to inconsistencies in service delivery models across different areas (13).

3.4 Self-Harm and Suicide in the South Eastern Region

3.4.1 Suicide in the South Eastern Region

The Central Statistics Office published comparative statistics on suicide in all counties and cities in Ireland in the years 2008, 2012 and 2013[9]. A summary of this data, as relevant to the counties and city served by SHIP in the South Eastern region, is presented in the Table 3, below. Key comparative statistics are highlighted in the graph that follows, figure 3.

Table 3: Suicides and Suicide Rates Nationally and in the Counties of the South East[10]

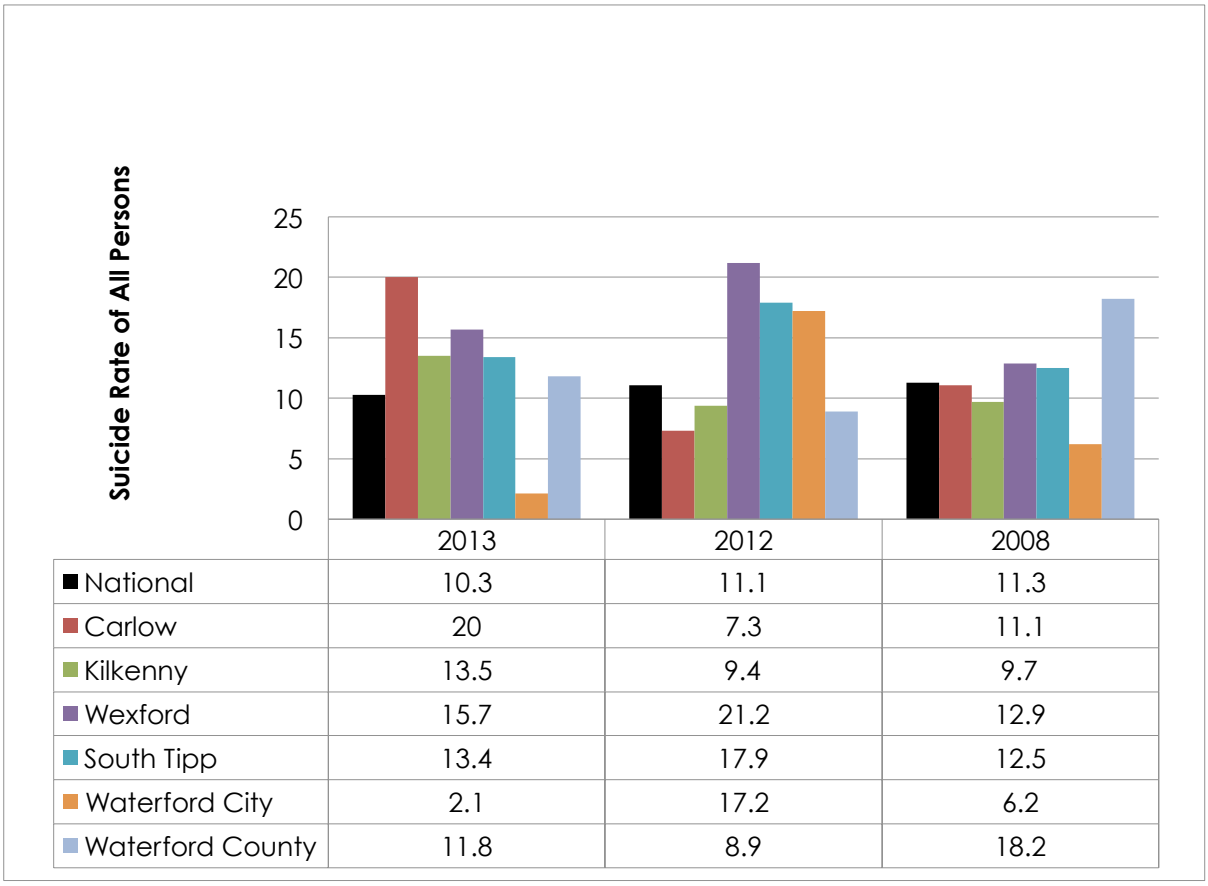
	Number of Suicides in 2013[11]			All Persons Suicide Rate			Male Suicide Rate			Female Suicide Rate		
County	**Total**	**Male**	**Fe-male**	**2013***	**2012**	**2008**	**2013***	**2012**	**2008**	**2013***	**2012**	**2008**
National	475	396	79	10.3	11.8	11.3	17.4	19.6	17.2	3.4	4.1	5.3
Carlow	11	9	2	20	9.1	11.1	32.6	18.1	11.1	7.3	0	11.4
Kilkenny	13	13	0	13.5	12.5	9.7	27	22.9	10.7	0	2.1	8.7
Wexford	23	18	5	15.7	22.6	12.9	24.8	35.9	22.9	6.8	9.5	2.9
South	12	12	0	13.4	14.6	12.5	26.9	26.9	22.4	0	2.2	2.3

[8] Over 8,200 young adults in total
[9] The county refers to the county of residence of the deceased
[10] The rates of suicide related to the deaths per year, per 100,000 deaths
[11] 2013 data is by year of registration

Tipp												
Waterford City	1	1	0	2.1	8.6	6.2	4.4	35.1	17.5	0	0	0
Waterford County	8	8	0	11.8	10.3	18.2	23.6	14.8	20.7	0	0	9.2

Table 3 above reveals that in all counties, and in all years, male suicide rates were higher than female suicide rates, consistent with national patterns. The graph below shows that for every year, both Wexford and South Tipperary had suicide rates exceeding the national average. In both 2012 and 2013, at least four of the six areas (counties and city) analysed had suicide rates that were higher than the national average.

Figure 2: National suicide rate and county suicide rates in the South Eastern Region



	2013	2012	2008
National	10.3	11.1	11.3
Carlow	20	7.3	11.1
Kilkenny	13.5	9.4	9.7
Wexford	15.7	21.2	12.9
South Tipp	13.4	17.9	12.5
Waterford City	2.1	17.2	6.2
Waterford County	11.8	8.9	18.2

3.4.2 Self-Harm in the South Eastern Region

The National Registry of Deliberate Self-Harm shows that rates of self-harm and suicide vary significantly across regions. Rates of self-harm in the South East are about average compared to national figures, although slightly higher for men. The table below highlights the numbers of people from Local Health Office areas in Carlow/Kilkenny, Waterford and

Wexford[12] who presented to hospitals with self-harm in 2013. The table also shows the national ranking of the county in terms of incidence of self-harm presentations. The table reveals that for women, the rates of self-harm in areas in the South East rank average, or below average for women, and above average for men, significantly so in Carlow / Kilkenny (4).

Table 4: Rates of Self-Harm Presentation by Local Health Office Area 2013

LHO Area	Men		Women	
	No. of People	Rank out of 32	No. of People	Rank out of 32
Carlow/Kilkenny	128	**7**	125	15
Waterford	117	**9**	113	20
Wexford	125	11	144	13

Between 2012 and 2013, the national rate of hospital-treated self-harm decreased by 7% for men and 5% for women, an overall average of 8%. Between 2012 and 2013, there was a significant decrease in the number of women presenting for self-harm in Waterford city (-34%) and Wexford (-21%). No significant decrease for men was noted in the HSE South area between these two years, but an increase was observed in Carlow. The gender of people presenting to hospital with self-harm was similar in the South Eastern Regional hospitals to the national: 47% men and 53% women in the South East, with the national average being 46% and 54%. In November 2012, in 24% of the referrals in the HSE South for the Child and Adolescent Mental Health Service, a history of suicidal ideation or self-harm was part of the reason for referral. This is comparable to the national average of 25% (17).

Promisingly, with regard to repetition of self-harm presentations in the South East, there were slightly lower rates of repetition in the (12.5%) compared to many areas. Dublin South had the highest rate of repetition at 19.9% and the North Eastern Region had the lowest at 11.6% (4).

[12] Note that data on South Tipperary is not available separate from North Tipperary. North Tipperary did not fall under the catchment area of the SHIP programme at the time of evaluation

3.4.3 Continuum of Care: Services Available for SHIP Clients

The SHIP Programme is provided within the context of a range of services[13] available to those presenting with self-harm or suicide-related issues, as detailed in the table below. The table shows the range of services that can refer in to SHIP and whom SHIP counsellors refer on to, as well as a brief description of the service and its geographical availability in the region.

Table 5: Continuum of Care of Services Available for SHIP clients

Service	Description	Referral		Availability
		In	Out	
GPs	Community medical service	Yes	Yes	Regional
SCAN	Fast-track priority referral and assessment service for individuals presenting as at risk of suicide. Conducted by specialised nurses in GP surgeries	Yes	No	Wexford and parts of Waterford City
Self-Harm Specialist Liaison Nurse	Assessment for persons presenting to A&E in with self-harm or suicide-related issues	Yes	Yes	Regional
Community Mental Health Services (adult and child	A psychiatric assessment and community based or in-patient specialised care	Yes	Yes	Regional
Community Counselling Services	Counselling provided by community and voluntary organisations which may be general or specialised	No	Yes	Limited
Other community supports	Youth, substance misuse and other community care services	No	Rare	Varies by service type and area

As detailed in the overview section, a number of these services have developed in the time period since SHIP was initiated. This means that in the region, there is a continuum of services considered by key stakeholders as a strength in relation to the capacity to provide for co-ordinated care for a range of mental health needs.

3.5 The Policy Context for Suicide and Self Harm Services

3.5.1 Connecting for Life: Ireland's National Strategy to Reduce Suicide 2015 – 2020

Connecting for Life(18) is Ireland's second national suicide reduction strategy. The first national strategy, Reach Out(19), spanned from 2005 – 2014 and during its lifetime saw a number of significant achievements in the field of suicide response and prevention, not least the establishment of the National Office for Suicide Prevention, the establishment and roll out of innovative servies such as the SCAN (Suicide Crisis Assessment Nurse) service.

Connecting for Life is an ambitious and comprehensive strategy that seeks to empower communities and individuals to improve their mental health and wellbeing while reducing

[13] Please note that this may require additional review by the Steering Group and is in first draft only

national rates of suicide and presentations of self-harm. Specifically in relation to self-harm the strategy aims for:

> *Reduced rate of presentations of self-harm in the whole population and amongst specified priority groups (p ix)*

This and the other stated outcome regarding a reduction in suicide will be realised through the achievement of Connecting for Life's seven overarching goals and 23 specific actions to support implementation of these goals:

1. To improve people's understanding and attitudes toward suicidal behaviour, mental health and wellbeing
2. To provide support to the local community in relation to prevention and response to suicidal behaviour
3. To identify and implement approaches that effectively reduce suicidal behaviour and improve mental health among priority groups
4. To enhance access to services for people vulnerable to suicidal behaviour
5. To provide safe and high-quality services for people vulnerable to suicide
6. To reduce access to means of suicidal behaviour
7. To improve evaluations and research relating to suicidal behaviour(18)

The national strategy advocates, in line with international evidence, cross-sectional coordination of suicide prevention, reduction and response efforts, as no single intervention has been found to reduce suicide rates. It notes that strategies must also be localised and culturally specific, must be developed using evidencebased research as well as consultation involving various populations and cohorts, e.g. service-users, families and communities. Connecting for Life also advocates for prevention strategies that address priority groups known to have higher risk of suicidal behaviour, naming specifically those with repeated incidents of self-harm.

3.5.2 Vision for Change: Ireland's National Mental Health Strategy

The national mental health strategy also addresses the issue of self-harm. Its opening line states that 'each citizen should have access to local, specialised and comprehensive mental health service provision that is of the highest standard '(20). Self-harm is referred to throughout the strategy as a type of suicidal behaviour or precursor to suicide, and within the strategy there is specific direction in relation to self-harm interventions:

> *'Assessing the risk of repeated suicidal behaviour, as well as the broader psychosocial needs of deliberate self-harm individuals attending A&E departments, is therefore an important task. The need for all deliberate self-harm individuals attending A&E departments to be given a comprehensive assessment by a suitably trained health professional followed by appropriate referral and follow-up has been recognised both nationally and internationally' [p256].*

Given that only a minority of self-harming individuals will present to A&E, the spirit of this recommendation, as well as the clear direction for appropriate follow-up should be considered. The requirement for a comprehensive assessment provided by a suitably trained health professional is now being met in a primary care setting through the provision

of the SCAN service in Wexford and Waterford. The need for appropriate referral and follow up is facilitated by the recent development of a range of services across the continuum of care in the South Eastern Region, with further plans to expand the availability of suitable support services, which complement SHIP, by providing more intensive services for individuals who require them, such as dialectical behavioural therapy.

3.5.3 International Policy Context: World Health Organisation

The World Health Organisation (WHO) have stated that crisis intervention services and evidence-based interventions form a key part of a national suicide prevention strategy (7). WHO highlight the importance of providing targeted programmes for groups vulnerable to the risk of suicide,which can be conceptualised on three levels (7):

1) **Universal:** that target the whole population
2) **Selective:** that target at-risk populations (but not individuals)
3) **Indicated:** for people displaying early signs of suicide potential

Indicated prevention interventions include programmes or interventions that include the assessment and management of suicidal behaviours, which are considered to include '*self-harm that may or may not have a fatal intent or outcome (p12)'*(7). Within this strategy, strong personal relationships, the presence of religious or spiritual beliefs, subjective personal well-being and positive coping strategies all protect against suicide. Well-being and coping include, in this context, inherent personality traits as well as learned behaviours such as optimism, emotional stability, problem solving skills (including help-seeking), a developed self-identify and good self-efficacy (7)(21).

WHO also note that the success of a national suicide prevention strategy can be measured not only by a reduction in suicides or hospitalised suicide attempts, but also by the number of suicide prevention interventions successfully implemented. The public health model of suicide prevention indicates a need to understand the problem using national data, to understand causes and protective factors, and to develop and evaluate interventions such as SHIP. Where these models are shown to be effective, WHO recommends scaling interventions at a national level as well as implementing on-going evaluation processes. This model is illustrated below.

Figure 3: Public Health Model for Suicide Prevention (WHO, 2014)

3.6 Summary

This chapter highlights that generally, the issue of self-harm is not disproportionately burdening counties in the South Eastern Region, although for men the rates are above average. Promisingly, rates of repeat self-harm presentations in the South East lie at the lower end of the spectrum nationally, although the burden of suicide remains heavier in some counties in the South East compared to the national average.

Since 2012, there has been a significant decline in women presenting with self-harm in Wexford and Waterford. The decline is happening in the context of momentum across the spectrum of services responding to this issue, driven by increased integration and innovative service development. This integration has resulted in the development of referral pathways into SHIP as well as alternative supports for those people who may not be suited to SHIP but require specialist support. The approaches taken by services in the South Eastern region in many cases exceed goals that have been outlined in current relevant national strategy documents. In relation to care for those who are self-harming or presenting with suicidal ideation, there are some areas that demand further investigation, potentially presenting an opportunity for improved care in relation to self-harm response, namely the low rates of referrals to community-based services from hospital, and the three in ten people currently being discharged from hospital without a referral.

Recommendations outlined in national and international strategy indicate that the service provided by SHIP is a core service located in a continuum of services and supports that form part of a national suicide prevention strategy.

4 Efficacy for the Therapeutic Approach

4.1 Overview

The Self-Harm Intervention Programme (SHIP) has been developed as a means to provide specialist counselling to people at risk of suicide and self-harm. It is part of a continuum of services aimed at preventing suicide, responding to self-harm or supporting mental health. SHIP is based on a time-limited counselling model. Time-limited counselling, as its name suggests, refers to therapy that is limited in its provision, as opposed to unlimited open-ended counselling terminated by the client at a time of their choosing (22). The time-limited counselling model has been used by SHIP since its foundation, as well as in other HSE services such as Counselling in Primary Care (CIPC) (23). This section outlines the literature surrounding time-limited counselling, its uses and effectiveness in primary care services such as SHIP.

4.2 Time-Limited Counselling as an Alternative to Longer Term Interventions

While traditional long-term therapeutic interventions have been found to be effective, the need to identify and practice more efficient treatment regimens has become increasingly important (24). Although first used in the United States, there has been a recent growing trend within treatment literature in the United Kingdom, Canada and now Ireland, to evaluate treatment models that require limited counsellor input in order to achieve more cost-effective interventions (24). Rather than merely providing therapy faster, brief therapy provides services differently. Franklin and colleagues called for a shift in the philosophy of therapy from a focus on deficits, to adopting strengths-based assessments; time-limited counselling does exactly this (25). Duvall and colleagues (2012) maintain that time-limited therapy must be based on a process which is collaborative, highly respectful and taps into client preferences, skills and abilities (26). This strengths-based approach means clients require a briefer amount of involvement and are better to embrace their own resources. They become the primary agents of change, which results in better clinical outcomes (27).

Therapy has traditionally focused on assessment during the early session with treatment or reduction of symptoms being left for a later stage; time-limited therapy, by definition, moves straight to symptom reduction (28). Time-limited therapy has been shown to be very effective in terms of clinical outcomes, attributed to the solution-focused nature of the approach from the very beginning of the intervention (29). Continued evaluation of brief therapy has led to a strong trend of support for this practice. Also underpinning the model is the need for a therapeutic culture to be developed that entails rapidly building and maintaining a therapeutic alliance, which is key to success, most particularly in brief interventions, where this is less time to build counsellor client relationships over an extended period (29). Research suggests that ‘constructive change’ accelerates most significantly during the first three sessions (30). Thus time-limited therapy capitalises on bringing about therapeutic change when it is most significant – at the beginning.

Since the introduction of brief therapy, studies have consistently shown constructive change to occur earlier rather than later in the treatment process (30). In a seminal paper looking at the dose-effect relationship, Howard and colleagues found 30 % of clients had improved by the second session. Furthermore, 65% of clients reported significant symptomatic relief within the first two sessions, increasing to 75% after six months and 85% after one year (31). It appears that while substantial improvements can be made in the early stages of therapy, they are followed by ever-diminishing returns whereby clients become "stuck" and begin to slow down or even stall completely in their progress [11,12]. The efficacy of time-limited therapy appears across a diverse range of populations and settings. For example, a systematic review of the effectiveness of brief therapy found clients experienced significantly greater symptom reduction than those receiving treatment as usual for clinical depression borderline personality disorder, and in reducing parasuicidality [13,14, 3].Other studies have shown brief therapy to be effective treatment for gambling addiction (36) and have been demonstrated brief intervention to be *'therapeutically effective in the treatment of children and adolescents with mental health problems'* (37). In all of the above studies, these benefits remained intact for at least six months following the initial intervention – demonstrating the long-term sustainability of brief therapy.

Clearly there are benefits to be derived from the adoption of a brief therapy model. However as with any mental health service provision, brief therapies cannot be a 'one-size-fits-all' model of care (24). Indeed Malan first suggested brief therapy would be most beneficial to those with *'mild illness, recent onset, and good motivation'* (38). More recently, other components of suitability have been identified, including interpersonal history and presenting problem complexity. Social support has also been identified as an eligibility criterion, as clients who are particularly sensitive to interpersonal loss may find it difficult to engage in therapy in which the working bond is quickly dissolved (39). Thus it appears that time-limited therapy may not be the most effective form of treatment for every client.

There has been also been research into what is not addressed during the course of brief therapy, proving a caution as to potential challenges innate in the model (40). When discussing potential limitations of this approach, Feltham argues

> *'early enthusiasm has given way to some extent to acknowledgement that clients do sometimes outwardly comply with brief therapy but inwardly suppress some of their significant concerns… The tendency for innovative approaches to be hailed as panaceas is strong, and brief therapy should be placed in perspective'* (41).

Studies looking at clinicians' views of time-limited counselling have found time-limits to influence the therapeutic approach in the form of the choice of therapy, as well shifts in problem definition and approach, and increased directiveness. These findings have prompted concerns about a focus on symptom removal over facilitating maintenance of treatment gains (42). However these concerns have been somewhat allayed by research demonstrating longitudinal improvements in clinical outcomes as outlined above.

4.3 Efficacy of Talking Therapy for Self-harm

The Nice Clinical Guidelines on the longer-term management of self-harm (43) recommend that people who self-harm should be offered three to 12 sessions of psychological intervention structured for people who self-harm with the aim of reducing self-harm. They note that the intervention should be tailored but might include CBT, psychodynamic or problem-solving elements. Therapists providing this intervention, they note, should have specific training and supervision for this.

Evidence that psychosocial interventions are effective in reducing self-harm and suicide are increasingly promising. Until recently, the most conclusive evidence was a systematic review of 23 randomised control trials of treatment for self-harm in 2009 with inconclusive results on the effectiveness of various treatments, but which found promising results for a number of psychosocial interventions, including problem-solving therapy and dialectical behavioural therapy (44). However, more recently, a multi-site longitudinal study from Denmark that involved more than 18,000 people over an 18 year period produced new evidence that was missing from the 2009 Cochrane review just mentioned. In this study, the researchers sought to clarify whether psychosocial therapy after self-harm was linked to lower risks of repeated self-harm, suicide, and general mortality (45). They compared the outcomes of people who had self-harmed by whether they had received psycho-social therapy after their intervention or not. The following were the key findings:

- In the first year of follow up, people who had received psychosocial therapy were less likely to have had a repeated episode of self-harm than those who had not received psychosocial therapy (6.7% vs. 9%).
- At 10 year follow-up, people who had received psychosocial therapy were less likely to have had a repeated episode of self-harm than those who had not received psychosocial therapy (15.5% vs 18.4%).
- At 10 year follow-up, fewer deaths by suicide were reported among those who had received psychosocial therapy than those who had not (229 vs. 314 per 100,000).
- At 20 year follow-up there remained a lower risk of repeated self-harm among those who had received an intervention than those who had not (there was an actual risk reduction rate of 2.6%). This was more significant for females and for young people.

4.4 Summary

There is a growing evidence base for the efficacy of the time-limited psycho-social support intervention provided by SHIP for people in the South East Region. Lazarus and Fay state that *"It is redundant to say brief therapy, when therapy should always be as brief as possible"* (46). Indeed it would appear the bulk of the literature would support this claim. However, despite increasingly favourable research literature for the efficacy of brief counselling interventions, policy makers must be cognisant that this model will not meet every need of each and every client. It is hoped that this evaluation and subsequent research on Ireland's model of time-limited counselling for this target group will contribute to this growing evidence base.

5 Overview of the SHIP Programme in Practice

5.1 Overview

This chapter provides background information on the SHIP service, specifically outlining the approach that underpinned service development, the clients' target group, the structure of the service and the roles involved in service delivery including the counsellors, coordinator, administrators and the steering group. This chapter also provides a summary of seven key lessons that have informed the development of the model since its establishment in 2004.

5.2 SHIP in Practice

SHIP is a service for individuals who express their emotional distress through physical self-harm or express suicidal ideation. As a specialist short-term counselling intervention it is available across both primary and secondary care. The SHIP service can be provided as a single support or as part of a multi-agency care plan for clients with more complex needs such as self-harm and mental health (co-morbidity) or self-harm and substance use (dual diagnosis). However, SHIP is not appropriate and does not function as a crisis response service.

The SHIP Counselling Service is provided across the five counties of the HSE South Eastern Region, which includes Wexford, Waterford, Kilkenny, Carlow and South Tipperary. Clients of the service, who receive treatment at no cost, are referred to SHIP by health or allied health professionals.

The service offers time-limited therapeutic counselling. The number of sessions is agreed between the counsellor and client up to a maximum of twelve sessions. In the first session of this time-limited process, the counsellor and client also agree on the purpose of the service and the specific client goals. The first session also involves signposting to other services where these are needed.

Progress and change is measured at a number of points in the process, namely the beginning, middle and end of the counselling contract. In the first session, clients are also asked to complete the CORE-OM, a brief validated measure of symptoms, general well-being and functioning, and risk to self or others. The client is also given another opportunity to complete the CORE-OM assessment in the second to last session, which assists both the client and counsellor to review progress, and if required, identify referral needs. Clients are also given the opportunity to evaluate their experiences with SHIP using an evaluation form adapted from the Nation Counselling Service Client Evaluation System. Both the CORE-OM outcomes data and the information from client evaluations have been analysed in this evaluation report, and provide rich data in relation to client profile, outcomes and views of the service. There is a mid way review of the process in and around the sixth session, which also supports both the counsellor and client to assess progress and to decide whether and how many further sessions are required to attain the client's goals (up to 12 sessions).

Towards the end of the SHIP programme, If the client requires it, there is also potential to 'bank a session', which means that a session can be kept in reserve for up to six weeks

after the end of the regular weekly sessions should the client which to use this. The 'session in the bank' was developed to support clients who struggled with the idea of the supports coming to an end. There is also an opportunity for a counsellor, following discussion and agreement with the SHIP Counselling Coordinator, to extend the therapeutic contract beyond 12 counselling sessions in unique circumstances. Clients can also be re-referred to SHIP anytime six months after completion of process. However, if an individual is experiencing significant life events or trauma (such as the death of a family member), an immediate re-referral would be considered.

Referrers are notified by letter when the counselling contract is ended, in order to support continuity of care. Where needed, clients are referred on to more specialised services, on-going supports, or are pointed towards appropriate community-based support services.

Figure 4:The SHIP Information Leaflet

The SHIP service works within the HSE's *"Children First Guidelines"* and is subject to the HSE Feedback Policy *"Your Service, Your Say"* and other relevant HSE policies.

The service is also subject to relevant legislation on Freedom of Information and Data Protection.

Information sheets on confidentiality, attendance policy and other relevant issues are provided to clients at the start of counselling.

S.H.I.P.
SELF HARM
INTERVENTION PROGRAMME

SHIP Counselling Co-ordinator,
Lismore Park Primary Care Centre,
223 Lismore Park,
Waterford.

Tel: 087 2586028

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Designed & Printed by Modern Printers (056) 7721739

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Self Harm Intervention Programme (S.H.I.P.)

What is the Self Harm Intervention Programme (SHIP)?

The Self Harm Intervention Programme is a professional counselling service offering short term counselling to individuals aged 16 and over who are experiencing suicidal ideation or the impulse to self harm.

SHIP is available in Wexford, Waterford, Carlow, Kilkenny and Tipperary S.R.

The SHIP service is not a crisis response service so it is not suitable for individuals who are at immediate risk or who may require an immediate response.

How to Access the Service?

Access to the service is by written referral from a relevant health care professional to:

SHIP Counselling Co-ordinator,
Lismore Park Primary Care Centre,
223 Lismore Park,
Waterford.

Telephone enquiries:
087 2586028

- Clients aged between 16 and 18 will require parental consent.
- Referrers should have the client's informed consent for the referral and advise clients of the "opt in" system. All referrals must include the referrer's and the client's full address and contact telephone number.
- When the referral is received by SHIP, clients are sent a letter asking them to opt in for counselling by ringing the dedicated telephone number in the letter and leave a message
- Where there are concerns about a client's vulnerability, referrers are asked to continue to support the client, as appropriate, while waiting until they hear about the outcome of the 'opt in' system.

Referrers are advised by SHIP of the outcome of the referral.

Please note that clients who do not opt in will not be offered an appointment at this time with SHIP. However they can be referred again at a future point.

SHIP Structure

The SHIP counselling service is provided in partnership between the HSE Suicide Resource Office and the National Counselling Service in the south east.

All Counsellors/Therapists providing the SHIP service

- are professionally qualified
- are accredited with an appropriate professional body
- adhere to professional practice and the relevant code of ethics of their accrediting bodies.

5.3 SHIP Target Group

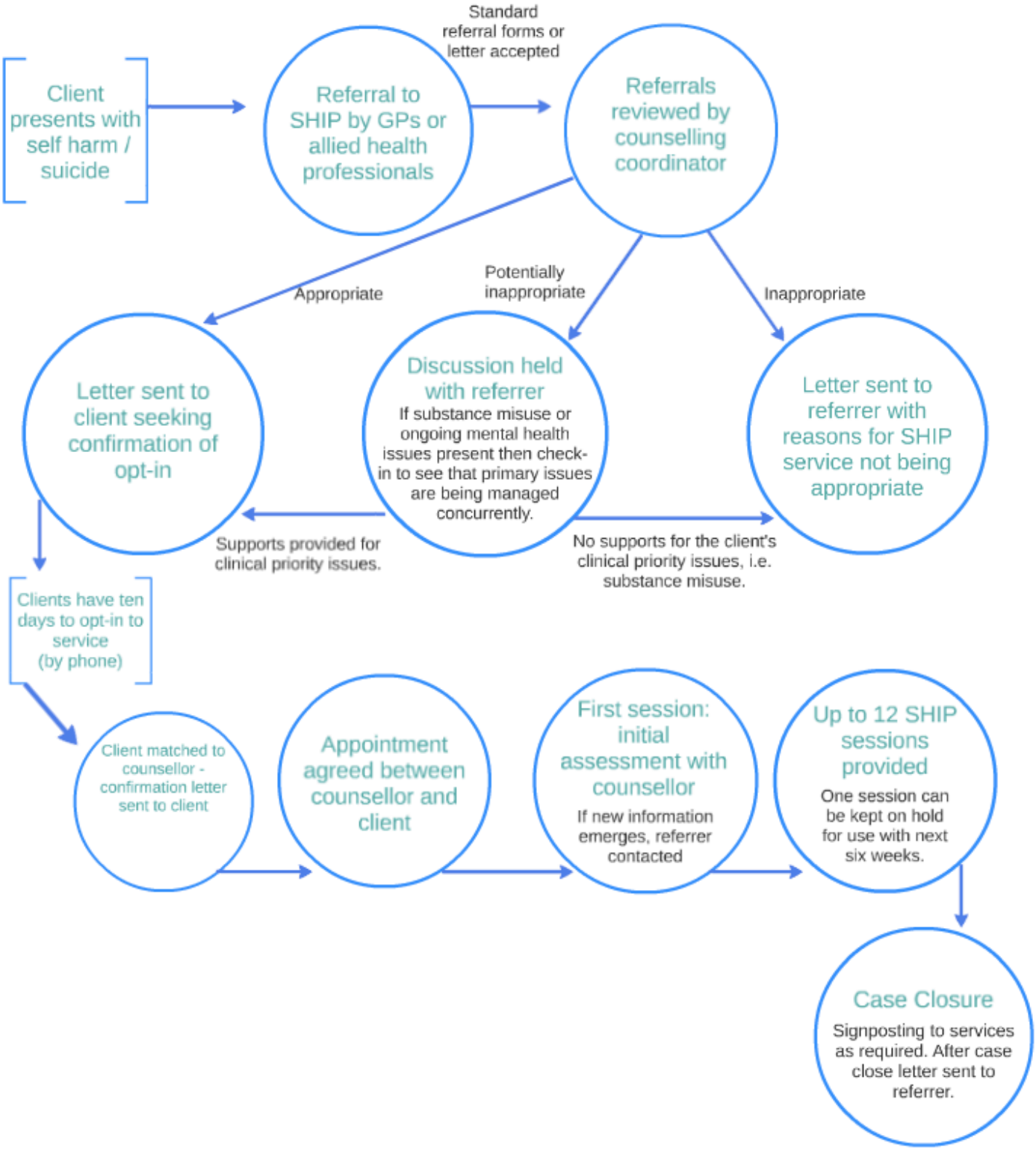
SHIP is available for people who are 16 years of age or over; with parental consent required for clients aged 16 and 17. SHIP is intended for clients who present with self-harm or suicidal ideation. SHIP can be considered as an intervention in its own right or alongside other mental health interventions where the presenting issues are more complex. People who present the following conditions are generally considered inappropriate for the SHIP brief intervention model:

- Acute psychosis
- Chronic intractable mental health issues which have remain unchanged after two full years of psychiatric intervention
- Severe recurrent clinical depression
- Borderline personality disorder

However, where there is on-going management of some more long-term clinical issues, SHIP can become part of the managed care plan. Clients experiencing substance misuse issues, or those who experience on-going depression or other mental health issues requiring clinical management, need to be in receipt of appropriate concurrent supports in order to be considered appropriate to the SHIP service.

The diagram on the following page illustrates the SHIP service provision model and the process by which referrals are managed in order to ensure that the service is provided to those most appropriate and therefore most likely to benefit from it.

Figure 5: The SHIP Referral Process



5.4 The Contract Counselling Model

The SHIP service delivery model is an adaptation of the service delivery model used in the Counselling in Primary Care scheme (CIPC). Independent counsellors provide a contract-based service to SHIP, who are sourced by an independent health personnel-contracting company (CPL Healthcare Ltd). The counsellors generally also provide counselling services elsewhere: to private clients, to the CIPC programme, or to clients of other community-based support services, which ensures diversity of caseload. Another key advantage of this model, as opposed to one where full-time counsellors are employed with the health service and work from a fixed site location(s), is a panel of well-trained professionals that can be managed to respond to changing rates of client need in a given month and can provide services over a broad geographical area. Counsellors provide services across the South Eastern Region from local HSE premises and in one situation provide counselling to over-16s through a youth services agency managed by Tusla.

5.5 The SHIP Therapeutic Approach in Practice

SHIP is provided by therapists from a range of backgrounds including counselling, psychotherapy and psychology. All counsellors in SHIP have a QQI Level 7 qualification in Human Sciences or equivalent in an Allied Health Profession. They also must possess an accredited qualification in counselling, psychotherapy or clinical/counselling psychology. All SHIP counsellors must be accredited with one of the following organisations as appropriate :

- The Irish Association for Counselling and Psychotherapy (IACP)
- The Psychological Society of Ireland (PSI)
- A relevant section within the Irish Council for Psychotherapy (ICP)

SHIP counsellors are provided with an induction and training programme in order to be able to confidently and safely provide specialised counselling with SHIP. They are also provided with on-going professional support through case management, peer group supervision and additional training days. The primary counselling approach is based in the humanistic counselling paradigm, which recognises people's innate drive towards self-actualisation and their creativity as important sources of healing within the counselling process (1).

No one single therapeutic approach or model is considered entirely sufficient to meet the needs of the client group in all situations. As such, SHIP utilises a range of therapeutic techniques. As noted by Dr O'Neill, it was felt while planning the service that 'a rigid therapeutic approach would fail to engage with the complexity of the issues that SHIP clients routinely present in the therapeutic encounter' (47). A central point in the SHIP therapeutic model is the emphasis on the importance of the therapeutic alliance and creating a safe space for the client and counsellor within which the counselling takes place. 'The therapeutic task is, through the therapeutic alliance, to gain a shared understanding of the unique set of circumstances of the client, past and present, which lead to or maintain self harming behaviour and suicidal ideation as perceived solutions to the problems of living' (47).

It follows that one of the client objectives of SHIP can be 'the client learning new ways of experiencing and tolerating particular emotional states which are experienced by the

client as life-threatening' (47). A further feature of the SHIP therapeutic model is that a 'robust approach is required to bring out into open inherent and covert hostility whether directed at the self, significant other or in transferential terms the counsellor/therapist. The purpose of this approach is to bring such feelings out into the open so that they can be worked with'(47).

Over the course of the service's development, SHIP counsellors have grown more experienced in managing self-harm and suicidal ideation. A further component of the therapeutic model is 'to always fully explore of the consequences of recent or planned episodes of self harm with the client' (47). The rationale underpinning this type of exploration has been further strengthened by three developments:

- The provision of evidence-based good practice guidelines in management of self-harm in a therapeutic environment[14]
- The provision of specialised intervention training, specifically skills-based courses including STORM (NOSP funded self-harm training programme)[15] and ASIST (registered training programme developed by www.livingworks.net)[16]
- Joint training with HSE Social Inclusion on screening and brief intervention for substance misuse and Traveller cultural awareness training
- On-going review and development by the team through individual supervision, case management meetings and peer-group supervision.

5.6 Overview of Staff and Management Structures of SHIP

5.6.1 SHIP Counsellors

SHIP Counsellors must have, at minimum, a primary degree in human sciences or equivalent in a relevant allied health qualification, plus a QQI accredited qualification in counselling, psychotherapy or counselling/clinical psychology. For counsellors working in SHIP, additional training is provided in psycho-educational self-harm and suicide prevention interventions, namely STORM and ASIST as well as child protection training. Counsellors must also attend regular supervision with the SHIP coordinator. Supervision is provided fortnightly for the initial induction period and then is provided monthly. The transition from fortnightly to monthly supervision is agreed between the coordinator and counsellor. Supervision has a dual role of monitoring implementation of the SHIP model and policies to ensure quality and compliance with the model and safe practice, as well as providing professional supports to counsellors in order to support them to manage the therapeutic space. As noted by Dr O'Neill, SHIP counsellors "are not just be dealing with life and death themes in the transference, they are also dealing with such themes in reality" (47). There are also regular meetings between all counsellors and the counselling coordinator in order to support professional development and skills.

5.6.2 SHIP Administration

The day-to-day administration of SHIP is undertaken by an administration team who, with the Counselling Coordinator, manage most of the communications in and out of the programme. In general, this process involves logging calls and referrals by letter, forwarding these to the coordinator for a clinical review to establish suitability and eligibility. Once the referral is accepted by the Coordinator, the administration team send

[14] These been informed by the NICE guidelines, CG133 – Self Harm Longer-Term Management (Nov 2011)
[15] Further information on this self-harm intervention model is available from http://stormskillstraining.com/
[16] Further information on this suicide intervention model is available from: https://www.livingworks.net/programs/asist/

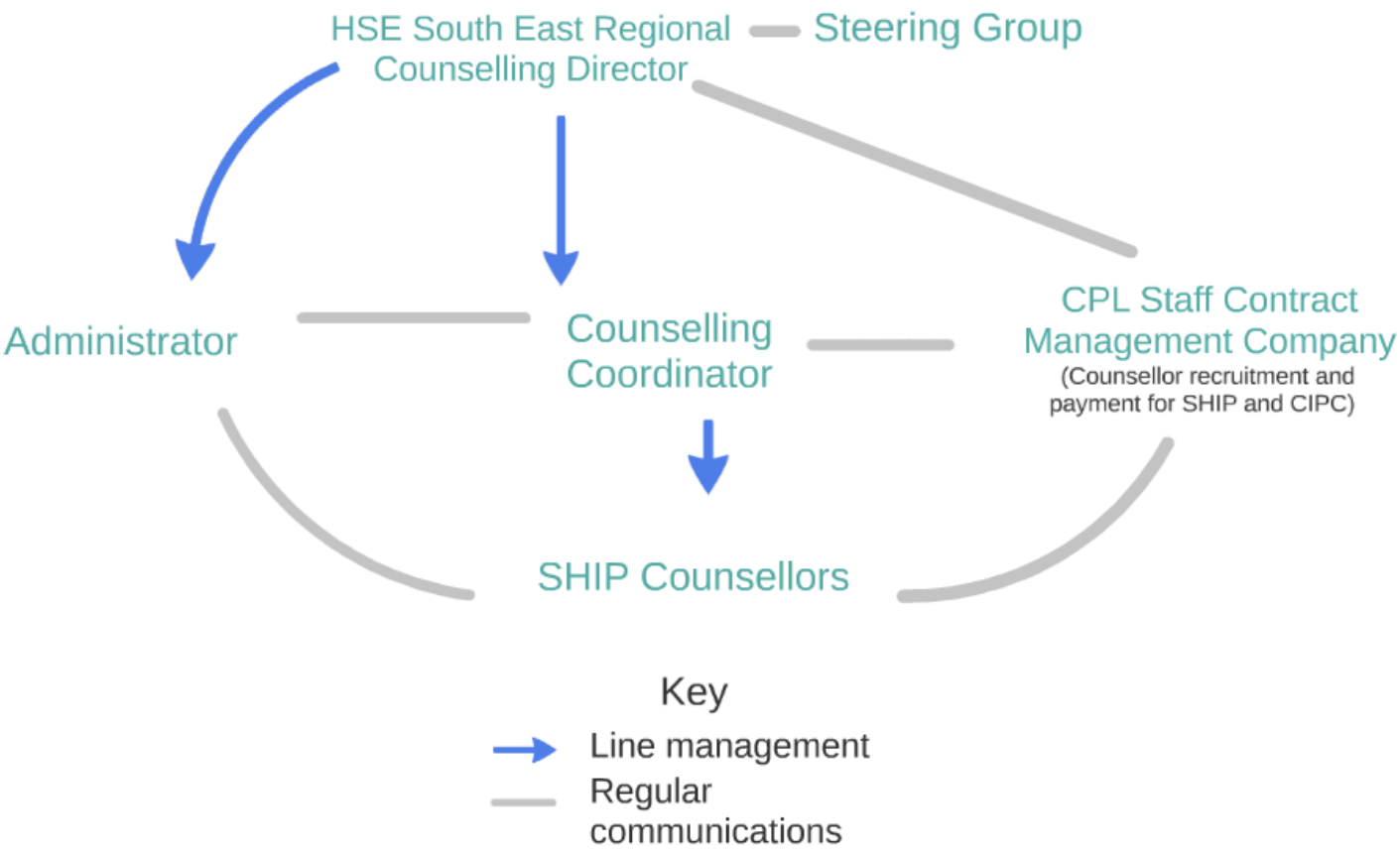
out letters to the client inviting them to telephone and confirm their interest in attending SHIP (opting in) and then matching clients to counsellors and locations. Once the client attends, a letter is also send to the referrer stating that the SHIP referral has been taken up on. Administrators also record the end of the process, sending letters to referrers stating that the SHIP programme has been completed. Administrators also have a key role in processing counsellor hours and processing invoicing with the contracting agency.

5.6.3 SHIP Management

The day-to-day running of SHIP, which predominantly consists of overseeing the referral and allocation process and providing supports and supervision to the panel of counsellors, is undertaken by the Counselling Coordinator who spends 30 – 50% of hours on such tasks. The remainder of the Coordinator's time is spent on direct service provision. The Counselling Coordinator reports to and is supervised by the Director of Counselling of the National Counselling Service South East, who leads out on the strategic development of the SHIP programme and is directly accountable for the clinical and operational governance of the SHIP service. The Director of Counselling also oversees the CIPC, and the National Counselling Service for adult survivors of childhood abuse in the region.

An interdisciplinary steering group also supports the programme consisting of senior HSE staff in substance misuse, mental health and suicide prevention roles, one of whom chairs the group. The steering group meets quarterly and has been integral in supporting the strategic development of the programme. The structures of the programme are illustrated in the diagram on the following page:

Figure 6: SHIP organogram of structures; which have supported service development



5.7 Development of the SHIP Service 1998 - 2014

In 1998, the National Task Force on Suicide published a report, which had a number of recommendations, including the establishment of low-threshold easy to access counselling service (48). In response to this, and with reference to locally identified needs, the SHIP Counselling Service was initially established in 2004 with one full-time counsellor to serve the county of Wexford. The SHIP service also anticipated Action 19.2 in 'Reach Out National Strategy for Action on Suicide Prevention' (DOHC 2005) to 'Evaluate the NCS model of counselling service provision making recommendations for further service development as appropriate'.

Prior to the establishment of the SHIP service, options for accessing services for people experiencing self-harm or suicide-related behaviours in Wexford were a referral by their GP to either a local psychiatric hospital, the general hospital accident and emergency department or HSE mental health services. There was no service available for people who did not require urgent referral to mental health services but needed support for these issues[17]. There was also a desire, based on evidence from research detailed in the 1998 Task Force report, to provide a counselling service which could be accessed from outside

[17] This summary of the service provision landscape at the time of the establishment of the programme was provided by the SHIP Advisory Group in a focus group

of mental health services. One advantage of this type of model was to avoid stigmatisation that can be associated with accessing mental health services.

Initially, it was intended that the service would be run on a pilot basis for 12 months, targeting individuals at risk of suicide and self-injury, most specifically in the 16 – 45 year-old age bracket[18]. The original aims for the project were:

- To enable individuals who are at risk of suicide and para-suicide to have a choice in terms of the available interventions
- To provide a non-judgmental, client-centered service where potential clients can begin to explore and understand the nature of their emotional distress
- To empower individuals to explore alternative coping strategies
- To assist individuals to take control of their lives by providing a service which promotes the personal autonomy of the individual

Core to SHIP's development has been the constant improvement of the service and development of the model and its implementation. This development has been based on feedback from clients, services and counsellors, and review and planning through the steering group structure. The development has been possible as the management structures of SHIP have utilised opportunities to grow and develop the service as these became available. Key milestones in service development are highlighted in the table below:

Table 6: Significant milestones in the development of SHIP

Year	Role Responsible	Significant milestone in the development of SHIP
1998	National Task Force on Suicide	Report that calls for 'easy to access counselling service'
2000	HSE	Establishment of National Counselling Service (NCS), which was available for adults who had experienced childhood abuse. This was the first example of a counselling service that could be directly accessed by the service users
Early 2003	National Office for Suicide Prevention (NOSP)	Call for submissions to respond to issues related to self-harm and suicide
Mid 2003	HSE Regional Director of Counselling and HSE Regional Suicide Resource Officer	Proposal for development of a short term counselling service for people presenting with suicidal ideation or suicide, based on an adaption of the NCS model, was presented on behalf of South East Health Board
End 2003	NOSP and Mental Health Directorate	€80,000 repeat funding provided for a pilot of a short term counselling programme in Wexford. Half of the funding was provided by NOSP and half by the Mental Health Directorate.
End 2003	HSE Regional Director of Counselling and HSE Regional Suicide Resource Officer	Person specification and job description based on the NCS Counsellor/Therapist role were developed and an adaptation of the NCS model of service for short term counselling was also developed. This described a direct provision service, i.e. time limited counselling delivered by an HSE employee.

[18] The history contained in this chapter is adapted from the PhD Thesis of Dr. Gerard O'Neill, Regional Director of Counselling, and is also drawn from a focus group with the project steering group.

Mid 2004	South Eastern Health Board	Counsellor/Therapist for SHIP recruited reporting to the Regional Director of Counselling
Mid 2004	Initial SHIP Steering Group established	The initial steering group included the HSE Regional Suicide Resource Officer, the HSE Regional Director of Counselling and the Counsellor/Therapist. The steering group developed a brochure while the Counselling Therapist and the HSE Regional Director of Counselling undertook a large number of site visits to GPs and HSE health/ mental services. A suite of policies and staff support structures were developed for SHIP based on the NCS clinical protocols.
Mid 2004	SHIP service	First SHIP clients start
Early 2005	SHIP Steering Group renewed	Membership of the steering group extended to a representative from the HSE Mental Health General Manager, HSE Clinical Psychologist, and HSE Substance Misuse Services
2005 – 2011	SHIP Steering Group	Supporting the consolidation and development of service delivery model and service integration including: • Contracted Rehab Care to undertake a process evaluation and make recommendations for future development • Counselling therapist received training in ASSIST, STORM, which further informed development of the model
2005-2009	Director of Counselling	• Further development of the therapeutic model through part of a Doctoral Thesis in conjunction with the SHIP Counsellor/Therapist • Started using contract counsellors to manage waiting lists and provide holiday cover
2007	Counselling Therapist	Participated as part of a working group that developed the 'Understanding Self-Harm Training and Resource'. This training has been made a standard part of the HSE South East HSE training programme and in 2014 has been included as part of the NOSP national training programme.
2008	SCAN Steering Group, Chaired by HSE South East Suicide Resource Officer	Development of the SCAN Pilot. SCAN is a mental health nursing service provided in GP surgery's to provide assessment advice and support to GP's for clients presenting to their service with suicidal ideation or potentially suicidal. The SCAN pilot was conducted in Wexford and Dun Laoghaire and provided client pathways and increased referrals into SHIP.
Mid 2010	HSE South East Mental Health Services (Wexford, Waterford)	Extension of A&E liaison service hours (to 8am – 8pm), which provided client pathways and increased referrals into SHIP
Mid 2011	HSE South East Mental Health Saving Initiative	Call for submissions to respond to issues related to self-harm and suicide
End 2011	HSE South East Mental Health Saving Initiative	Confirmation received for expansion of SHIP into remaining counties with the South East, namely; Carlow, Kilkenny, Tipperary South and Waterford
2011 – 2013	HSE National Mental Health Services	A national steering group was established to develop the National CIPC model. As the HSE Regional Director of Counselling was involved in this group and the steering group of SHIP, the outsourcing model was developed concurrently and learning was shared between the two processes.

Early 2012	Regional Director of Counselling and CIPC Counselling Coordinator	CIPC programme in the South East began. The service delivered time-limited contract counselling through a third party provider. This model of service provision was utilised and adapted to inform the regional expansion of SHIP. The SHIP Counsellor/Therapist role was assigned the role of Counselling Coordinator by the Director of Counselling; this included new and additional tasks in relation to staff induction and supports, reviewing referrals and allocating clients to counsellors.
Early 2012	SHIP Steering Group	CPL healthcare (http://www.cplhealthcare.com) was contracted to support personnel management of contract counsellors.
2012	SHIP Steering Group	• Roll-out of SHIP service to Carlow, Kilkenny, Tipperary South and Waterford • The Counselling Coordinator began attending Steering Group in an executive role • Two referral systems continued in operation
Early 2013	Regional Director of Counselling	• Reconfiguration of regional counselling services • Single referral point for SHIP established • SHIP Administration support extended an additional half-day to equal a total of two days following reconfiguration of counselling services • Client evaluation system introduced
Mid 2013	Regional Director of Counselling and Counselling Coordinator	SHIP Counsellors encouraged to use the CORE-OM outcome tool in their individual practice as a means of generating practice-based evidence.
Late 2014	SHIP Steering Group	SROI research commissioned to assess outcome and value of SHIP service
On-going	HSE Regional Director of Counselling	Designing an integrated model of service delivery for the three counselling services

5.8 Key Lessons from the Development of SHIP to Date

5.8.1 Overview

Core to the ethos of SHIP is the use of research, information and stakeholder feedback to improve the SHIP model. SHIP is informed by evidence-based practice as well as practice-based evidence. This means that the processes are developed to take learning externally from research as well as from practitioners and client feedback.

This section details some key lessons from the development of SHIP up until the point of this evaluation. These lessons come from an analysis of existing SHIP literature, including a process evaluation of the service undertaken in 2004 [55], as well as interviews and focus groups with the steering group members. In each of the seven key lessons below, the context for learning is documented and a key lesson summarised that considers implications either for SHIP or for other areas considering implementation of the SHIP model.

5.8.2 Lesson One: A Balanced Self-Harm Caseload is Required

According to the SHIP steering group, experience and counsellor feedback has shown that providing a service to clients who are self-harming can result in higher levels of stress and

anxiety than other types of counselling provision. This is borne primarily of heightened concerns and risk in relation to client well-being, which is immediately threatened by their self-harming and suicidal behaviours and the need for concurrent increased management of client risk. The potential organisational risks posed by increased work-related stress are threefold: firstly, counsellors will experience 'burnout', which will have negative effect on counsellors, and potentially their family. Secondly, increased stress could potentially result in a lower quality of service provision to this high-risk group. Finally, counsellor burnout can lead to a higher turnover of counsellors on the panel. A high turnover could lead to increased numbers of counsellors leading to a panel without the benefit of as much specialised experience. A high counsellor turnover would also lead to increased training costs for SHIP. Feedback from SHIP counsellors over the course of the project, which is supported in other research on case-mix for psychotherapists[19], has shown that counsellors benefit from a diverse case mix rather a caseload consisting solely of clients who present with self-harm or suicidal ideation.

An example of setting limits on caseloads has been provided through the National Counselling Service model, where counsellors working with adult survivors of childhood abuse were capped at 16 client contact hours per counsellor per week. This model of best practice was utilised by SHIP, whose policy at the time of the evaluation was that counsellors do not routinely exceed 10 contact hours under the SHIP programme. Turnover in SHIP has been low (two counsellors have left and seven have joined since the service went regional), which has been of benefit to SHIP in providing a stable panel of highly experienced counsellors.

Key Lesson

Placing a cap on contact hours with clients presenting with self-harm and encouraging a diverse case mix can help to prevent burnout. This should be considered as part of a suite of measures, including access to skilled supervision and other professional support structures, aimed at promoting a positive working environment and encouraging professional practice and support service sustainability.

5.8.3 Lesson Two: Allow Adequate Time for a New Interagency Service to Achieve Referral Capacity

In the initial year of establishment of SHIP, significant resources were spent on face-to-face promotion of the service with GPs, health services, and mental health services. Introductory presentations and meetings were considered by the steering group to be vital to creating awareness and acceptance of the service with professionals. These promotional efforts contributed to its subsequent status as a viable referral option for suitable clients.

The need for dedicated and significant resources for promotion was also highlighted in the second roll-out of the SHIP service in 2012 to Carlow, Kilkenny and South Tipperary. In Waterford, where the SHIP service was rolled out at the same time as the other counties, there was much better uptake and referrals. One hypothesised reason for the difference in uptake across the counties was that a number of senior HSE staff operated across the counties of Waterford and Wexford, therefore prior knowledge of the programme has a positive affect on uptake of the new service. To get a similar level of professional familiarity and trust in the service in other areas requires significant resources in terms of promoting the service.

[19] Reference to be added

Key Lesson

Both prior to and at the earliest point in the development of a new service, adequate consideration, planning and resources must be dedicated to promoting the service. This means ensuring that appropriate information on the service, referral pathways, quality measures within the service and the approach to interagency working should be communicated consistently, clearly and regularly to gain referrer and other stakeholder confidence. Indicators are that it may take up to 18 months for a new service to reach referral capacity.

5.8.4 Lesson Three: Dedicate Adequate Resources to Management, Co-ordination and Administration to Maintain Service Quality

Key Lesson

Clear clinical and operational governance structures with clear lines of accountability are essential to maintain the service quality in SHIP. To support these structures, it is essential that SHIP should have dedicated administrative support. The benefits of SHIP being firmly embedded within the broader counselling infrastructure are also clear, drawing on best practice from the NCS and also CIPC. In relation to the Co-ordinator's post, an average of one third to one half of the post is required for coordination of the programme at its current stage of development. This time is spent on data collection, supervision, promotion and management of referrals and is vital to providing high quality services. When full development is reached relative to the population base it will increase to three quarters of the post.

5.8.5 Lesson Four: Ideally Services Should be Planned as Part of a Spectrum of Mental Health Services

The introduction of the SCAN service and the A&E Liaison Nurse role in Waterford and Wexford General Hospitals both contributed to an increase in appropriate referrals to the SHIP programme and increased capacity to direct clients with different needs or clients who were contraindicated for the SHIP service to alternative support services. In terms of other services, a dialectical behaviour therapy programme has been introduced, which is considered a suitable alternative for some people presenting with chronic, recurring episodes of self-harm associated with borderline personality presentation or other mental health issues and would not be suitable for SHIP. As one steering group member commented,

> *'If there are no other services available then it is more challenging to manage inappropriate referrals as there are no other options to send people to. More choice means better referrals and this results in a better service for the client'.*

Key Lesson

New service development will be more effective if part of a wider strategy that seeks to ensure a continuum of services to meet diverse mental health related needs. Important strategic factors include the availability of suitable alternative services for people who self-harm but are contraindicated and the capacity of services to make suitable referrals to the programme.

5.8.6 Lesson Five: Establish Budget and Governance in the Initial Stages of Pilot Design

While the SHIP programme is widely considered a successful intervention within the South East region, the steering group has challenges in ensuring a commitment of funding to maintain levels of service provision.

Key Lesson

To support the continuation and growth of a successful pilot, it is beneficial in initial planning stages to reach agreement with key funders on a potential long-term strategy for the continuation of the programme, post pilot, contingent on its proven success. Ideally, the initial project plan will include clear direction on future governance structures and funding streams.

5.8.7 Lesson Six: Address Travel Time and Contract Flexibility with Counsellors at Recruitment / Induction

Key Lesson

Where a similar operation model is being adopted for a self-harm counselling service, it is important that a number of factors are considered and discussed with counsellors at the induction stage.

- Guidance on ideal proximity to the counselling sites should be provided and the implications of living outside this distance to the service discussed with counsellors prior to them being inducted into the programme. This is due to the fact that in quieter weeks or months the numbers of individuals receiving counselling within a geographic area may be reduced, potentially to one or two in a given session.
- Substantial travel time required of the counsellor may cease financial viability if there are only a small number of appointments, as counsellors must cover their own travel costs. Efforts can be made to book consecutive appointments to assist in schedule management, however, at initial contracting.
- A preference should be clearly outlined for counsellors who can provide services both in and outside of office of hours to ensure maximum accessibility for clients.

5.8.8 Lesson Seven: Continue the 'Session in the Bank' Clinical Protocol to help Clients Manage Counselling Process

The first evaluation of the programme identified reluctance on the part of some clients to re-contact the service in times of distress. The evaluation highlighted the need to ensure clients were clear that re-contacting the service was indeed appropriate and encouraged.

SHIP introduced the 'session in the bank' as a response to this. This means that the last session can be held over for a client to use when they need, up to six weeks after the end of the regular weekly sessions. This session is not used in all cases, however. Informal feedback from clients and counsellors to the Counselling Co-ordinator indicates that having the option of coming back for one session was helpful for these clients.

The session in the bank is considered particularly useful for clients who were ambivalent about closure, individuals who did not want SHIP sessions to end and individuals who were

aware of an upcoming event that may present challenges for which they thought they require additional supports.

Key Lesson

When operating a time-limited counselling model, it is important to communicate clearly to clients that reconnecting with the service in times in distress is encouraged, and that 'time-limited' describes the counselling contract for a time-period, and not for all engagement with the service. Having an additional session reserved for a time period can also be a positive step in providing choice and options for clients.

5.8.9 Lesson Eight: the importance of SHIP being linked into the Broader Counselling Infrastructure

Within the South East since early 2013, the Director of Counselling with counselling and administrative staff have been working on the design of an integrated model of service delivery for the three HSE provided counselling services (SHIP, CIPC, NCS). As a starting point to this process, the referral point for all three counselling services has been centralised. The process also involves the development of cross referral protocols to simplify the client pathway. This aims to improve the experience of clients and their referrers.

Co-ordination of services also aims towards efficiencies and maximising the dividend from shared governance frameworks, for example standardized qualifications for counsellors and psychotherapists, shared supervisory structures and opportunities for professional training and development. There is potential for this work to further support replication of SHIP, as all HSE areas are already providing CIPC and the NCS.

5.9 Summary

With leadership from HSE and an interdisciplinary steering group, the SHIP service was developed between 2004 and 2014. The delivery model is based on an adaptation of that used in the Counselling in Primary Care Scheme (CIPC).

Reflective of the commitment of the steering group to continual learning and quality improvement based on new emerging evidence and structured stakeholder feedback, the service has been continually developed. Significant developments to the model over this period included the extension of the service to new geographical regions; the development and on-going improvement of structured induction, training and supervision and support systems; the clarification of processes in relation to service user communication (particularly in relation the time limited nature of the service); efficiencies and systematisation of referral and administration processes and the introduction of validated outcome tools.

Senior stakeholders and steering group members regard the current therapeutic and organisational model as well developed, coherent, clear and replicable. Learning from the programme has been recorded in detail in order to inform future potential development of similar services.

6 Profile of SHIP Clients: Demographics and Presenting Issues

6.1 Introduction

This chapter of the report draws on data from a file audit in order to provide details of the experiences and characteristics of clients who attended SHIP. This chapter details demographic information of SHIP clients as well as outlining the risk factors and levels of distress with which clients presented to the service.

6.2 Data and Methodology

The file audit data consists of 85 randomly selected client files. The audit was undertaken on agreed data that was extracted from recording forms and, to a lesser degree, narrative fields within the files. This information was completed by the counsellor following counsellor-client dialogue. Some information was recorded using template forms with pre-selected categories or check boxes, while other information was recorded as case notes.

6.3 Client Demographics

In total, the file audit sample consists of 85 cases which are representative of the broader service-user population of SHIP in terms of gender and age. Selected files consisted of 33 (38.8%) males and 52 (61.2%) females. The age range of the sample was 15–67, with an average service-user age of 30.13 years. Nearly 70% of the sample were married or partnered, while 20 (23.5%) of the sample were single, with no information[20] available for the remaining six. Within the sample, 32 (37.6%) people had children while the remaining 53 (62.4%) did not. In terms of employment, just 17 (20.0%) people were employed, 29 (34.1%) were unemployed and the remaining 39 (45.9%) were students.

Table 4.1: Demographic details of SHIP service-users

Demographic	Service-User
Gender	
Male	33 (38.8%)
Female	52 (61.2%)
Age range	15-67 years
Mean age	30.13 years
Marital Status	

[20] Individuals for whom there was 'no data' or 'missing data' means there was no information regarding a certain variable when the case file audit was carried out.

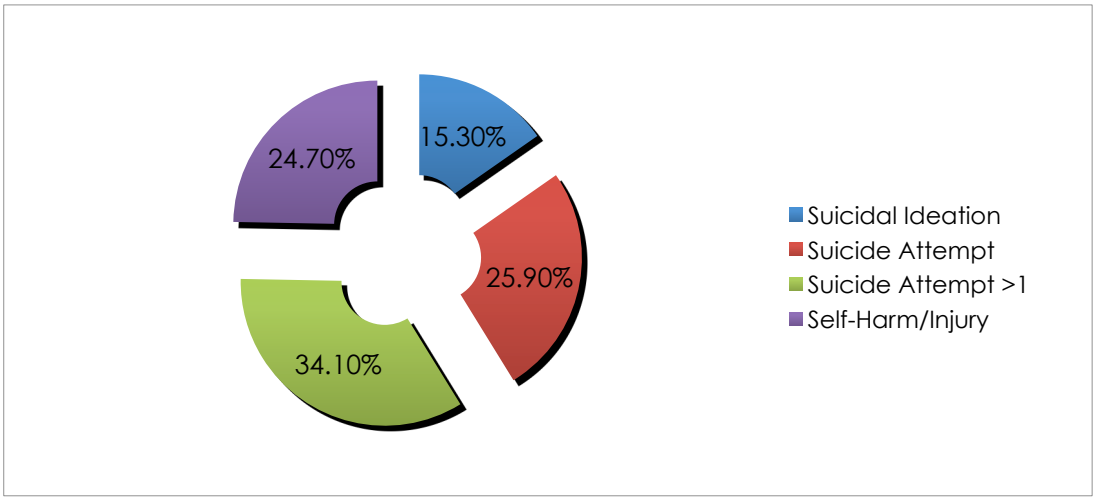
Married/partner	59 (69.4%)
Single	20 (23.5%)
No Info	6 (7.1%)
Children	
Yes	32 (37.6%)
No	53 (62.4%)
Employment Status	
Employed	17 (20.0%)
Unemployed	29 (34.1%)
Student	39 (45.9%)

6.4 Risk Factors Associated with Suicide

The file audit identified a number of factors deemed to be associated with suicide. These included previous suicidal ideation or attempts, alcohol and drug use, psychiatric disorders, physical health problems, hopelessness and/or helplessness, relationship disruptions and/or loss, perceived social isolation, and financial or housing difficulties.

Suicidal ideation has been strongly linked with suicidal risk. SHIP looked at previous suicide attempts with reference to lethality, availability and intent. Within the file audit, clients were grouped according to suicidal ideation and behaviours. Suicidal ideation only had been experienced by 15% of people (n=13), and suicidal ideas are assumed to have been present for those who previously attempted suicide. 26% had experienced a previous suicide attempt (n=22), and 34% (n=29) had experienced more than one previous suicide attempt. Prior experiences of self-harm/self-injury was reported by 25% (n=21). Clearly with nearly 85% of the present sample admitting to previous self-harm or at least one suicide attempt, the present group of SHIP clients constitute a high-risk sample. Frequencies for these categories are shown in Figure 4.1.

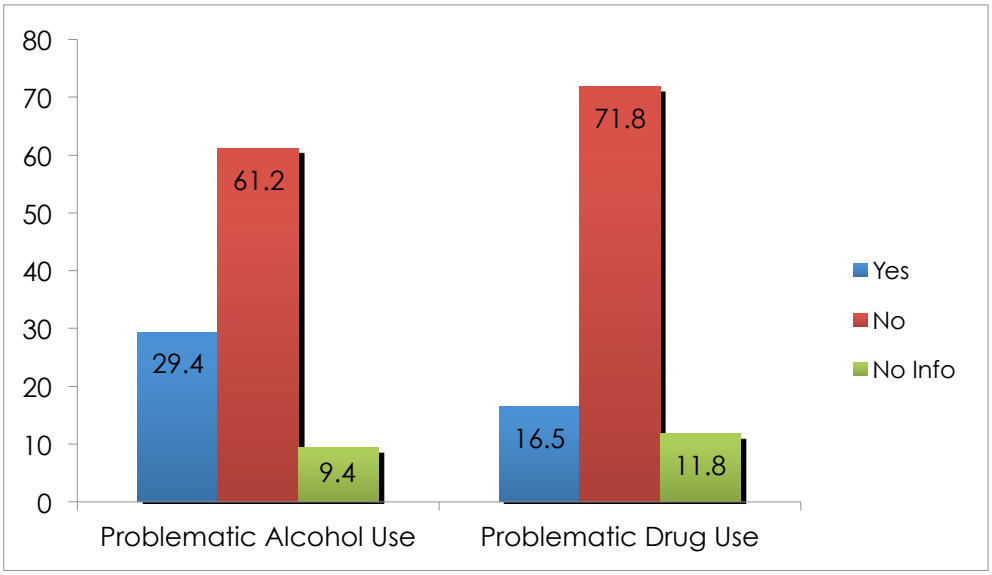
Figure 4.1: Previous Attempts at Suicide or Self-Harm



The harmful use of alcohol and drugs has also been linked strongly with suicidal behaviours. Counsellors at SHIP asked clients about alcohol and drug abuse in terms of both frequency and amount. For the purposes of the present file audit, the presence of problematic alcohol or drug use was determined by the counsellor and indicated by 'Yes' or 'No'. As illustrated in figure 4.2 below, 25 (29.4%) of this sample of SHIP service users were deemed to have problematic alcohol use, while 52 (61.2%) were not problematic drinkers. There was no information on the alcohol consumption of 8 (9.4%) participants.

In terms of illicit drugs, 14 (16.5%) of this sample were engaging in problematic drug use, while 61 (71.8%) were not. There was no data for 10 (11.8%) individuals.

Figure 4.2: Problematic Drug and Alcohol Use.



The presence of one or more psychiatric diagnoses or conditions has also been well established as a significant predictor for suicidal behaviours. The present file audit categorised the prevalence of certain psychiatric conditions within the sample into primary diagnosis, secondary diagnosis, and tertiary diagnosis. This breakdown allowed the analysis to capture the co-morbidity of psychiatric disorders, i.e. the presence of one or

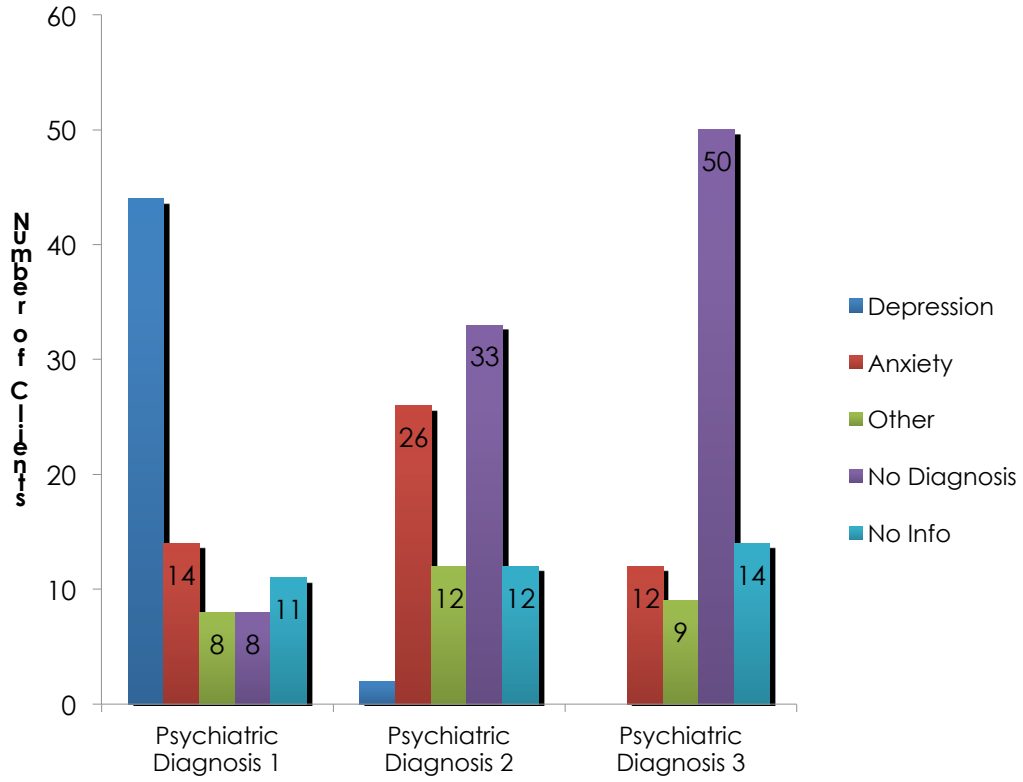
more disorders co-occurring with a primary disorder. See Figure 4.3 below for an illustration of these results.

By far the most prevalent primary diagnosis of this sample was depression, with 44 (51.8%) of the sample having been diagnosed with the disorder. Other present conditions included anxiety disorders[21] (n=14; 16.5%), and other disorders[22] (n=8; 9.4%). While there was no information for 11 (12.9%) individuals, a further 8 (9.4%) service users reported not having been diagnosed with any psychiatric disorder.

Looking at co-morbid psychiatric diagnoses, the most common category was 'none' with 33 (38.8%) service users. Following this, anxiety disorders were reported by 26 (30.6%) individuals, 'other' diagnoses was reported by 12 (14.1%), while 2 (2.4%) service users suffered from depression.

No third psychiatric disorder was reported by 50 (58.8%) of the service users in the current sample. Of those who did report a tertiary diagnosis, 11 (12.9%) reported panic attacks, 9 (10.6%) reported 'other' diagnosis and 1 (1.2%) individual reported suffering from anxiety.

Figure 4.3: Psychiatric History of Service-Users



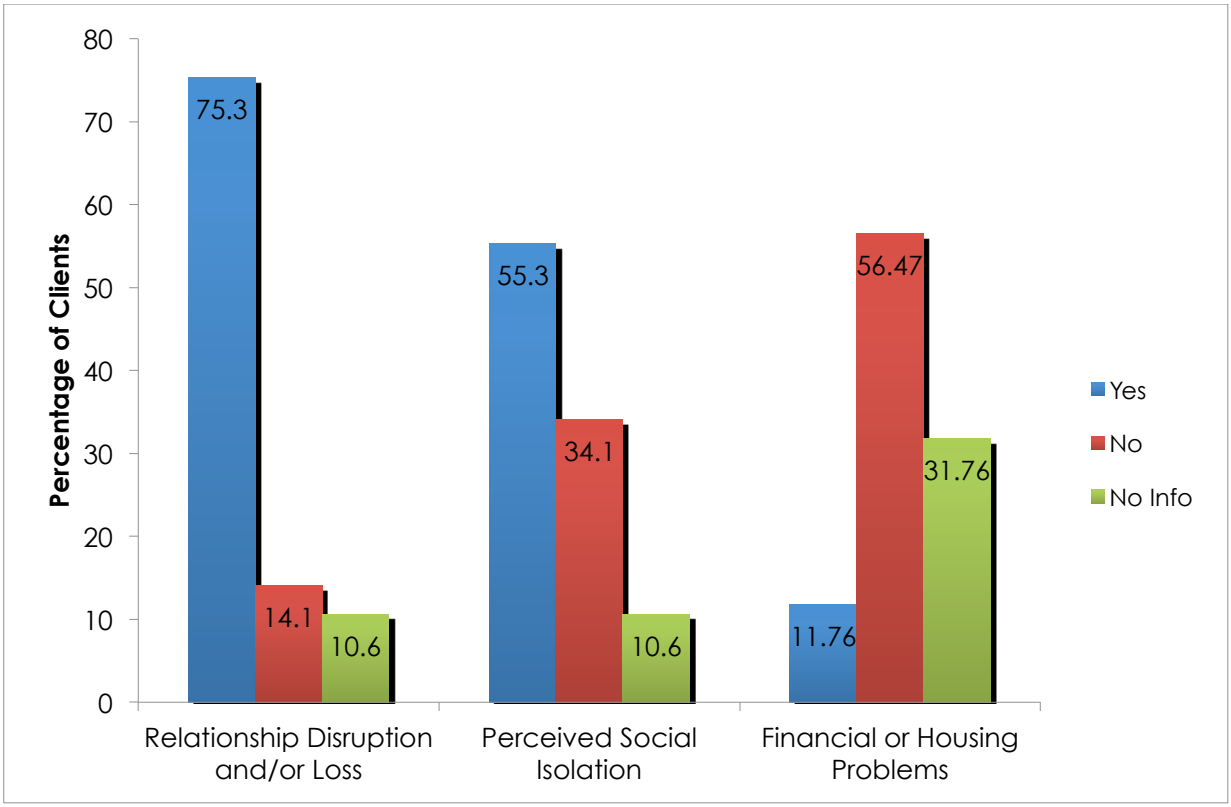
The file audit of SHIP service users also examined whether or not perceived social and financial stressors were present in services users' lives. A large majority of the present sample of service users admitted to having experienced disruption and/or loss of a

[21] 'Anxiety Disorders' in this report refers to any form of anxiety disorder, e.g. generalised anxiety disorder, social anxiety disorder, panic disorder, agoraphobia, simple phobias.
[22] 'Other Disorders' in this report refers to any other psychiatric disorder not listed. This could include psychotic illnesses, personality disorders etc. However due to the nature of data collected, it is not possible to distinguish between these 'other' diagnoses.

relationship in the months leading up to their contact with SHIP (n = 64; 75.3%). While there was no information on this topic for nine (10.6%) individuals, 12 (14.1%) service users said they had not experienced these relationship difficulties.

Another majority of 47 (55.3%) of the sample perceived themselves to be socially isolated at the time of accessing support at SHIP. However 29 (34.1%) service users did not perceive themselves to be socially isolated, with no data for nine (10.6%) participants. In terms of financial difficulties, there was a large amount of individuals for whom there was no data on this subject (n = 26; 31.7%). However, a further 10 (11.8%) service users reported having financial or housing concerns, while the remaining 48 (56.7%) did not.

Figure 4.4: Presence of Social and Financial Stressors



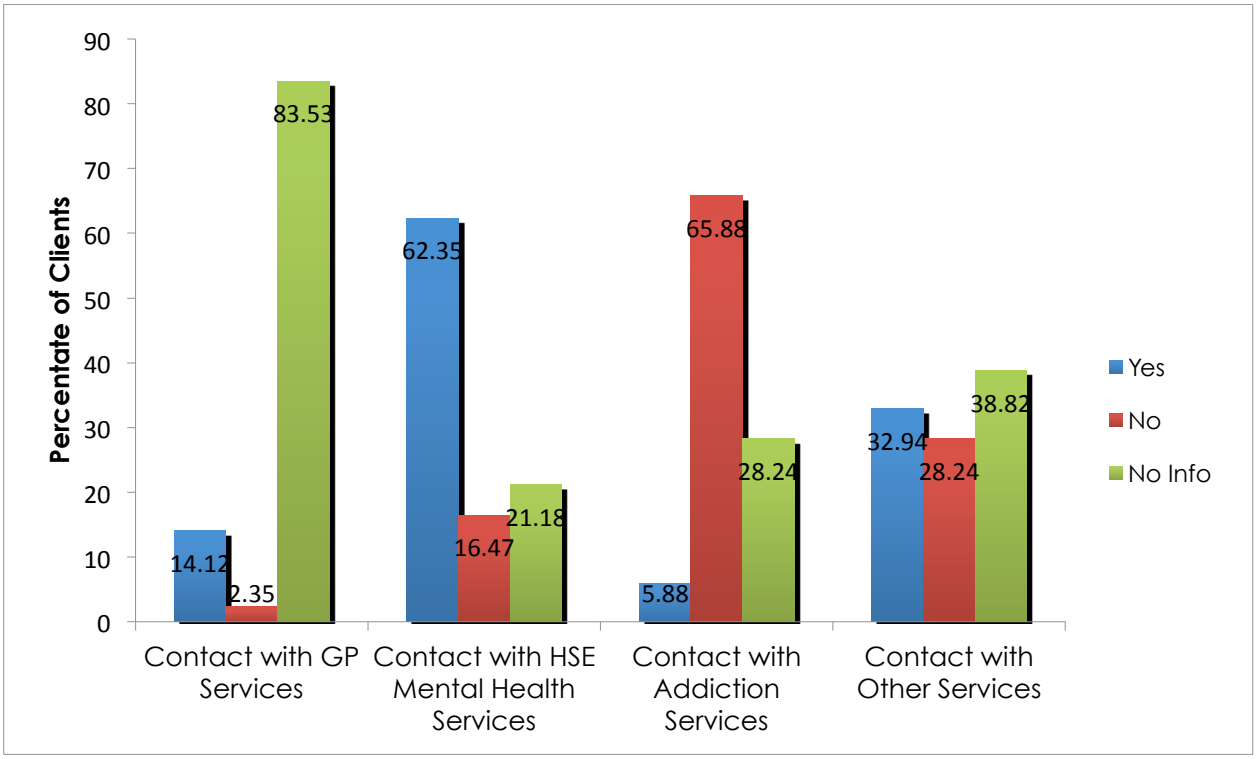
Client contact with alternative services was also examined by the present file audit. Contact with the GP, HSE mental health services, addiction services, and other services were all investigated (See Figure 4.5 below).

The most common service with which the current sample had contact was the HSE Mental Health Services (n = 53; 62.4%). A further 28 (32.9%) of the sample stated having had contact with 'other' services, although it is unclear as to what these services were, and 12 (14.1%) had been in contact with GP services[23], while only 5 (5.9%) had previous contact with addiction services.

[23] This point requires further clarification with Athol in relation to cross referencing this to referral data

A total of 56 (65.9%) of this sample of service users have not had contact with addiction services, 24 (28.2%) have had no contact with 'other' services. In total, 14 (16.5%) service users said they had not had contact with HSE Mental Health Services.

Figure 4.5: Contact with Other Services



6.5 Summary

The findings give an insight into the service-user population of SHIP. It is vitally important to have an awareness of a service's clientele in order to ensure that the service meets the needs of those who use it most. Furthermore, this knowledge also allows a service to target groups that it may not be reaching as adequately.

More than 60% of SHIP's clients were female. Nearly 35% of its service-users were unemployed. The vast majority of service-users (nearly 70%) were married or partnered, while nearly 40% of the sample had children. The average age observed was 30 years old, with a varied age range of 15–67. Consistent with a service dealing with suicidal behaviours, by far the most common diagnosis among service-users was depression (nearly 45%). More than 10% of the sample suffered from anxiety as a primary psychiatric diagnosis.

In terms of presenting problems, only 15.3% of SHIP service-users were experiencing suicidal ideation at the time of presenting to SHIP (i.e. thinking of suicidal behaviours), while the remaining 85% had either attempted suicide at least once, or had a history of self-harming. Substance misuse also appears to be a common feature among SHIP service-users, with 30% reporting misuse of alcohol and 16.5% reporting illicit drug misuse. At presentation to the service, there were also very large numbers of service users who reported recent disruption to or loss of a relationship (more than 75%) as well as perceived social isolation

(more than 55%). The file audit evidences the high-risk nature of the SHIP client group in relation to suicide risk factors and also provides evidence that the SHIP therapeutic model has the inherent capacity and flexibility to respond to a wide range of presentations across primary and secondary care mental health services.

7 Client Outcomes

7.1 Overview

This chapter provides an analysis of SHIP client outcomes using the results of 80 self-rated CORE-OM questionnaires. This measure was completed both pre and post therapy in order to determine outcomes in terms of clinical change. Preceding an analysis of the client outcomes, a context is provided: the gap in evidence that existed both in general psychology in relation to outcome reporting over much of the last two decade is analysed. This gap was also present in SHIP prior to the introduction of the CORE tool to the service in 2013. This chapter also provides evidence for the efficacy of CORE-OM as an outcome measurement tool while providing a discussion and context for the data that the tool provides.

7.2 CORE-OM Tool

Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM) is a widely accepted brief outcome measure for routine use in a variety of mental health services and settings. It has been used within SHIP as a brief outcome measure of symptoms, general well-being, functioning, and risk to self or others. CORE-OM is widely regarded as providing a detailed, reliable and sensitive measure of clients' levels of distress on presentation to a service and, if repeated on exit, the tool is a useful outcome measure of a mental health intervention.

7.3 The Need for Shared Outcome Measures

CORE-OM was originally developed in response to a growing body of literature that criticised the lack of a unified outcome measure in therapy. As early as 1970, the possibility of developing a core outcome battery for use across studies focusing on the evaluation of the psychological therapies was being discussed (50). The United Kingdom's Strategic Review of Psychotherapy was the first Government-sponsored paper to identify the need to develop and utilise common outcome measures as part of a framework of clinical effectiveness (51). The wide variability of measures in routine use in the UK, and indeed elsewhere at the time, meant there could be little comparability of measures, and therefore outcomes, across services(52). Froyd and colleagues went further to argue that '... Without some direct action, psychological therapy outcome measurement will remain in a state of disarray, if not chaos…' (53).

The fact that so many inadequately tested and developed measures were in widespread use contributed to a widespread and damaging myth that the potential efficacy of psychotherapy was unmeasurable (54). Various surveys in both the UK and the United States assessed the extent of variability within services in relation to outcome measures. Froyd and colleagues found psychotherapy studies reporting outcome data from 1430 measures, of which 851 (60%) were used just once and 278 provided no psychometric data on the measures (52). They found that only a small number of tools were being used by more than a handful of services, thus giving some standard for comparability. These included the Beck Depression Inventory, the Hospital Anxiety and Depression Scales, the General Health Questionnaire, the Rosenberg Self-Esteem Inventory, and the Inventory of Interpersonal Problems [6, 7, 8, 9, 10]. This 'chaos' resulted in successive calls by numerous stakeholders to develop a standard outcome measure or framework which was short, pan-

theoretical, sensitive to clinical changes, valid and reliable, and could add to case management as well as provide inter-service comparison (60).

7.4 CORE-OM

CORE-OM was devised to address this gap in both service delivery and research (61). The CORE-OM comprises 34 items addressing domains of subjective well-being (4 items), symptoms (12 items), functioning (12 items) and risk (6 items: 4 'risk to self' items and 2 'risk to others' items) (62). Half of the items focus on low-intensity problems (e.g. 'I feel anxious/nervous') and half focus on high-intensity problems (e.g. 'I feel panic/terror'). Items are scored on a five-point scale from 0 to 4 (anchored '*Not at all*', '*Only occasionally*', '*Sometimes*', '*Often*', and '*All or most of the time*'). Eight items are keyed positively (phrased positively) with the remaining items keyed negatively (63). In terms of psychometric properties, this measure has been widely accepted; internal reliability and test-retest reliability are high with scores showing excellent convergent validity against the dominant measures mentioned above (64). This demonstrates that CORE is still in fact measuring the same symptoms and risk as measured previously in the most commonly used tools, however, with the added advantage of being in one brief measurement tool. In order for any tool to be useful in assessing meaningful change over the course of therapy, it must demonstrate two key properties: reliable change and clinically significant change (50). As already suggested, CORE-OM demonstrates good psychometric properties of reliability. Importantly, this outcome tool has also shown to be capable of detecting clinically significant change in groups between pre-and post-therapy administration of the tool, i.e. as indicated when a client's CORE-OM score moves from the clinical to the non-clinical population (65).

Since validation, the CORE-OM has been shown to be useful for use in a wide range of settings, including primary and secondary care psychological services (62) general population samples, as well as with students, teenagers (66), and cross-culturally in countries as diverse as the UK, North America and South Africa (67). As a result of the initial success of the measure, several variations of the CORE-OM have been devised to facilitate the routine use and administration of the measure by a larger group of professionals from psychologists, to school counsellors and general practitioners (68).

Therefore it appears the CORE-OM is a valid, reliable and sensitive user-friendly tool, which is appropriate for use across a range of settings and populations, including that of SHIP. Thornicroft and Slade have posed a question as to whether *"mental health outcome measures be developed which meet the following three criteria: (1) standardised, (2) acceptable to clinicians, (3) feasible for on-going routine use? We shall argue that the answers at present are 'yes', 'perhaps', and 'not known'"* (69). Evans and colleagues argue that the CORE-OM stands on a strong platform of research and can now answer 'yes', 'largely', and 'generally' to these criteria (64).

7.5 Appropriateness of CORE as an Outcome Tool for SHIP

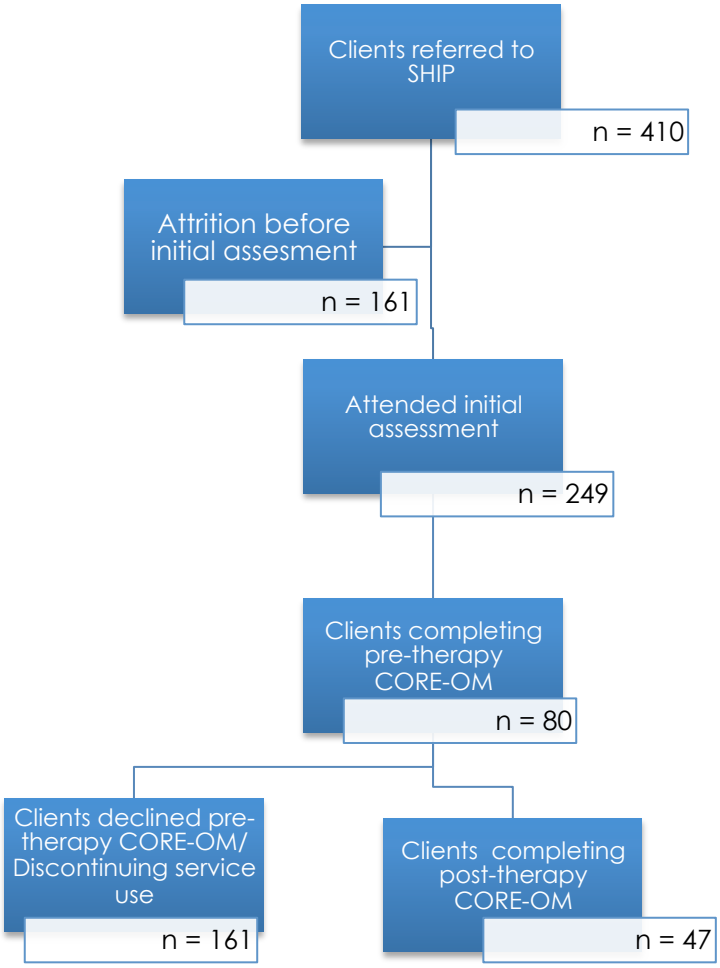
It can be concluded that CORE-OM is an appropriate tool for routine use within SHIP and will provide useful data not only for the evaluation of the service itself, but also for comparison to other services in the sector. The tool also provides professionals with important clinical data in relation to risk that assists in providing tailored services.

SHIP has used the CORE-OM as an outcomes tool since early 2013. This next section of the chapter provides an analysis of the data derived from CORE-OM for over 80 service users,

giving an accurate, reliable, and comparable measure of client outcomes from pre to post engagement of SHIP.

Below is an illustration of client throughput through the SHIP service. As can be seen in Figure 7.1, there was baseline (BL) CORE-OM data obtained for 80 service users, with one service user providing post therapy CORE-OM data only. This represents 32% of those service users who attended for initial assessment at the service.

Figure 7.1: Consort or 'flow' diagram for client throughput through SHIP.



The difference between the number of completed CORE-OM assessments (both pre and post) and the whole population receiving services over this time is due to range of factors, including the bedding in of a new service, the reluctance by some clients to complete assessments and some clients not completing the last session of their programme. This limitation suggests that a repetition of this aspect of the research should be undertaken once more complete data is available.

7.6 Analysis of SHIP CORE-OM data

The sample analysed in this section of the report includes 80 CORE-OM responses from service users. As discussed previously, the tool acts as a screening tool to determine the levels of distress and impaired functioning of clients presenting to SHIP, and also measures change in these levels of distress over the course of therapy.

The population for this sample consisted of all clients attending the service since the introduction of the tool. However, between 44 and 47 (55%-59%) people out of 80 completed both pre and post on each assessment and a further number of clients completed neither the pre nor post assessment (rates of completion are discussed further in section 7.7 below). Despite the large rate of participant attrition from pre to post measures, the analyses were run with the full sample for two main reasons. Firstly, the CORE-OM acts as a screening tool and enabled an examination of the psychological distress (or lack thereof) of those attending the SHIP service. Secondly, as there is no accompanying data with the CORE-OM scores, e.g. demographic data, there can be no investigation of this missing data's randomness. Therefore, at the risk of introducing bias into the dataset and significantly reducing the power of the dataset, the full dataset was analysed.

The analysis examined a range of variables pertinent to the SHIP service from CORE-OM completion rates to levels of distress at presentation to SHIP and subsequent changes in these variables over the course of therapy. Due to the high-risk nature of the population specifically targeted by SHIP, an analysis of the risk sub-scale of the CORE-OM was also carried out. Outcomes as measured by the CORE-OM were also assessed with respect to the two main variables of gender (i.e. male/female) and time of testing (i.e. pre/post). The effects of both of these variables were examined independently (i.e. does gender impact on CORE-OM score or does time of testing impact on CORE-OM scores), as well as any potential interaction (i.e. does gender influence any potential change in CORE-OM scores over time). This analysis makes it possible to determine if both groups (i.e. male/female) change in the same way over the two time points.

7.7 CORE-OM Completion Rates

Completion rates for both baseline and follow-up data were adequate. More than half of the sample (58%) completed the CORE-OM at both pre- and post-therapy time points. A significant number (33%) of service users completed a baseline CORE-OM but no follow-up measure at the end of therapy. One service user completed the CORE-OM at the end of therapy only.

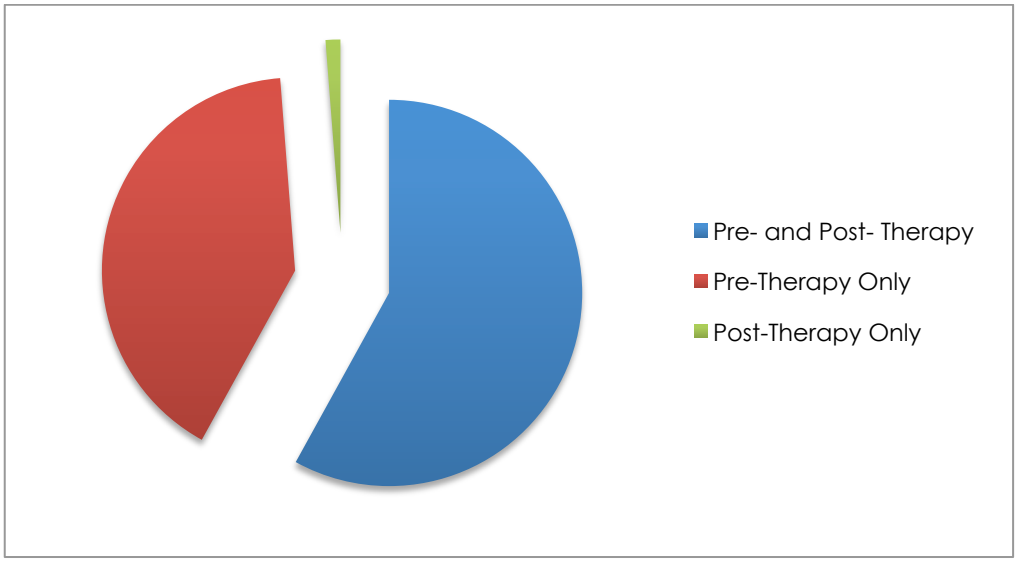
Previous research examining CORE-OM completion rates has found an average of 43% of clients completed both the pre and post CORE-OM measures (63). The SHIP service would compare very favourably to these, with an average of 58% completion at both time points. However, it should be noted that if all service users who completed an initial assessment are to be considered the full sample, then completion rates at baseline fall to 32% and 18% for both pre and post completion. These would be considered low by comparison to other studies which have used the CORE-OM tool in secondary care settings, achieving completion rates as high as 98%(63).

Table 7.1: Percentage of CORE-OM completion pre- and/or post-therapy

Time of CORE-OM Completion	Male		Female		Overall sample	
	N	(%)	N	(%)	N	(%)
Pre – and post therapy	16	(51%)	31	(62%)	47	(58%)
Pre – therapy only	14	(45%)	19	(38%)	33	(41%)
Post – therapy only	1	(4%)	0	(0%)	1	(1%)
Total	31	(100%)	50	(100%)	81	(100%)

There was a substantial attrition rate of participants who completed a baseline CORE-OM with 41% not completing the measure following the termination of therapy. Therefore, in looking at rates of improvement in terms of outcomes with the present sample, consideration should be given to the large amount of missing data. This is discussed further in the summary of key findings, 7.11.

Figure 7.2: CORE-OM Completion Rates



7.8 Analysis of SHIP CORE-OM data; Clinical Cut-Off

The initial descriptive statistics of the CORE-OM presented in Table 7.2 suggest a general improvement in terms of client wellbeing, problems, functioning and risk to self and others. Looking to the means, these differences appear to be substantial. Whether or not these differences are statistically significant as well as whether there are gender differences is explored in more detail throughout the remainder of the chapter.

Table 7.2: Mean and N of CORE-OM

Sub-scale	Pre Therapy Mean (n)	Post Therapy Mean (n)
CORE-OM Wellbeing	2.23 (80)	1.08 (47)
CORE-OM Problems	2.12 (80)	1.01 (45)
CORE-OM Functioning	1.85 (80)	0.94 (45)
CORE-OM Risk	0.82 (80)	0.32 (45)
CORE-OM Total	1.80 (80)	0.83 (45)
CORE-OM Total less Risk	1.99 (79)	0.95 (44)

Further to looking at the general improvement trend in the means, the analysis also examined the proportion of SHIP service users who presented above the clinical cut-off point. Clinical scores are computed as the mean of all completed items multiplied by 10 so that clinically meaningful differences are represented by whole numbers. In this way, clinical scores can be between zero and 40 without altering the psychometric properties of the instrument. Following numerous research studies which have investigated this research tool, a total CORE-OM score of 10 or above places an individual into the clinical range, while under 10 is considered normal for both males and females.

In the present sample, a very large proportion (81%) of clients presented to the SHIP service within the clinical range. As expected due to the nature of the service that SHIP provides, only one quarter of the sample (24%) fell into the normal population. At the end of therapy, the follow-up CORE-OM measure saw the number of those in the clinical range drop very substantially, going down to as low as 24% for males and 28% overall. Therefore, nearly three quarters (72%) of those who completed a post-therapy CORE-OM measure were in the normal range at follow-up.

Table 7. 3: Baseline and follow-up CORE-OM Scores, i.e. CORE-OM scores at presentation to SHIP service and at termination of therapy

	Male		Female		Overall sample		Sample Characteristics	
Baseline CORE-OM								
	N	**(%)**	**N**	**(%)**	**N**	**(%)**	**Median**	**S.D**
Below Clinical Cut-Off	7	(24%)	8	(16%)	15	(19%)	5.67	2.8
Above Clinical Cut-Off	23	(76%)	42	(84%)	65	(81%)	10.07	7.86
Total	30	(100%)	50	(100%)	80	(100%)		
Follow-Up CORE-OM Score								
Below Clinical Cut-Off	13	(76%)	21	(70%)	34	(72%)	4.9	2.7
Above Clinical Cut-Off	4	(24%)	9	(30%)	13	(28%)	16.0	7.2
Total	17	(100)	30	(100)	47	(100)		

7.9 Analysis of CORE-OM change scores

In order to determine any amelioration of psychological distress as measured by CORE-OM, total change scores were analysed. Previous research (61) has established benchmarking regarding the degree by which CORE-OM scores have to change before it can be attributable to the SHIP counselling service, as opposed to normal fluctuation in feelings.

A change of more than 0.48 per question is needed for there to be 'reliable change', whether that be improvement or deterioration. For simplicity, this figure is rounded and adjusted for the clinical scale. Therefore, if a CORE-OM total score changes by five or more points, the service user has shown 'reliable change'. The terms used to categorise change scores are described below:

- Clinical change: occurs if a client moves from above the clinical cut-off at baseline to below the clinical cut-off at follow-up. Clinical change could also move in the other direction if a service user disimproves over the course of therapy.
- Reliable improvement: used to describe those service users who show positive reliable change, but stay within the clinical population.
- Recovery: happens when a service user demonstrates both reliable improvement and moves from the clinical to the non-clinical population.

The table 7.4 below illustrates service user change scores from pre-to-post-therapy. As can be seen in the table, the majority of service users (65%) reported CORE-OM scores that were indicative of reliable improvement. The majority of the cohort who improved, 45% of the entire sample, was deemed to have 'recovered'. This compares favourably with other studies that have demonstrated similar levels of recovery(62). One fifth (20%) of the sample showed reliable 'improvement' but did not move from clinical to normal populations and so were not deemed to have recovered.

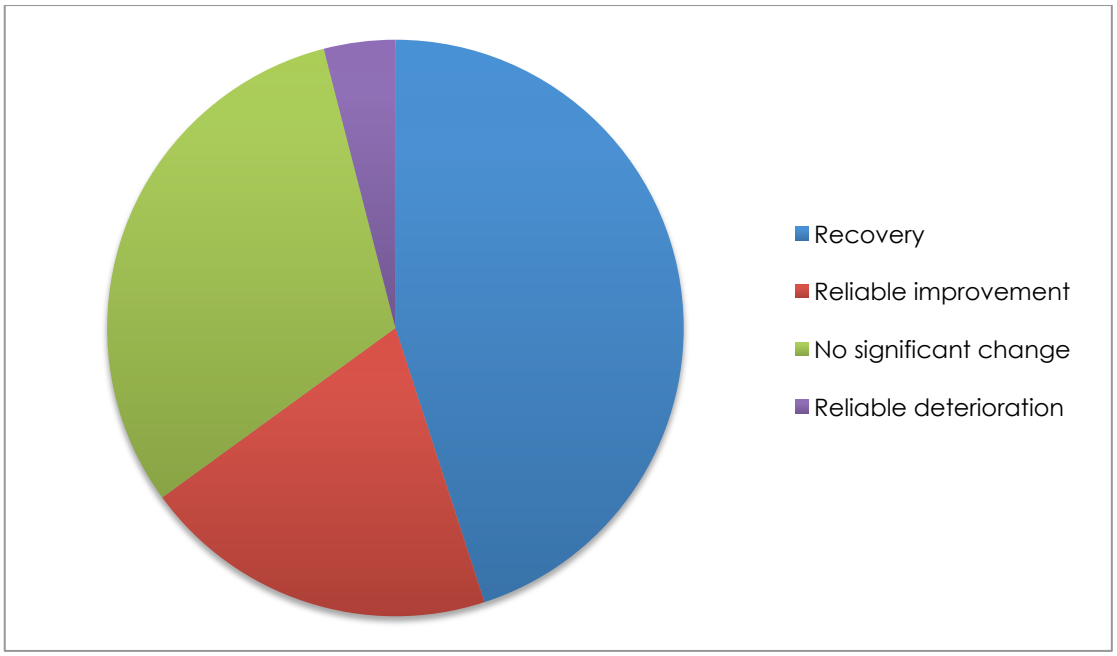
Two clients reported reliable deterioration following therapy, however these clients did not cross the clinical cut-off point and so their deterioration was not deemed to be clinical. A further proportion of the sample (31%) remained within the same population (clinical vs. normal) as their baseline CORE-OM measured and did not meet the criteria to demonstrate reliable statistical change.

Table 7.4: CORE-OM Change score from pre- to post-therapy

	Number of Clients	Percent	Cumulative
Recovery*	22	45%	All 'Improved' 65%
Improvement**	9	20%	
Reliable & clinical deterioration	0	0%	
Reliable deterioration only	2	4%	All reliably 'worse'4%
No significant change (presented above cut-off)	7	15%	All 'no change' 31%
No significant change (presented below cut-off)	8	16	
Total	48		

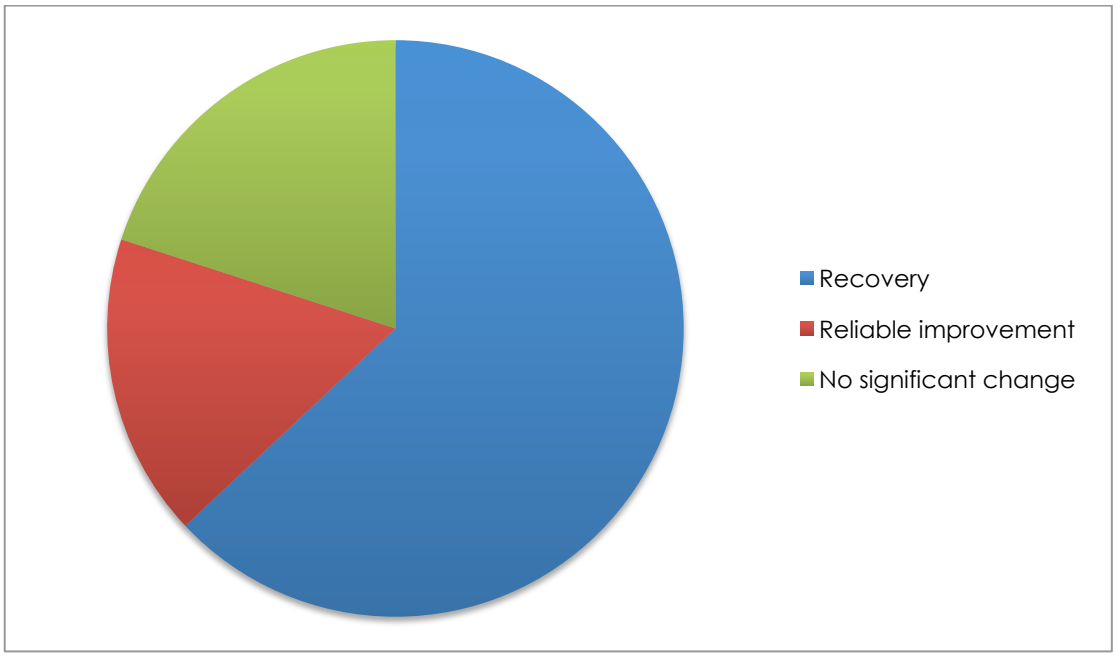
As illustrated in Figure 7.3 below, 65% of clients demonstrated reliable improvement with the most likely outcome for service users being 'recovery'. A substantial proportion of clients (20%) showed reliable improvement while 31% of clients showed no significant change.

Figure 7.3: Proportion of client improvement



Due to the high risk nature of the client population that SHIP targets, it is also worth examining the outcomes of those who come to the service in considerable psychological distress, i.e. those with a CORE-OM total score above the clinical cut-off. Of those who were clinically distressed at presentation to the SHIP service, a large majority (63%) of these clients were 'recovered' at the end of therapy. A further 17% of these service users showed reliable improvement at the end of therapy, while the remaining 20% did not change significantly following therapy. Of those who presented to SHIP within the clinical range, there was no service user who deteriorated significantly.

Figure 7.4: Proportion of client improvement for those who presented above the clinically distressed cut-off point / Measurement of significant change in distressed sample



*NOTE: No participant who presented to the SHIP service reported a total CORE-OM score that indicated a reliable deterioration.

7.10 Analysis of Client Risk

As SHIP specifically targets a suicidal or self-harming population, the risk component of the CORE-OM tool was analysed to determine the level of risk of clients who present at the service. Barkham (63) has established benchmarks in order to categorise risk severity. All scores greater than zero constitute some risk: scores greater than five are indicative that the client is clinically at risk, while those scoring greater than 10 are considered to be high risk.

Looking at the figures in table 7.5 below, only a quarter (26%) of the clients using the SHIP service reported no risk at all prior to therapy. A further 14% of service users displayed some level of risk but were below the clinical cut-off. At presentation to the SHIP service, the majority of service users (60%) were deemed to be clinically 'at risk', with the majority of these service users demonstrating high levels of risk.

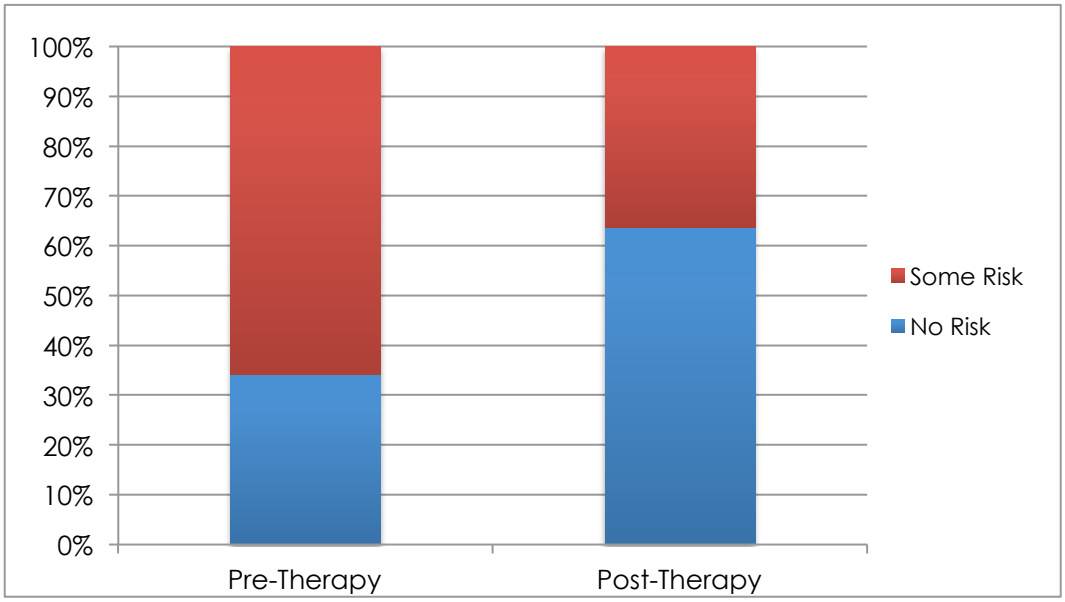
Following therapy, risk scores were substantially reduced, with 65% of service users reporting no risk at all. A further quarter (24%) of SHIP clients showed some risk following therapy, but these did not reach clinical levels. Only one in ten (11%) SHIP service users demonstrated clinical levels of risk following therapy. This figure is substantially lower than the 60% of clients who displayed clinical risk at baseline.

Table 7.5: CORE-OM Risk scores pre- and post-therapy.

	Number of Clients	Percent		Number of Clients	Percent
Category of risk pre-therapy			**Category of risk post-therapy**		
No risk	21	26%		30	65%
Some risk (but less than clinical risk)	11	14%		11	24%
Clinical levels of risk	16	20%		0	0%
High levels of risk	32	40%		5	11%
Total	80	100%		46	100

As most clients score zero on all risk items, any score on the risk scale is some cause for concern. Figure 7.5 below groups service users into 'some risk' versus 'no risk'. In order to give an accurate representation of change in this domain from pre to post therapy, only those who completed a CORE-OM at both time points were included in this analysis. Of the 44 clients who provided full data, a very high proportion (29 clients; 65.9%) of service users reported some degree of risk at baseline, i.e. any score greater than 0. This figure fell substantially following therapy, with only 16 clients (36.4%) reporting some degree of risk.

Figure 7.5: Change in risk scores from pre-to post-therapy



7.11 Analysis of CORE-OM/Gender interaction on total score

A mixed between-within subject analysis of variance was conducted to assess any impact of time of testing (pre/post) or gender on CORE-OM total score. These analyses were also conducted for all sub-scales of the CORE-OM and are reported elsewhere (see Appendix A for a full table of results).

There was no interaction effect found between the time of testing and gender, as well as no main effect of gender on either of the total measures of overall distress as measured by

the CORE-OM. There was, however, a statistically significant decrease in overall distress scores on the total score following therapy.

As the general trend in previous analyses has suggested, total distress scores for both males and females reduced, moving from clinically distressed to a normal range. Illustrated in Figure 4.10 below, both males and females total distress minus risk scores also decreased from a clinical to normal range.

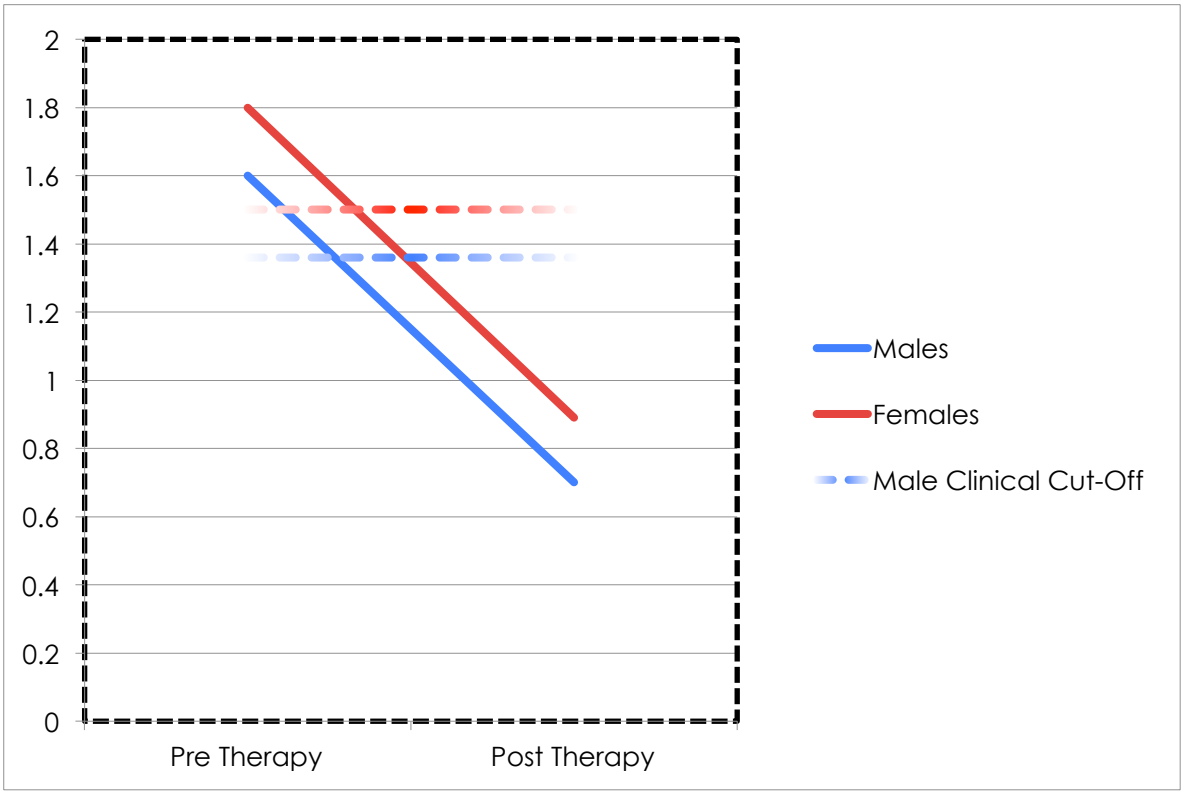


Figure 4.10: Mean CORE-OM Total Distress scores for males and females

7.12 Summary and Discussion of Key Findings

The findings demonstrate clearly that those service users who present at SHIP in considerable psychological distress also present a very high risk of suicide and self-harm.

The findings report very encouraging data for the SHIP service and its potential value to those who avail of its services. A very large proportion (81%) of clients presented to the SHIP service within the clinical range. This figure is comparable to the 76.5% of service users within the clinical range reported elsewhere following research in secondary care(63) settings.

Looking to benchmark data for CORE-OM change scores, the findings provide evidence that the SHIP service is meeting the needs of service users, and thus reducing levels of psychological distress. This samples rate of 'recovery' of 45%, places these rates of recovery as just 'below average' in terms of primary care counselling services, where the average rate of recovery is 51%. While these figures are just slightly below the average recovery rates of UK counselling services, the time-limited model utilised by the SHIP service reflects impressively on the recovery rates. Given that 12 therapy sessions were completed by only 31% of SHIP clients (section 8.6), it is likely that further counselling exposure would further improve client outcomes.

Furthermore, the average reliable improvement rate in primary care counselling services is 20%, a figure matched exactly by SHIP. This is notable considering that SHIP provides time-limited counselling as opposed to more resource-intensive unlimited models.

The SHIP service also had slightly raised reliable deterioration rates (4% vs. 1.3%) while demonstrating a slightly greater portion of clients who reported no reliable change (31% vs. 27.9%). These figures demonstrate that the SHIP service compares well with both primary and secondary care counselling services.

The analysis also examined the level of risk of SHIP service users as measured by a sub-scale of the CORE-OM. As mentioned previously, as the majority of individuals would be expected to score zero on the risk sub-scale, any score on the risk sub-scale should be some cause for concern. Nearly three quarters of the sample (74%) displayed some level of risk at presentation to the SHIP service. Two thirds of the sample (60%) reported clinical levels of risk, with the majority of these being in the high-risk category. These figures are higher than the level of risk displayed by clients at other secondary care counselling services (56%)(63), as well as other services, such as student counselling settings (52%)(70). Therefore it would appear the sample presented to SHIP are higher risk than would be expected at primary or secondary care counselling services. While this risk is reduced considerably following therapy (65% of the sample displaying no risk), these figures could explain the slightly lower rates of recovery at the SHIP service, i.e. the patients tend to be in more distress on presentation at the service.

A mixed between-within subject analysis of variance was also carried out in order to assess any impact of time of testing (pre/post) or gender on CORE-OM total score. This analysis of CORE-OM scores for 80 clients reveals that there were no significant differences between genders in terms of psychological distress. There was, however a significant reduction in levels of psychological distress as across all of the sub-scales of the CORE-OM from pre therapy to post therapy. Sub categories include wellbeing, problems (or symptoms), functioning, risk, total distress, and total non–risk distress. With the exception of female risk scores, which were close to the threshold for normal functioning at post testing, of significance is that fact that all scores went from clinically distressed to within a normal range following therapy.

While the outcomes for clients are very encouraging, as mentioned throughout the report, completion rates of the CORE-OM tool present a challenge within the report. Firstly, only 80 of the possible 249 clients who attended an initial assessment completed a pre-therapy CORE-OM assessment. This could be for a variety of reasons, including the bedding in of a new service, the reluctance by some clients to complete assessments and some clients not completing the last session of their programme. It is also unknown how many of the clients who attended the initial assessment continued into a course of therapy at the SHIP service, and if not the reasons for this.

Given the stark nature of presenting problems and risk behaviours that are evident for service-users at first presentation to SHIP, there is a clear and urgent need to provide rapid services to these individuals. The encouraging findings in terms of the reduction in psychological distress of SHIP clients provides strong evidence for the effectiveness of SHIP's brief therapeutic intervention. Clearly SHIP has demonstrated that it provides a very effective intervention to those individuals who are desperately in need of these services.

8 Service User Satisfaction Questionnaire Evaluation: Key Findings

8.1 Introduction

This chapter outlines the key findings from the SHIP service user satisfaction questionnaire. It provides an overall demographic profile, background and reasons for accessing SHIP, as well as self-rated characteristics of service users following the therapeutic intervention. This section also summarises service user satisfaction with certain aspects of the SHIP service.

8.2 Data and Methodology

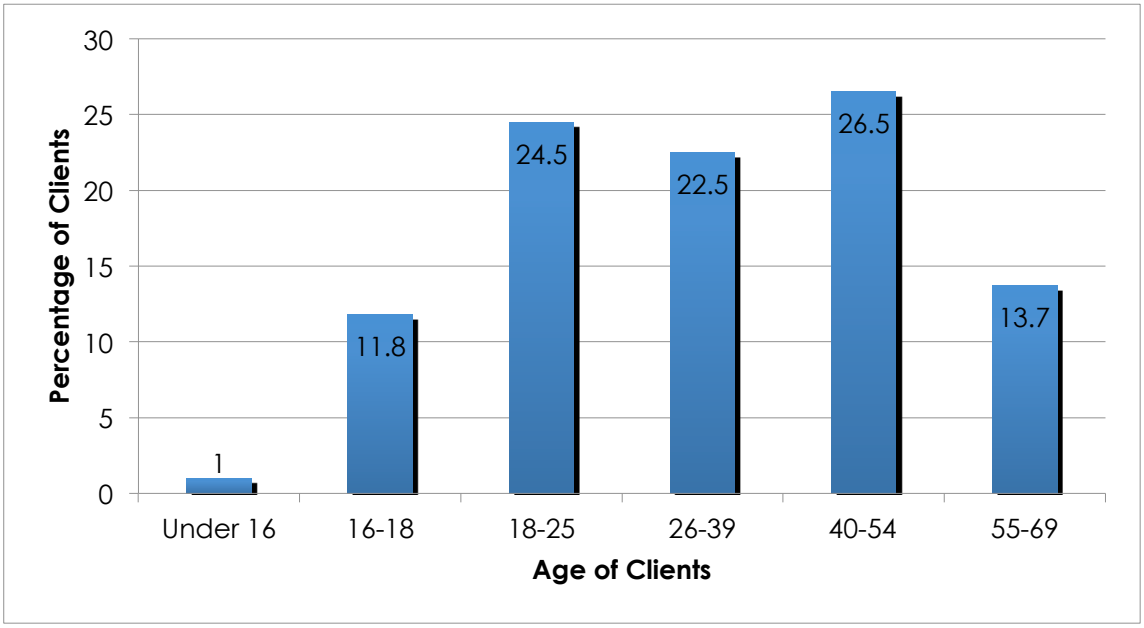
The data within this chapter is from 102 self-rated anonymous service user satisfaction questionnaires following the therapeutic intervention. The SHIP evaluation form was developed from the National Counselling Service Client Evaluation System (see Appendix). Each participant self-reported demographic details including gender, age, referral pathway to SHIP, waiting time to access the service as well as the type of counselling received.

Service users were also asked to retrospectively rate the presence of certain difficulties (e.g. self-harming behaviour, suicidal thoughts, suicidal intent) when they first arrived at SHIP. As well as this, service users rated levels of change in their social, emotional and behavioural wellbeing. This data provides a service user perspective that mirrors some of the categories explored within the CORE-OM clinical assessment and outcomes tool. Finally service users were also asked to give details of the circumstances of how their counselling was ended, and furthermore, whether or not they were satisfied with this ending.

8.3 Client Demographics

In total, there were 102 responses to the evaluation, 39% (40) of whom were male and 61% (62) were female. There was a substantial spread across the ages with 40–54 (27) age group being the most represented among this group of clients. SHIP also saw one person under 16 (1%), 12 people aged 16–18 (11.8%), 25 people from 18–25 (24.5%), 23 people from 26–39 (22.5%), and 14 people from 55–69 (13.7%). Unfortunately there may be some overlap in responders in the 16–18 and the 18–25 categories as individuals who were 18 may fall into both groups. However the number of these individuals is likely to be small and the assumption is made that those over 18 would place themselves in the 18–25 year old category. Figure 3.1 below summarises the age range of presenting clients.

Figure 3.1: Age range of SHIP clients



8.4 Referral Pathways into SHIP

There were also variable pathways of referral into SHIP with the majority of service-users, 72 (71%), being referred to SHIP by another person or service. Only six service users (6%) reported that someone else did not refer them to SHIP, with 24 (23%) clients providing no information to this question.

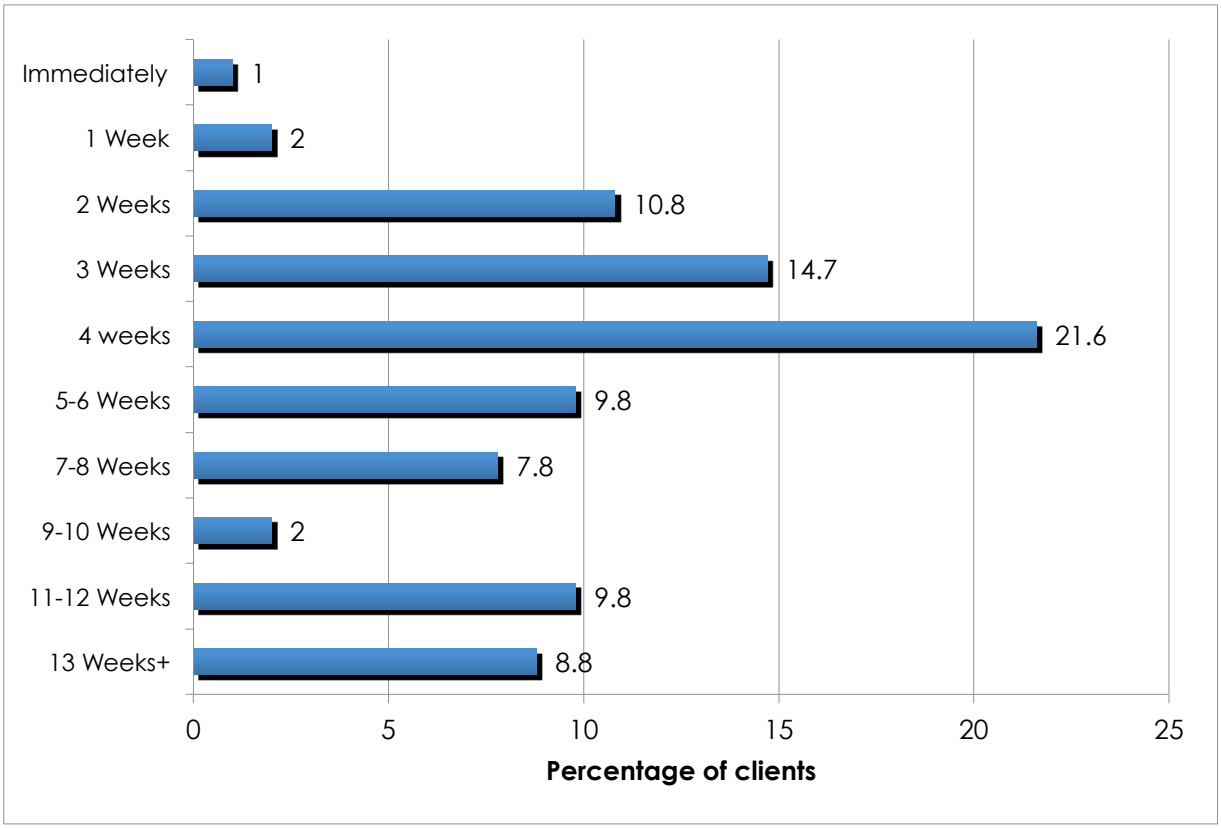
Those who stated they were referred to SHIP by someone else said that they were largely referred by a health care professional. The terms 'Doctor', 'GP', and 'Psychiatrist' were all given in the client's responses and so for this report will all be given separate categories of response. Of those referred by another individual or service, 44 (43.1%) were referred by a 'Doctor', nine (8.8%) were referred by a psychiatrist, while four (3.9%) were referred by their GP. It is likely that there is some overlap between the 'doctor' category and the other two. Other sources of referrals were nurses (n= 5; 5%), social workers (n= 1; 1%), youth workers (n= 1; 1%), and friends (n= 2; 2%).

8.5 Waiting Time to Access SHIP

Information about waiting times was gleaned from the anonymised service user evaluations. This information highlights some facets of the service that can benefit from minor reviews, although it should be noted that the information from the surveys was purely from the client's memory and not recorded by SHIP.

The data from the service users' evaluations shows significant variability between the lengths of time in weeks that clients had to wait before being seen by a SHIP counsellor, which ranged from one client being seen immediately (1%) to nine clients (8.8%) waiting more than thirteen weeks for their first session. The most commonly reported waiting time for service users of SHIP ranged between two weeks (n= 11; 10.8%), three weeks (n= 15; 14.7%), and four weeks (n = 22; 21.6%).

Table 7: Waiting time to access SHIP according to client evaluation



The waiting times noted by clients in their evaluation forms as detailed in this graph differ from records on waiting list times provided by SHIP. This is to be expected, given the different sources of information and interpretations of waiting times, as discussed in more detail below. At the time of writing, SHIP provided a current snapshot showing waiting times ranging from 10 patients waiting up to five weeks (in Waterford) and no waiting list (in Dungarvan and Carlow). At the time of this evaluation, SHIP did not keep retrospective data on waiting lists and the surveys from which the client waiting times were gleaned were anonymous, so direct comparison between SHIP-recorded and client-reported waiting times was not possible. This gap in information informed the recommendation regarding waiting list management.

SHIP management highlighted a number of variables that can impact on waiting lists including referral rates for particular areas (for instance in the snapshot provided, Waterford was experiencing particular waiting lists at that time). The availability and capacity of counsellors for a particular area also played an role in longer waiting times; in some instances the availability of counselling premises contributed to a longer waiting time.

8.5.1 Difference in Interpretation of Waiting Time

The difference in the perception of waiting times between the client evaluation forms and SHIP records may be explained by the different starting and end points to being on the waiting list. The process from the point at which a patient makes the referring agent aware of their self-harming is outlined as follows

1. Client presents with self-harm / suicidality
2. Referral to SHIP by GP or allied health professional
3. Referrals reviewed by counselling coordinator
4. Letter sent to client seeking confirmation of opt-in
5. Client opts in to the service within 10 days
6. Client is matched to counsellor, confirmation letter sent to client
7. Appointment agreed between counsellor and client
8. First counselling session is provided

SHIP have identified the point that they consider the person to be on the waiting list to be from when they 'opt-in' at point 5, and that the person is no longer on the waiting list from when a counsellor is identified, at point 6. However, from a patient's perspective, the waiting time is likely to be considered from point 2, when the referral is made, to point 7, when they first see a counsellor.

8.5.2 Steps Taken to Mitigate Waiting times

SHIP management had a number of mechanisms to monitor waiting lists and manage clinical risk:

- The SHIP Information Leaflets reminds referrers that SHIP is not a crisis response service and referrers are also asked to support the client as judged appropriate whilst waiting for counselling.
- Waiting lists were compiled by county as a snapshot which was updated and monitored on a weekly basis by the Counselling Coordinator and administration team.
- The Counselling Coordinator flagged and discussed any problem waiting lists with the Director of Counselling as part of the routine clinical governance framework.

Where excessive waiting times were identified, management had taken steps to redeploy a counsellor from one geographical area to another in order to meet greater need or increasing the number of counsellors through recruitment. The SHIP management also noted that in terms of risk management, the potential client on the waiting list had already received an assessment from their GP, the SCAN nurse or their psychiatrist, depending on the available services in their area. Referrers were also asked to support clients whilst awaiting the SHIP service.

8.5.3 Challenges to the Management of Waiting Times

While a number of steps were regularly taken to mitigate waiting times, there remained a number of challenges in relation to waiting list management:

- The fact that SHIP was a service still in development and the uncertain nature of the project's funding meant that a full investment in certain aspects of the service could not be developed, this has an impact both on waiting times and on the capacity for information management.
- The fact that that the crisis response service SCAN is currently only available in Wexford and parts of Waterford city means there is a variation in the types of assessment available to clients prior to being referred to SHIP.
- The shortage of counsellors with the appropriate qualifications and experience meant that at times there was not a pool of suitably qualified people to draw from.
- The lack of a suitable IT system for managing data meant that it was harder to monitor and report on waiting times.

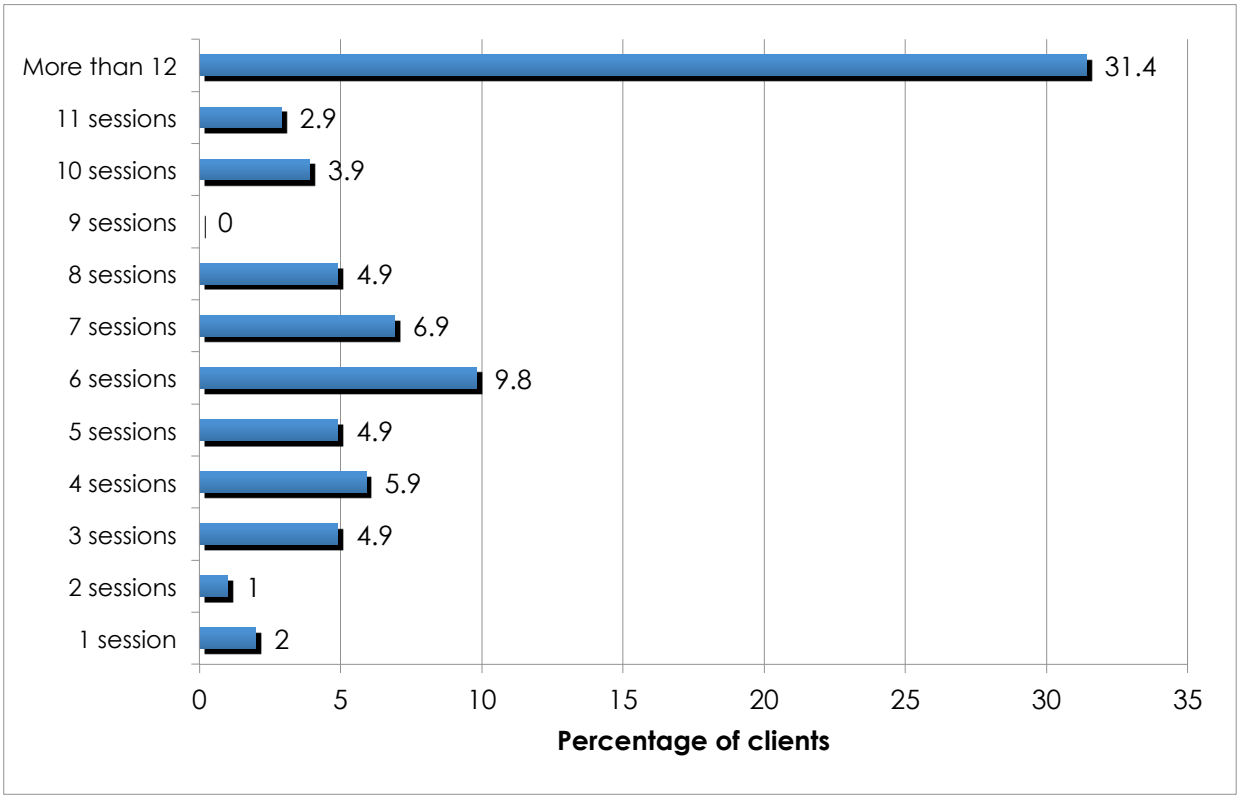
A number of recommendations in relation to reducing waiting times, managing patient expectations and updated methods for monitoring waiting lists have been made in the final recommendations chapter of this report.

8.6 Therapy Received by Clients of SHIP

The vast majority of clients who attended SHIP received individual therapy (n= 94; 92.2%) with only one individual (1%) reporting having received group therapy only, and five individuals (4.9%) reporting having received both forms of therapy. In line with the literature around best outcomes in time-limited therapy, the overwhelming majority of clients appeared to have received one-on-one support from the service.

The number of sessions that each client received was also recorded by the evaluation. As is illustrated by Figure 3.3 below, after accounting for missing data for four individuals (3.9%), the most common response in this evaluation was more than 12 sessions (n= 32; 31.4%). Following this, the most common number of sessions received by clients was 6 (n= 10; 9.8%).

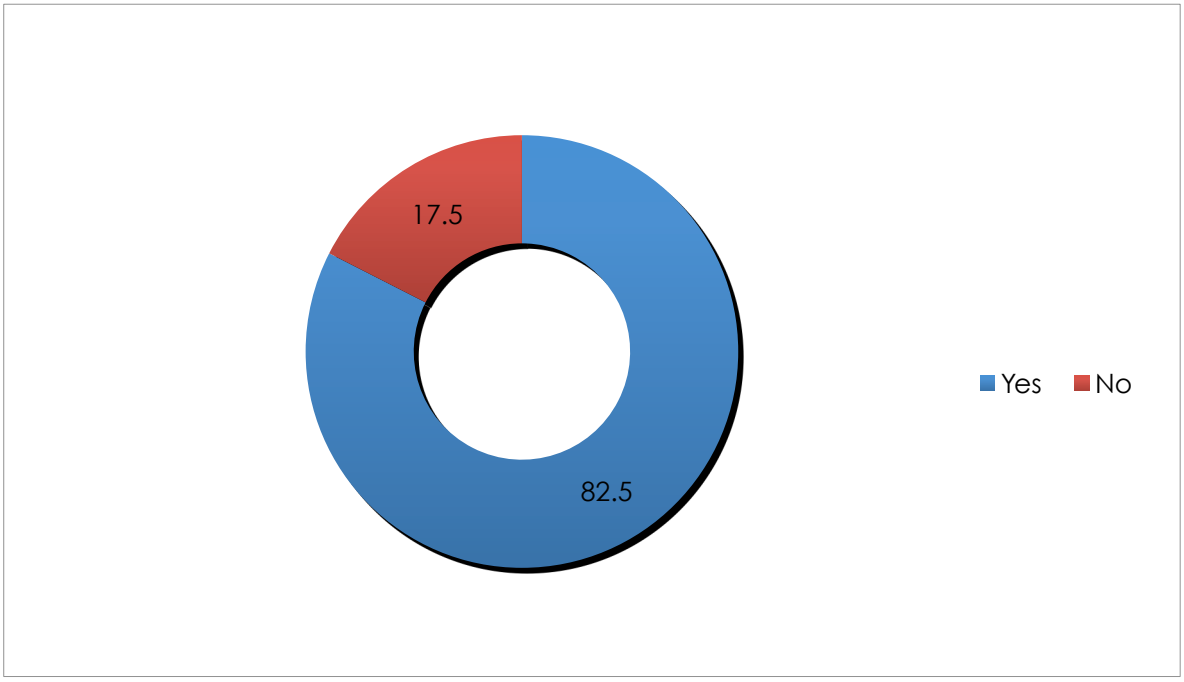
Figure 3.3: Number of sessions received by clients



As indicated in Figure 3.3 above, the majority of clients received upwards of ten sessions of therapy at SHIP. The average number of sessions received by clients of SHIP was 9.27 sessions.

Furthermore, the majority of clients believed that the number of sessions they received was sufficient. Excluding the five (4.9%) non-responders, 80 clients (82.5%) in the sample felt the number of sessions they received were sufficient, while 17 clients (17.5%) in the sample felt the number of sessions they received was insufficient.

Figure 3.4 Client satisfactions with number of sessions



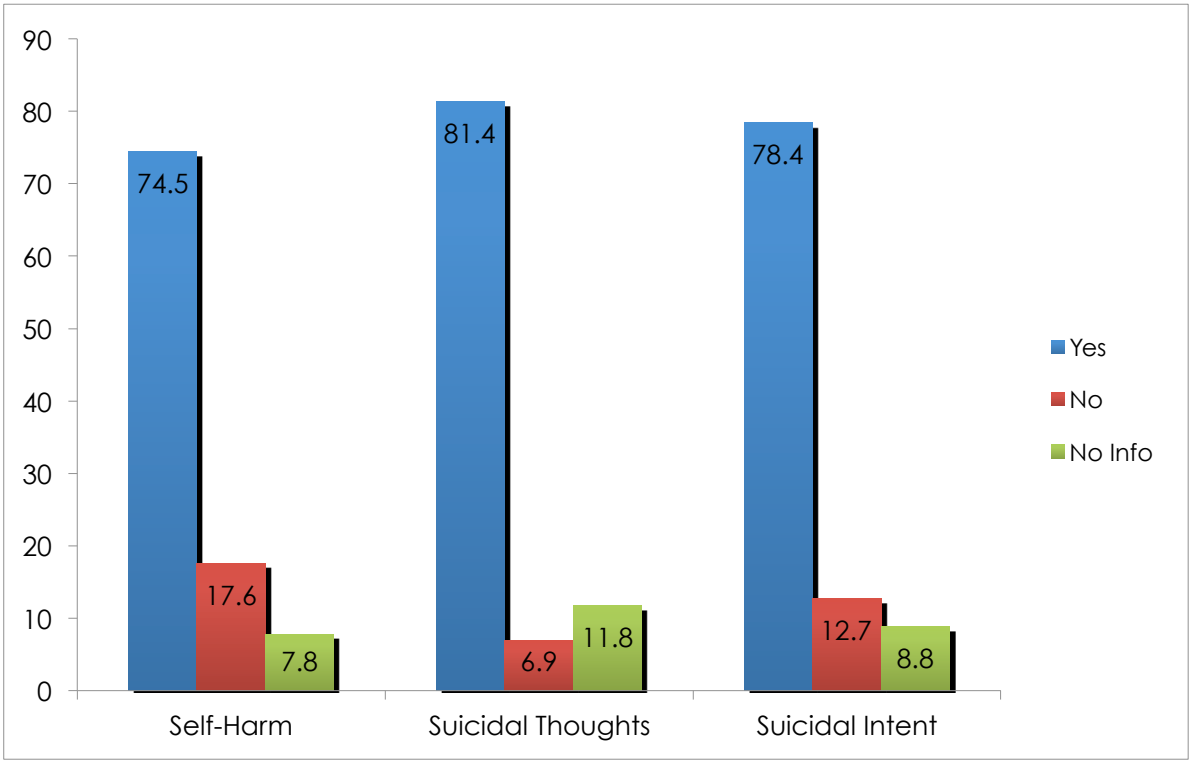
8.7 Presentation of Clients at SHIP

In order to gauge clients' sense of their presentation and needs when first attending SHIP, the Service User Satisfaction Questionnaire asked service users to respond 'Yes' or 'No' to the following question: 'Did the difficulties you sought help with include …'

- *'Self-Harming Behaviour (e.g. overdosing or cutting yourself)'*
- *'Suicidal Thoughts/Ideas (e.g. "my life is not worth living" or "I have no future")'*
- *'Suicidal Intent or a plan to end my life (e.g. "I have thought of particular ways to end my life")'*

As is illustrated in Figure 3.5 below, a substantial proportion of service-users at SHIP reported exhibiting self-harming behaviours (n= 76; 75%), suicidal thoughts (n= 83; 81%), and suicidal intent (n= 80; 78%) at initial presentation for counselling.

Figure 3.5 Clients presentation at SHIP



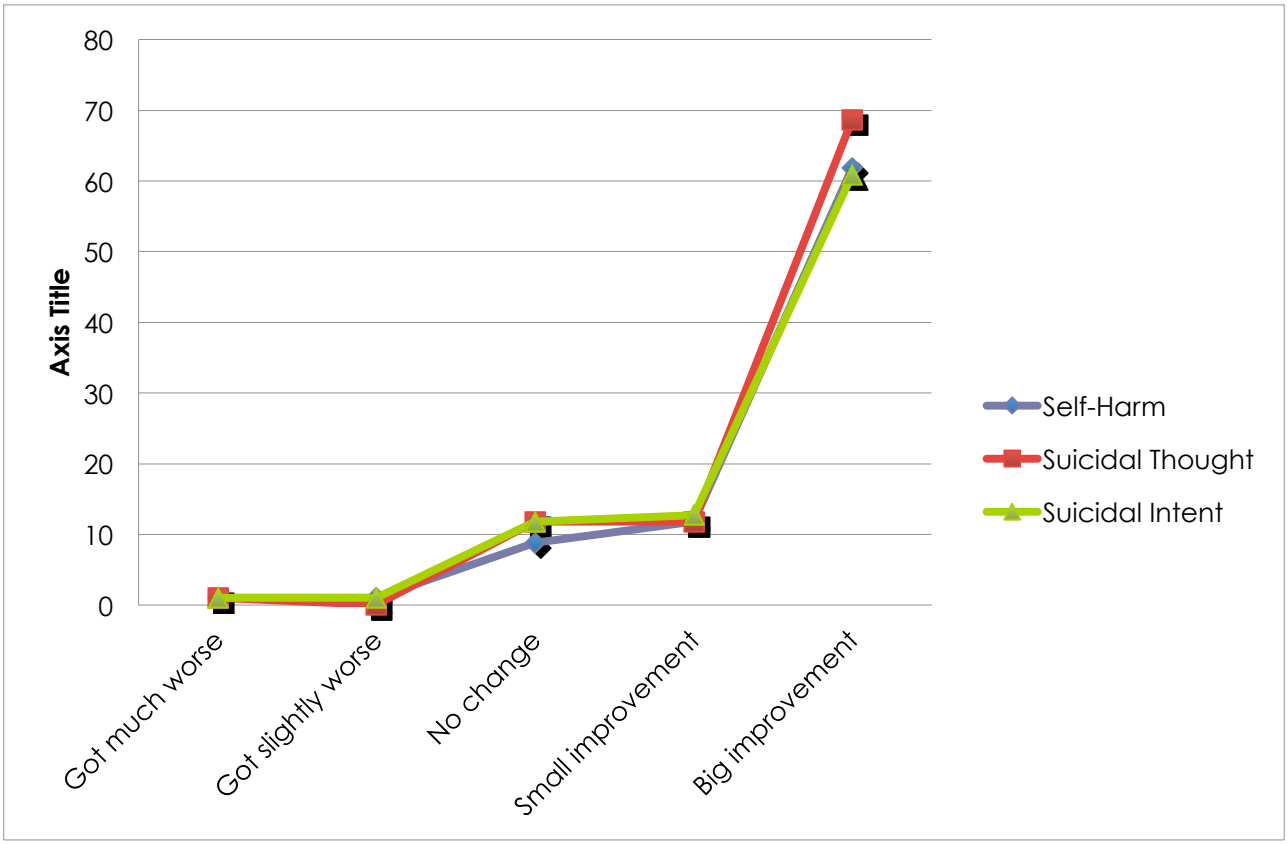
8.8 Self-rated Outcomes

Following the therapeutic intervention, the sample was also asked to self-report *'How did this change as a result of counselling?'* over the time-limited period. Across the three domains noted above, service users rated their own change on a basic scale ranging from

- 'Got much worse'
- 'Got slightly worse'
- 'No change'
- 'Small improvement'
- 'Big improvement'

As can be seen in Figure 3.6 below, the majority of service-users considered that they had made a 'big improvement' across the domains of self-harm (n= 63; 62%), suicidal thoughts (n= 70; 69%), and suicidal intent (n= 62; 60%). The general trend in the data across the three domains is similar, with 'small improvement' being the second most prevalent outcome of therapy across the three with improvements of 12% (n= 12), 12% (n=12) and 13% (n= 13) respectively. While this was the exception, there was however, one client (1%) who believed they had gotten 'much worse' in each domain.

Figure 3.6 Self-rated improvement in clinical outcomes following therapy

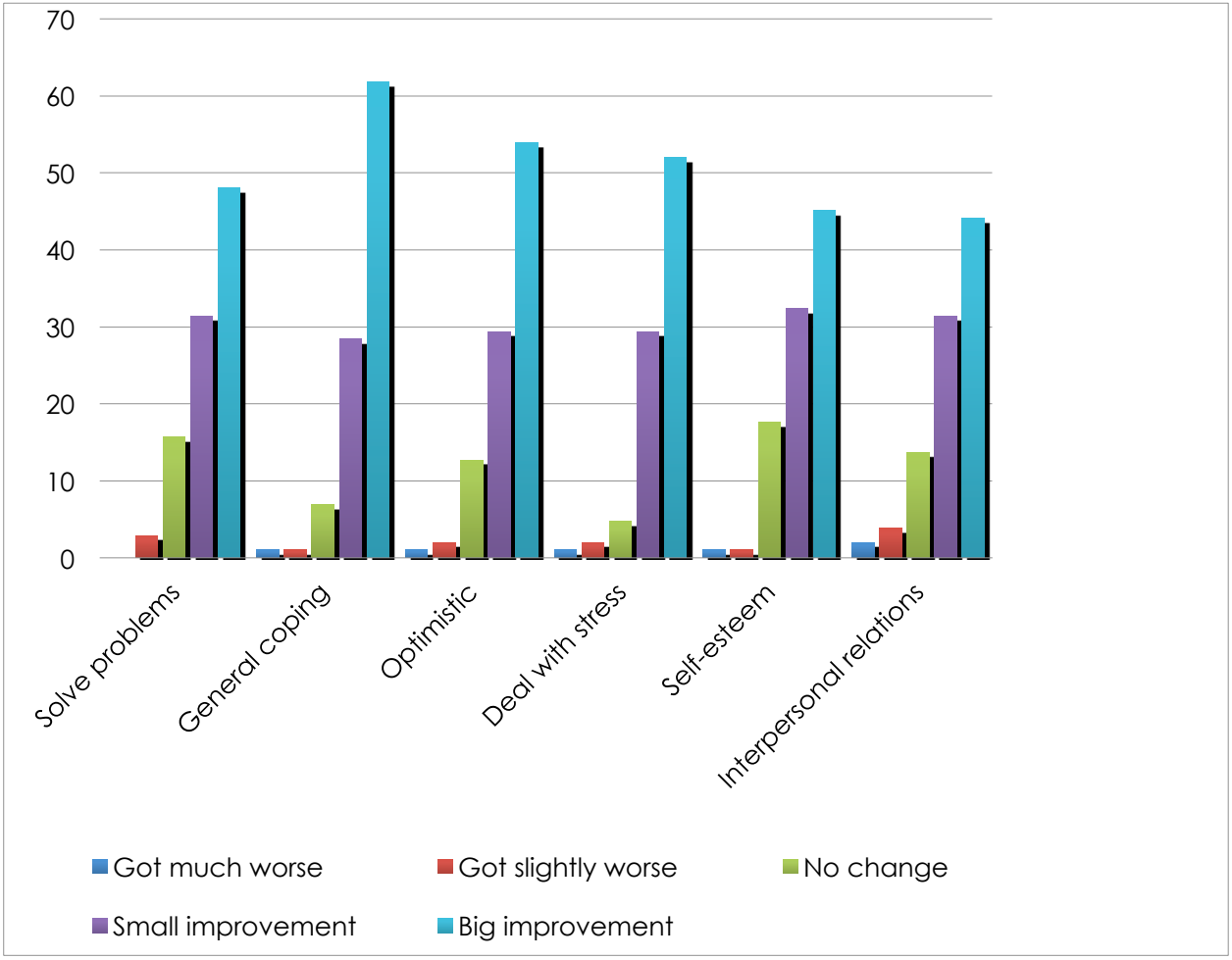


In addition to the three domains relating to suicidality and parasuicidality, service users were also asked to rate their change over the course of therapy in terms of their social, emotional and behavioural functioning. Service users were asked 'How much if any of the following areas have changed for you as a result of going to counselling?' Clients rated change scores across the domains of

- '*Ability to solve problems*'
- '*Ability to cope generally*'
- '*Feeling more optimistic about the future*'
- '*Your way of dealing with stress*'
- '*How you feel about yourself generally*'
- '*Getting on better with family and friends*'

According to service user ratings (see Figure 3.6 below), the vast majority made a 'big improvement' across all domains of ability to solve problems (n= 49; 48%), general coping skills (n= 63; 62%), optimism (n= 55; 54%), ability to deal with stress (n= 53; 52%), self-esteem (n= 46; 45%), and relationships with family and friends (n= 45; 44%).

Figure 3.6 Self-rated improvement in social functioning following therapy



Similar to previous findings in self-harming and suicidal behaviour, the second most prevalent rating for service-users was 'small improvement' across all of the domains of 31% (n= 32), 28% (n= 29), 29% (n= 30), 29% (n= 30), 32% (n= 33), and 31% (n= 32) respectively.

Taken together, these findings present a very positive outlook on the outcomes expected of SHIP. According to clients' self-assessment, they perceive significant benefit from therapeutic intervention in this service, not only in reducing suicidal and self-harming behaviours, but also in providing a boost for their social, emotional and behavioural, all protective factors against future suicidal ideation.

8.9 Ending the Therapeutic Relationship

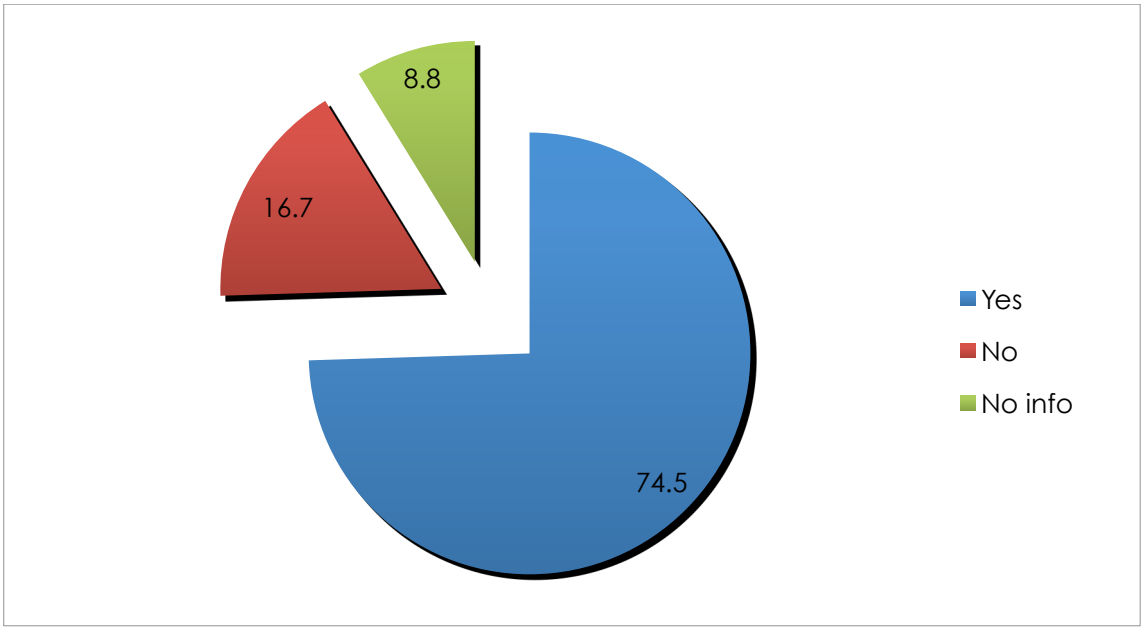
As had been suggested in the literature that investigated time-limited therapy, the circumstances around building and then unwinding the therapeutic relationship can have an important impact on the effectiveness of the therapy itself.

Of the 102 service-users who took part in this evaluation, 68 (66.7%) of them reported that they had an agreed ending to therapy with their counsellor from the beginning. Nine individuals (8.8%) reported they had not agreed an ending with their counsellor, while there were 25 non-responders (24.5%).

Service-users were also asked about the decision to end therapy. The response rate to this question was quite low (n= 45; 44%), however of these responses, 22 service-users (49%) said it was their decision to end therapy while 23 (51%) of service-users said it was not their decision.

Finally, when asked if they were happy with how the therapy had ended, 17 service-users (16.7%) said they were not happy. There was no response to this question from nine service-users (8.8%). A large majority of 76 service-users (74.5%) said they were happy with how the therapy had ended (see Figure 3.7 below).

Figure 3.7 Client satisfactions with ending of therapeutic relationship



8.10 Summary

Reflecting the outcomes of the CORE-OM clinical assessment in the previous chapter, the majority of service-users considered that they had made a 'big improvement' across the domains of self-harm, suicidal thoughts, and suicidal intent. There was also a significant self-assessed change recorded in relation to protective factors for suicidal ideation, specifically in the ability to solve problems, general coping skills, optimism, self-esteem, and relationships with family and friends.

The vast majority of the clients were satisfied with the number of sessions they received from SHIP as well as how the therapy ended.

Waiting times were an area identified as having potential for improvement, with client evaluations showing that just under half of clients waited for the service for more than three weeks, while nine clients waited more than thirteen weeks for their first session. Overall, however, this evaluation review showed high levels of client satisfaction and reported positive change as a result of attending SHIP.

9 SHIP Counsellors: Structures and Supports

9.1 Overview

This evaluation included a detailed exploration with the 16 SHIP counsellors of their experiences as SHIP service providers. Counsellors were engaged in the research through online survey as well as through semi-structured phone interviews with counsellors that lasted on average 39 minutes, ranging from 25–56 minutes.

9.2 Profile of Counsellors

9.2.1 Educational Background

The counsellors providing services for SHIP are well qualified in their field. In line with criteria required by SHIP, all counsellors had undergraduate qualifications in health or social care and post-graduate qualifications in counselling or psychotherapy. The majority of counsellors, 63% (10 people), were educated to at least a Masters level.

9.2.2 Length of Service

The SHIP counselling team were experienced practitioners. 75% (12 people) were practicing as qualified counsellors for at least five years at the time of the survey, with the other four counsellors having at least two years of experience. In terms of providing specialised counselling for self-harm, 69% of the team (11 people) had been providing services with SHIP for at least two years, and the other five people had been providing the service for less than two years.

9.3 Commitment, Competency and Support

9.3.1 Overview

A bespoke questionnaire was developed for this evaluation to measure the therapeutic commitment, role support and role competency of the SHIP counsellors in relation to working in the specialised area of self-harm and suicide prevention. The instrument was a 27 item questionnaire adapted from the validated Mental Health Problems and Perceptions Questionnaire (71), based on a model developed by Shaw et al in 1978 (72). This instrument was chosen because it has been developed across a range of disciplines to measure the therapeutic commitment, role competency and role support of general health professionals in working with specialised issues where they did not have specialised training (there are also validated versions of the tool for working with people with alcohol misuse, and people with drugs problems) (73).

SHIP counsellors, as detailed previously in this section, were all qualified and accredited counsellors, but who generally did not have specialised training in self-harm or suicide prior to working with SHIP, (as few suicide-specific counsellor training programmes are available within Ireland). Therefore the tool was considered appropriate as an assessment.

9.3.2 Results of the Mental Health Problems and Perceptions Questionnaire

In the questionnaire, there were 27 items or statements. Participants were asked to indicate their agreements with the statements. Fourteen of the 27 items in the questionnaire

collectively measured the therapeutic commitment of SHIP counsellors to clients who are self-harming or experiencing suicidal ideation, and included statements such as

> *I feel that I have a number of good qualities for work with clients with self-harm or suicide-related problems*
>
> *Caring for people with self-harm or suicide-related problems is an important part of a counsellor's role*

Four items measured perceptions of role support for counsellors and included items such as

> *If I felt the need when working with clients with self-harm and suicide-related problems, I could easily find somebody who would help me clarify my professional difficulties*
>
> *If I felt the need I could easily find someone who would be able to help me formulate the best approach to a client with self-harm or suicide- related problems*

Finally, nine items measured perceptions of their own role competency and included items such as

> *I feel that I can appropriately advise my clients about mental health, self-harm and suicide –related problems*
>
> *I feel that I have a clear idea of my responsibilities in helping clients with self-harm and suicide related problems*

For each of the three domains, the scores were summed and averaged to assess the level of role competency, support and therapeutic commitment for the group. SHIP counsellors scored highly in each domain, with none falling below average. To compare, research by the World Health Organisation with 1300 GPs in nine European countries used the Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ) to measure the role support, security and therapeutic commitment of GPs working with patients with hazardous alcohol use. This research found that 27.1% of the GPs scored high on the perception that they were working in a supportive environment, four-fifths (83.9%) of the GPs felt secure in their role, while only one-quarter (27.1%) felt therapeutically committed(74).

A comparison with two studies using the MHPPQ (both in relation to general nurses working with mental health[24]) found that SHIP counsellors scored higher in each of the three domains: a higher score indicated stronger perceptions of role support, their competency and their therapeutic commitment. The table below shows the mean scores and standard deviation for each of the three domains:

[24] A review of the literature found no studies involving counsellors that used the MHPPQ for comparison

Table 8: Comparative mean and standard deviation (SD) of role support, competency and therapeutic commitment

	SHIP Counsellors	**Roche et al** (75)	**Lauder et al** (76)	**Maximum Achievable**
Role Support	26.94 (SD 7.55)	20.6 (SD 3.97)	19.1 (SD 3.6)	28
Therapeutic Commitment	86.44 (SD 1.73)	81.5 (SD 9.07)	67.1 (SD 10.2)	96
Role Competency	56.31 (SD 6.24)	52.5 (SD 7.42)	34.3 (SD 7.5)	63

This shows that the counsellors displayed a very strong therapeutic commitment to their self-harming clients, a high regard for their role support and positive perception of their competency to undertake the role. The finding is particularly significant in relation to role support, where there is an almost perfect score: 27 out of a possible 28. Each of these areas is explored within this chapter with additional detail from the qualitative interviews, specifically in relation to induction and training, support structures and counsellor ability to provide specialised services to their clients.

9.4 Stress and Protective Mechanisms for Counsellors

9.4.1 Overview

In acknowledgement of the professional challenges of working with high-risk client groups such as people who are self-harming or suicidal, a range of supports are provided to counsellors through the SHIP structures. These supports include line management support and peer group supervision, as well as an expectation that the counsellors avail of clinical supervision. This table details the type of support, frequency and nature of participation.

Table 9: SHIP Counsellor Support System

Type of Support	**Line Management Supervision**	**Clinical Supervision**	**Peer Group Supervision**
Description	One to one meetings with the Counselling Coordinator	One to one meetings with an external professional clinical supervisor	Group meetings to discuss cases, issues and approaches with the SHIP counselling team
Frequency	Monthly (fortnightly for new therapist)	As per the requirements of their accrediting body	Quarterly
Obligation to Participate	Compulsory	Compulsory (also compulsory for continued professional accreditation	Voluntary but encouraged

It was assumed by SHIP management throughout the planning of the programme that there would be increased stress as compared to standard whole population counselling and that this would require an equal increase in supports provided, compared to general counselling services. This assumption has shown to be correct in that counsellors regard the work as higher stress and appreciate and require the additional supports, as detailed in the following sections.

9.4.2 Increased Counsellor Stress in Relation SHIP Work

When the Counselling Team in SHIP were asked if there was a difference between their work with SHIP and their work with other clients, the majority of counsellors were providing other publically funded but less specialised counselling services, such as CIPC, as well as private counselling. The majority of the counsellors (nine people) conveyed in interviews that they felt an increased emotional burden, such as stress or anxiety, when working with SHIP clients, as illustrated by the following quote:

> *It takes a toll, it's quite intense. In every session you're dealing with quite serious risk, both the self – harm and potential to progress to risk of death. (Counsellor #2)*

> *SHIP clients are higher risk, by nature then these cases are more stress and anxiety inducing. (Counsellor #6)*

The increased emotional burden on counsellors was largely attributed to the increased risk to health and life that the clients posed to themselves, and a concurrent increase in worry and stress for professionals supporting them, which was highlighted by seven (just under half) of the counsellors. They reported feeling a real risk of losing a client due to a completed suicide.

Two counsellors also mentioned that there was an increased burden on them in terms of time and/or administration when working with SHIP clients as compared to clients in their other work areas because the clients in SHIP had higher support needs, which resulted in increased time communicating with other services for the client or more paperwork from writing up notes about the client.

9.4.3 Protective Mechanisms against Stress: Line Management

When asked in interviews if the counsellors received a proportionate increase in support from SHIP managers due their work with a high-risk client group, over three quarters of respondents (10/13) said that they did. There was a general positive regard for, and importance placed on, the support system for SHIP counsellors. This is mirrored in the findings earlier in this chapter that showed a very strong perception of professional support for the counsellors. The comments below illustrate a uniform sense of good will from the counsellors regarding the support system, and in particular the support from the Counselling Coordinator:

> *Accessing good supervision and case management is vital when working with SHIP clients. Within SHIP there are very experienced practitioners and we have regular peer supervision which makes you feel part of a team. (Counsellor 10)*

> *The support we receive in SHIP is really, really, really good. A lot of this has to do with the personality of [the Counselling Coordinator]… You never feel like you're bothering him or overloading him. I've always felt very supported. The work has never caused me difficulties. (Counsellor 7)*

I feel very respected as a practitioner and I know that contributes to sustaining me in the work. (Counsellor 12)

The value of the system of collegial support in the form of peer group supervision and informal support from other SHIP counsellors was also very positively regarded and considered an important part of the programme.

Three people noted some mixed feelings regarding the support system: while they also valued the supports, they had some reservations. One counsellor said she couldn't avail of all of the supports because of barriers with travel/distance to the sessions, and one counsellor felt the change in the peer supervision agenda to include review of models, theories and approaches led to it being less supportive than it had been previously.

9.4.4 Protective Mechanisms against Stress: Maximum Caseloads

Another protective mechanism used both by SHIP and the counsellors was to implement a maximum caseload. In policy, the maximum SHIP caseload is set at 12 clients per week. However, in practice, all counsellors have the ability to set their own caseload maximums, and the majority had a working rule of 10 clients or less a week, with half of the counsellors choosing not to take more than five SHIP clients in a week. All but one of the counsellors who answered (12 people) said in interviews that they were regularly at their maximum. Counsellors were not required to work over their preferred case number, which was supported by the fact that counsellors with a maximum number of weekly clients identified felt supported by SHIP in this.

Counsellors were also asked whether there was a minimum number of clients that they would need to see in a week in order to make it economically viable for them to provide services to SHIP. Three-quarters of the counsellors said that the minimum number of clients they needed to see in a week was three or fewer (one quarter of the counsellors had no minimum number for viability), with only two people needing to see four or five to make engagement with SHIP viable. Generally, counsellors had a minimum because they were travelling a long distance to work and needed to justify the costs of both travel time and petrol.

9.4.5 Protective Mechanisms against Stress: Self-Care

The final protective mechanism utilised by counsellors in relation to stress was self-care. Over the course of the interviews, almost one third of counsellors (five people) highlighted the importance of their own self-care practice as a protective mechanism for their well-being and capacity to be sustainable in this type of intensive work.

It can be more difficult at times, but that is the work I'm involved in, the work I have been trained in, and the work I feel I can do. I have decided this caseload for myself. It's normally four to five. This is because of professional sustainability, self-care, and the need to manage. (Counsellor 5)

9.5 Other Support Structures in SHIP

9.5.1 Overview

An aim of this evaluation was to assess the effectiveness of the support structures in place for the team. Areas reviewed included a fit for purpose policy framework, a meaningful and effective supervision and performance management system, relevant training, work

culture and team communication. The previous section has highlighted the value of the supervision and supports for counsellors. This section highlights counsellors' positive perception of induction and training and the policy framework that supports their work.

9.5.2 Induction and Training

As outlined previously, all counsellors undertaking work with SHIP are qualified and accredited counsellors and/or psychotherapists with undergraduate and postgraduate qualifications. However, in most instances counsellors did not have specialised skills for working with self-harm or suicidal ideation when they began providing services to SHIP. This meant that there was a need for a strong induction and training programme to prepare counsellors for this more specialised work. A typical induction and training programme provided to a counsellor in their first year included certified ASIST and STORM training as well as a number of other certified and uncertified programmes.

In questionnaires, counsellors were asked whether they felt the induction appropriately prepared them for their work. All counsellors bar one agreed that their induction into SHIP prepared them fully to work with the SHIP programme.

9.5.3 Policies

To assess the counsellors' perceptions of whether policies were fit for purpose, the questionnaires asked them to rate how much they agreed with a number of statements. The results indicate a relevant and effective policy framework within the service. All counsellors unanimously agreed that

- They were aware of all of the policies and procedures underpinning their work with SHIP.
- They were clear on the steps they need to take if they have a concern regarding child protection
- SHIP manages data protection and confidentiality well
- They know what steps to take if someone presents with a clear suicidal intention

Although the team appeared to be generally confident about policies and their application across the team, there were some unmet needs identified. A general statement regarding clarity in policies was asked (no specific policies were mentioned in this statement) and two counsellors felt that they were not always clear on the policies guiding their work in SHIP. Therefore, there may not be complete comprehension of policies other than those previously mentioned, such as child protection and confidentiality. There may be a need to ensure that *all* counsellors have an opportunity to understand and feed back on policy issues in order to ensure there are as few gaps in confidence or knowledge as possible.

9.6 Interagency Working, Referrals and Gaps

9.6.1 Overview

SHIP counselling is provided to clients with very specific needs for a limited time period. This means that in order to provide as effective a service as possible to the people who need it most and in order to feel confident that clients will receive appropriate support at the end of their time-limited counselling contract, clear and effective referral pathways to and from SHIP services are needed. The counselling team had less confidence in relation to referrals into SHIP and out to other services than they did about other issues discussed in the

evaluation. While the majority of counsellors felt that communications with other services were good, some areas for potential improvement were highlighted.

9.6.2 Referral Onwards from SHIP

In interviews, counsellors raised concerns both about the availability of other suitable services and about the quality of other services potentially accessed by SHIP clients.

Regarding availability of services, over half of the counselling team (nine people) said that at times it is difficult to access a *more* specialised service for clients when they need it, while conversely, over two thirds (11 people) said that at times it is difficult to access a *less* specialised community-based service for their clients when they need it. In terms of confidence in quality of service provision, two fifths of the team (six people) did not feel confident that their clients would receive appropriate support when they referred on (six people felt confident about this, four were neutral). Examples of the types of concerns raised are illustrated in the following comments:

> *We can refer them into the National Counselling Service but there's a six month waiting list there. I think there is a lack of services available. Likewise if there are issues with education, parenting courses, I don't have enough information on when or where these services are provided. I feel at a loss at the end of the counselling contract sometimes. (Counsellor 13)*

> *Generally there are waiting lists for counselling. For bereavement there is often a waiting list too… we refer on to HSE service or Console. I recommend community based services but don't necessarily refer on to them. The biggest problem is clients are ready to move on and eligible for services, but services aren't ready to receive them. (Counsellor 1)*

9.6.3 Potential for Group Support

As noted previously, counsellors were concerned at the lack of less specialised support services for clients to move on to at the end of their SHIP contract. Following on from this, in interviews counsellors were asked whether they felt a structured support group for SHIP clients to move onto at the end of their counselling contract would be valuable. A large majority of the counsellors, (three-quarters, or 12 people), felt that this would be a valuable addition to the range of services provided:

> *There's such potential for people to learn from each other. They could realise that they're not alone and there are others like them. (Counsellor 11)*

Counsellors mentioned a number of specific target groups that they felt would potentially benefit more than others. Specifically, three people felt it would benefit young people in particular:

> *…you can't just have one group and everyone avail of it. You have to look at commonalities in addition to the experience of self-harm. (Counsellor 2)*

> *I think in particular [it would suits] teenagers and young people. I think it would be really useful for them. (Counsellor 8)*

Three people were unsure about the potential of groups; one person felt it would not be a good idea. Precautions were mentioned by counsellors in planning such a group, including the need to consider recruitment carefully, as many clients would be wary of group processes and the need to ensure that people at different points in self-harm should not be in the same group, if possible, to avoid triggering of those who had moved away from self-harm by those still actively self-harming.

9.6.4 Referral into SHIP and Promotion of the Service

While most people felt that referrals into the programme were working well, or had no opinion on it, a significant minority (six people) discussed in interviews the feeling that they had, at times, received inappropriate referrals to SHIP from other services. The following comments highlight the mixed experiences of counsellors in relation to this issue:

> *I don't deal with the referrals coming in. I'm handed the file of the person coming in. I have no contact really with referrers. (Counsellor 13)*

> *I can only think of one referral that wasn't appropriate… it was a person with long-term psychiatric mental health issues who needed a lot of support and was consistently in psychiatric services. I'd say it was a well-meaning attempt to try something different. (Counsellor 12)*

> *Mental health services, particularly psychiatry – will send anybody in without necessarily looking at the parameters. Sometimes the referral letter would suggest that they are aware that the referral is inappropriate and they send them in. Particularly where there's comorbidity with alcohol or substance misuse. (Counsellor 1)*

While a number of counsellors felt it was working well, or this information was not something they felt they could comment on, it is clear that many counsellors feel a need to communicate referral pathways and inclusion criteria more clearly to referrers to promote increased suitability of referrals and access to the programme. This was also evident in their commentary on promotion of the programme.

Of those who had an opinion in the survey, half agreed and half disagreed (5 counsellors each) that '*the service is promoted well. Those who need to know about SHIP*'. In interviews, only three people felt confident that the service was well promoted. Five of the counsellors felt that not enough people knew about the service and six people had mixed feelings about whether there was sufficient awareness.

> *[When I started] it seemed to me that SHIP was like a well-kept secret. Nobody had heard about it... We need more advertising. (Counsellor 8)*

When asked about who or what groups of people need more or better information about the service, respondents primarily noted primary care providers/GPs (four counsellors), community-based providers such as youth and social services (three counsellors), and members of the public (three counsellors). One counsellor highlighted a cautionary consideration for disseminating information about the service to the public:

If there was increased knowledge in the community, there'd have to be very clear about what the referral criteria is in order to avoid causing people frustration. (Counsellor 10)

And another counsellor commented on the value of an approach that ensures the public have awareness of the service:

I know it's not a self-referral service but sometimes you just need to give the patients the information so they can ask their GPs. (Counsellor 1)

Some counsellors noted that the level of knowledge among other services depended upon the geographical area of where professionals were based. In particular, counsellors expressed concerns about professionals in Tipperary and Carlow[25] having less awareness than in other areas.

9.6.5 Extension of Service Provision

SHIP services are provided to people aged 16 and over. For 16 and 17-year-olds to avail of the service, parent or guardian consent must first be provided. The file audit revealed that 13% of SHIP's clients are aged between 16 and 18, and there is no similar service for young people provided in the region, or indeed nationally. Given the prevalence of self-harm among young people in the South Eastern Region (see chapter two for a detailed age breakdown in relation self-harm), counsellors were asked whether, if it were to be considered, they would like to provide SHIP counselling services to people aged 14 and 15.

Of the 15 counsellors who answered this question, 14 of them said that they would like to provide SHIP services to people aged 14 and 15. Counsellors highlighted the need for additional training in working with youth. When asked what type of training they felt would support them in their work with this group, most counsellors suggested either general training on adolescent development (seven people), or specialised therapeutic approaches and tools such as family therapy, art therapy, CBT, trauma and brief solution-focussed therapy (six people). One counsellor also suggested a need for training on social media and its relationship to mental health and self-harm. Also highlighted was the need to develop procedures to encourage and facilitate parental involvement.

9.7 Counselling Premises

The premises from which the counsellors operate was the focus of a small number of issues highlighted in an earlier evaluation of the SHIP programme, such as the need for better or more comfortable furnishings [48]. When asked in interviews if there was anything they would change about any aspect of the service, three counsellors raised issues with their premises, including a lack of suitable premises, a lack of suitable facilities within premises, or isolation due to the location or absence of other services in the facility.

Counsellors were asked if they were or would be happy to operate out of a community and voluntary premises (as opposed to HSE). There was unanimous agreement across the counselling team that operating out of a non-statutory premises would be perfectly

[25] This information does not identify individual counsellors, as it was not necessarily counsellors working in these areas who expressed the concerns.

acceptable if this was considered useful in the future. The following factors were more important to the counsellors than who owned or ran the premises:

- That it was fit for purpose in relation to location, size and space
- They would be covered by relevant insurance working from it
- That it afforded confidentiality
- That it had low noise or interference from outside the room
- That it was warm and comfortable

This reveals that the range of potential locations for a service such as SHIP is not restricted by the other services occupying the building (i.e. HSE or community services). However, clear criteria exists that defines a suitable premises, relating primarily to safety, accessibility and comfort.

9.8 Outcomes for Counsellors

9.8.1 Work Satisfaction

In interviews, counsellors were asked why they choose to provide services for SHIP. Counsellors who answered this question unanimously agreed that the work with the SHIP client group was particularly rewarding. The most commonly stated reason as to why counsellors found the work rewarding was the visible change in well-being of the clients in such a short space in time, as illustrated by these quotes:

> *Every human being is struggling and suffering. When I see the change, the second CORE results, that's quite satisfying. To hear his hope for life going forward compared to where he was when he started, that's a very good outcome. (Counsellor 10)*

> *Self-harm and suicidal ideation become options for some people to cope with their stress. When they discover that there are other ways of dealing with stress, it is very empowering for them and for the therapist. (Counsellor 12)*

Other reasons included feelings of privilege to be working with a service that they felt was so valuable and so needed, belief that the service was aligned with their social justice values, and that the high energy demand working with such high risk stimulated them.

9.8.2 Increased Knowledge, Skills or Confidence

The counsellors were asked whether there had been positive outcomes for them as a result of working with SHIP since starting with the project. Three-quarters of the counsellors (twelve people) said that they had improved their skills or knowledge base or become more confident in their practice, as illustrated by the comments below:

> *I am less anxious working with clients that are suicidal, due to feeling more competent and confident to assess their risk and support them. (Counsellor 16)*

> *I have increased confidence in working with this client group, and with suicide and self-harm. I now pay more attention to evidence based practice. I also feel that I have become more confident as a therapist. (Counsellor 5)*

As well as increased skills, knowledge or confidence, two counsellors also shared that they had subsequently progressed to further education or training directly related to SHIP as a result of their interest being piqued by this work.

9.8.3 Reduced Isolation and Increased Experience of Collegiality

Professional counselling and psychotherapy is traditionally provided by individual counsellors in private practices, resulting in few opportunities for collegial support, skill-sharing or problem solving, with the exception of the one-to-one clinical supervision. An important positive outcome mentioned in interviews by half of the counsellors (eight people) was that they felt less isolated, professionally, as a result of becoming part of the SHIP team. The following quotes illustrate the value placed on this by half of the team:

> *I have an increased sense of team and shared learning that you don't get in private practice. We only meet as a group four times a year, but there is a real sense of cohesion that is very important to my work. (Counsellor 2)*

> *Peer supervision in SHIP has been handled so gracefully, so compassionately. I really hope if SHIP continues and grows, that that is held on to, that non-blaming, inquisitive but non-judgemental about practice and cases, allowing space for the therapist to have her own reactions and to take care of herself. This is so important and different to working in isolation. Meeting colleagues is very important. (Counsellor 12)*

9.8.4 Affected Income

Two counsellors mentioned that the specialisation they have developed while working in SHIP has led to increased specialisation and a concurrent improvement in professional reputation, resulting in increased referrals to their private service[26], as illustrated by the following quote:

> *I am more employable because I'm more specialised (Counsellor 1)*

However, three counsellors highlighted that the higher rates of 'Did Not Attend' clients compared to private or SHIP meant that there occasionally was a loss of income for them as a result of SHIP. Counsellors are not usually reimbursed the full amount for missed sessions by SHIP if the cancellation takes place at least 24 hours prior to the session. Two counsellors also highlighted an increased administrative burden associated with more paperwork, which was not completely covered by the additional €20 administration fee paid by SHIP to counsellors per each client. This concern is illustrated by the following:

> *I love my work with the clients but the admin and paperwork is time-consuming and tiresome. Our fees do not reflect the additional work we put in… the closing can take 20 – 30 minutes to complete paperwork… a standard letter to GP, filling out CORE, tidying up and going over each page. 15 – 20 minutes to write up each session. That particular time is not included in our fees. (Counsellor 3)*

[26] As detailed previously, many counsellors have private practices, however they are not permitted to engage privately with clients they have met through SHIP.

These counsellors also noted that the higher risk a person is, the more paperwork is required relating to health and safety, or relating to communications and referrals. One counsellor offered a potential solution to this:

> *I would like some way of taking the administrative load from counsellors – I'm not an administrator or a statistician. I would hand over calculations of the CORE scores, notifying referring agents of beginning and end. I would find a more useful way to advise admin about the close of client cases. It's quite a lot of client hours. (Counsellor 8)*

9.9 Summary

The evaluation reveals a group of experienced professionals working in a rewarding although challenging and high-stress environment. Counsellors reported that within SHIP the risks attendant with this specialised service provision are thoughtfully and effectively mitigated by a wrap-around professional support system, a strong collegial culture, a robust policy framework and an appropriate and effective induction and training programme from the perspective of the counselling team. Overall these factors were considered to provide the basis for SHIP operating as a specialist service.

There are a number of opportunities for improvement, identified by counsellors, in relation to improved interagency collaboration, and increased service provision options, namely increasing services to the 14–15 age group and reviewing the potential for follow-on group supports. The counsellors' perceptions of the promotion of the SHIP service and the inappropriateness of a very small number of referrals indicate that there may be potential for improvement in the quality of information and its dissemination, which can in turn ensure the right people who need to know about the service know about it, and can be appropriately referred. Some counsellors felt that it may be appropriate to have additional administrative support to allow them to focus their energy on client, rather than administrative, work. Apart from these changes, the current system to ensure counsellors are fully competent to do their work and supported to do so was considered effective, appropriate and sufficient.

Part Three of the Report: Social Return on Investment Analysis

10 Introduction

10.1 Overview of Information Considered as Part of the SROI Valuation Process

This section of the report provides a cost benefit analysis of the SHIP service using a Social Return on Investment (SROI) methodology. This work is evaluative, meaning it considers the retrospective value of the work over a given period, reviewing the relationship between all inputs and outcomes over this period. SROI is a method of assessing the value of the outcomes of a service. To do this, the SROI is used to compare how much it costs to run a service compared to the value of what happens as a result of the service. This means that all outcomes are given a monetary value, even outcomes which do not have an easily identifiable market price.

To arrive at a robust estimation of the return on investment, a number of discounts are considered as part the SROI valuation process. The discounts applicable to the SHIP SROI are outlined below[27]:

Attribution: The amount of responsibility that the intervention or programme can reasonably seek to claim for the overall outcome. Few services are provided in a vacuum; any social service providers work in conjunction with other providers. Service users also benefit from other supports, such as family and friends. These supports will play a role in creating or supporting positive change for the service user/client, and this contribution needs to be analysed and accounted for if the true value of a service's contribution is to be assessed. The contribution of other organisations or people to the overall outcome must be clarified: a percentage of overall responsibility for the change is applied as a discount to the valuation for each outcome.

Deadweight: The change likely to have occurred had the person not engaged in the intervention. To account for this, a percentage of the value ascribed to the change for the beneficiaries needs to be discounted, as this change would have occurred anyway, without the intervention.

Drop-Off: The reduction in the influence that the original activity of the service will have on the outcome over time. While an outcome may have an impact over a number of years, the causality between the original activity (training, counselling etc.) and the outcome in year two or three post-service provision is likely to be much reduced. Calculating drop-off provides an estimate for this. The SROI also considers the length of time that each outcome is estimated to last for. Some outcomes last for only a small time, such as the value of entertainment, while others, such as the education, can have lasting effects on a person's life.

Displacement: An assessment of how much of the outcome displaced other outcomes, i.e. an outcome that may have been transferred from one stakeholder group to another as a result of an intervention. In this SROI, negative and positive outcomes were explored with each stakeholder group and no displacement was identified as a result of the SHIP intervention.

[27] Displacement has not been discussed, as this was not applicable to the SHIP SROI.

Outcomes and the discounts identified above are established though multiple sources. First and foremost, the views of the stakeholder groups experiencing the outcomes are collated. These views are then compared with relevant research and available outcome data from other sources.

A detailed summary of each aspect of these calculations is available with the SROI impact map. The impact map is a large excel spreadsheet containing the outcomes experienced and data on how many individuals experienced each type of outcome, data on the monetary valuations used, sources of all data and discounts for each outcome. The impact map also includes valuations for all inputs to the programme. In the same way as outcomes are valued, all inputs are valued. This means that monetary inputs such as funding, inputs such as volunteer or board time are all accounted for and valued along with capital inputs such as the provision of premises.

By comparing all inputs against all outcomes, an SROI is able to provide a robust estimation of the return on investment. This is the social good generated for every €1 invested in the service.

The SROI for the SHIP counselling service indicates that the social return on investment is €9.10 for every €1 invested in the service. This valuation does not include the value of a reduction in suicide because it is a difficult outcome to prove, even though stakeholder feedback from the research suggested decreased suicidality as a likely outcome from the project. If this outcome were included, the return of investment of the SHIP counselling service would be significantly higher with a return of over €12 to every €1 invested in the programme.

10.2 The Seven Principles Underpinning SROI

SROI is underpinned by seven principles that inform all elements of the methodology:

Principle 1: Involve Stakeholders: The first step in the process is identifying who is affected by the organisation's work. To make this identification, a stakeholder analysis was undertaken with the SHIP steering group. Stakeholders were also asked if anyone or any organization was, in their opinion, affected by the work of the organisation.

Principle 2: Understand What Changes: All stakeholders are asked about the negative as well as the positive outcomes of the programme for them. SROI is about understanding everything that changed, not just the positive things.

Principle 3: Value the Things that Matter: Stakeholders are involved in discussing how much the changes resulting from the programme are worth to them. When a market value for an outcome is not readily available, such as in the case of self-esteem, a proxy value is identified with reference to relevant research and a rationale provided for why the valuation is considered appropriate.

Principle 4: Only Include What Is Material: Not everything that emerges through the process will be 'material'. Materiality in the context of SROI means that a piece of information will affect the final SROI calculation or could affect any planning decisions (based on the outcomes of the report) made on the basis of this information being excluded. If it could affect a planning decision, then the information is considered material. As part of the materiality assessment, positive outcomes with valuations of less than €2000, were considered immaterial, i.e. these had no effect on the final valuation. As part of the aim of

being transparent, however, all negative outcomes have been included regardless of the valuation. A materiality table is included in the appendix which provides a rationale for the materiality assessments.

Principle 5: Do Not Over Claim: Throughout the report, all value assessments are undertaken conservatively and veer on the side of undervaluing rather than overvaluing outcomes. Throughout the report, undervaluing has informed the selection of proxy indicators.

Principle 6: Be Transparent: All the calculations undertaken to arrive at an assessment of social value must be clear and traceable to the interested reader. To assist with readability, an impact map is available. As discussed, this outlines all the calculations within an assessment.

Principle 7: Verify the Result: This report has been validated by the international SROI Network. This process confirms that the evaluation has been undertaken in line with the seven principles. This important step should provide the reader with some additional confidence that considerations of value have been undertaken in line with good practice.

10.3 Overview of the SROI Methodology

The methodology was guided by the seven principles of SROI and included the following steps, described in more detail in the remainder of this chapter. Steps in the methodology were:

1) Agree the scope
2) Develop a stakeholder map
3) Undertake interviews with clients and family
4) Undertake Interviews and surveys with professional groups
5) Analyse outcome data
6) Conduct research to support assumptions
7) Undertake a sensitivity analysis
8) Develop conclusions and recommendations.

These steps are described in more detail below:

Step One: Agree the Scope

This SROI reviews all inputs and outcomes over a nine-month period between Jan and Sept of 2014. The SROI analysis includes all inputs from and outcomes for every service who engaged with SHIP. The project scope was agreed in consultation with the steering group of SHIP as a first step in the process.

Step Two: Develop The Stakeholder Map

A stakeholder map was developed in consultation with key staff and steering group members through a focus group. The impact map identifies all organisations potentially affected by SHIP, either negatively or positively. All stakeholders were also asked about any other groups they could identify as receiving either negative or positive outcomes.

Step Three: Interviews with Clients and Family

In-depth qualitative semi-structured interviews were conducted over the phone with clients and family members. The research involved 25 client interviews. Recruitment initially occurred through SHIP, where 78 letters were sent out to clients, these were randomly

sampled with every second client on the service's client list being selected for interview. Thirty-seven people agreed to participate and 14 declined. There was no response from the rest. Twenty-five of those who agreed to participate proceeded to interview. Interviews lasted on average 45 minutes and included questions on both negative and positive outcomes, how much SHIP was responsible for the change that occurred and how much was due to other service and family involvement, how long they expected this change to last, the value of the change to them and how this affected their life, as well as how they found the quality of the services provided. Based on the CORE-OM outcome scores, an analysis of client interview responses was undertaken by gender and no significant differences were found between their outcomes[28]. No other significant differences were observed within this cohort by service managers or through the interviews that would have substantiated the client group being separated into different subgroups within the SROI analysis. As such, clients were considered as a homogenous group.

Eight family member interviews were conducted. Seventeen service users were asked for permission to contact their family members. Ten service users gave consent for a family member to be contacted, and seven did not[29]. Interviews with family members lasted an average of 20 minutes and included similar themes to those described for client interviews.

For both client and family member interviews, answers were typed and read back to interviewees and were then thematically analysed using excel. Coding was undertaken by one researcher and reviewed for consistency by another member of the research team.

Step Four: Interviews and Surveys With Professional Groups

Professionals from organisations who referred into or worked with clients of SHIP were either interviewed or distributed surveys. The list of relevant professionals was discussed and agreed with the project steering group. Professionals were asked questions in relation to negative and positive outcomes for them in their own work, the value of any outcomes to them, how much these outcomes were due to the work of SHIP, and their views of the quality of the service. Professionals interviewed were

- **Suicide Resource Officers and National Counselling Service Coordinators:** A brief online survey was sent to all professionals in this group to garner their views on the service and how this service would fit into their local service provision structures. Responses were received by 11 out of 18 of this group, a 61% return rate. This group was not included in the SROI calculations, as they received no direct outcomes as a result of the SHIP programme.

- **Service Providers in the Areas of Youth and Addiction:** Phone interviews averaging 30 minutes using a bespoke semi-structured interview schedule were undertaken with a representative purposively sampled group of service providers and refereeing agencies in youth, addiction and mental health services. The transcripts were sent to service providers for their approval following interviews for ratification. Overall, eight service representatives were contacted. These groups were included in the SROI as they accrued time saving outcomes in relation to their own service

[28] A mixed between-within subject analysis of variance was also carried out in order to assess any impact of time of testing (pre/post) or gender on CORE-OM total score. This analysis of CORE-OM scores for 80 clients reveals that there were no significant differences between genders in terms of psychological distress.
[29] Four service users explained that their family or partner did not know they attended the SHIP service or that they self harmed, and three service users did not feel comfortable with their family member being interviewed.

provision. Given that material outcomes were the same, these providers were considered as one grouping.

HSE Mental Health Staff (GPs and GPs SCAN nurses): A brief bespoke online survey was sent to a list of the 44 referring agencies. Follow-up emails and phone calls were undertaken with individuals marked as frequent referrers to encourage participation in the survey. There was 36% return rate. Outcomes for all HSE staff groups included a reduction in staff time and staff stress. These outcomes have been valued and included in the SROI calculations. Different disciplines were treated homogenously as HSE staff, as these had the same outcomes.

- **Steering Group**: Focus group and phone interviews were undertaken with five members of the group. A three quarter day focus group was held with members of the steering group followed by phone interviews. An opportunity for feedback on the report was provided to the steering group once the report was drafted. The SROI valued the time that this group provided to the programme as part of the HSE's inputs, however, as they experienced no direct outcomes, they did not appear in the impact map as a separate group.

- **Counsellors:** Counsellors were given a preliminary survey and asked to participate in interviews. The survey was an adapted validated tool, the Mental Health Problems and Perceptions Questionnaire. All counsellors also participated in the semi-structured phone interview averaging approximately 35 minutes. Counsellors were able to log one hour's work time in their time sheets to account for this engagement. There was a 100% engagement rate, with 16 counsellors taking part in the research. Counsellors were not included in the SROI calculations, as there were no outcomes for this group that could not have been gained through alternative work situations[30]. The cost of the counsellors is included within the HSE calculations as the funding body.

Step Four: Data Analysis

Qualitative Analysis: Analysis of interview transcripts was undertaken using a coding system. This involved an initial coding of themes followed by review and refinement of the coding by the researcher before being reviewed by a colleague for consistency and accuracy. Changes and refinements were made at each point until the research team was content that the themes were an accurate assessment of the main collective views of each stakeholder group.

Quantitative data: Quantitative data was collected through online or paper-based survey and was analysed in excel. Findings from this analysis were contrasted with outcomes from the CORE-OM analysis, which was analysed in SPSS.

Step Five: Conduct Research to Support Assumptions

Research was undertaken to identify or support stakeholder views in relation to deadweight and proxy valuations of outcomes, i.e. the monetary value given to each outcome. This involved a review of literature with a particular emphasis on outcome and valuation-focused peer reviewed articles. Proxy valuations were derived from a

[30] It is common practice with an SROI assessment to disclude outcomes attained by project staff, as it is assumed that staff would be able to attain these outcomes in another paid position (i.e. payment for time, job satisfaction).

combination of research and participants' views (stated preference). In the case of high value proxies, such as those related to the outcomes for clients concerning an improvement in mental health or a reduction in social isolation, these were developed with reference to research in medical outcome valuation fields (i.e. QALYS[31]) or valuation research (Wellbeing Valuation[32]).

Step Seven: Sensitivity Analysis

The analysis was subject to sensitivity testing, which involves reviewing potential logical scenarios other than those identified within the SROI report in order to review how changes in assumptions create a change in valuation. The calculations and alternate logic that was reviewed is outlined in detail in the final chapter.

Step Eight: Development of Conclusions and Recommendations

The findings from the SROI were combined with the findings from the other sections of the report: the outcomes analysis and thematic analysis of stakeholder views. Recommendations were developed from these findings in conjunction with the steering group.

10.4 The Theory of Change

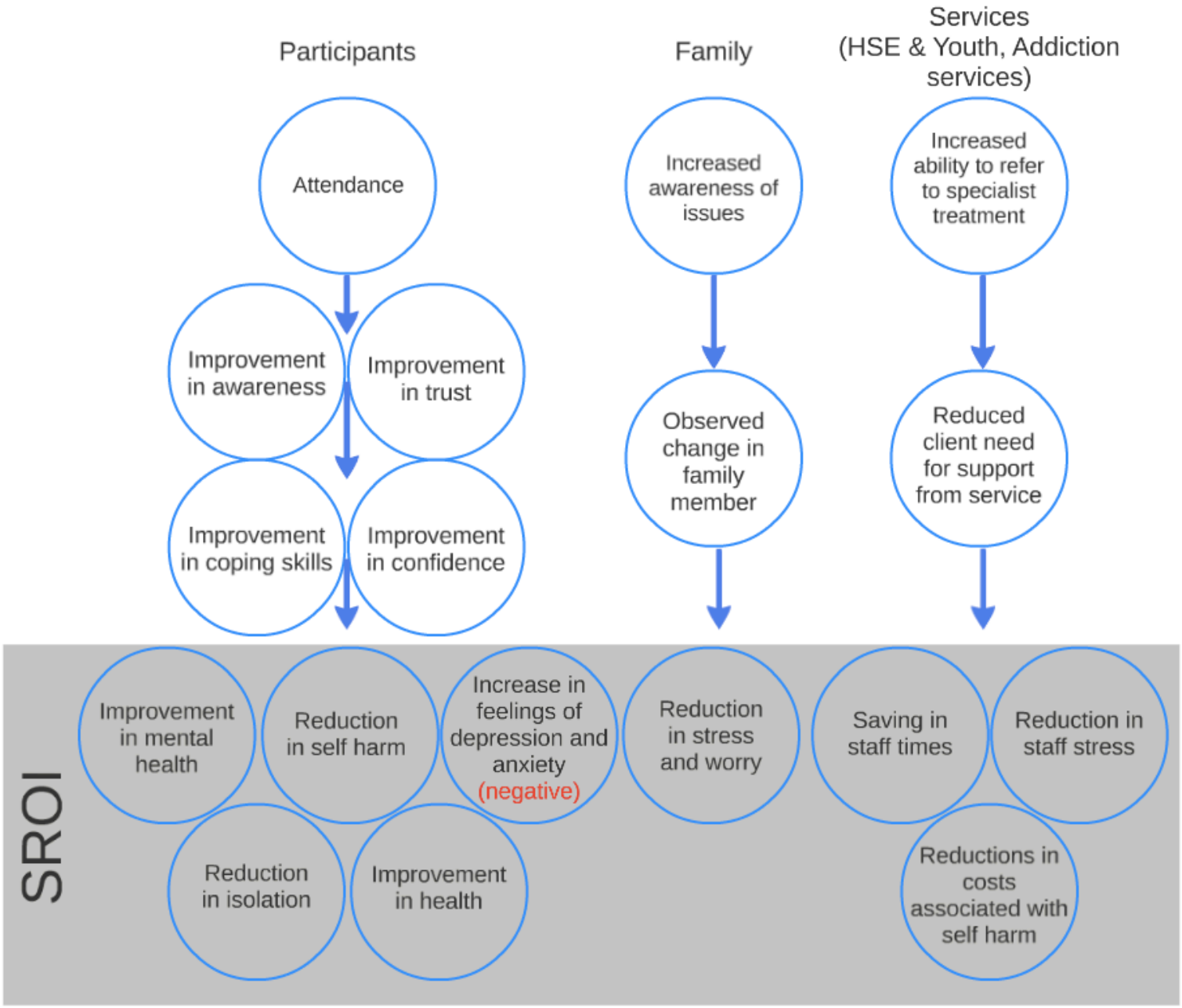
Developing an understanding the theory of change, i.e. the sequence of events that resulted in a change for a significant number of people in a stakeholder group, is central to the SROI process. The theory of change in SROI emanates not from the planning of the service or from the views of managers or staff, but from the people or stakeholder groups that experienced this sequence of changes. The theory of change is therefore built on the real world experience of those affected in any way, negative or positive, by the event being reviewed in the SROI. The graph on the following page identifies the SHIP theory of change through interviews and surveys with the various stakeholders.

To avoid overvaluation, the end of the chain of events is valued rather than each step in the chain. While all steps are important to achieve an overall outcome, the final outcome from the theory of change holds the most value for participants and is reliant on other steps in the process being achieved.

[31] QALYs are defined as: 'a measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One QALY is equal to 1 year of life in perfect health. QALYs are calculated by estimating the years of life remaining for a patient following a particular treatment or intervention and weighting each year with a quality of life score (on a zero to 1 scale). QALYs are used to assess the value for money of a medical intervention. (https://www.nice.org.uk/glossary?letter=q)

[32] The Wellbeing Valuation 'approach derives monetary values for different goods and services, like health, housing and social relationships, by estimating the amount of money required to keep individuals just as happy or satisfied with life in the absence of the good'. (www.hact.org.uk pg22)

SHIP Theory of Change



10.5 Summary

SROI provides a robust assessment of value by reviewing the significant and relevant self-reported outcomes for each client group. A chain of outcomes, i.e. increased awareness, leads to increased engagement, which then leads to increased knowledge, which leads to increased skills, which leads to behavioural change — only the end outcome will be valued to avoid double counting (in this case) behavioural change. The valuations provided for each outcome draw from the experience and opinion of those most affected by the outcome. This information is also triangulated against research into the valuation of these changes.

To ensure that the value of the impact of SHIP is not overestimated, a number of discounts are applied. These include reductions to account for the change that would have occurred regardless of whether SHIP had not provided a service and a reduction to account for the influence of other agencies or of family and friends.

Finally this analysis, which is also detailed in the impact map, has been externally validated by the U.K SROI Network to ensure that it considers the seven principles that underpin SROI. One of these principles is to avoid overvaluation of impacts. In line with this principle, this SROI has not considered the value of a potential reduction in suicide. While the rationale for this and a discussion of the likelihood of a reduction in suicide is contained within this chapter, the value itself is not represented in the SROI itself.

11 SROI Assessment of Outcomes and Value for SHIP Clients

11.1 Introduction

This section of the report details the self-reported outcomes, where relevant cross-referenced with CORE-OM outcomes, that occurred for clients of the SHIP programme, and provides estimates of the value of the changes that clients experienced as a result of attending SHIP.

11.2 Client Attendance Records and Other Supports at the Time of Interview

Twenty-six clients participated in interviews. The purpose of the interviews, which averaged 45 minutes in length, was to understand the value of outcomes experienced by clients attending the SHIP counselling service. All interviewees attended the SHIP counselling service in the SROI period from January to September 2014.

Below is a summary of clients' stages in their counselling journeys, and what additional support services they were attending:

- Two thirds (n=17) of interviewees completed up to a maximum of 12 therapeutic counselling sessions with SHIP and were no longer attending sessions.
- Over a quarter (n=7) of interviewees had not yet completed SHIP counselling sessions and had one or two sessions left.
- Two clients (n=2) had withdrawn after completing a minimum of three counselling sessions and had no plans to continue attending SHIP.
- Over two thirds (n=18) reported accessing one or more other service supports at the time they were attending SHIP.
- Over two fifths (n=11) reported that they continued to meet with their GP while attending SHIP, followed by over a quarter (n=7) attending a psychiatrist or another mental health services at the same time as SHIP.
- Four clients (n=4) indicated they had accessed another counselling service for a brief time or attended a support group at the same time as SHIP.

Over this time, 308 clients attended the SHIP, a figure which has been used to estimate the total number of clients who experienced change, i.e. if 40% of the interviewees experienced a change, then the overall value of change has been calculated by working out 40% of 308.

11.3 Theory of Change

A theory of change is a model for explaining how engagement in an activity leads to changes for participants. The theory of change model was used as a basis for discussion of change with clients in the interviews. The following is a description of the way in which the SHIP counselling service functions from the perspective of the client and the outcomes clients attained. This description details the link between the activity provided and the outcomes achieved:

Following a number of counselling sessions, clients reported an increase in knowledge about the process and an increase in trust with their counsellor. Over the course of the counselling, two thirds of interviewed clients reported a general improvement in coping skills (n=17) as a result of clients being able to discuss their issues and talk openly about their experiences with SHIP counsellors. The following quote best illustrates this improvement:

> *I found that I was better able to manage stressful situations at home, with children and in my work life. I went from not being able to cope with anything to not being phased by these stressful situations. (Client 30)*

Another general improvement reported by over two thirds of interviewees (n=18) was improved confidence, which resulted from an improved understanding of their feelings of depression and anxiety while attending SHIP sessions. Following these improvements, interviewees reported that they experienced the following outcomes:

1. An improvement in mental health: Just under three quarters of interviewees (n=19, 73%) experienced a significant improvement through a reduction in feelings of depression and anxiety, both in terms of frequency and intensity.

2. A reduction in self harm: Over two thirds of interviewees (n=18, 69%) reported a reduction in self harm tendencies, both in terms of frequency and intensity.

3. An increase in feelings of depression and anxiety (negative outcome): Three interviewees (n=3, 12%) experienced the negative outcome of an increase in feelings of depression and anxiety following the completion of counselling sessions. Interviewees stated that this negative outcome resulted from discussing past experiences with SHIP counsellors and bringing feelings of past experiences back into counselling sessions.

4. A reduction in isolation from family and friends: Just under half of interviewees (n=11, 42%) felt a reduction in feelings of isolation or improved communications and connection with family and friends.

5. Improvement in health (diet and fitness): Just under half of interviewees (n=12, 46%) experienced a moderate to significant increase in physical health (defined as either improvements in fitness routine or diet).

No clients experienced an increase in confidence and/or increased coping skills without also experiencing an improvement in mental health or a reduction in self harm. All SHIP clients indicated that when a final outcome had been achieved, an increase in confidence and coping skills was also attained. This means that an improvement in confidence or the attainment of coping skills was not achieved as a stand-alone outcome for any of the SHIP clients.

The contribution of clients was viewed as their time attending specialised therapeutic counselling sessions, up to a maximum of twelve sessions. However, in line with standard SROI practice, this input was not valued in monetary terms.

11.4 Outcome 1: A Significant Improvement in Mental Health

Valuation of Outcome

Nearly three quarters (n=19, 73%) of interviewees experienced a reduction in feelings of depression and anxiety, resulting in improvement of mental health. The remaining three clients (n=3) did not experience this change, while four clients (n=4) experienced only a small change, which was not considered significant enough to be valued as part of the SROI.

When triangulated with the results of the CORE-OM outcome analysis, the results have reasonable parity. This analysis showed that the majority of service users (65%) reported CORE-OM scores indicative of reliable improvement in mental health. To calculate the number experiencing this change, the average of these two figures has been taken and multiplied by the full population over the period of the SROI. Therefore, an improvement can be estimated to have occurred for 213 clients[33]. The impact of an improvement in mental health is best illustrated by the following quotes:

> *My depression has reduced, and I was a lot worse with depression than I am now. I did not realize how serious these issues were. After my first few sessions, these feelings began to reduce as I became more aware of my feelings. I have not visited my GP about my depression since I first started going to SHIP because I'm managing things much better. (Client 30)*
>
> *There has been a massive change. Before attending SHIP, I was very suicidal and was self harming, but since I have attended SHIP I am no longer self harming. (Client 14)*
>
> *I have seen a big change in my life. Before SHIP I was taking medication to manage my depression. Now I have been able to get off the medication and I no longer have those feelings anymore. (Client 16)*

When interviewees were asked about the value of this outcome, all clients (n=19) who experienced an improvement in mental health initially described this outcome as 'priceless'. A common sentiment was that the value of improvements in mental health outweighed the value of the other material objects in their lives put together[34].

To determine a more precise value for the improvement in mental health, medical research on Quality of Life Adjusted Years (QALY) was referenced. QALY is an estimation of the impact of health services on the quality and length of life (77). Another way of understanding this is the calculation for the number of years that would be added by the intervention and the quality of these years for an individual (78).

According to research on QALY values, it is generally accepted that the measured willingness-to-pay for one additional QALY is between £25,000 - £30.000 in U.K currency (or €34,647[35]) (79). Research indicates that, on average, severe depression reduces the 'value of a life-year by 0.2 to 0.4 QALYs' (79). Other research estimates this at specifically 0.352

[33] (65% + 73% / 2) x 308 = 213 clients
[34] In this value exercise, the price of the family home was not included in this assessment.
[35] Calculated using XE Currency Converted on 19/05/2015.

(80), which is the figure used within this report. Using this data, the value of reducing serious depression is equal to €12,192[36].

Research shows that the average length of improvements in mental health as a result of counselling sessions can be estimated at at least 18 months and likely towards two years for the majority of clients. Recent studies have shown single session therapy has been associated with benefits up to 18 months later. 'In terms of durability of improvement, treatment effectiveness of the single session was found at an 18 month follow up" (Perkins & Scarlett, 2008)(26).

Discounts to Valuation

Attribution: To calculate attribution, interviewees were asked how much the improvement in mental health was due to other supports in their life, such as family, friends and other services. The average interviewee responded that other organisations or family contributed to 35% of this change. Interviewees reported the main sources of attribution as being friends and family (n=12), and engagement with other health and mental health services, like their GP, psychiatrist or community health nurse (n=5). This means that 65% of an improvement in mental health can be attributed to the SHIP counselling service.

Deadweight: The change that would have occurred anyway without the SHIP counselling service was estimated at 20%. This means that one in five clients may have experienced this positive change without SHIP. This figure is very conservative considering that the majority of clients reported experiencing feelings of depression and anxiety for years prior to attending SHIP, and that other medical and mental health services had not individually been able to support this change. This assessment of deadweight is supported by research in a general manner (81), which maintains that depression is a chronic and reoccurring illness that is not improved, in most cases, without some form of treatment. The outcome analysis of the CORE-OM data also takes into account previous research (61), which has established benchmarking regarding the degree by which CORE-OM scores can change in order for conclusions to be drawn about whether this change can be attributed to the SHIP counselling service as opposed to normal fluctuation in feelings. Other research addressing the question directly or including control studies was sought to investigate likely change in mental health without intervention, however a thorough search did not reveal any studies to further support estimation of deadweight[37].

Drop off: The reduction in causality between the outcome and the SHIP counselling service was estimated at 30% annually. This figure means that, for those interviewees maintaining the outcome, it is assumed that the contribution of SHIP to the value of the outcome each year is reduced by nearly a third.

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[36] (0.352 x €34,647) = €12,192

[37] Finding research on or controlled studies about individuals whose mental health issues improved without assistance or engagement with therapeutic intervention is challenging. A lengthy, detailed search, described below, resulted in no substantive findings. Searches of MeSH (Medical Subject Headings) of "suicide", "mental distress", "self-harm/care", "self-help", "mental health", "without/forgoing/no therapy/intervention/support", "randomized/control study" was undertaken with Boolean operators including "and", "and not", "near" and "( )". Databases included the UK's National Institute for Health and Care Excellence Healthcare Database (PubMed), the US National Library of Medicine, and University of Dublin, Trinity College Library. Additional, less structured, searches on the internet were also conducted using search terms and phrases to highlight potential avenues of inquiry. These included phrases including but not limited to "mental health measures "non-intervention"", "do not choose therapy" ""Control study" near "no intervention/ therapy/ support" near "suicide/self harm".

11.5 Outcome 2: A Reduction in Self Harm

Valuation of Outcome

Self harm is defined as a "broad spectrum of non-fatal acts of self-poisoning and injury … not a diagnosis behaviour associated with a range of mental health disorders and social distress"(82). Self harm is also viewed as a common indicator of suicide risk (82).

Over two-thirds of interviewees (n=18, 69%) experienced a significant reduction in the frequency or intensity of self harm or stopped self harm completely. For the remainder, four interviewees (n=4) experienced only a small change in relation to this outcome, and just over a quarter (n=7) did not experience any change or did not present with self harming issues.

When calculated across the entire SHIP population between January to September 2014, it is estimated that this outcome was experienced by 213 clients[38]. The impact of this reduction in self harm is described by the following quotes:

> *I had attempted suicide at a younger age after ending a harmful relationship in my life and I was still dealing with these issues while attending SHIP. I definitely have more control over it, and I still have some thoughts about self-harm but SHIP has helped me block it. (Client 16)*
>
> *I have not harmed myself again since attending SHIP. (Client 13)*
>
> *These feelings don't even enter my head. These thoughts that I had before don't even happen anymore. I don't think that way anymore. (Client 29)*

The value of this reduction in self harm to the individual has been calculated using a proxy valuation of the cost of psychological interventions for the treatment of anxiety. Research (83) indicates its value at €874 in 2006, which has an inflated adjusted value of €1,008 in 2014 prices[39]. Based on research, the average length of this outcome was reported as two years (59).

Discounts to Valuation

Attribution: Attribution for this outcome was based on responses from clients in interviews. It was calculated that 28% of the reduction in self harm was a result of support of friends and family members (n=9) or the influence of mental health and health services such as a psychiatrist, GP, HSE mental health service or support group (n=5). This means that 72% of a reduction in self-harm is estimated to be due to the SHIP counselling service.

Deadweight and Drop off: The reduction in causality between the outcome and the SHIP counselling service was estimated at 30% annually. This means that for those maintaining the outcome in year two, it is assumed that just under a third less of this benefit is as a direct result of SHIP in year two.

[38] (69% x 308) = 213 clients

[39] Difference of costs between 2006 and 2014 was determined by using an inflation calculator using the euro area consumer price index (https://www.statbureau.org/en/eurozone/inflation-calculators)

Deadweight was calculated at 20%. This figure is based on interviewees reporting that a reduction in the desire to self harm without counselling support was not possible, and that other interventions had not worked in the past. However, to ensure a conservative valuation, a figure of 20% has been used.

11.6 Outcome 3: A Reduction in Social Isolation

Valuation of Outcome

Nearly half of interviewees (n=11, 42%) reported a significant reduction in feelings of isolation as a result of attending SHIP. The remaining interviewees (n=11) did not experience this change at all, and four (n=4) experienced a small change in relation to this outcome, which was not considered significant enough to be valued as part of the SROI. Given these figures, it is estimated that 129 clients[40] experienced this outcome from the entire SHIP population between January and September 2014.

A reduction in isolation was defined as either a large increase in the ability to communicate with family or friends, or feeling more able to connect with other people where previously they were unable to engage to the point of avoiding social activities with others. A general sentiment named by interviewees (n=4) was that prior to SHIP, they would not leave their homes or go out with friends due to feelings of depression or anxiety. The impact of a reduction in isolation is described in the following quotes:

> *It is something that has definitely improved, but I am not the most vocal person in the room. After going to SHIP, I am not afraid to let my voice be heard, and less nervous about walking into uncomfortable situations with other people. I'm no longer debilitated by uncomfortable or new social situations. (Client 30)*

> *The reason that I felt isolated was because of the way I thought about myself. I used to think I was alone. (Client 29)*

> *I've always been a major introvert, but I have started to talk with people more and noticed my habits have changed especially at work. (Client 7)*

Some interviewees (n=6) described their feelings of isolation as having a connection with depression and suicidal ideation. This relationship is also reflected in research: 'social isolation, loneliness and being divorced, widowed or single also increase the risk of suicide for older men'(19).

The value of this change has been estimated at £1,850, which is based on the value of being a member of a social group using Wellbeing Valuation[41] techniques (10, 11), equivalent to €2,606[42]. Given the interrelated nature of these two outcomes, the length of time for this outcome has been tied to that of an increase in mental health at two years.

[40] (42% x 308) = 129 clients
[41] Note while some HACT calculations should not be used for other value assessments, such as an improvement in mental health, as this would lead to a double counting of some outcomes, being a member of a social group is not affected by any restrictions and so can used in this SROI without danger of over claiming.
[42] Calculated using XE Currency Converter on 20/05/2015.

Discounts to Valuation

Attribution: Attribution for a reduction in isolation was calculated as 50%. Other important factors named by interviewees were the support of friends and family members (n=7) and the influence of other mental health services, like support groups (n=2). This means that 50% of a reduction in isolation can be attributed to the SHIP counselling service.

Deadweight and drop off: The reduction in causality between the reduction in isolation and the SHIP counselling service was estimated at 30% annually. The change that would have occurred anyway without the SHIP counselling service was calculated at 20%. This means it is estimated that one in five clients would have experienced this reduction in isolation without SHIP.

11.7 Outcome 4: Improvement in Health (Diet and Fitness)

Valuation of Outcome

Just under half of the interviewees (n=12, 46%) reported a significant improvement in physical health and fitness as a result of lifestyle changes inspired by SHIP. The remaining 11 interviewees did not experience this outcome, and three (n=3) experienced only a minor improvement that was not valued as part of this calculation. Given this figure, it is estimated that 142[43] of SHIP clients experienced this outcome in the SROI period between January to September 2014.

An improvement in physical health was defined as either (1) an improvement in their fitness routine where previously the individual had limited or no exercise in the six months prior to attending the SHIP counselling service, or (2) a more well-balanced and healthier diet, where previously diet and nutrition were poor (including not eating and over eating).

In some cases, interviewees (n=4) reported they had lost weight and were sleeping more regularly, which they reported as a result of the influence of SHIP. This improvement in physical health is best described by the following quotes:

> *It was a combination of counselling and running and I've kept that up since going to SHIP. I definitely saw an improvement in terms of sleeping more, and improved diet and nutrition, and less alcohol consumption. (Client 30)*

> *Before going to SHIP I used to eat a lot more unhealthy food. Since going to counselling session I've made changes to what I'm eating and I feel a lot better. (Client 33)*

> *The counsellor suggested that I started going to yoga because I had trouble going to sleep. It was a good suggestion because it's helped me become more mindful and get some exercise and it's become part of my life. (Client 28)*

The value of an improvement in physical health has been estimated using a proxy valuation of the yearly cost of the cheapest gym in the Wexford area[44] which has an

[43] (46% x 308) = 142 clients

[44] Membership fees for a low-cost local gym Enniscorthy, Co. Wexford are €40.00 per month and approximately €325.00 per annum (http://www.enniscorthypool.ie/leisure-pass/). This price was the lowest cost compared with three other local gyms.

annual membership of €325. The timeframe for this outcome has been connected to that of an improvement in mental health at two years.

Discounts to Valuation

Attribution: Attribution for this outcome was based on client interview responses. It was calculated that 38% of the improvement in physical health was a result of support of friends and family members, like partners or children (n=11), or influence of mental health and health services, like a psychiatrist, GP, or a community health nurse, which accounted for a smaller amount of this change (n=3). On average 62% of the improvement in physical health was attributed to the SHIP counselling service.

Deadweight and Drop off: The reduction in causality between the outcome and the SHIP counselling service was estimated at 30% annually. Deadweight, the change that would have occurred anyway without the SHIP counselling service, was estimated at 20% based on client feedback from interviews as to the estimation that they would have made this change without SHIP.

11.8 Outcome 5: An Increase in Stress Related to Feelings of Depression or Anxiety (Negative Outcome)

Valuation of Outcome

As with all interviews, clients were asked if there were any negative outcomes as a result of attending SHIP counselling sessions. A small number of clients (n=3, 12%) identified the negative outcome of an increase in feelings of depression and anxiety following the completion of the counselling sessions. This can be best described by the following quote:

> *There was too much for me to process and by the end of my sessions, I was left feeling very emotional. I did not feel like I was ready to start going into parts of my life. (Client 31)*

Three clients (n=3, 12%) reported an increase in feelings of depression and anxiety after completing the programme. The remaining interviewees (n=23, 88%) did not experience any negative outcomes. It is therefore estimated that 37 clients[45] experienced this negative outcome when calculated across the entire SHIP population between January to September 2014. Results of the CORE-OM outcome analysis show that only two clients (n=2) had some deterioration following therapy, which provides a more conservative estimation of those affected negatively by the service. In line with principle of conservative valuation, the higher figure from the interviews has been used in the SROI.

It is important to note that Interviewees (n=3, 12%) reported that the value or impact of this negative outcome was lower than the value of the benefits accrued to them from the counselling sessions. When discussing this negative outcome, interviewees indicated this value as significantly lower than the value of the benefits accrued to them. Therefore, the value of this additional stress has been calculated at the cost of a quarter of the value of the benefit of an improvement in mental health, which is consistent with the views of clients

[45] (8% x 308) = 25

reported in interviews. This increase in feelings of depression and anxiety is best demonstrated by the following quote:

> *The only bad thing I can think about it, it was upsetting dealing with the dark sides of myself. The service had to deal with some of these issues, before I could get better. They explained that this could happen, and made sure that I knew that I could deal with this once I got home. (Client 24)*

As previously stated, the general cost for one additional QALY was estimated as €34,647 (79). Research shows that, on average, severe depression reduces the value of a life year by 0.352 QALYs, which is the figure used previously within this report (80). To calculate a minor increase in feelings of depression for clients, at 25% of the positive valuation of an increase in mental health, it is estimated that the value of this outcome equal to €3,048[46].

Discounts to Valuation

Attribution: Attribution for this outcome was based on responses from clients in interviews. It is estimated that 20% of an increase in feelings of depression and anxiety resulted from clients accessing other medical or mental health services at the same time as SHIP. This means that 80% of this increase in feelings of depression and anxiety can be attributed to the SHIP counselling service.

Deadweight and drop off are the same as those in the section on an improvement in mental health.

11.9 Summary

Interviews with clients (n=26) found the following outcomes were a result of the influence of SHIP counselling sessions:

- Just under three-quarters of interviewees (n=19) experienced an improvement in mental health, both in terms of frequency and intensity.
- Over two-thirds of interviewees (n=18) reported a significant reduction in self harm tendencies in relation to both frequency and intensity.
- Just under half of interviewees (n=11) experienced a reduction in feelings of isolation or improved communications and connection with family and friends.
- Just under half of interviewees (n=12) experienced significant increase in physical health defined as either improvements in fitness routine or diet where previously diet and nutrition was not regarded.
- A minority of interviewees (n=3) reported an increase in feelings of depression and anxiety after completing their SHIP sessions. Interviewees stated this negative outcome was a result of bringing up feelings of past experiences during counselling sessions, but was described as being a lower value than the benefits accrued overall from SHIP.

[46] (0.25/0.352 x €34,647)= €3048

12 SROI Assessment of the Outcomes and Value of SHIP to the Family Members of SHIP Clients

12.1 Introduction

This section of the report reviews the outcomes that occurred for family members of SHIP clients and the value of this change. Ten family members (60% of the total family members) completed interviews, which included six partners, three parents and one sibling.

In total, when 19 clients were asked if a family member would participate in an interview, nine clients (n=9) declined. Of this group, three interviewees (n=3) declined to comment on their reasons and six (n=6) indicated they had not told their family about their past physical or mental health experiences or that they were attending the SHIP counselling service.

Based on this information, it was estimated that 193 clients[47] of the SHIP population between January and September 2014 had informed a family member about their involvement in the SHIP programme, and that a proportion of these may have experienced positive or negative outcomes as a result. It is therefore estimated that 115 clients[48] had not informed their families about attending SHIP.

Interview questions for family members focused on outcomes experienced by themselves, and not outcomes experienced by SHIP clients. In line with standard SROI practice, the contributions of family members were not valued as part of the calculation.

12.2 Theory of Change

The theory of change, which describes the changes that occurred for interviewees, speaks to whether clients developed skills and methods for coping and self-managing their stress as well as reduced negative feelings in relation to emotional distress and suicidal ideation. This change results in clients feeling more present and involved in their families and appearing happier and more in control of their lives. This had a positive impact on the family, which led to a reduction in worry and stress for family members.

12.3 Outcome 1: A Reduction in Stress or Worry

Valuation of Outcome

Two-thirds of interviewees (n=6, 60%) reported a significant reduction in their feelings of stress or worry as a result of their family member attending the SHIP counselling service. If this change is estimated across the entire SHIP population between January to September 2014, reduction in stress and worry was experienced by 19 family members.[49]

A reduction in stress and worry was defined as a significant reduction in the frequency and intensity of feelings of stress or worry to the point where these feelings are no longer

[47] (10 / 16) x 308 = 193 clients
[48] (6 / 16) x 308 = 115 clients
[49] (60% x 193) = 115 clients

present. A number of interviewees commented that this change meant that time was created for other activities in life. A reduction in feelings of stress and worry is described in the following quotes:

> *I felt a lot better when my partner was getting happier about their issues. She was a lot happier after each session, and was talking about issues and positive things in life. (Family Member 2)*

> *There has been a change for myself and my daughter, as she has been more aware of my sister's problem. During the holidays, we used to dread a large family occasion. This was the first year where there was not any drama for our family. (Family Member 5)*

> *There was a lot less stress and burden in my life, because I was not carrying all the burden in my family. So when my partner was at an appointment, I would get some time to myself and with our kids. (Family Member 4)*

The value of this reduction in stress and worry is calculated based on a proxy of the costs for a mindfulness programme focused on reducing stress, low mood and anxiety. This proxy was identified by interviewees as reasonable, however a number also identified that a course or supports for themselves was unlikely to achieve quite the same outcome as their loved one getting effective supports. The average cost for a low-cost eight week mindfulness programme was estimated as €300[50].

Discount to Valuation

Attribution: Attribution for this outcome was based on responses from clients in interviews. It was averaged that 58% of the improvement in stress or worry related to the family member attending SHIP was a result of the support of friends and family members, like partners or children (n=7), or influence of mental health and health services for the family, like a psychiatrist, GP, or a community health nurse (n=3). This means that approximately 42% of a reduction in stress or worry can be attributed to SHIP.

Deadweight and drop off: The change that would have occurred regardless of the SHIP counselling service was conservatively estimated as 20%. This figure is based on three respondents (n=3) indicating that a reduction in feelings of depression or anxiety would have been possible if other counselling services or supports were accessed instead of SHIP. Drop-off and time frame have been connected to the outcome related to client mental health, given the close connection of these outcomes.

12.4 Summary

Nearly two-thirds of family members claimed that SHIP had resulted in a reduction in stress and worry for their families. Based on feedback from family members, clients experienced an improvement in mental health, resulting in a reduction in stress and worry for the family. Given these figures, it is estimated that this reduction was experienced by 193 clients from the entire SHIP population between January and September 2014.

[50] The cost for this proxy was based on the costs of three eight-week mindfulness programmes based in Ireland, the Centre for Mindfulness Ireland, Mindfulness at Work, Mindfullness.ie. Two programmes cost €350 and one programme cost €290. All programmes noted that a key outcome was effectively dealing with stress and anxiety.

13 SROI Assessment of the Outcomes and Value of SHIP to the HSE

13.1 Introduction

The HSE is the only funder or contributor of resources to the SHIP programme. The ways in which the HSE supports the programme through in-kind contribution (provision of a building) and direct funding is detailed in the table below. The HSE benefits from the existence of SHIP. The outcomes for the HSE have been derived from interviews and survey with key mental health practitioners in HSE services across the regions where SHIP operates and include 1) savings to staff time, and 2) reduction in staff stress. Four key stakeholders (people in senior management positions) were interviewed and a survey was completed by 11 other key stakeholders. These were purposively selected as being representative of the main HSE referring agencies to SHIP.

13.2 Inputs

Inputs are considered any cash or in-kind contribution made to the SHIP service by the HSE. No agencies outside of the HSE contributed finance or in-kind resources to the programme.

Even though in-kind contributions may not appear on the balance sheet, SROI considers inputs of both cash and in-kind contributions. This includes valuing the contribution of time by board members as well as in-kind provision of services such as room provision. All inputs are listed in the table below for the period from Jan to Sept 2014.

Table 10: SROI Inputs

Type of contribution	**Detail**	**Amount**
Board time contribution / HSE staff not directly paid by HSE to work for SHIP	This information was attained through interviews with board members. The average contribution of the non-SHIP staff attendees to the steering group was seven hours between Jan and Sept 2014. This included meeting attendance and preparation. All hours have been valued at the average pro-rata pay rate of - €77,000, or €38 an hour. For four members, this translates to €341 per person, or €1,367 in total.	**€1,367**
HSE direct payment of key staff and admin and travel	Including the following staff and programme costs: - One tenth FTE (full time equivalent) of the Director of Counselling (the Director has overall responsibility for three regional counselling services and additional clinical governance role for other regional and national remits. On average, a tenth of his available time is directly related to the clinical or operational overview of the management of SHIP) - One third FTE of an admin role - FTE Coordinator	**€80,977**

	- Admin and travel	
Total payment to Counsellors and the contracting firm between Jan and Sept 2014	This is the total payment made to counsellors via the recruitment form CPL, and including all CPL related recruitment costs.	**€178,936**
Estimated equivalent rent costs for in-kind room provision (HSE owned or rented premises)	Premises are provided to SHIP headquarters by the HSE in a long-established HSE owned health clinic. To calculate the comparative cost of this space, market research was undertaken which indicates the square footage as equivalent in value to a rental costs of €8,880.	**€8,880**
Room costs for counsellors (in-kind)	The service uses the equivalent of 15 days of room use per week. Note that most rooms are not available to rent at commercial rates. A number would also not be fully utilised if SHIP were not using the rooms. To estimate the cost of this resource, an average community room hire cost has therefore been estimated at €50 a day. These costs have been calculated for 50 weeks of the year, resulting in an overall in-kind HSE contribution of €37,500. In addition, SHIP pays for one the Hire of one premises, in Kilkenny as well phone and heat, which is used for two days in the week and comes to €12,850.	**€50,350**
Total contribution from HSE from Jan to Sept 2014 (direct and in-kind contributions)		**€320,510**

13.3 Outcome 1: Savings to Staff Time

Valuation of Outcome

Eight of the 11 HSE respondents (working in frontline services) stated that a referral to SHIP reduces the time that they themselves or a member of their team needs to spend with a client. On average, this was estimated at a saving of just over five hours of staff time per client per referral to SHIP. Based on the proportion of referrals, of which 48% came from HSE mental health services, it can therefore be estimated that this saving was relevant for 146 shared HSE and SHIP clients. This saving is described in the words of one survey respondent below:

> *'I am a clinical psychologist and the service and [SHIP has] freed me up to work with a different client group'. (HSE respondent 5)*

The value of staff time savings have been estimated based on the mid-point of a clinical psychologist pay scale (89), which translates to an hourly cost of staff time of €30[51]. Therefore, per client there is a savings to the HSE of €150.

[51] €60,959/52 weeks/39 hours= €30

Discounts to Valuation

The period of the outcome is one year only, and deadweight has been pinned to that in the section on client outcomes, implying that if clients had addressed these issues without intervention, this would have also had the effect of reducing the need for staff engagement.

13.4 Outcome 2: Reduction in Staff Stress

Valuation of Outcome

Eight of 11 staff from frontline services stated that SHIP has reduced stress on staff as a result of them no longer having to deal with self harm and suicide related issues. HSE respondents explained that by being able to refer to a specialist service that was relatively quick to access, the stress in relation to managing high-risk clients, for whom they did not always have appropriate and immediate supports, was significantly reduced.

A proxy valuation for this outcome is the time taken to provide internal additional line management/supervision, as six out of the eight who answered the question relating to how the organisation managed stress stated internal supervision as the preferred method within the service. Two services stated that additional external supervision is the means used to manage staff stress. The cost of internal supervisory management can be estimated conservatively at the equivalent of a working hour a month, since the SROI period this is equivalent to nine hours. If a mid-point senior clinical role in HSE (89) is calculated at €79,070, nine hours is equivalent to €350[52].

It is conservatively estimated that additional stress management supports may be required for every one in ten staff members. This information is based on interviews, which highlighted that supports are not required in every instance. Therefore, for the 146 shared clients between SHIP and mental health services, it is estimated that additional stress reduction supports may be relevant in 14 instances.

Discounts to Valuation

The time for this outcome is one year with a provision for deadweight of 20% (aligned with the outcome of what may have improved for clients with SHIP intervention).

13.5 Outcome 3: Reduction in Costs Associated with Self Harm Presentations

Valuation of this Outcome

Interviews with clients from SHIP indicate that self-harm was reduced as a result of engaging with SHIP. A reduction in self-harm will have the effect of a reduction in costs to the HSE. A control study undertaken in the UK indicates that self harming individuals cost the health service over £1,500 per year compared with only £65 per year in the control group (non self harming) (90). Irish data on of a similar nature is not available. The difference in costs between the two groups (£1,435) translated into euros equals €1,996.[53].

Discounts to Valuation

The timeline, deadweight and drop off for discounts to valuation has been pinned to those in the client outcome related to self-harm (2 and 20% and 30% respectively), given the

[52] 79,070/52 weeks/39 hours = 39 an hour x 9 hours = €350 per staff member
[53] http://www.xe.com at June 1st, 2015

obvious connectedness between these outcomes. As discussed in the client outcomes section of the SROI chapter, 213 clients were estimated to have reduced self-harm.

13.6 Summary

Key stakeholders within the HSE identified three main ways in which SHIP has provided an outcome to other aspects of the HSE. These were 1) a reduction in staff time spent with clients in shared care of SHIP and the predominantly mental health services, 2) a reduction in staff stress related to managing high risk clients without appropriate and timely specialised supports, and 3) research into the wide-ranging cost savings related to reducing self-harm. These are connected with A&E visits and well as other psychiatric and health focused social care costs.

14 SROI Assessment of the Outcomes and Value of SHIP to GP Referrers

14.1 Introduction

Approximately 25% of referrals (98 of 410) in the SROI period came from GPs. Five of the higher referring GPs were engaged in the research through online survey. GPs identified two outcomes from engaging with the SHIP process: a savings in GP time and a reduction in staff stress as a result of having a specialist service to refer high-risk clients on to.

14.2 Outcome 1: Savings to GP Time

Valuation of Outcome

All five GPs maintained that a referral to SHIP reduced their follow-up time with clients. The average time savings for GPS averaged five hours per client. To calculate the costs of 5 hours of GPs time, the hourly rate for GP average earnings is required. An OECD report (1) states that in 2011, Irish GPs earn on average three times the national average wage. In 2014 the average national wage per hour was €22.11(91), therefore it can be estimated that an average hourly rate for a GP is approximately €66.33. At five hours per client, the value of a saving of GP time is therefore €332.

Discount to Valuation

The period for this outcome is one year. Deadweight is the same as an improvement in mental health for SHIP clients due to the connected nature of these two outcomes.

14.3 Outcome 2: Reduction in Staff Stress

Valuation of Outcome

The other outcome that GPs recorded in relation to their clients attending SHIP was a reduction in stress for their staff members. All five GPs recorded this as an outcome of the programme, commenting that they had no systems in place to support staff to manage stress, so existing supervision or time for supports could not be included as a proxy for this outcome. In place of this, the value of a reduction in stress has been calculated at a half day's absence leave[54]. A half day of leave is equivalent to €232[55], with this estimated to affect 18 GPs (GPs who were frequent referrers have been counted whereas infrequent referrers have not been counted).

Discount to Valuation

The length of time of the outcome is one year. Deadweight is the same as an improvement in mental health for SHIP clients due to the connected nature of these two outcomes.

[54] The HSE 'Policy for Prevention and Management of Stress in the Workplace' states that or released potential harm to others can be a source of workplace critical stress, and furthermore that stress can result in increased sick leave absence from work.
http://www.hse.ie/eng/staff/Resources/hrppg/Policy_for_Preventing_Managing_Stress_in_the_Workplace.pdf
[55] 3.5 hours x €66.33 per hour = €232

14.4 Summary

GPs are a significant stakeholder in SHIP, presenting an important gateway into the SHIP service and accounting for 25% of referrals overall. They also receive benefits from the process, which were clearly identified by the GPs engaged in the research.

15 SROI Assessment of the Outcomes and Value of SHIP to Youth and Addiction Services

15.1 Introduction

Three senior staff members from community and voluntary services and one staff member from HSE addiction services were interviewed in relation to whether their services received any outcomes from SHIP. One of these services was able to directly refer to SHIP; the others supported referrals indirectly through the clients' GPs and played an active role in ensuring that clients accessed the service. Overall, these services estimated that over that 52 of their clients had attended SHIP, 34 of which were directly referred to SHIP.

15.2 Reduction in Client Contact / Follow-up Time

Valuation of Outcome

All community and voluntary services interviewed stated that SHIP had reduced direct client contact time for clients who were self harming and referred to SHIP. It was estimated that if clients had not been referred to SHIP, the time that services would have spent with these clients would be increased, creating time for other service users to receive a service. This time has a value based on the average hourly rate of staff performing the service, which was calculated at the equivalent of €38,000 per annum or €19 and hour. The average savings in time for workers supporting clients and their family members is approximately 35 hours, resulting in a savings of €665 per client to the service. This was true of clients referred directly and indirectly into SHIP.

Discount to Valuation

The period for this outcome is one year. Deadweight is the same as an improvement in mental health for SHIP clients due to the connected nature of an improvement in client mental health and a reduction in contact time.

15.3 Reduction in Staff Stress

The other outcome that youth and addiction services agreed on was a reduction in staff stress as a result of having a referral pathway for self harming clients or those presenting with suicidal ideation. Three services recorded this outcome. However, when calculated at one hour a month of additional supervision at an average manager's salary, it did not meet the materiality threshold of €2000. The materiality threhold is the amount of value that an outcome needs to have to be significant in relation to the overall value assessment. Valuations under €2,000 affect the overall SROI by less than a cent and are therefore not considered significant enough to justify inclusion. This outcome had an annual value of around €750 (managers time valued at around €21 per hour (salary of €42,000), 12 hours per year by three equals approximately €750.

15.4 An Increase in Opportunity for Family Members to Access Services

Valuation of Outcome

Two services also identified an additional unintended outcome of families having increased access to services. Interviewees commented that when the issue of self harm was addressed through a referral to SHIP, other family members were able to raise their own issues that had previously not been discussed as, it was felt, the attention needed to be focused on the self harming. Issues raised included things such as domestic violence and substance use.

The small numbers of families involved mean that that this outcome did reach the materiality threshold of €2.000 (this change was valued at the equivalent of additional outreach work to the family costing €500 per family). So while this outcome has not been valued in the SROI, the importance of appropriate referral pathways for families with complex needs identified though the interviews should still be highlighted.

15.5 Summary

As a result of having SHIP, a specialist service, to refer to, community and voluntary services saved organisational resources, which could then be provided to other service users in need. The fact that staff were not dealing with specialist issues such as self harm meant that staff stress was reduced as well as the related organisational supports to manage this stress (i.e. supervision). Also, having appropriate pathways for clients managing high-risk situations meant that other important issues could be dealt with in families with multiple or complex needs.

16 The Value of a Reduction in Suicide and why this has not been Included in the SROI

16.1 Introduction

This brief section of the report discusses the rationale for excluding the likelihood and value of SHIP reducing death by suicide. Information is also provided on the cost of suicide in Ireland, compared with the U.K, Scotland and New Zealand. A summary is given of how inclusion of these costs would have affected the final SROI valuation, had even one reduction in a death by suicide been included in the SROI calculations.

16.2 The Value of Reducing Suicide

According to Reach Out, the National Suicide Strategy (19), the costs of a prevented suicide in 2002, is €1,748,249. The cost per suicide for direct costs such as emergency services stands at €3,593 per death, with the human costs estimated at €1,245,947 per suicide. The difference is made of up of loss of market and non market loss of productivity.

For anyone experiencing a suicide in his or her close family or friends, this figure will most likely seem a gross underestimation. Putting a value on the life of a loved one is an understandably impossible task. However, to support policy making this is a necessary undertaking. The costs provided within the Irish Suicide Strategy are largely comparable to other international cost estimations of suicide:

- Scotland: £1,290,000 per case in 2004 (92), approximately €1,806,868

- New Zealand: $2,483,000 (NZ dollar) per case in 2005 (93), approximately €1,627,009

- England: £1.670,000 per case in 2009 (94), approximately €2,338,915

16.3 Estimations of how SHIP may have Reduced Suicide

Research has clearly demonstrated a clear link between self harm and death by suicide. Research published in 2003 and conducted with 11,500 U.K based patients over a 15-year period, has estimated the risk of suicide in relation to hospital presentation with self harm. The research found that the risk of suicide 'in the first year of follow-up was 0.7% which was 66 times the annual risk of suicide in the general population. The risk after 5 years was 1.7%, at 10 years 2.4% and at 15 years 3.0%' (95). This research is in line with the findings of a systematic review of large research projects on the same topic which analysed the findings of 90 research projects and found that 'The strong connection between self harm and later suicide lies somewhere between 0.5% and 2% after 1 year and above 5% after 9 years. Suicide risk among self harm patients is hundreds of times higher than in the general population'(11).

Using the conservative estimate of .5% it can be posited that of the population attending SHIP, of which data shows that 85% had previous experience of self harm or non-fatal

suicide, then it could be estimated that 13[56] individuals may have been prevented from death by suicide.

16.4 Why a Reduction in Suicide has not been included in the SROI Calculation

This SROI has stopped short of valuing a saved life through the prevention of a suicide. The reason for this is that despite the group having significant clinical improvements and being at a high risk of suicide, there is no available evidence to prove that suicides were prevented. Irish research shows that suicide is a rare event even among at-risk groups. For example, in the group with the highest suicide rate – young unemployed males – the annual suicide rate would seem to be no higher than 125 per 100,000 population or 1 in 800 (8).

One of the principles of SROI is that outcomes should not be overvalued. In line with this principle, while a hypothesis can be made that SHIP's interventions have prevented a suicide, the comparatively rare nature of suicide to a regional population means that this hypothesis is unable to be tested. Within research relating to outcomes from clinical interventions for self harm, suicide is considered 'too infrequent to be the main outcome event for a clinical trial of intervention after non-fatal self harm'(11). This logic and the fact that conservative valuation is core to the SROI methodology, means that the potential of SHIP to have prevented suicide has not been included in the SROI valuation.

16.5 Summary

While the value of SHIP in reducing suicide has not been estimated and valued within the SROI process, this shows the increase in the social return of SHIP if even one suicide could be shown to have been prevented. This should be considered within the context that while a reduction in suicide could not be proven, within the interviews, a number of clients stated that SHIP had saved their lives. If the impact of the prevention of 13 suicides is included in the SROI analysis, this results in an increase of the SROI figure from €9.10 to €19.09. The value of one prevented suicide increases the SROI to €12.88.

[56] 308 x 85% x.5% = 13 individuals

17 SROI Sensitivity Test and Conclusion

17.1 Overview

This SROI has been based on actual outcomes experienced by clients of SHIP and other stakeholders. However, some assumptions have been made in relation to deadweight and drop off. Undertaking sensitivity analysis provides an estimate of what the impact would have been if different assumptions had been used. This chapter outlines the sensitivity tests undertaken, which include reviewing alternate proxy values, upward revisions of deadweight and drop off and downward revisions of the estimates for those affected by the intervention.

SROI is a precise methodology, although the final valuations are based on a series of assumptions and the final valuation is therefore likely to be more generally accurate than specifically accurate. This general accuracy is a strength of the methodology and critiqued in a transparent manner. Supporting transparency and critique are the aims of this chapter of the report. Ideally, this discussion will also encourage stakeholders to question for themselves how much certain outcomes are worth.

17.2 The Discount Rate

In this study, all the financial values in year two and three have been calculated using a discount rate of 3.5%, the standard rate recommended for the public sector by HM Treasury in the U.K (96). This figure appears in the top left of the impact map.

17.3 Increasing Deadweight and Drop Off

The estimation for deadweight (the percent of change that would have occurred without the SHIP service) has been calculated by considering two primary pieces of information. The first is the stakeholder feedback, the most significant theme of which was that change would have been very unlikely without SHIP. Respondents based this opinion on prior experience with services that had not led to significant improvements in their feelings related to self harm and suicidal ideation.

The second source of information considered important in relation to assessment of deadweight is the analysis of the CORE-OM outcome measure, which, through a statistical analysis, considered the change that would have occurred anyway, and addressed this in the assessment of clinically reliable change. Taking these two pieces of information into consideration, a very conservative estimation of deadweight at 20% has been undertaken.

If deadweight were increased by 50% (from 20% to 30%) across the board, the overall impact would be lowered to €7.98. If it was assumed that there would be no outcomes without SHIP, which many of the clients maintained was likely, then the value would be as high as €11.40. If drop off increased to 50%, the SROI valuation would be brought down to €8.09.

Attribution was calculated based on very specific interviewee feedback and so alternate scenarios have not been considered.

17.4 Alternate Downward Valuations not used in the SROI

The highest valuation within the analysis is for a reduction in mental health. However, this has not been downwardly revised, given that it was lowest value in the range of potential values that were identified through the research (i.e. QALY and Wellbeing Valuation methods). The impact of a higher valuation for mental health has been discussed in the section below.

If the proxy for a reduction in social isolation was reduced from €2,606, which uses wellbeing valuation estimates to a proxy such as attendance at a social club, for example €400 per year, then the overall SROI reduces to €8.55.

All other outcomes were considered to have no other reasonable lower valuations with as robust a rationale as the one supplied within the analysis.

17.5 Alternate Upward Valuations not used in the SROI

This section of the report outlines some upward valuations that were not selected for use within the SROI, a lower value figure being selected, in each instance. The information is provided to highlight alternative ways of viewing the value of the programme.

An alternate valuation for the benefit of 'an increase in mental health' is provided by the Wellbeing Valuation work of Daniel Fujiwara[57]. To derive the value for the absence of mental distress or depression, Fujiwara and colleagues used large data sets to compare how different life changes affected happiness or wellbeing as stated by very large numbers of people. The impact of an increased income was also calculated in the same manner by comparing information from these data sets, once done this data could be used to estimate the value of other life changes such as moving to a safer neighbourhood. This method values the alleviation of depression at £36,766 (85)(77). Using an online currency exchange calculator, this figure translates to €46,477 as of July 2014.

SROI principles require that conservative estimates be undertaken where possible. As such, the QALY valuations (€12,159) were selected rather than Fujiwara's wellbeing estimates. Had the wellbeing valuation been used, the final SROI figure for the return on investment would have been €28.31.

In reading the chapters, readers are encouraged to assess for themselves the value of an improvement mental health. One way of doing this is to imagine what they would pay for the restored mental health of themselves or a loved one. Would this be equivalent to holiday, a new car, or does Fujiwara's valuation of over forty five thousand seem like a reasonable payment for reducing mental anguish and depression? Valuation of change of such important things are by no means easy, so this chapter should also be read with acknowledgement of the fact that those who experienced this change commonly assess its valuation as priceless.

[57] Wellbeing valuation (WV) is recognised by the UK HM Treasury Green Book guidance on policy evaluation (15). In essence, the WV approach derives monetary values for different goods and services, like health, housing and social relationships, by estimating the amount of money required to keep individuals just as happy or satisfied with life in the absence of the good. The process uses large national data sets, and so avoids potential respondent bias that may be present in other methodologies such as stated preference, i.e. asking people the value of a non-market good.

17.6 Variations in Amount of Change

While triangluation of the interview data and the CORE-OM coutcome data provided a fairly robust basis from which to estimate the amount of change experienced by all SHIP clients. To account for positive bias in the data collection a sensitivity test was undertaken. This test involved a 10% reduction in all estimated numbers of people experiencing each outcome and led to a final valuation of €8.20.

17.7 SROI Conclusion

The Social Return on Investment (SROI) ratio is calculated by dividing the value of the total impacts by the total inputs in a given time period. The SROI ratio for SHIP is 1: €9.10. This means that for every euro invested into SHIP there is a return to the individuals and services of over nine euro.

The sensitivity text showed that most alternate logical scenarios in relation to deadweight and drop off provided a fairly small range of alternate valuations, with the range existing between €7.98 and €11.40. The use of alternative valuations couched the SROI within a range of values between €8.55 and €28.31, the later being due to a much higher, although defendable, valuation for a change in mental health for clients. A downward 10% decrease in the numbers of all affected by the programme reduced the value to €8.20.

This final SROI figure is comparatively high in relation to general SROI terms. As discussed, one reason for the high rate of return is the effectiveness of the programme in creating change. The other reason is the low cost model on which the service is based, largely due to the outsourced counselling model, time-limited nature of the service and low overheads.

18 Research Findings, Recommendations and Conclusion

18.1 Research Summary Findings

The SHIP Client Group is at High Risk of Suicide

SHIP is reaching its intended client group. An analysis of service self-reported suicide risk, involving 120 client evaluation forms as well as an analysis of counsellor-assessed client risk, identified through a client file audit involving 85 files evidences the high risk nature of the client group and the high levels of support need of these individuals.

The analysis of the service user evaluation, which includes clients' self- reported reasons for attending SHIP, show that a substantial proportion of service users reported experience of self-harming behaviours (75%), suicidal thoughts (81%), and suicidal intent (78%) prior to engaging with SHIP. At the time of presenting to SHIP, 15% of service-users were experiencing suicidal ideation, while the remaining 85% had either attempted suicide at least once or had a history of self-harming. Additional risk indicators were apparent through the file audit: 45% of clients had a diagnosis of depression and more than 10% of the sample suffered from anxiety as a primary psychiatric diagnosis. The file audit also indicated that substance misuse was also a common feature among SHIP service-users, with 30% reporting misuse of alcohol and 16.5% reporting illicit drug misuse. At presentation to the service, there were also very large numbers of service users who reported recent disruption to or loss of a relationship (more than 75%) as well as perceived social isolation (more than 55%).

There are Clinically Significant Improvements in Wellbeing among SHIP Clients as a Result of the Intervention

SHIP clients show a general improvement in terms of client wellbeing, problems, functioning and risk to self and others after engaging in counselling with SHIP. An analysis of pre and post therapy data from CORE-OM, a validated clinical outcome tool, was undertaken with 80 clients. The tool measures changes in wellbeing, problems (or symptoms), functioning, risk, total distress, and total non–risk. The analysis found that, with the exception of female risk scores, scores for men and women across all six areas went from clinically distressed into normal ranges following therapy. Although a limitation was noted in relation to the numbers of incomplete post evaluations, the findings provide strong evidence for the effectiveness of SHIP's brief therapeutic intervention. SHIP is clearly demonstrated to provide an effective clinical intervention to those people who are self-harming and may be at risk of suicide.

Clients Report Significant Decreases in Suicidal and Self Harming Behaviours and Increased Protective Factors

Reflecting the outcomes of the CORE, the majority of clients stated that they had made a 'big improvement' across the domains of self-harm (62%), suicidal thoughts (69%), and suicidal intent (60%). Service users also reported that they had made a 'big improvement' across the following protective factor categories: ability to solve problems (48%), general coping skills (62%), optimism (54%, ability to deal with stress (52%), self-esteem (45%), and

relationships with family and friends (44%). The agreement of clinical assessment and client self-assessment of positive change as a result of attending SHIP adds additional weight to the assertion that SHIP is an effective and important intervention for those at risk of suicide and self-harm.

The Time Limited Aspect of the Service is Well Managed

The majority of the clients (82.5%) were satisfied with the number of sessions they received from SHIP. A large majority of 76 service-users (74.5%) said they were happy with how the therapy had ended, indicating that this evidence-based time-limited intervention is fit for purpose and generally well managed in relation to service users.

SHIP Counsellors are Committed and Confident in their Role

An adapted version of a validated tool, The Mental Health Problems and Perceptions Questionnaire, was used to measure the therapeutic commitment and perception of competency for their role with SHIP counsellors. There were high ratings for both therapeutic commitment and perceptions of competency, supporting the assertion that the SHIP counselling team are committed to their client group and confident in their role providing a specialised psychosocial intervention to this group.

SHIP Supporting Structures for Counsellors are Effective and Fit for Purpose

Counsellors scored the support they receive in their role in SHIP as nearly perfect. The risks attendant in providing specialised services to a high-risk client group are considered by the counselling team to be thoughtfully and effectively mitigated by a wrap-around professional support system, a strong collegial culture, a robust policy framework and an appropriate and effective induction and training programme.

SHIP is Regarded Positively by all Referring Agencies

All referring agencies, including GPs, HSE mental health services, addiction and youth services had positive regard for the professionalism of the SHIP service. Agencies stated that SHIP reduces the time they spend on issues related to suicide and self harm, and reduces staff stress, as they are able to refer clients to a specialised, appropriate and well-regarded service provider.

Organisational Learning has led to the Continual Development and Improvement of the Service

Reflective of the commitment of the SHIP service to continual learning and quality improvement based on new emerging evidence and structured stakeholder feedback, the service has been continually developed from its establishment in 2004 to the current iteration of the model, which the research reveals is regarded by all stakeholders to be well developed, coherent, clear and replicable.

Significant developments to the model, originally based on the NCS model, have included the extension of the service to new geographical areas using an adaptation of the CIPC service model; the development and on-going improvement of structured induction, training and supervision and support systems; the clarification of processes in relation to service user communication, particularly in relation the time-limited nature of the service; efficiencies and systematisation of referral and administration processes and the

introduction of validated outcome tools. The clarity of the current model and its related systems and processes supports potential replication to other areas within Ireland.

Stakeholders Support Extension of the SHIP Service to a Younger Client Cohort

SHIP services are currently provided to people aged 16 and over. The file audit revealed that 13% of SHIP's clients are aged between 16 and 18. There is no similar service for younger people provided in the region, or indeed nationally, which may be considered an urgent gap to be filled, given the prevalence of suicide among young people in Ireland. Counsellors, steering group members and other service providers with mental health, youth and addition services were widely supportive of a potential extension of the SHIP service to a younger age group, namely 14 and 15 year olds, with appropriate training provided to counsellors to undertake this service.

Access and Appropriate Referrals Can Be Increased Through a Revised Promotion Strategy

There were variable pathways of referral into SHIP, with the majority of service-users (71%) being referred to SHIP by another person or service. 44% of these referrals came from GPs. The counsellors perceived a need for more robust promotion of the SHIP service and identified a small number of inappropriate referrals. Other service providers also pointed out that annual information provision would assist in ensuring consistent high quality referrals. The purpose of additional promotion would be to ensure that the service is known to people in need, and can be appropriately referred particularly in Carlow, Kilkenny and South Tipperary.

Waiting Times Can Be Further Reduced

Management of waiting times were identified as an area with potential for improvement. Client evaluations showed that just under half of clients waited for the service for more than three weeks, with nine clients waiting more than thirteen weeks for their first session. Reducing waiting times would be dependent on a number of factors, including need (which is variable), resources to respond to need, the number of counsellors available and the potential locations available for the service to run from.

The CORE-OM Tool is a Useful Outcome and Assessment Tool

The CORE-OM tool has provided a robust outcome framework from which to evaluate the service. In particular, benchmarking has supported an in-depth analysis of findings. It is recommended that the HSE review CORE-OM software for continued formalised use within the SHIP service.

The Social Return on Impact Evaluation Indicates that SHIP Provides Good Value for Money

The Social Return on Investment (SROI) ratio is calculated by dividing the value of the total impacts by the total inputs in a given time period. The SROI ratio for SHIP is 1: €9.10. Therefore, every euro invested into SHIP provides a return on the individuals and services of over nine euro.

This final SROI figure is comparatively high in relation to general SROI terms. As discussed, one reason for high figure is the effectiveness of the programme in creating change. The

other reason is the low cost model on which the service is based, largely due to the outsourced counselling model, time-limited nature of the service and low overheads.

18.2 Recommendations

Recommendation 1: Continue to Provide the Service Regionally and Support National Roll Out

The SHIP service would continue to be provided in the South Eastern Region, with the HSE providing confirmation of secure funding into the future. It is recommended that the service is replicated nationally, supported by all relevant regional and local agencies, as a core part of a national suicide prevention strategy.

Recommendation 2: Develop a Programme Manual to Support Programme Replication

Programme sustainability, improvement and replicability will be well-supported by the development of a programme manual. This manual should describe the service in detail, including, although not limited to;

- Vision and values
- Model and approach,
- Training and support requirements for staff at all levels,
- The outcomes framework and system for collecting pre and post evaluative data,
- Referral criteria and pathways to and from the service,
- Health and safety issues and risks and their prevention
- Management, and promotion and communications about the programme.

Recommendation 3: Extend Service Provision to a Younger Cohort

The SHIP programme should be extended to the 14 – 16 year old age group. This would benefit from training supports for counsellors, internal review at mid way and end points of the first year of implementation, as well as engagement of youth when providing premises and referrals.

Recommendation 4: Identify and Implement a Suitable Information Management and Outcome Reporting System

To improve monitoring of client progress, outcomes and programme effectiveness, identify and implement a suitable IT system for information management, with particular reference to CORE-OM which has proven a beneficial and robust outcome measure within this evaluation. Such an information management system should be complementary to the outcomes framework for the programme and facilitate collecting of, analysis of, and reporting on clinical outcomes for clients, as well as supporting management of waiting times, as highlighted in the point below.

Recommendation 5: Management of Waiting Times

To continue the process of reducing waiting times, a clear understanding of patterns and potential blockages within the process will ensure that resources can be appropriately targeted. While there is currently on-going monitoring of waiting lists, and steps are being taken to mitigate waiting times, a number of additional steps can be undertaken to help manage this issue more effectively. All efforts to improve waiting times should be considered

in tandem with steps to secure a funding stream enabling sustainable resourcing decisions to be made.

Providing Additional Information to those on the Waiting List
Review the content of the opt-in letter to ensure it provides sufficient information on how the client can get onto the waiting list (e.g. by opting in) and where they can get further information, such as useful services clients can access whilst waiting for their appointment. Text confirmation can be provided once the client has opted in, informing them that they are on the waiting list with their position on the waiting list. Weekly texts would update the client when their position changes.

Monitoring and Recording: Implement an improved data collection system in relation to waiting lists. The researchers suggest using a control chart[58] or similar system to identify any waiting times that fall outside normal or acceptable ranges. It is recommended that four data points are included in this review: date of receipt of referral, date of sending opt-in letter, date of opt-in being received and initial appointment. Cases that fall outside of the target times will then be evident, so analysis of the reasons can be used to generate process improvements. The overall goal of this process is to progressively reduce waiting times.

Reducing Waiting Times: A number of the following measures should be considered for reducing delays and waiting times:

- All referring agents to be able to refer by email (reducing postage time), and be encouraged to do so. This may require a review of data protection for non HSE referrals.
- The counselling coordinator to review referrals daily (reducing delay between receipt of referral and response to it).
- Notify clients with a phone call or text (with a letter to follow) to inform clients that they are appropriate for the service, facilitating immediate opt-in (reducing waiting time in posting letter).
- Ensure counsellors have a minimum time between being allocated a client and the first appointment (or minimum number of slots that must be offered in a two week period), and that this is monitored.

Recommendation 6: Implement a Formalised Annual Promotion Strategy

To optimise awareness and referrals to the service by implementing a formalised annual promotion strategy which may include circulation of leaflets/posters/project information as well as conducting agency visits with identified organisations in health, mental health and addiction and youth services. As part of this process, stronger links to be forged with local addiction services and A&E services in areas where SHIP is operating.

[58] Control charts are a core technique used in Lean Health Care (Six Sigma methodologies) to monitor processes and to reduce anomalies in elements of a process in order to meet targets. A control chart can be used to reduce processing times such as waiting lists. Targets can also be increased over time, by altering the threshold at which cases are reviewed and actions implemented to respond to factors, which are considered to have led to the target not being met. Underlying this idea is the overall concept of continuous improvements.

Recommendation 7: Consider Extension of Referral Pathways

A number of organisations working with people at increased risk of self-harm under current structures cannot refer their self-harming clients to SHIP. The Steering Group should consider extending referral access to community and voluntary organisations in receipt of HSE funding in order to expedite access to the service for people who need it and reduce potential barriers to entry.

18.3 Conclusion

Deliberate self-harm is a major health problem associated with considerable risk of subsequent self-harm and completed suicide [44] [9] [10]. The provision of time-limited psychosocial interventions for people experiencing self-harm or suicide-related issues is recommended in international good practice guidelines [43].

This evaluation of SHIP shows that the service serves a client group at high risk of suicide, given a risk profile which includes high rates of previous suicide attempts and repeated acts of self-harm, mental health diagnoses, problematic alcohol and substance use and recent relationship difficulties (7) (12). The service has proven successful in supporting short-term outcomes associated with longer-term reduced suicide risk, bringing a number of risk factors from well below to normal functioning levels over the course of treatment. Clients of SHIP also benefited from an increase in well-being in a number of domains, which is positively associated with reduced suicide risk and includes optimism, emotional stability, problem solving skills (including help-seeking), a developed self-identity and good self-efficacy (7)(45)(21). These outcomes were achieved in a manner which presented excellent value for money, with a social return on investment of €9 for every euro invested in the programme by the state.

Programmes for people indicated to be at risk of suicide, including those who are self-harming, are considered by the World Health Organisation to be a core facet of a national suicide prevention strategy (7). SHIP was viewed by all stakeholders as providing a unique and important contribution to the continuum of care, and being significantly differentiated from other counselling services due its focus on suicide and self harm. The World Health Organisation recommends that interventions and programmes are evaluated, and where these are shown to be effective that they should be scaled up and evaluated in an on-going manner (7). This suggests that a key recommendation for this research may be the continuation of service provision in the South Eastern Region while replicating the SHIP service nationally as a core part of a national suicide prevention strategy.

In addition to replication nationally, the research indicates an opportunity and a need to extend service provision to a younger cohort. While self-harming behaviours peak in the late teens for females and males, a sharp increase in self-harming activity, particularly in young women, is evident from the age of 14 onwards (11). Ireland has one of the highest youth suicide rates in the EU (6). As self-harm is a key risk factor for suicide, interventions to help prevent suicide among identified self harming clients should be considered a key part of a national suicide prevention strategy (7). The opportunity to extend specialised service provision for self-harm such as SHIP to a younger cohort than those to whom it is currently

available seems like a logical step. Indeed, there was almost unanimous support across SHIP's stakeholders for this.

The research indicates that there may be a correlation between the programme's success and the robust structures that underpin it. A comprehensive policy framework, an intensive, tailored support system for counsellors and a targeted training programme ensure the development and maintenance of a confident and capable team of service providers for this high-risk client group.

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20 Appendix A: Additional Information regards CORE Analysis

Sub-Scale	Wilks' Lambda	*(X,Y)*	F	P	Partial Eta Squared
CORE- Wellbeing					
Time*Gender	0.99		(1,44)	0.058	0.81	0.00
Gender			(1,44)	2.31	0.14	0.05
Time	0.55		(1,44)	35.52	0.00**	0.45
CORE- Problems					
Time*Gender	0.99		(1,42)	0.26	0.61	0.01
Gender			(1,42)	0.10	0.75	0.00
Time	1.36		(1,42)	57.03	0.00**	0.58
CORE- Functioning					
Time*Gender	.99		(1,42)	0.14	.71	.00
Gender			(1,42)	1.97	1.67	0.04
Time	0.42		(1,42)	57.12	0.00**	0.58
CORE- Risk					
Time*Gender	1.00		(1,42)	0.00	0.99	0.00
Gender			(1,42)	0.38	0.54	0.01

Time	0.74	(1,42)	14.83	0.00**	0.26
CORE- Total					
Time*Gender	1.00	(1,42)	0.00	0.99	0.00
Gender		(1,42)	0.59	0.45	0.01
Time	0.42	(1,42)	59.02	0.00**	0.58
CORE- Total Less Risk					
Time*Gender	0.99	(1,41)	0.04	0.85	0.00
Gender		(1,41)	0.18	0.67	0.00
Time	0.38	(1,41)	68.10	0.00**	0.62

****denotes significant effect**

21 Appendix B: Role Competency, Support, Therapeutic Commitment

This table shows the list of statements provided to counsellors to assess their role competency, support and therapeutic commitment. As previously detailed, this questionnaire is an adapted version of the validated Mental Health Problems and Perceptions Questionnaire. Counsellors were asked to indicated their level of agreement on a seven point scale ranging from strongly disagree to strongly agree.

Table 11: Therapeutic commitment, competency and support tool (adapted from MHPPQ)

ROLE COMPETENCY
I feel that I know enough about the factors that put people at risk of self-harm and suicide-related problems to carry out my role when working with this client group
I feel I know how to treat people with long term self-harm and suicide problems
I feel that I can appropriately advise my clients about mental health, self-harm and suicide –related problems
I feel that I have a clear idea of my responsibilities in helping clients with self-harm and suicide related problems
I feel that I have the right to ask a client for any information that is relevant to their self-harm or suicide-related problem
I feel that my clients believe I have the right to ask them questions about self-harm or suicide-related issues when necessary
I feel that I have the right to ask a patient for any information that is relevant to their self-harm or suicide-related problem
I have the skills to work with clients with self-harm and suicide related problems
I feel that I can assess and identify the psychological problems of clients with suicide or self-harm related problems
ROLE SUPPORT
If I felt the need when working with clients with self-harm and suicide-related problems, I could easily find someone with whom I could discuss any personal difficulties I might encounter
If I felt the need when working with clients with self-harm and suicide-related problems, I could easily find somebody who would help me clarify my professional difficulties
If I felt the need I could easily find someone who would be able to help me formulate the best approach to a client with self-harm or suicide- related problems
When working with clients with self-harm or suicide-related problems I receive adequate supervision from a more experienced person
THERAPEUTIC COMMITTMENT
I am interested in the nature of mental health, self-harm and suicide, and the treatment of them

I feel that I am able to work with clients with self-harm and suicide-related problem as effectively as with other patients who do not have these problems
I want to work with clients with self-harm and suicide-related problems
I feel that there is nothing I can do to help clients with self-harm or suicide related problems
I feel that I have something to offer clients with self-harm or suicide related problems
I feel that I have much to be proud of when working with clients with suicide or self-harm related problems
I feel that I have a number of good qualities for work with clients with self-harm or suicide-related problems
Caring for people with self-harm or suicide-related problems is an important part of a counsellor's role
In general, one can get satisfaction from working with clients with self-harm or suicide-related problems
In general, it is rewarding to work with clients with self-harm or suicide-related problems
I often feel uncomfortable when working with clients with self-harm or suicide-related problems
In general, I feel that I can understand clients with self-harm or suicide-related problems
On the whole, I am satisfied with the way I work with clients with self-harm or suicide-related problems
When working with clients with self-harm or suicide-related problems I receive adequate on-going support from colleagues

22 Appendix C: SROI Appendices

22.1 Glossary

Attribution: An assessment of how much the outcome is a result of the activity or intervention of the organisation under review, and how much is due to other organisations or interventions.

Deadweight: This is an estimation of the amount of change that would have occurred without the intervention.

Displacement: Some value that is created may merely displace the same value for other stakeholders. Displacement is an assessment of how much of the outcome has displaced other outcomes.

Drop-off: As time passes after an initial intervention, the causality between the initial intervention and the continued outcome will lessen. Drop-off describes this relationship.

Duration: How long an outcome will last after the initial intervention.

Financial proxy: This is an estimation of a financial value for the outcome when a market value does not exist.

Impact map: This is a spreadsheet accompanying an SROI report which contains all the information and calculations that result in the final SROI assessment.

Inputs: The resources used to create the intervention by each stakeholder group.

Materiality: In an SROI, if information is material, this means that its inclusion will affect the final valuation within an SROI, and therefore affect decision making. If a piece of information or a stakeholder group will affect the SROI, this needs to be included in the process.

Outcomes: The changes that occur as a result of the intervention. In an SROI, outcomes include planned and unplanned, as well as positive and negative changes.

Outputs: The amount of activity communicated in numerical units, i.e. three people.

Stakeholders: People and organisations affected by the activity.

Theory of Change: The story about the sequence of events and changes that led to final outcomes for participants.

22.2 Materiality Assessment

This table outlines how decisions on materiality were made in relation to outcomes and stakeholder groups.

Stakeholder	**Outcome**	**Relevance.** The outcomes are related to the objectives and scope of the intervention or what happened to stakeholders as a result of the intervention.	**Significance.** The outcomes are of a scale that will have some influence on the final outcome of the SROI. The threshold for materiality in the SROI was €2,000. Values up to this changed the SROI by around a cent which was considered immaterial when considering the overall valuation band.	**Point at which the stakeholder or outcome was excluded from the SROI and rationale.**
	Improvement in coping skills	✔.	**X** The value of these outcomes were considered too small for inclusion within the review.	Excluded at the data analysis phase based on the logic that this outcome was a precursor to final outcomes included in the SROI.
	Improvement in mental health	✔.	✔.	n/a
	Reduction in self-harm	✔.	✔.	n/a
	Increase feelings of depression and anxiety (negative outcome)	✔.	✔.	n/a
	Reduction in isolation from family and friends	✔.	✔.	n/a
	Improvement in health	✔.	✔.	n/a
Family	Reduction in or	✔.	✔.	n/a

members	stress of worry			
Neighbours / extended family	Neighbours and extended family were considered too removed from outcomes to be included in the analysis. This group was also not mentioned within any interviews.			
Counsellor outcomes	Counsellors were considered staff members, in that outcomes in relation to job satisfaction could have been gained from other employment if this had been undertaken. In line with standard SROI practice, this group has been treated as employees and has not been included.			
HSE services	Savings to staff time	✔.	✔.	n/a
	Reduction in staff stress	✔.	✔.	n/a
	Reduction in costs associated with self harm presentations	✔.	✔.	n/a
GP services	Savings to staff time	✔.	✔.	n/a
	Reduction in staff stress	✔.	✔.	n/a
The Steering Group	This group was interviewed and their contribution recorded in inputs, however no members received any personal outcomes from engaging in the project.			
Youth and addiction services	Savings to staff time	✔.	✔.	n/a
	Reduction in staff stress	✔.	This was significant. However, when calculated at one hour a month of additional supervision at an average managers salary (€750 (managers time valued at around €21 per hour (salary of €42,000), this did not meet the materiality threshold of €2,000 as the outcome had an annual value of around €750. This was therefore excluded at the valuation stage due to not meeting the threshold. .	
	An increase in opportunity for family members to access services	✔.	While important for those families that could receive other services, the estimated small numbers (2 families) meant that this did not meet the materiality threshold. This change was valued at the equivalent of additional outreach work to the family costing €500 per family at two families, the overall annual value was only half the €2000 of the materiality threshold.	

23 Appendix D: SHIP Evaluation Form

Self-Harm Intervention Programme
Service User Satisfaction Questionnaire

This questionnaire is anonymous, you do not need to write your name.

1. ABOUT YOU

- Are you …….. Male ☐ Female ☐

- How old are you?

Under 16 ☐ 16-18 ☐ | 18-25 ☐ 26-39 ☐ 40-54 ☐ 55-69 ☐ 70+ ☐

2 ABOUT YOUR EXPERIENCE OF COUNSELLING

- The service uses an "opt in" system whereby we ask you to phone to confirm that you would like to use this service, do you have any comments to make on this system? .....

.....

.....

- How long did you wait between phoning to opt in (say that you are interested in using the service) and actually starting counselling? ☐

- If you had to wait a while before starting counselling, how was this for you?

.....
....

.....

.....

.....

- Did you have Individual Counselling ☐ Group Therapy ☐ Both ☐

- How many counselling sessions did you have? ☐

- Did you feel this was sufficient? Comment if you wish. Yes ☐ No ☐

.....

.....

.....

3. DID THE DIFFICULTIES YOU SOUGHT HELP WITH INCLUDE ……

SELF-HARMING BEHAVIOUR (for example, overdosing or cutting yourself) Yes ☐ No ☐

How did this change as a result of counselling? Did it ……

Get much worse ☐ Get slightly worse ☐ No change ☐ Small improvement ☐ Big improvement ☐

SUICIDAL THOUGHTS / IDEAS (for example, "my life is not worth living" or "I have no future") Yes ☐ No ☐

How did this change as a result of counselling? Did it ……

Get much worse ☐ Get slightly worse ☐ No change ☐ Small improvement ☐ Big improvement ☐

SUICIDAL INTENT OR PLAN TO END MY LIFE (for example, "I have thought of particular ways of ending my life") Yes ☐ No ☐

How did this change as a result of counselling? Did it ……

Get much worse ☐ Get slightly worse ☐ No change ☐ Small improvement ☐ Big improvement ☐

4. HOW MUCH IF ANY OF THE FOLLOWING AREAS HAVE CHANGED FOR YOU AS A RESULT OF GOING TO COUNSELLING? (please tick box)

	Got much worse	Slightly worse	No change	Small improvement	Big improvement
Ability to solve problems					
Ability to cope generally					
Feeling more optimistic about the future					
Your way of dealing with stress					
How you felt about yourself generally					
Getting on better with family and friends					

5 A. THE ENDING OF YOUR COUNSELLING

Did you agree the ending with your Counsellor? Yes ☐ No ☐

or

Did your Counsellor advise you it should end? Yes ☐ No ☐

or

Did you decide to end it yourself? Yes ☐ No ☐

5 B. WERE YOU HAPPY ABOUT HOW YOUR COUNSELLING ENDED? Yes ☐ No ☐

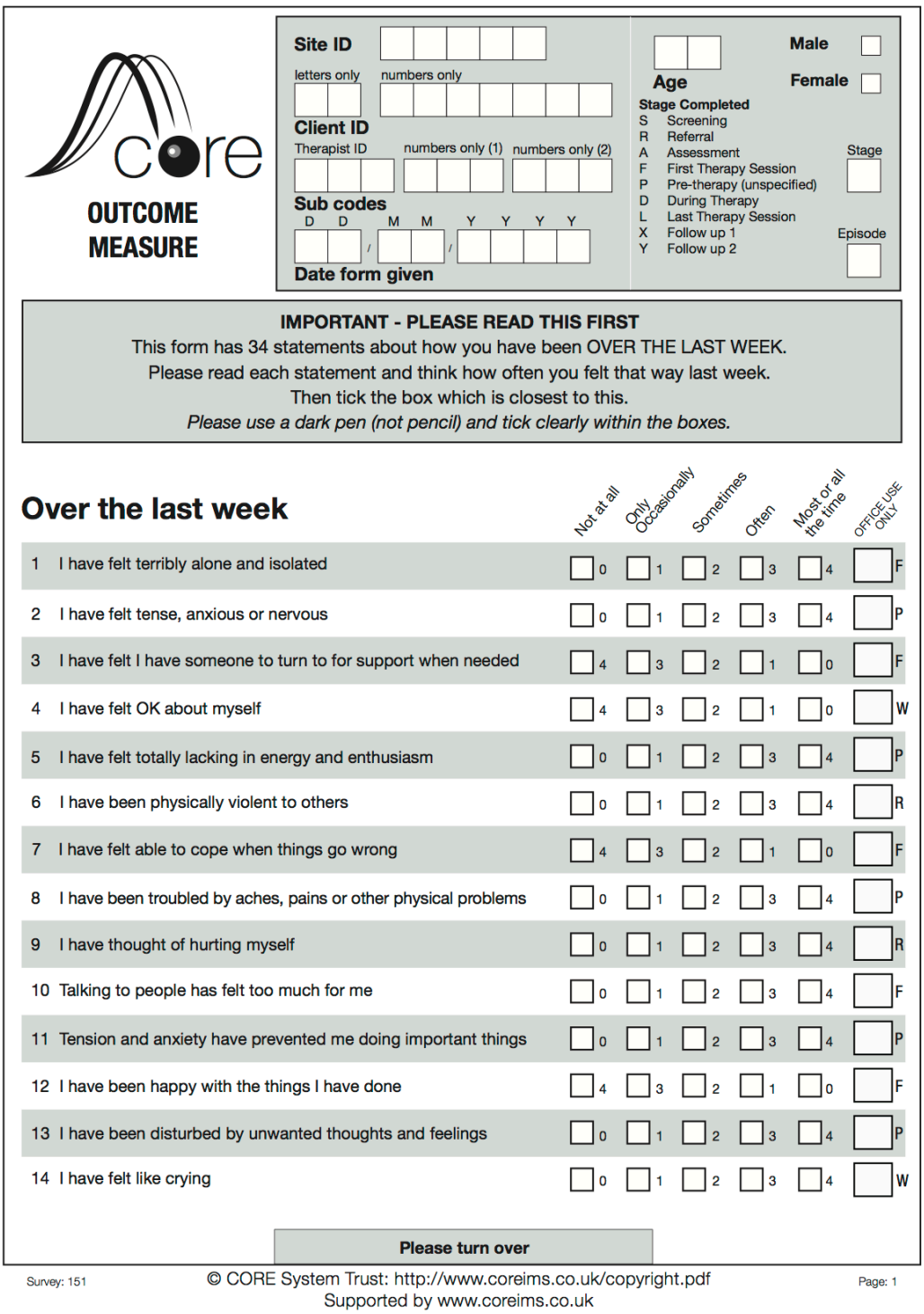
Please comment:

6. DID YOU ACHIEVE WHAT YOU WANTED AS A RESULT OF ATTENDING THE SHIP COUNSELLING SERVICE?

7. ARE THERE ANY OTHER COMMENTS YOU WANT TO ADD ABOUT YOUR EXPERIENCE OF THE SHIP COUNSELLING SERVICE?

Thank you for your time.

24 Appendix E: CORE OM Tool



OUTCOME MEASURE

Site ID

letters only | numbers only

Client ID

Therapist ID | numbers only (1) | numbers only (2)

Sub codes

Date form given: D D / M M / Y Y Y Y

Age

Male

Female

Stage Completed

S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last Therapy Session
X Follow up 1
Y Follow up 2

Stage

Episode

IMPORTANT - PLEASE READ THIS FIRST

This form has 34 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week

		Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
1	I have felt terribly alone and isolated	0	1	2	3	4	F
2	I have felt tense, anxious or nervous	0	1	2	3	4	P
3	I have felt I have someone to turn to for support when needed	4	3	2	1	0	F
4	I have felt OK about myself	4	3	2	1	0	W
5	I have felt totally lacking in energy and enthusiasm	0	1	2	3	4	P
6	I have been physically violent to others	0	1	2	3	4	R
7	I have felt able to cope when things go wrong	4	3	2	1	0	F
8	I have been troubled by aches, pains or other physical problems	0	1	2	3	4	P
9	I have thought of hurting myself	0	1	2	3	4	R
10	Talking to people has felt too much for me	0	1	2	3	4	F
11	Tension and anxiety have prevented me doing important things	0	1	2	3	4	P
12	I have been happy with the things I have done	4	3	2	1	0	F
13	I have been disturbed by unwanted thoughts and feelings	0	1	2	3	4	P
14	I have felt like crying	0	1	2	3	4	W

Please turn over

Survey: 151

Page: 1

Over the last week

	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY	
15 I have felt panic or terror	0	1	2	3	4		P
16 I made plans to end my life	0	1	2	3	4		R
17 I have felt overwhelmed by my problems	0	1	2	3	4		W
18 I have had difficulty getting to sleep or staying asleep	0	1	2	3	4		P
19 I have felt warmth or affection for someone	4	3	2	1	0		F
20 My problems have been impossible to put to one side	0	1	2	3	4		P
21 I have been able to do most things I needed to	4	3	2	1	0		F
22 I have threatened or intimidated another person	0	1	2	3	4		R
23 I have felt despairing or hopeless	0	1	2	3	4		P
24 I have thought it would be better if I were dead	0	1	2	3	4		R
25 I have felt criticised by other people	0	1	2	3	4		F
26 I have thought I have no friends	0	1	2	3	4		F
27 I have felt unhappy	0	1	2	3	4		P
28 Unwanted images or memories have been distressing me	0	1	2	3	4		P
29 I have been irritable when with other people	0	1	2	3	4		F
30 I have thought I am to blame for my problems and difficulties	0	1	2	3	4		P
31 I have felt optimistic about my future	4	3	2	1	0		W
32 I have achieved the things I wanted to	4	3	2	1	0		F
33 I have felt humiliated or shamed by other people	0	1	2	3	4		F
34 I have hurt myself physically or taken dangerous risks with my health	0	1	2	3	4		R

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

	(W)	(P)	(F)	(R)	All items	All minus R
Total Scores						
Mean Scores (Total score for each dimension divided by number of items completed in that dimension)						

39726

Survey: 151

25 Appendix F: Interview Schedules and Surveys

23.1 Interview Questions - Clients

Interviews were semi structured, meaning that interviews were managed as far as possible as directed discussions, with interviewees being encouraged to tell their story and discuss outcomes and the impact of the programme on them, as naturally as possible. Interviews lasted on average 45 minutes.

Introduction

Researcher to explain; 1) the purpose and nature of SROI, i.e. how much change and valuation (how much this change is worth to them), as well as the role of SHIP in creating this change, 2) confidentiality, anonymity and limits to this (i.e. child protection), 3) their right to stop or pause the interview at any point, 4) onwards referrals and additional supports in relation to distress or emerging issues 5) offer a space for clarifications and questions.

Questions

1. Introduction question

Can you please tell me about what changed for you as a result of engaging in the SHIP programme (researcher to record all the outcomes mentioned, prompts included: mental health and wellbeing, family and friends, self esteem and confidence, physical wellbeing, drugs and alcohol). The researcher to let them know that a series of questions will be asked in relation to each area of their life where they have experienced change.

2. Mental Health:
    a. Did you experience any changes in relation to your mental health as a result of attending SHIP (prompts: anxiety, depression), can you tell us about these changes.
    b. How important was this change to? Why?
    c. If SHIP had not existed, how else may you have got the same outcome, (prompts; discuss and seek value, this may have involved reviewing the value of alternate courses of actions to achieve the same outcome).
    d. Had you attended other services to assist you in the past, had they helped?
    e. If SHIP had not existed, how likely would it be that you would have made or received this change from elsewhere?
    f. How much of this change (in per cent) was due to other factors such as other health services, family friends and so on?
    g. In relationship to mental health were there any negative outcomes as a result of you attending SHIP?
    h. In your estimation how long will this change affect you? What will you need to do to maintain this positive change?
3. Self Harm:

a. Did you have an experience of self-harm prior to attending SHIP? Can you tell us a little about this? Has this changed since leaving SHIP (gather details on the extent of reduction of self harm)
b. How important was this change to? Why?
c. How much is this change worth to you? (Prompt: discuss the notion of valuation, what might they have done to get the same outcome?)
d. Had you attended other services to assist you in relation to self-harm in the past, had they helped?
e. If SHIP had not existed, how likely would it be that you would have made or received this change from elsewhere?
f. How much of this change (in per cent) was due to other factors such as other health services, family friends and so on?
g. In your estimation how long will this change affect you? What will you need to do to maintain this positive change?

4. Family and Friends:
    a. Has attending SHIP affected your relationships with family and friends, what were these like before SHIP, what were these like after?
    b. How important was this change to? Why?
    c. Why did this change occur?
    d. How much is this change worth to you?
    e. If SHIP had not existed, how likely would it be that you would have made or received this change from elsewhere?
    f. How much of this change (in per cent) was due to other factors such as other health services, family friends and so on?
    g. In your estimation how long will this change affect you? What will you need to do to maintain this positive change?
5. Physical health / diet / drugs and alcohol:
    a. Has attending SHIP affected your heath, specially your diet or exercise or your use of drugs or alcohol? What changed for you and why?
    b. How important was this change to? Why?
    c. How much is this change worth to you / what else may you have done to achieve the same change?
    d. If SHIP had not existed, how likely would it be that you would have made this change?
    e. How much of this change (in per cent) was due to other factors such as other health services, family friends and so on?
    f. In your estimation how long will this change affect you? What will you need to do to maintain this positive change? Are you likely to / have you?

6. General
    g. Were there any negative outcomes to your organisation or any other people or organisations involved with SHIP?
    h. What are the strengths of SHIP?
    i. What are the weaknesses of SHIP?
    j. Is there anything you would change or improve about the service?
    k. Anything else to add?

23.2 Interview Questions - Family

Interviews were semi structured, meaning that interviews were managed as directed discussions whenever possible, with interviewees being encouraged to tell their story and discuss outcomes and the impact of the programme on them as naturally as possible. Interviews lasted on average 20 minutes.

Introduction

Researcher to explain; 1) the purpose and nature of SROI, i.e. how much change and valuation (how much this change is worth to them), as well as the role of SHIP in creating this change, 2) confidentiality, anonymity and limits to this (i.e. child protection), 3) their right to stop or pause the interview at any point, 4) offer a space for clarifications and questions.

Questions

1. Introduction question

Can you please tell me about what, if anything, changed for you as a result of your partner or family member engaging in the SHIP programme (researcher to record all the outcomes mentioned, prompts included: family relationships, their wellbeing / stress). The researcher to let them know that a series of questions will be asked in relation to each area of their life where they have experienced change.

2. Stress / worry / concern / wellbeing

a. Has your family member attending SHIP improved your wellbeing in any way / how?
b. How important was this change to? Why?
c. How much is this change worth to you / what else may you have done to achieve the same change?
d. If SHIP had not existed, how likely would it be that this change would have occurred?
e. How much of this change (in per cent) was due to other factors such as other health services, family friends and so on?
f. In your estimation how long will this change affect you? What will you need to do to maintain this positive change? Are you likely to / have you?

6. General

a. Were there any negative outcomes to your organisation or any other people or organisations involved with SHIP?
b. What are the strengths of SHIP?
c. What are the weaknesses of SHIP?
d. Is there anything you would change or improve about the service?
e. Anything else to add?

23.3 Interviews Questions – Referrers (HSE, Addiction and Youth Services)

Interviews were semi structured, meaning that interviews were managed as directed discussions whenever possible, with interviewees being encouraged to tell their story and

discuss outcomes and the impact of the programme on them as naturally as possible. Interviews lasted on average 30 minutes.

Introduction

Researcher to explain; 1) the purpose and nature of SROI, i.e. how much change and valuation (how much this change is worth to them), as well as the role of SHIP in creating this change, 2) confidentiality and anonymity 3) offer a space for clarifications and questions.

Questions

1. Introduction question

Can you please tell me about what, if anything, changed for your service as a result of the establishment of the SHIP programme (researcher to record all the outcomes mentioned, prompts included: more referrals pathways, savings in time within the service, staff stress). The researcher to let them know that a series of questions will be asked in relation to each service outcome. Note that when additional outcomes were named by specific services similar questions were asked to support understanding in relation to deadweight and attribution etc.

2. Savings in staff / service time for clients attending SHIP

   a. Does your service save time / resources when shared clients attend SHIP? If so what is the average saving in staff time? What kind of staff time is saved (i.e. role)? What is an average annual salary for this kind of role?
   b. How important is this change to your organisation?
   c. What did you used to do with service users prior to SHIP?
   d. Were there any factors leading to this change?

3. Staff stress

   a. What is your staff experience of SHIP, has this had any other impacts on them?
   b. How important is this change to your organisation?
   c. To achieve the same outcome (If SHIP did not exist) what could the service do?
   d. Were there any factors leading to this change?

4. General

   a. Were there any negative outcomes to your organisation or any other people or organisations involved with SHIP?
   b. What are the strengths of SHIP?
   c. What are the weaknesses of SHIP?

2. Is there anything you would change or improve about the service?
3. Anything else to add?

23.4 Survey for Referrers to SHIP Counselling Service

The following questions were used in an online survey designed for referrers to the SHIP counselling service. Questions were based on information obtained through interviews with a number of referrers. The software used was Sogo Survey. Information about the survey was distributed through the SHIP counselling service's referral pathways.

Hello
This survey has been sent to you as a referrer to the SHIP (Self Harm Intervention Service). The survey should take only **FIVE MINUTES** of your time. The survey is anonymous. If you would like to discuss these issues rather than complete a survey please call the lead researcher: Caroline Gardner on 0871357189. The survey will be open for one week.
Many thanks for your opinions and time. Your efforts will assist in the development of recommendations for the future of the SHIP service.

Are you a:

- GP
- Community or voluntary service
- HSE Service Provider - Mental Health
- HSE Service Provider – other than Mental Health
- Other please state:

Approximately how many of your clients have been referred to SHIP since Jan 2014?

Who made this referral?

- You or your staff
- A GP
- Not sure
- Another mental health service
- Liaison staff
- Other, please state

Before SHIP where would you have referred people who presented with self harm or suicidal ideation? (tick as many as relevant)

- We would have managed them within our service
- We would have referred to second level Mental Health services
- There was nowhere to refer
- Other……..

How satisfactory were referral pathways / service provision for people who are self-harming prior to SHIP?
1 - 5

How satisfactory are referral pathways / service provision for who are self-harming following the development of SHIP?
1-5

If you refer a client to SHIP does this reduce your contact or follow-up time with this client?
yes / no

If you answered yes, on average how many hours of contact time are saved for each client, as a referral of to SHIP

(i.e. if you didn't refer to SHIP you would generally have worked with a client once a week for an hour for 15 weeks, you did not have to do this so 15 hours of staff time has been saved).

Has SHIP reduced stress on your staff as a result of them no longer having to deal with self-harm issues?
yes / no

If yes, how would you usually manage such stress?

- We have no structures to specifically respond to this kind of stress
- Additional supervision or managerial supports
- External supervision
- Other, please name……..

Has the SHIP service resulted in any other outcomes for your service? Please detail what these are (please offer details of how many people were affected by these outcomes if possible).

Please rate the following statements (1 very much disagree – 5 very much agree)

- SHIP fills is a vital service for people experiencing self-harm
- SHIP is a professional and well run service
- Client feedback on SHIP service is very good
- The waiting times for SHIP are very good
- If SHIP did not exist some clients would not receive an appropriate self harm intervention

Has the programme resulted in any negative outcomes for your service or your clients, if yes please detail?

Have you any other comments to make in relation to your organisations experience of SHIP?

To help us track who has completed the survey and send appropriate reminders it would be really appreciated if you could let us know your name and organisation. You do not have to and please note that all answers are confidential within the quality matters research team. Please enter name and organisation below:

if we had additional questions we would like to discuss with you based on your answers would you mind if we called you?

yes / no

Many thanks for your time.

23.5 Survey for Stakeholders of SHIP Counselling Service

The following questions were used in an online survey designed for national stakeholders to the SHIP counselling service. The software used was Sogo Survey. Information about the survey was distributed through the SHIP counselling service's professional networks.

1. Explain the purpose of the research and interview process; explain confidentiality and voluntary participation of respondent.
2. What is your role?
3. In your geographical area, what primary level, issue-specific or specialised service(s) are available to individuals with self-harm or suicidal ideation?

4. In your opinion, is the current level of support for people who are self-harming or who have suicidal ideation adequate, in your area?
5. Is there a need for specialised service/s for individuals with self-harm or suicidal ideation in your area, accessible at primary care level?
6. Do you think that the SHIP model would be an appropriate response to a gap in service provision for people who are self-harming or have suicidal ideation, in your area?
7. Is there any other primary care model or service, you know of, that may be appropriate for people who are self-harming or have suicidal ideation?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