Bristol Crisis Service for Women

NEEDING ATTENTION:

an evaluation
of services for women who self-injure

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Published by: Bristol Crisis Service for Women
PO Box 654, Bristol BS99 1XH
Tel: 0117 9251119

Acknowledgements

The assistance and contributions of the following are gratefully acknowledged:

All the people who generously shared their experiences of using or providing services for women who self-injure.

Sue Gardner, for her interest and stimulating discussions in the early stages of the project, and Lesley Doyal for her skillful editing of this report.

The Department of Health's Mental Health Task Force, who funded the work.

Needing Attention
ISBN 0 9531346 6 5

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BRISTOL CRISIS SERVICE FOR WOMEN AND SELF-INJURY

Bristol Crisis Service for Women is a small voluntary organisation based in central Bristol and currently comprising two part-time paid workers and twenty-five volunteers. The organisation was founded in 1986 by a group of women who had personal experience of using psychiatric services or of self-injury, and was set up to support women in emotional distress. From their own experiences, these women felt that an organisation run by and for women was best suited to meet the needs of vulnerable women. BCSW provides a telephone helpline for any woman in emotional distress, offering a caller the chance to talk through and explore her feelings and situation in confidence, without the fear of being judged or dismissed. About half the helpline calls concern self-injury; others may be about childhood abuse, problems in relationships, eating distress or other issues. The organisation also runs and supports self help groups, has an information service and produces literature about self-injury. Local and national publicity has generated large numbers of requests for information, advice, help, support and training on self-injury, from a wide range of people and organisations: individuals who self-injure, their families and friends, and workers who come into contact with people who self-injure.

The Crisis Service is run by a collective of twenty-five volunteers. These volunteers staff the helpline and receive comprehensive training and support for this work. Volunteers also work alongside the paid workers in carrying out many other aspects of the organisation's work.

Bristol Crisis Service for Women receives funding from a variety of sources including charitable trusts, central and local government agencies and individuals. Much of the funding has been in the form of one-off grants for specific projects. The organisation is seeking to develop a solid funding base, to enable the continuation and expansion of its services and to enhance its ability to respond to the increasing need for crisis support in the community.

Because of the widespread lack of understanding of self-injury and of information about it, funding was secured from the Mental Health Foundation in 1994, to develop the self-injury training and information work, which had previously been unfunded.

The Mental Health Foundation funded project is now (August 1995) entering its last six months and work has so far included: research into the experiences and needs of women who self-injure and publication of the findings; publication of a set of information booklets; and the development and delivery of training to professionals who work with people who self-injure. The work will continue with a conference in Bristol in September 1995, leading to the development of good practice guidelines for agencies working with people who self-injure, and the publication of a training manual, in early 1996, to further the training work and increase its availability.

The purpose of this evaluation is to review the work of Bristol Crisis Service for Women; assessing its effectiveness, defining aspects of good practice both in service provision and in worker training and support, and identifying areas for change and improvement.
The different elements being examined are the helpline, the information service and self-injury support groups. To inform this, the needs of women who self-injure are considered, together with a brief review of currently available services.

A variety of evaluation methods was used including questionnaires with helpline callers, to get feedback about their experience of using the helpline, and interviews with support group members and facilitators about their experiences. Questionnaires or interviews were carried out with all BCSW helpline workers, to draw out their understanding, from the helpline work, of the reasons for self-injuring and of women's experiences of using other existing services. BCSW workers were also consulted about their own experience of working on the helpline and of the training and support offered by the organisation.
The helpline and information service monitoring records were analysed and questionnaires were sent out with all posted information for a limited period to get feedback on the usefulness of literature. 'Dummy' calls were made to the helpline to get some external appraisal of the service, and a call diversion was used for a short period to count the number of unanswered calls made to the helpline.
Workers in a range of outside agencies (including accident and emergency departments, the ambulance service, social work teams, community mental health teams, counselling agencies) were contacted to identify existing services for women who self-injure, and to find out workers' and agencies' information and training needs in working with self-injury.

WOMEN AND SELF-INJURY:
needs and services

In a survey of 76 women who self-injure, Lois Arnold found that most women see their self-injury as one way of coping with difficulties in their lives (Arnold 95). Many women cited childhood experiences of sexual, physical or emotional abuse or neglect as being important in leading to their hurting themselves. Other childhood experiences felt to have a bearing included loss of or separation from parents (for example by being taken into care), or a parent being ill or alcoholic. A common theme was a lack of communication in the family, the child having had to develop her own strategies for understanding and dealing with events, her experiences and her feelings, without appropriate nurture, support or guidance from the adults around her. Many of the adult experiences which were felt to have led to self-injuring paralleled these childhood ones, for example rape or sexual abuse, involvement in abusive relationships and a lack of support or communication in adult life.
Self-injuring is carried out in response to powerful feelings. Lois Arnold's findings are that these may be overwhelming emotional pain (grief, sadness or despair), feelings of self hatred, anger or acute anxiety. Self-injury is for many a way of coping or surviving, of carrying on, of bearing what might otherwise be unbearable. It may function as a temporary release of and relief from the feelings of overwhelming pain, or feelings of shame, guilt or dirtiness, and may provide a sense of control for a woman, at least over her own body, when she is feeling otherwise utterly powerless.

The needs expressed by women participating in the survey and reported by helpline workers include being able to talk to someone about their feelings and the immediate situation and being listened to with respect and care. Women want their experiences and needs taken seriously, and want to feel accepted and supported in their struggles. Longer term needs include exploring, understanding and coming to terms with the causes of the self-injuring, which are individual and complex, and with the related feelings. Practical factors such as housing, work situation and relationships may also be important issues to address if a woman is going to be able to make and sustain changes in her life.

A wide range of professionals come into contact with women who self-injure, and this may be a rare, occasional or regular part of their work. Few workers have had in depth training on the issue. Some workers reported feelings of frustration when faced with patients or clients who self injure, feelings which at worst may lead to punishing attitudes and practices, perhaps keeping someone waiting a long time, treating them with little respect, seeing them as 'undeserving', as they have caused their own injury. Other workers reported feelings of impotence and inadequacy, feeling they do not have the skills, expertise or time to help. Some services only have short contact with individuals, and may, like accident and emergency departments or ambulance

services, be set up to deal mainly with physical trauma and not with emotional issues which are likely to take time to resolve.

In inpatient settings particularly it may be difficult for staff to distinguish between a suicide attempt and self-injuring which has no suicidal intent. A woman's self-injury may be seen as demonstrating that she is potentially suicidal, and needs to be constantly observed. This response to self-injury seems necessary to protect the woman herself, but may inadvertently serve to intensify her feelings of powerlessness, and increase her need to hurt herself.

Some agencies have clear guidelines about responding to self-injury, which promote good care for service users and clarity and support for workers. In agencies where workers felt some satisfaction with their own personal and the agency response to individuals who self-injure, key features were recognition of and some effective way of dealing with the feelings aroused in staff by self-injuring. This might be staff sharing and supporting each other in informal ways, together with skilled supervision of the client work. For some it has been important to recognise that staff may 'hold' a lot of the distress, turmoil and powerful feelings for the client. In groupwork settings, group supervision has been found useful to deal with the splits and conflicts which may be provoked in staff as a result of the work. Some workers also said it was important to them to recognise their own self harming behaviours.

Some agencies exclude individuals who self-injure. This may be due to an unwillingness to admit a self-injuring individual to a service because she is seen as too difficult or damaged, or it is felt that she may be too disturbing for other people using the service. It may be temporary exclusion from therapeutic setting because the woman is seen to have used a 'mood altering' activity and is therefore not able to make full use of sessions at that time. It may be used as part of behaviour modification therapy. Exclusion is often experienced by individuals as rejecting and punishing, and may reinforce the feelings of isolation, 'badness' or unacceptibility. Some agencies require individuals to contract not to self-injure over the period of counselling or treatment. Agencies which offer a time-limited resource, perhaps short term counselling, may recognise that this kind of support may be inappropriate for someone who has been self-injuring over a long period and may make a referral to a community mental health team or other local resource, depending on the individual's needs. However, many workers reported a frustrating lack of suitable agencies to refer to.

TELEPHONE HELPLINE

BCSW runs a telephone helpline on Friday and Saturday nights for women in emotional distress, and receives many calls from women who injure themselves. The phone lines are staffed by trained volunteer workers. A woman calling the helpline will be listened to and helped to explore her feelings and what lies behind them, if she wants to do this. There is a one hour time limit on calls. The helpline service is confidential.

Evaluation: process and problems

The intention was to bring together as much information from as wide a range of sources as possible.
Brief records are routinely kept of the time and length of calls, and of the issues raised in them. The issues are categorised for simplification and brevity. For example, sexual abuse, ritual abuse and rape are recorded together, as are depression and isolation. 'Mental health' covers aspects of emotional health not included in other categories together with uptake of statutory psychiatric services. Other categories used are drug/alcohol abuse, eating distress, problems with relationships or family, violence, silent calls. Calls usually fit in to several categories and these are all recorded. The caller's age and where she is ringing from are also recorded if they are known. It is not possibe to ask the caller for any information about herself at the time of the call, so questions about ethnic origin, sexual orientation and disability were included in the caller questionnaire. The call monitoring records were collated and analysed.

Getting detailed feedback from callers about a confidential helpline service is obviously problematic, particularly where the issues are so sensitive. Several options, some used by other helplines, were considered, in consultation with helpline workers. These were: ringing the caller back after a set period of time (1day/1week/1 month) to run through questions about the effectiveness of the helpline call; transferring the caller to an independent researcher at the end of the call, to talk about the call; asking for the caller's name and address so that a questionnaire could be sent to her following the call. Although it was felt that it might be possible to use some of these methods with particular callers, none was felt to be generally appropriate. One of the main issues is the invasion of privacy and loss of confidentiality if callers are asked to give their names and addresses or phone numbers for a return call. Additionally it was felt to be intrusive to ask a caller to comment on her experience at a time when she may be feeling very vulnerable. It can be difficult to end a call and leave the caller feeling safe. To ask her to review the process of the call immediately afterwards could well re-open the difficult issues she has been dealing with, leaving her feeling very exposed and without further opportunity for support. This would be unethical.

The benefits of obtaining information in the above ways were felt to be outweighed by the probable negative effects on callers, and none of the above methods was used.

It was felt that a questionnaire which could be returned anonymously was the best, though limited, method of obtaining feedback from callers. The questionnaire included questions about the appropriateness and accessibility of the helpline, how the caller felt about the call and also brief monitoring questions on age, ethnic origin, sexual orientation and disabilities.
The caller questionnaire was distributed as widely as possible, with SHOUT (a national newsletter about self-injury, produced in Bristol, and with 200 subscribers) and also made available at other agencies, relevant conferences and to self-help group members.
Women were invited to complete the questionnaire if they had used the helpline and to return it anonymously. The same channels and methods were used to publicise and distribute the caller questionnaire as are used to publicise the helpline, so it is hoped that the questionnaire reached a representative sample of helpline users.

A series of calls was made to the helpline by 'stooge callers'. These women were asked to make short calls to the helpline, to talk about something that was a real problem or stress in their lives, and to record their observations about the types of responses and reactions they had from the helpline worker. This gave a valuable external appraisal of the experience of using the helpline and of the service callers receive. However, the 'stooge callers' were not distressed at the time of the calls and so their reflections and comments on the calls are from a different perspective than other callers'.

The volunteer recruitment, training and selection process and also the support offered to volunteers when working for the organisation, are routinely monitored and evaluated. This is achieved by trainer and trainee evaluation of individual training sessions and of the training course as a whole. Additionally, when volunteers have been working with the organisation for three months they are asked to complete a questionnaire about their training and support to date, and their further needs. This information was also obtained from experienced volunteers, together with their impressions of the effectiveness of the helpline service for callers, and their knowledge, from helpline calls of women's experience of using other services.

Other helplines were consulted on their working methods and evaluation procedures and these were compared with those of BCSW.

The long term effectiveness of the helpline service is problematic to assess. Outcome measures that would give some indication are complex to define as they are intensely personal and concern emotional wellbeing. One caller may

be desperate to stop injuring herself and would see that as her goal. She may use the helpline at critical times when she needs some support. Another woman might use a call to the helpline to 'ground' herself after a 'flashback', a re-experiencing of a traumatic incident. Yet another may need to talk to someone after hurting herself to break the isolation she feels. Because there is no follow up contact, the organisation has no information about the impact of a call on an individual's life. Some women do use the helpline regularly over a period of time, indicating that they do feel benefit from the service and are able to access it when in need.

Findings

Helpline monitoring

The total number of calls per year received by the helpline increased to over 600 in 94/95.

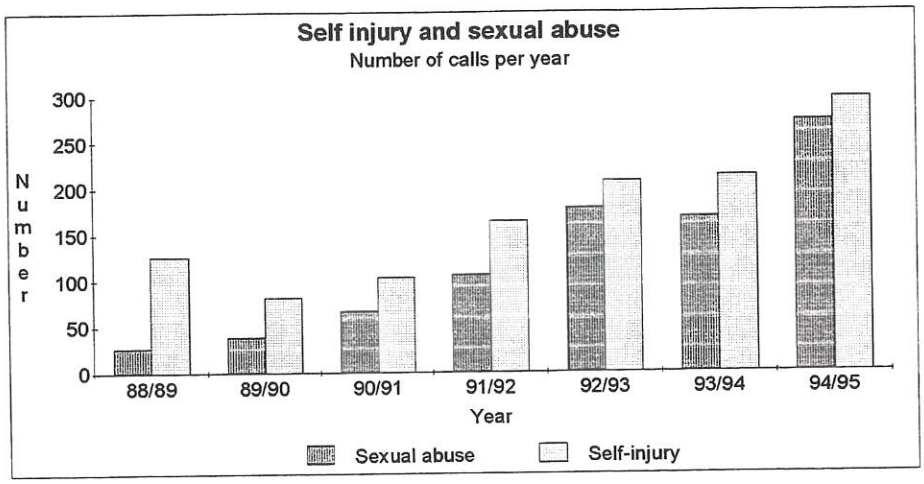
Year	Number of calls
89/90	271
90/91	291
91/92	386
92/93	492
93/94	405
94/95	623

The length of calls varies considerably. In 94/95, 52% of calls were shorter than thirty minutes, 82% were shorter than an hour, and 97% were shorter than 90 mins. 3% were between one and a half and two hours long. The number of calls that can be taken in a three and a half hour session is obviously limited, and 18% of calls in 94/95 were longer than an hour despite the policy of restricting call length to an hour. This policy is an attempt to maximise the number of women who can use the helpline in any evening, without sacrificing the time and attention available for each caller. It is also to avoid helpline workers getting exhausted, as the work can be stressful and demanding.
In the six month period April to September 94, regular callers (callers who call more than twice in any two months) accounted for 75% of calls which were over one hour long. There are implications for training here; possibly helpline workers are finding it difficult to end calls with callers they know and have a relationship with. In this six month period regular callers made a total of 109 calls, 52% of the total number.

A 'call diversion' was used over a short period in early 1995 to check how many calls were unanswered during a helpline session, due to the two phone lines being engaged. An average of thirty seven calls per night were unanswered.

This may have been a few callers redialling frequently, or larger numbers of callers trying to get through to the helpline.

Of the issues raised in calls, self-injury is the commonest (a concern in 297 calls in 94/95, ie 48% of all the year's calls). Sexual abuse was a concern in 273 calls in the same year (44% of the year's calls) and the frequency of occurrence of these two issues has shown a steady increase over the years the helpline has been operating.

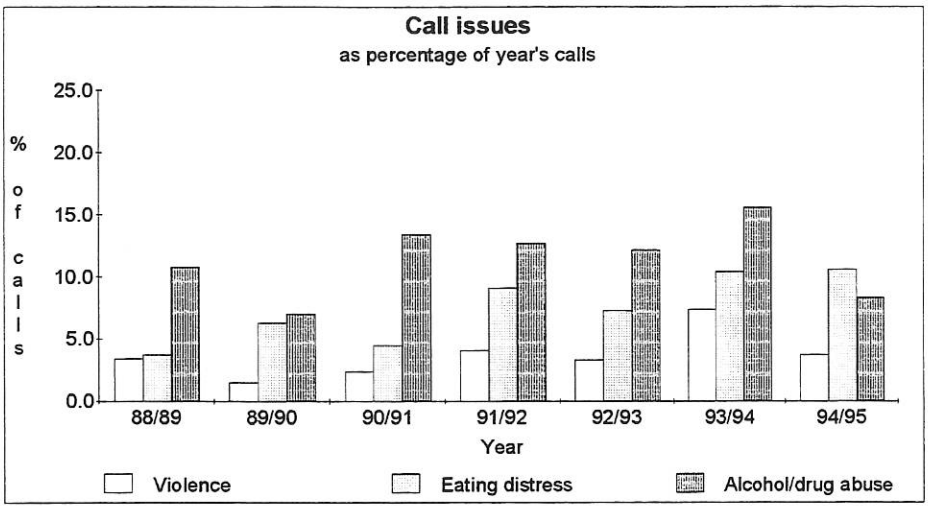


This increase parallels BCSW's growing reputation as a helpline with expertise around these issues. It also possibly reflects increasing general public awareness and acknowledgement of the issues and their impact on women's lives and emotional wellbeing, making it a little easier for women to talk about their experiences.
In 93/94 half of all callers talking about self-injury also referred to a history of childhood sexual abuse, and one fifth of these callers also mentioned having some problems with food.

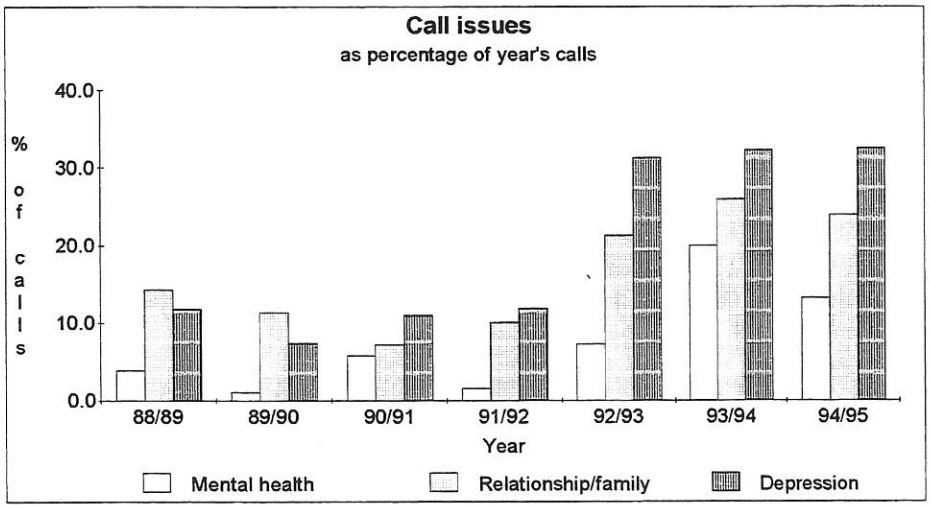
There has been a fall in the number of silent calls received in the last two years, from about 20% of all calls to 10%. A call is recorded as silent if the caller puts the phone down shortly after it has been answered, without saying anything, or if the caller stays on the line, but does not speak, perhaps feeling so distressed it is difficult to begin talking. Silent calls and ways of responding to them have been more thoroughly addressed in recent volunteer training, and the fall in numbers of silent calls may reflect the helpline workers' effectiveness in responding to them.

A very small number of abusive calls are received by the hepline. Helpline workers will not continue a phone call where they are being personally abused and will warn the caller of this and then end the call if the abuse continues.

Eating distress, violence and alcohol/drug use have been fairly consistent as call issues over the years and do not show any distinct trends. They are regularly mentioned in calls but are not often the main issue of a call. Again this reflects BCSW's publicity (which has increasingly been focused on self-injury and sexual abuse), and also the existence of specialist agencies dealing with these issues.

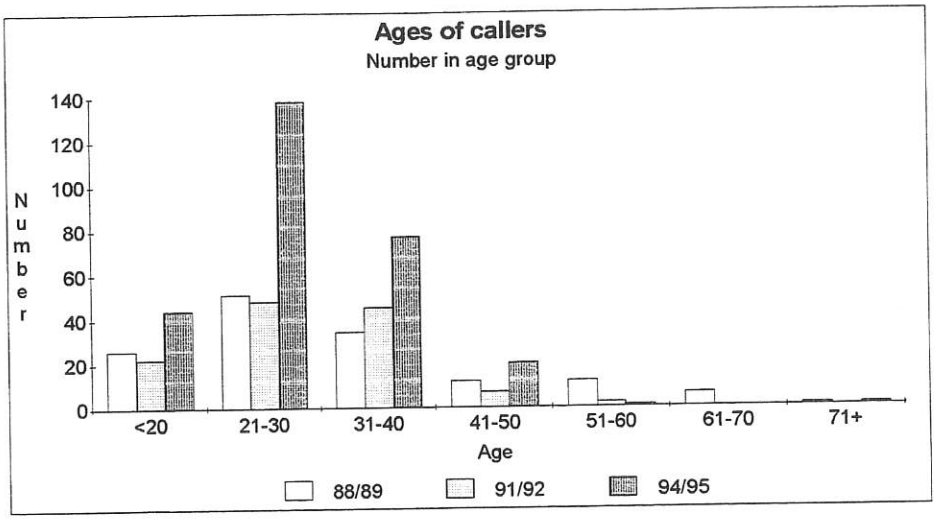


In contrast, the number of calls about mental health, depression, and problems with relationships or families has shown a significant increase since 91/92. This coincides with the introduction of 'care in the community' and may represent the increasing numbers of people seeking 'out of hours' support.



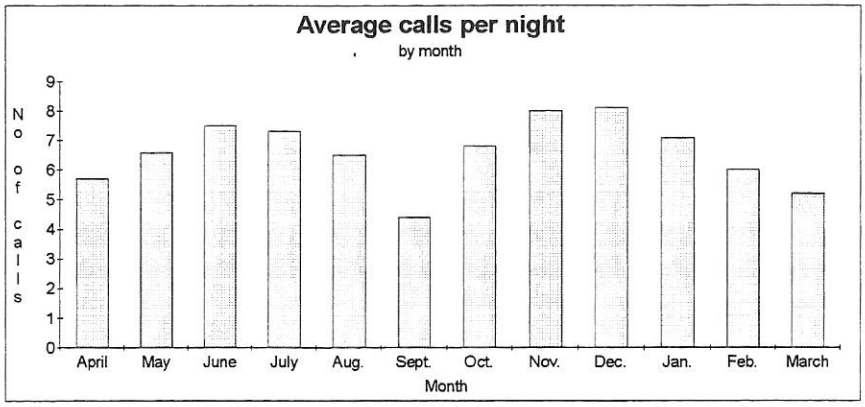
The age of caller is often not known but sometimes this information is volunteered. Of the calls where caller age is known (fairly consistently around 35% of all calls) there has been slightly less spread of ages in more recent years. In 94/95 99% of callers whose ages were known were younger than fifty,

and all were younger than sixty, whereas in 88/89 13% were fifty or older. The commonest age group calling the helpline is 21-30 years old (49% of those whose age was known, in 94/95). Many of the callers have heard about the helpline from articles in magazines or newspapers, so the age spread may to some extent reflect magazine readership. Magazines are a particularly effective publicity medium as they are often kept for a long time, re-read, passed on to friends or left in waiting rooms where they are available to lots of people.



Two three month periods (October to December 94 and April to June 95) were looked at to ascertain the busiest times for the helpline. More calls were received between 9pm and 9.30pm than in any other half hour period. (the helpline runs from 9pm to 12.30am), and there was another smaller peaking between 10.30pm and 11pm. Fewer calls were received between midnight and 12.30am than in any other half hour period. It would be useful, in the light of requests for a service in the early hours of the morning, to investigate whether less calls are received in this period by BCSW because the lines are already busy, whether women are aware that the service closes down at 12.30am and are reluctant to begin a call this late knowing how limited the time is, or if this is a period when demand is actually low. This could be explored by consultation with service users and with helplines which run round the clock.

The seasonal distribution of calls was examined and it was found that more calls were taken in November and December, (an average of 8.1 calls per night) and in June and July (an average of 7.4 calls per night) than other months. The quietest months were March (average of 5.2 calls per night) and September (average 4.4 calls per night).



Callers' experiences: findings from caller questionnaires

All who answered the question on ethnic origin (95% of respondents) defined themselves as 'white UK'.
The age distribution was heavily weighted to the 21-30 age group. None of the respondents was aged under 20, (compared with 16% of helpline callers in 94/95).

Age	Percentage
21-30	70
31-40	10
41-50	15
51-60	5

65% were heterosexual, 15% lesbian and 10% bisexual, the remainder (10%) did not answer the question on sexual orientation.
35% of respondents identified as disabled, 85% of these specifying emotional or mental health problems, which they experience as disabling.

The majority (75%) felt the helpline times were appropriate for them, but many (90%) said it would be better for them if the times were extended: if the helpline was open for longer hours, for more nights of the week, or if there were more lines available. Some specified times which would be particularly useful to them, the early hours of the morning being the most difficult time for many women and the time they would be most likely to want to use the helpline.

'I would find it more useful if it were available later at night when I can feel very lonely and frightened of myself if I can't sleep'

A few would prefer a daytime service, when they had the privacy to make a call. Many said the ideal was to have helplines in every city, open 24 hours a day and seven days a week. Crisis times are obviously not restricted to Friday and

Saturday nights, but some said it helped knowing that they would be able to use the helpline on Friday or Saturday night if they needed to.

'I feel very relieved when the weekend comes because I know that if I do get frightened I have someone (BCSW) *who cares and will help me feel better. As soon as the weekend is over I worry in case I need someone.'*

50% had found it difficult to get through to the helpline, because the lines were engaged when they tried.

'More people and more telephones are needed. The first time I phoned I was very very desperate. The phones were engaged and I didn't have the guts to call back.'

Once through, all who responded to the questionnaire found calls useful, and felt understood and supported by the helpline worker.

'I was experiencing a very strong urge to self-harm prior to the call. This had gone by the end of the call by working out why and what to do instead.'

'It is helpful to know someone will listen to you and not treat you as a freak or be totally gobsmacked if you say 'I've just cut'.'

Some found it difficult to express themselves in words, particularly at the beginning of a call, and felt that helpline workers had conveyed the warmth and calmness needed to allow them to slowly begin to talk, and also to express their feelings of pain, anger or frustration.

'The woman I spoke to made me feel that it was alright to call as I was very nervous.'

Detailed feedback from 'stooge callers' revealed that occasionally helpline workers were slightly more 'facilitative' than the 'stooge caller' wanted, the caller feeling she could usefully have been left with more quiet time to bring her thoughts together. However, some callers like and request a lot of input from the helpline worker to feel assured that they are being listened to and are not alone.
Difficulties with the ending of calls were mentioned. A few women had found it very hard to cope with calls finishing, and being left feeling alone and frightened.

'I just felt sad I had no more support until next week'

'Sometimes I feel like a weight has been lifted off my shoulders. Other times it helps to talk but I still feel desperate, especially if my time has run out for the call - I usually ring late.'

Helpline workers also reported problems with ending calls, being aware of both the caller's needs and of the limitations of the helpline service. Another issue raised in connection with this is the caller's awareness that other women may be trying to get through to the helpline and feeling both needy and undeserving of time and attention.

'I felt that I was taking up someone's time who could have been speaking to someone more important that me, but the person I spoke to made me feel important.'

'I needed longer but felt guilty for taking as long as I did, approx 10 mins - as I thought other people would be wanting to get through.'

For some callers the cost of calls is a problem and limits the length of time they feel able to stay on the phone.

'I dersn't (sic) *stay on the phone too long as I have to explain the call when the bill comes in (to my parents).'*

Helpline calls come from all over the British Isles and the organisation is unable to carry the cost of calls, although realising that cost is a factor preventing some women accessing help they need.

Volunteer recruitment, training and performance

The volunteer recruitment process involves women contacting the organisation, having heard about it in the local media, seen posters or visited the local volunteer bureau. Women are then invited to join the next training course, which includes an ongoing assessment process. There is at present a good range of ages and mix of class backgrounds and sexual orientation. However, Black, Asian and other minority ethnic groups are under-represented in the collective.

The volunteer training course consists of ten sessions, some evenings and some whole days, totalling 37.5 hours. Overall aims of the training are to equip the volunteers with skills in telephone counselling; to raise awareness of the issues of concern to women who ring the helpline and build confidence in working with these issues; to establish a safe, supportive and committed group of women who can work well together; and to familiarise new volunteers with the ethos and ways of working of the organisation.
The training is experiential and all sessions include counselling practice. Topics addressed in training sessions include counselling skills, feminist perspectives, self-injury, sexual abuse, eating distress, inequalities (eg race, class, disability, sexual orientation). All volunteers attend the initial training course and this is followed by occasional ongoing training days on topics requested by volunteers,

eg further training on sexual abuse, working with self-injury, ritual abuse, supervision skills.
Feedback from volunteers shows that they find the training an interesting and essential preparation for the helpline work, and may find it an empowering experience in itself.

'The issues covered have made me think a lot and re-evaluate my perceptions, particularly about my identity as a woman.'

'I feel it has changed me and and made me feel more accepting and happy with myself and my feelings.'

'I feel I have developed as a person and as a helper.'

At the end of the training most are initially apprehensive about taking calls and it is routine for new volunteers to 'sit in' on helpline sessions, supporting the women who are answering the phones, before they take calls themselves.

The support systems were under review during the period of this evaluation and improvements effected. After working on the helpline a volunteer receives 'day-after counselling' from a peer to talk through any feelings or issues arising from the helpline work. This peer support system was modified so that each volunteer has a regular support partner with whom she can develop a support/supervision relationship, rather than as previously getting the day-after support from whoever is down on the rota for that day. In addition to this individual support, group support meetings were being held. These were irregularly attended and a decision was made to establish smaller support groups (organised roughly geographically), to give more continuity and safety for workers in a closer group.
Helpline volunteers found the day-after support helpful, particularly to talk through their feelings about calls they had found tough, and to be given constructive suggestions about how a call might have been handled differently.

'Sometimes I don't realise (until talking it through with the day-after counsellor) *just how much something has got to me or how much it has affected my mood/personal life.'*

'It is good to talk about worries about not handling a call very well, and get feedback and constructive suggestions or affirmation'

'I find it very helpful if I have experienced calls which have left me feeling very inadequate, sad or confused.'

Volunteers had varied experience of support meetings. They had been most useful when actively facilitated by a group member.

'Support meetings are a good way of getting to know the other volunteers personally, so it is easier to open up and talk about the work'.

'I 've found support meetings very valuable, and most useful when small - so there is more space to explore issues.'

' ..... useful as long as everyone who wants to contribute something or express something is encouraged to do so.'

There is felt to be a need for a forum for discussion of the broader issues such as helpline policy as well as for the support and supervision of the direct helpline work.

'I want to discuss issues like abuse with other volunteers to help me develop my approach and politics.'

'I have found individual supervision very helpful in other areas of my life so I would welcome this, but I'm not sure how easy it would be to administer'.

'Group supervision could be useful to look at practice and thrash out policy issues.'

Discussion

The helpline service is used virtually to capacity and provides a much valued resource to many women. Financial insecurity has prevented extension of the helpline hours, (the funding for the co-ordinator post has been piecemeal and uncertain over the last three years). Provision of an additional line would not in itself be prohibitively costly and would enable more callers to get help, but would involve significant extra administration, co-ordination, training, support and supervision input - resources which are currently stretched.

More rigorous monitoring of volunteer characteristics is needed together with targetting of under-represented groups for future intake of volunteers. It is anticipated that any progress made in recruiting a wider range of volunteers would also have the effect of broadening the caller group, though monitoring of this is difficult. Pro-active publicity is needed to effect these changes, along with further training for existing workers in anti-discriminatory practices.

The initial counselling skills training is basic, and volunteers have requested additional training after beginning work on the helpline to develop and support their work. There is scope for much ongoing training and this could be formalised so that volunteers are committed to attending a number of hours relevant training each year. This would incur further costs, whether training was bought in, or volunteers attended outside courses, but workers' support and development is an essential component in provision of a safe and ethical service.

Group and individual supervision by an external supervisor could be usefully introduced, if financially possible, to help maintain and improve standards, to develop skills and awareness and generally promote the health of the organisation. The present support systems work but could be enhanced by some additional input of this sort. This could also help with some issues that arise, such as consideration of the policy of limiting calls to one hour, and supporting workers in maintaining this boundary.

INFORMATION SERVICE

The organisation receives many enquiries, mostly for information about self-injury, Bristol Crisis Service for Women's services, or for details of services in other areas.

A resources database has been established consisting of 1,300 records of services around the country. Information has been gathered from a range of sources to set up the database and care was taken to ensure information was correct when entered onto the database. A service can be accessed by location (town, county, or region), by who it is for (eg young people), by the actual services offered (eg groups, counselling, helpline, advice) and by topic (eg sexual abuse). Listings of services can be viewed on the monitor or printed out to send to an enquirer. For example, it is possible to get a listing of general counselling services for young people in Birmingham, or of agencies in the North West offering support groups for women survivors of sexual abuse.
The initial volunteer training involves an introduction to using the resources database and volunteers arrange further sessions to familiarise themselves with its use.

A set of three booklets on self-injury was published by BCSW in October 94. Together with leaflets about the helpline, self-injury, and training and workshops these booklets are the main written information sent out to enquirers.
Publicising the booklets has attracted many orders and enquiries. (A total of 545 requests for information in 94/95 compared with 200 in 93/94).

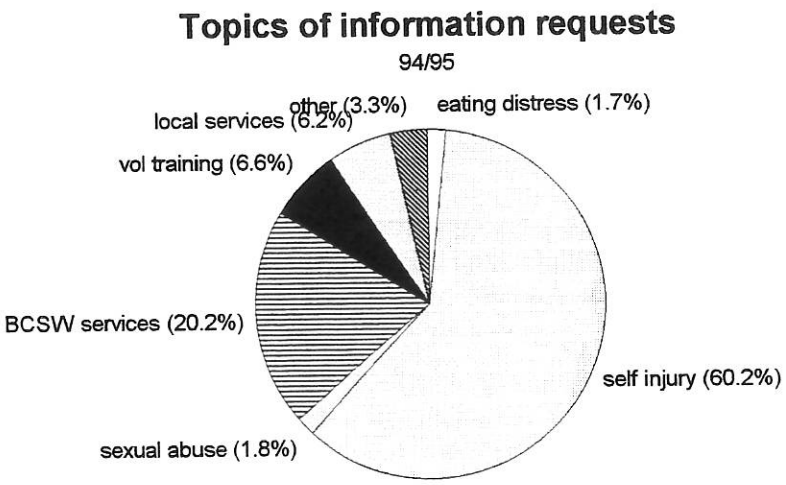
Evaluation: process and problems

Use of the services database was monitored.
Requests for information, which are routinely recorded, were analysed. Details recorded usually include the name, occupation (if known) and address of the enquirer, the date and nature of the request, and the response from BCSW.
A questionnaire and stamped addressed envelope were sent out with all posted responses to requests for information for a six week period in early 1995. The questionnaire invited feedback on the usefulnessness of the information sent, and the purpose it was needed for. Respondents were asked to give details of anything they had found particularly helpful, and of anything additional they would have liked to have had included. The questionnaire asked about details of local services if these had been requested: had they been followed up and were they useful? It also contained monitoring type questions to discover how well publicity is working and who the information is reaching. Of 90 questionnaires sent out, 32 were returned, a response rate of 35.5%.

Findings

Helpline callers and other enquirers often ask about support groups and other services in their local area, and the database is useful in providing this information. If there are no records of the type of service required, it is usual to give a local contact such as a MIND group, Women's Centre or Rape Crisis Centre who are likely to have more detailed local information. There are usually three workers present on helpline nights so that if information from the database is needed, one woman can do a database search while the others continue their calls.
In 94/95 6.2% of all information requests were for details of groups in the enquirer's local area. The respondents to information service questionnaires who were sent details of services in their local area followed these up and found the contact useful.

In the year April 94 to March 95, a total of 545 requests for information was received. 60.2% of these were for information about self-injury, including many requests for information, guidance and support in setting up self-injury support groups. Other requests were for information about the services offered by BCSW (20.2% of requests), and including requests for training for other agencies (6.2% of requests). Information on other issues, such as sexual abuse (1.8%) and eating distress (1.7%) was also requested.



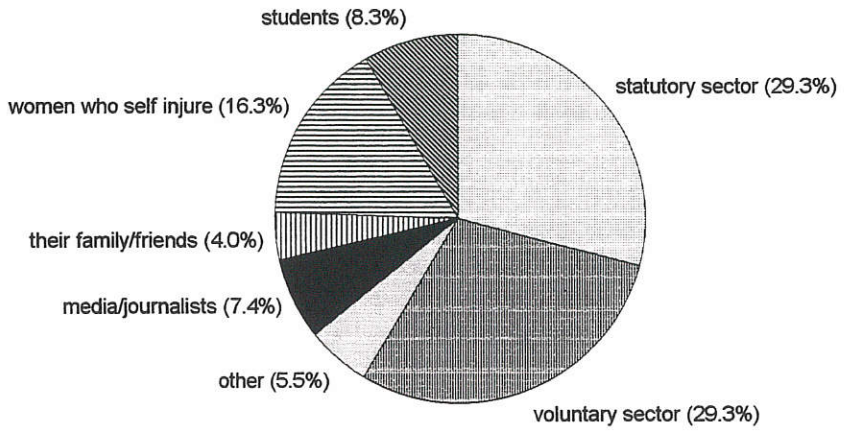
The range of requests for information is wide and sometimes outside the organisation's remit, for example, a request for detailed information about anorexia, or advice about individuals. These requests are referred on to a more appropriate agency, if possible.

Requests come from a range of sources. 58.6% were from healthcare workers, from both statutory and voluntary sectors, in a range of occupations including doctors, nurses, psychologists, resettlement workers, prison officers, welfare

advisors and many more. 20.3% of requests came from women who self-injure, or their family or friends, and 7.4% came from the media, researching for an article, a television or radio programme and sometimes wanting to interview a representative of the organisation or to be put in touch with a woman who self-injures and is willing to talk about herself. Students researching self-injury or related topics as part of professional training or academic courses made up 7.5% of enquirers.

Sources of requests for information

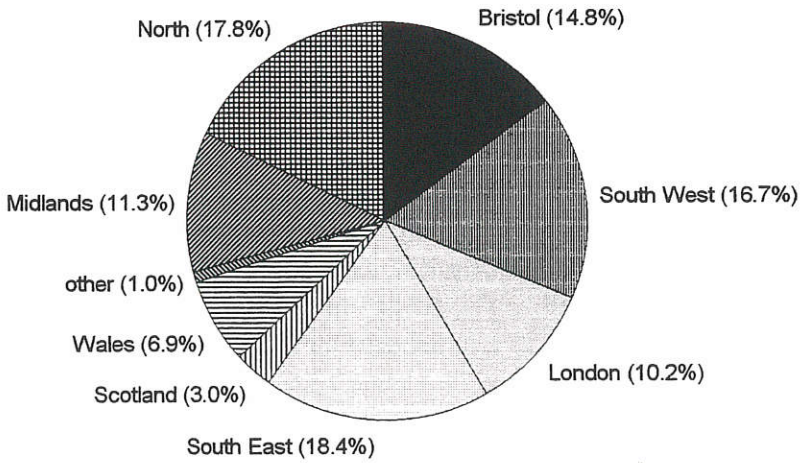
94/95



Requests for information came from all over the country. 'Other' in the chart below includes requests from N.Ireland, Eire and South Africa.

Requests for information from:

94/95



SUPPORT GROUPS

Self-injury self help/support groups have been run in Bristol since 1991, facilitated by ex members of the BCSW collective. The groups have been independent of BCSW, but the organisation has been keen to encourage and assist this initiative which offers face-to-face support for women. FACES (For Acceptance and Care to Express Self-harm) is a self-injury support group which provides members with a vital safe place to talk about self-injury. The emphasis is on 'giving acceptance to women, no matter how they express themselves, and to encourage and work on feelings and other forms of communication'. They look at what self-injury is, how women have been treated and explore their needs. Women are usually referred to the group via their community psychiatric nurse, day hospital or GP, or may find out about it from a poster or by word of mouth.

Evaluation: process and problems

Facilitators and group members were interviewed individually.
As with the helpline, defining criteria for evaluating 'success' or 'effectiveness' of the groups is problematic, though it is crucial to identify the intended functions of the group and indicate how well these are being met or addressed. The FACES groups aim to be a safe environment where women are accepted, and can explore their issues. The aim is not to stop the self-injuring but to create and maintain a forum where women can safely communicate their distress, a place where individuals are valued, not judged or labelled, and where they can better understand themselves.

Findings

The 'FACES' groups are closed for a period of time to give members safety and continuity and then may open to take in new members. Meetings are weekly, in the evening. Members make a commitment to the group and develop strong friendships within it, having contact and support with group members between sessions. It is important to group members that the group is outside the statutory services, though a condition of membership of the group is having some regular support outside the group, which may be for example, with a therapist, a CPN or a social worker. The group is not a woman's sole support. Group members are all equally responsible for the meetings. Ground rules are negotiated between members. Women leave the group to have a break, or when ready to move on. This may be when self-injury is no longer the most important issue to be looking at in their lives.

From time to time a second group is started. One daytime group, using a broad definition of self-harm, ran, on a drop-in basis, in a building with creche facilities, making it easily accessible to women with young children. This group worked

well, sessions were open and small and members found a value in being heard and sharing their experiences. However one problem with this group was that the broad definition of self-harm adopted meant that a woman who cut herself could still feel as isolated and different within the group as outside it. This is an important issue to consider and is a factor in favour of specific interest support groups.

Another group, outside Bristol, was visited. At the time of the visit the group was running without a facilitator. This group functions both as a support group for members and as a campaigning group to develop understanding of self-injury. In group time members value the understanding they get from each other, and the time to relax and talk about problems. They found they were less focused without a facilitator and were hoping to find someone else to take on the role. The previous facilitator had structured the sessions and introduced exercises, for example, to work with expression of anger.

A common theme in all the groups is the 'self-help' element. Group members gain a lot from being with others with whom they have some common experience. Knowing that they are not the only one who self-injures and meeting others who do is enormously important for some.

'Meeting someone face to face and seeing the scarred arms, hearing they'd got the same sorts of problems as me, it was such a relief.'

'There was something comforting about seeing scars worse than mine.'

Hearing about other women's experiences of services and recognising what has been helpful or unhelpful in the past was also found to be constructive.

'..... its not just the self-injury, but being able to talk about treatments as well, and finding out that they've been through some of the same things.'

'I do get a lot of support from services but I'm not allowed to talk about self-harm.'

'Going to the group gave me the courage to go to A&E. I'd never considered going before. I should have had stitches but I couldn't go.'

Sharing experiences and ways of coping, finding similarities and differences and being able to talk about and explore these can be significant steps in finding ways to develop other survival strategies.

'I found it a valuable space where I could go each week and be myself. I could let off steam about problems I'd got because of the self-injury and know I'd be understood by the others.'

self-help groups, and a document outlining guidelines for good practice in service provision.
The resources database is a useful tool, enabling helpline workers to offer details of potential local support for callers when appropriate. The countrywide scarcity of support groups and agencies with expertise in working with self-injury highlights the urgent need for development of these.

Bristol Crisis Service for Women has unique and valuable experience in the provision of a helpline and information service and may offer a model for the development of similar services in other areas. Additionally, the organisation's expertise in training and consultancy work is an important resource for agencies and professionals working to meet the needs of women who self-injure.

RECOMMENDATIONS

The following recommendations arise from the findings and are to varying extents dependent on the securing of funding to finance services.

Local service provision:

- increasing the availability of crisis support by the addition of an extra phone line and/or extending the helpline times.

- providing free ongoing counselling to local women, and developing drop-in and other local services in response to women's needs, to give varied, accessible face to face support to women.

- continuing the support of self-injury support groups locally.

Development of services nationally for those who self-injure:

- facilitating the development and running of self-injury self-help groups in other areas by: i) producing a handbook offering guidance and support for setting up and running groups, and ii) establishing a contact network of such groups and providing information, advice and consultation.

- continuing and developing self-injury focused training for professionals working with individuals who self-injure.

- extending the range of self-injury information provision.

- working in consultation with other interested parties to develop guidelines for good practice in the provision of services for people who self-injure.

REFERENCES

Arnold, L. (1995) *Women and self-injury. A survey of 76 women.* Bristol: Bristol Crisis Service for Women.

FURTHER READING

Self-injury

Arnold, L. (1994) *Women and self-injury booklet series. 1. Understanding self-injury. 2. Self-help for self-injury. 3. For family and friends.* Bristol: Bristol Crisis Service for Women.
Harrison D. (1996) *Vicious Circles.* London: Good Practices in Mental Health
Pembroke, L. (ed) (1994) *Self harm: perspectives from personal experience.* London: Survivors Speak Out.
SHOUT (Newsletter for women who self-injure), c/o PO Box 654, Bristol BS99 1XH. (Send £8/£4 (concs) subscription for 6 issues)

Helplines

Sanders, P. (1993) *Using counselling skills on the telephone.* Manchester: PCCS Books.
Telephone helplines group. (2nd edition,1993) *Telephone Helplines. Guidelines for good practice.* London: Broadcasting Support Services.
Telephone helplines group. (1995) *Helpline evaluation. Guidelines for helplines seeking to conduct an evaluation of their service.* London: Broadcasting Support Services.