National Clinical Programme for Self-Harm and Suicide-related Ideation

Updating the National Clinical Programme for the Assessment and Management of Patients presenting to the Emergency Department following Self-Harm

Irish College of General Practitioners
Coláiste Dhochtúirí Teaghlaigh Éireann

College of Psychiatrists of Ireland
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GLOSSARY OF ABBREVIATIONS

AAC	Augmentive and Alternative Communication
ADON	Assistant Director of Nursing
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behaviour Therapy
CfL	Connecting for Life
CHO	Community Healthcare Organisation
CMHT	Community Mental Health Team
CNS	Clinical Nurse Specialist
CORU	Ireland's multiprofessional health and social care regulator
CPsychI	College of Psychiatrists of Ireland
CSO	Central Statistics Office
DBT	Dialectical Behaviour Therapy
DES	Department of Education and Skills
DoH	Department of Health
ECP	Emergency Care Plan
ED	Emergency Department
EMP	Emergency Medicine Programme
ESP	Emergency Safety Plan
GP	General Practitioner
HSE	Health Service Executive
HEA	Higher Education Authority
HEI	Higher Education Institution
IAG	Implementation Advisory Group
ICGP	Irish College of General Practitioners
IMC	Irish Medical Council
LGBTQIA2S	Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual and Two-Spirit
MHC	Mental Health Commission
MHP	Mental Health Professional
MHSW	Mental Health Social Worker
MOC	Model of Care
NCHD	Non-Consultant Hospital Doctor
NCPSH	National Clinical Programme for Self-Harm and Suicide-related Ideation
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health (UK)
NGO	Non-Governmental Organisation
NICE	National Institute for Health and Care Excellence (UK)
NHS	National Health Service (UK)
NMBI	Nursing and Midwifery Board of Ireland
NOSP	National Office of Suicide Prevention
NSRF	National Suicide Research Foundation
ONMSD	Office of the Nursing and Midwifery Services Director
PLAN	Psychiatric Liaison Accreditation Network (UK)
RANP	Registered Advanced Nurse Practitioner
SCAN	Suicide Crisis Assessment Nurse
SHIP	Self-Harm Intervention Project
WHO	World Health Organisation
WTE	Whole-Time Equivalent

Foreword by Dr Amir Niazi

Clinical Design and Innovation brings clinical leadership to the heart of the decision-making process with the ultimate aim of improving quality, access and value of healthcare in the country. The Clinical Programmes have changed and continue to change how care is delivered using evidence-based approaches to system reform.

The overarching aim of the National Clinical Programmes (NCPs) is to standardise quality evidence-based practice across the Mental Health Services. NCPs provide a programmatic response with clear care pathways based on evidenced best practice. While the clinical programmes are outlined for specific areas of need, the intention has always been that they support and improve all mental healthcare.

The Self-Harm and Suicide-related Ideation clinical programme started out with a focus on self-harm in the Emergency Department. The Model of Care identified a pathway of care for people who had self-harmed and for people with suicide-related ideation. Experience of the implementation of the Model of Care has highlighted the fact that self-harm and suicide-related ideation is a constant feature of everyday clinical practice. This programme has affected admissions to approved centres, the work of GPs and the work of CMHTs. Where local area management teams and local clinicians have supported its use, this programme has been highly successful. Many of the evidence-based practices from the programme have spread to other parts of the service.

This update has built on the learning over the last five years of implementing the programme. It provides more detailed pathways of care in different clinical situations and has used practice-based evidence to help clinicians improve their practice. Using a detailed evidence review, this update addresses a number of practical issues, from replacing risk assessment tools with safety plans to providing clear guidance on how family members can be included in all assessments and discharge planning.

I am pleased to fully support this update and welcome the opportunity to further improve the service for individuals and their families who present in a suicidal crisis.

Dr Amir Niazi
National Clinical and Group Lead for Mental Health

Foreword by Dr Anne Jeffers

People who self-harm or present with suicide-related ideation are at increased risk of dying by suicide in the future. Providing expert interventions at times of crisis improves both engagement with services and outcomes. It takes bravery for people to reach out for help; when they do, our health services need to be able to respond.

In 2016 the National Clinical Programme for the Assessment and Management of Patients who Present to the Emergency Department (NCPSH) Model of Care (MOC) was introduced. It established a clinical framework to ensure that any person who presents to the ED following self-harm or with suicide-related ideation receives a compassionate, empathic, validating response, and a therapeutic assessment and intervention from a suitably trained mental health professional; that every effort is made to ensure that a family member or supportive adult is involved in assessment and safety planning, and that they are followed up and linked to appropriate next care. Consultant Psychiatrists, Mental Health Clinical Nurse Specialists and non-Consultant Hospital Doctors are responsible for delivering the programme, with Area Management Teams from each service ensuring it is fully implemented.

The funding and appointment of Mental Health Clinical Nurse Specialists has contributed to the improvements in response for people with self-harm or suicide-related ideation. But gaps in our services remain. The implementation of the NCPSH has provided several learning opportunities, and recent national and international evidence has provided further guidance on improving the services. The original Model of Care identified the need to develop access to urgent mental health care in a non-ED setting, along with ensuring people who present to the ED receive an optimum service. It is now timely to describe how those non-ED services can be developed and also to address ongoing improvements required in ED settings.

This update provides a framework to improve services for all who self-harm or present with suicide-related ideation, regardless of where they present. The changes recommended have been informed by evidence, by the experience of clinicians and managers, and by feedback from individuals and family members with lived experience of self-harm and suicide. I would like to thank all who are listed in the acknowledgements for their contributions to this update.

The framework for improvement is established. It is now up to all of us – funders, managers and clinicians – to put it in place.

Dr Anne Jeffers
National Clinical Lead Feb 2017 – June 2021

ACKNOWLEDGMENTS

The NCPSH team of Ms Rhona Jennings, Programme Manager; Dr James O'Mahony, National Nurse Lead; and Dr Katerina Kavalidou, Data Manager/Researcher has been central to delivering the programme and delivering this update.

We also wish to acknowledge the contributions of:

- The members of the NCPSH Implementation Advisory Group for their work in bringing this update to fruition and for their expert guidance over the years. Individuals are named in Appendix 1.
- Dr Brian Osborne, ICGP Assistant Medical Director, for his contribution to the update and in particular Chapter 7.
- Members of the NCPSH Research and Audit Committee for their ongoing advice on audit, research and monitoring of the NCPSH. Individuals are named in Appendix 1.
- Dr Amir Niazi, current National Clinical Advisor and Group Lead for Mental Health (NCAGL), and previous NCAGLs Dr Siobhán Ní Bhriain, Dr Philip Dodd and Dr Margo Wrigley.
- The many clinicians, managers, academics, family members and people with lived experience of self-harm and suicide who have kindly shared their experience and expertise over the last number of years.
- Professor Ella Arensman, Dr Eve Griffin and Dr Paul Corcoran and their colleagues from the National Suicide Research Foundation (NSRF). The NCPSH is indebted to their generous sharing of knowledge and expertise. NSRF has been central to the developments and training within the NCPSH.
- Mr John Meehan, Dr Philip Dodd and all the staff at the National Office for Suicide Prevention (NOSP) for their ongoing support and advice.
- The College of Psychiatrists of Ireland, including individual members, special-interest groups and faculties for their expert input.
- Executive Clinical Directors, Heads of Service, Area Directors of Mental Health Nursing and Assistance Directors of Nursing. Meetings at a national and a local level have contributed to this update.
- The Clinical Nurse Specialists and Clinical Leads who have delivered this programme over the last number of years. It has been a privilege to see such dedication and competence in delivering the first Mental Health Clinical Programme.

Finally, we also thank the people who have lost loved ones to suicide and those who have lived experience of self-harming who have provided insight and guidance. In particular, our thanks to Ms Siobhan O'Carroll for her ongoing work with the NCPSH. Siobhan's husband died by suicide in 2011, even though he, along with Siobhan, had been referred by their GP to a CMHT and attended the ED. Since he died, Siobhan has contributed to the development of the Model of Care, speaks at training events and, as a member of the Implementation Advisory Group, has provided further guidance and suggestions on how services can improve their interventions with families. Her gentle persistence reminds all of us – clinicians and managers – of the need to do better. This update is a further step in providing a better service.

EXECUTIVE SUMMARY AND RECOMMENDATIONS

Rationale, Vision and Objectives (Chapter 1)

Rationale

Experience since the introduction of the NCPSH has found a number of gaps in the original Model of Care. This update addresses these gaps, including identifying a non-ED service for crisis mental healthcare and introducing a Suicide Crisis Assessment Nurse to provide assessments in General Practice.

Vision

To ensure this clinical programme is embedded into everyday clinical practice so that every individual who presents to General Practice, Emergency Department, Community Mental Health Team or CAMHS following self-harm, or with suicide-related ideation, will receive a timely, expert assessment of their needs, and is connected to appropriate next care. That the individual and their family are valued and supported, by staff who themselves are valued and supported.

Programme objectives

- To improve the interventions and support for people who self-harm or have suicide-related ideation.
- To reduce rates of repeated self-harm.
- To improve access to appropriate interventions at times of personal crisis, ensuring the person receives the right intervention, at the right time, in the right place and by the right person.
- To ensure rapid, timely and safe linkage to appropriate follow-up care.
- To optimise the experience of families and carers in trying to support those who present with self-harm.

Literature Review Summary and Recommendations (Chapter 2)

- People who present following self-harm or with suicide-related ideation are at increased risk of dying by suicide in the future. Evidence supports the use of interventions in improving engagement with mental health services and reducing repeat self-harming.
- It is timely that the NCP advises a shift in emphasis from using risk assessment tools to using collaborative emergency safety planning. This is in keeping with the recovery ethos and supported by empirical evidence. The NCP recommends that, to address that need, all training curricula and clinical practice focus on assessment of need and include safety planning. Standalone and locally developed risk assessment tools should not be used. Clinical risk assessment processes should be improved, with emphasis placed on building relationships and on gathering good-quality information on the current situation, on past history and on the current social circumstances, to inform a collaborative approach to management using safety planning.
- The NCP should be delivered using a trauma-informed approach. Practitioners should receive training on trauma-informed approaches.
- People who present to health services following self-harm or suicide-related ideation should receive brief interventions in the form of empathic, validating, compassionate and trauma-informed response; a timely expert biopsychosocial assessment and intervention, including a written emergency safety plan, and follow-up and linkage to next appropriate care.
- Non-ED crisis assessment services should be developed by all mental health services in Ireland. These will include Crisis Assessment Teams and the use of SCANs (Suicide Crisis Assessment Nurses) to work with GPs.
- To ensure continued working in a genuine, empathic and compassionate manner, all services should ensure that practitioners have access to reflective practice and regular supervision, at a minimum every month, and increased at times of greater stress.
- All presentations should be discussed with a Consultant Psychiatrist. The timing of that discussion depends on the skill and experience of the mental health practitioner. It is recommended that all practitioners in their first six months in practice discuss a case with a Consultant before they discharge the patient. Every mental health professional will also receive clinical and professional supervision from an experienced clinician in the area of self-harm.
- Gathering information from families and supportive adults and providing family members/supportive adults with support is central to the NCPSH. Every effort should be made to provide the patient with a clear understanding of the value and importance of both gathering information from and sharing information with family members or a supportive friend. Confidentiality is paramount but there are situations where it can be breached. Even in situations where it is not appropriate to breach confidentiality, listening to family members/carers is important and is not precluded by confidentiality. Providing support for family members/carers is also important.
- All clinicians should ensure that all patients are given the time and space to be interviewed alone. Before requesting family or supportive friend input, clinicians need to understand the relationship the patient has with their family member, being aware of the possibility of intimate partner violence or family abuse.

Update on Services for People who Present to the Emergency Department following Self-Harm or with Suicide-related Ideation (Chapter 3)

- The mental health services should ensure that the NCPSH in the ED is delivered 24 hours a day 7 days a week.
- The four clinical components – an empathic response, an expert assessment and intervention, family involvement and follow-up, and bridging to next care – should be offered to all patients who present following self-harm or with suicide-related ideation.
- The NCPSH is led by Consultant Psychiatrists and delivered by a CNS, MHSW or NCHDs.
- It is the responsibility of the Clinical Director to ensure that the NCHD is supported to carry out all aspects of the NCPSH. This includes training, Consultant supervision and, in some of the busier services, ensuring there is extra staff to provide support where required.
- On-site Liaison Mental Health Services should be provided by one multidisciplinary liaison psychiatry team, as recommended in *A Vision for Change*. This includes all Model 4 and Model 3 hospitals.
- Access to Liaison Mental Health Services should be provided in all hospitals. In smaller hospitals this would include a 0.5 WTE Consultant Psychiatrist providing clinical leadership to a smaller team.
- In the interim, in those acute hospitals where Liaison Psychiatry services are not available, the Area Mental Health Service should fund appropriate Consultant Psychiatrist time to provide coordination of the mental health service available for patients presenting to the ED following self-harm or with suicide-related ideation.
- Child and Adolescent Liaison Mental Health services should be provided by one multidisciplinary liaison psychiatry team, as recommended in *A Vision for Change*. This may be on-site services in the larger hospitals and inreach provided by community-based CAMHS teams.
- The Area Mental Health service should fund appropriate Consultant child and adolescent psychiatrist time to coordinate the mental health service available to children in the ED and general hospital who present with suicide-related ideation or self-harm.
- All Consultant Psychiatrists should ensure they have a working knowledge of the NCPSH and that all patients, including those presenting out of hours, receive all clinical components.
- The mental health team should provide regular training for ED staff on mental health and suicide awareness.
- The Post Triage Mental Health Triage tool should be introduced in each ED. Training is required for ED staff.
- Parallel assessments addressing both mental health and physical health needs should be usual practice.
- Joint responsibility between ED teams and the mental health teams for patients within the ED will provide improved outcomes.
- Regular meetings between the ED staff and the mental health staff providing consultations in the ED should occur to address issues related to assessments, admissions and clinical responsibility of patients.
- ED staff and mental health staff working in the ED should use attendance at the local HSE Mental Health Engagement forum in order to obtain feedback from people who use the service.
- Connecting for Life Local Implementation Plans should include input from mental health staff working in the ED and in SCAN service.
- In keeping with A Vision for Change and the Code of Practice of the Mental Health Commissions, all services should develop acute assessment facilities outside of the ED.
- Each patient presenting to the ED following self-harm should be treated with respect and compassion. They should receive an empathic, compassionate, trauma-informed and validating response.

- Each ED should ensure there is high-quality, dedicated accommodation for the assessment of patients with mental problems.
- Each mental health service should ensure there is a clear pathway to transfer patients to a non-ED facility for mental health assessment, where there is no physical health problem and the need for mental health care is clearly differentiated.
- Each patient should be seen in a timely manner by ED staff and by mental health practitioners (usually CNSs or Psychiatrists).
- The interview should focus on developing a therapeutic alliance to instil hope and trust. Genuineness, empathy, acceptance and caring are central to this.
- Standalone and locally developed risk assessment tools should not be used. Clinical risk assessment processes should be improved, with emphasis placed on building relationships and on gathering good-quality information on the current situation, on past history and on the current social circumstances, to inform a collaborative approach to management using safety planning
- Each presentation should be discussed with a senior Psychiatrist (Consultant or Higher Specialist Trainee) or an Advanced Nurse Practitioner. The timing of that discussion depends on the training and experience of the mental health practitioner.
- An Emergency Safety Plan should be co-produced by the patient, a family member or supportive adult and the mental health clinician.
- This Emergency Safety Plan is aimed at co-producing, with the individual and their family member, a written plan for the following 24 hours. It should include how to provide a safe environment, who to contact in an emergency and what the next professional contact should be, while addressing what the individual needs to do, what the family member needs to do and what the service needs to do.
- The Emergency Safety Plan should include a safe environment, emergency numbers and plans for next care appointment.
- Every effort should be made to involve a family member or trusted adult in assessment and in safety planning.
- Family member/supportive friend should co-produce the emergency safety plan, along with the patient and the mental health clinician.
- Family members/supportive friend should be supported in supporting their loved one, including being given a copy of Would you know what to do if someone told you they were thinking of suicide?
- Confidentiality is paramount but there are situations where it can be breached, such as risk to the individual. Even in situations where it is not appropriate to breach confidentiality, listening to family members/carers is important and is not precluded by confidentiality.
- Family members/carers can also be provided with support without breaching confidentiality.
- ED staff should be able to access a mental health professional to provide advice and support to family members and to take any collateral history a family may wish to give.
- Specific training on confidentiality is required for all staff including ED staff.
- All clinicians should be aware of the possibility of intimate partner violence and the need to provide each patient with personal time and space to be interviewed alone.

Training and Governance are discussed in more detail in Chapters 9 and 10.

Child and Adolescent Services for Children who Self-harm or Present with Suicide-related Ideation (Chapter 4)

- Supporting children who self-harm and those with suicide-related thoughts is complex and requires more than can be addressed through the NCPSH.
- Full multidisciplinary Liaison Psychiatry services for children should be developed, in line with recommendations from *A Vision for Change*. A CNS funded through the NCPSH should be available in each of the three Dublin paediatric hospitals, to provide liaison between the mental health staff in the ED and the community-based CAMHS teams and other community-based services.
- Full staffing of community child and adolescent mental health teams should be implemented. CAMHS teams should be encouraged to develop crisis supports for children.
- The Area Management Teams of the mental health services should ensure that all components of the NCP are implemented for children presenting to the ED and to CAMHS services following self-harm or with suicidal ideation.
- Training in skills for assessing and supporting children and their families, as identified in the NCPSH training schedule, should be made available to all staff working in CAMHS teams.
- The development of a National Lead and a lead for CAMHS in each CHO, as recommended in the Youth Mental Health Task Force Report (2017), would facilitate the full implementation of the NCPSH for children.
- The Higher Education Authority has developed a framework for suicide prevention for students in higher education. Staff working with children and young adults should have a working knowledge of this framework (HEA 2020).
- Development of SCAN in primary care should be considered and developed once appropriate CAMHS community and liaison psychiatry services have been established.

Groups with Specifically Identified Needs (Chapter 5)

- A number of identified groups who present to the ED or to the GP following self-harm or with suicide-related ideation require enhanced input from the mental health professional to ensure they are linked to appropriate next care.
- These groups include those with substance misuse, those who are homeless, asylum-seekers, members of the Travelling community, deaf people, the LGBTQIA2s+ community, people with chronic health conditions, autistic people and older people.
- All staff carrying out a mental health assessment in the ED or in SCAN should have skills in carrying out opportunistic screening and interventions for those at risk of alcohol and substance misuse, including training in SAOR (Screening, Ask and Assess, Offer Assistance and Referral).
- Each ED and GP should have clear policies and pathways for accessing onward referral to relevant local addiction services.
- Each ED should have access to onsite addiction specialists. This needs to be developed through the Primary Care Addictions Programme and the Dual Diagnosis Clinical Programme.
- People who are homeless benefit most from mental health services that are delivered alongside other services, such as daycare or shelter. A SCAN practitioner in crisis mental health care would be ideally placed to provide clinical expertise to teams working with the homeless population.
- A SCAN or equally qualified mental health professional should be available to work with the homeless population who present with self-harm and suicidal behaviour, providing biopsychosocial assessment and intervention. In addition the SCAN would liaise between the specialist mental health services for the homeless and the secondary care mental health service.
- All staff carrying out mental health assessments in the ED and in SCAN should receive training in understanding gender and sexual identities.

- All staff carrying out mental health assessments in the ED and in SCAN should receive cultural awareness training in addressing the mental health needs of Travellers, asylum-seekers and refugees.
- All staff carrying out mental health assessments in the ED and in SCAN should receive training to better support the varying needs of autistic people and those with ADHD. Staff need to be aware of the different communication methods used by some autistic individuals.
- All staff will ensure that reasonable accommodation and access are provided for people with a disability.
- Non-English speakers must have their interview facilitated by appropriate interpreters/translators. Services should ensure that their phone number and video facility is available for use.
- Deaf or hard-of-hearing patients must have their interview facilitated by an Irish Sign Language interpreter. Services should ensure that the phone number and video facility for an ISL interpreter is available for use. Information on specialist mental health services for the deaf and hard of hearing community are available at www.chime.ie.
- All staff carrying out mental health assessments in the ED and in SCAN should receive training to better support people with physical illnesses, including chronic pain.
- A mechanism should be put in place to identify people who frequently present the ED following self-harm. These people require particular attention and collaborative care planning to include all agencies involved in their care.

Bridging and Linkage to Next Appropriate Care (Chapter 6)

- The responsibility for ensuring that all patients receive effective follow-up and linkage to next appropriate care rests with all Cs who provide on-call clinical supervision.
- Each service should ensure that a procedure is in place to ensure handover of details of all patients who present out of hours.
- Each patient's GP should receive immediate communication by secure Healthlink on the patient's presentation and emergency safety plan. If this is not possible, a phone call should be made to the GP within 24 hours.
- All patients, including those assessed out of hours, should receive a follow-up phone call from a Clinical Nurse Specialist or equally qualified mental health professional employed through the NCPSH, within 24 hours of discharge from the ED or SCAN. In very rare cases this may not be clinically appropriate and this fact should be recorded in the notes.
- In some cases it will be appropriate for the CNS, MHSW, NCHD or Consultant to provide brief follow-up support. This would usually be to a maximum of three contacts, providing further expert advice to the GP and supporting the patient in engaging with next appropriate care.
- Each CNS and SCAN professional should liaise with the resource officers for suicide prevention in their area and develop a list of community supports in their area.
- In developing Connecting for Life Action Plans, NOSP should ensure that there is input from the CNS, SCAN and the NCPSH office.

Pathway of Care for Persons Presenting to GP following Self-Harm or with Suicidal Ideation (Chapter 7)

- It is recommended that Connecting for Life Local Action Plans include the provision for GP and ED assessment of self-harm and suicide-related thoughts, as outlined in the Clinical Programme.
- The GP should be the first point of access to people who self-harm or who have suicidal ideation.
- Training for GPs should focus on exploring suicidal ideation, identifying local and community-based referral pathways, support family involvement, and brief psychosocial interventions.
- Each general practice should have access to a Suicide Crisis Assessment Nurse or mental health practitioner. These would be Clinical Nurse Specialists or equivalent mental health professionals who can address suicide crisis assessment needs. These practitioners will be employed by the mental health services and have access to the clinical support of a Consultant Psychiatrist.
- SCAN should complete interventionist assessments, develop a collaborative safety plan with the patient and a family member or supportive adult; provide a follow-up phone call, and linkage to next appropriate care.
- General Practitioners and Secondary Care Mental Health services should aim to develop effective communication, including the joint development of referral protocols, and quarterly meetings to include GP staff, the SCAN service and the CMHT.
- Information on service provision within Primary Care and community should be available for all GPs.
- All CHO areas should have access to a non-crisis, time-limited, specialist counselling service, with effective communication between health professionals and counsellors within such a service.
- Resources from NOSP, in particular the booklet 'Would you know what to do if someone told you they were thinking of suicide?', should be available for all GPs through https://www.healthpromotion.ie/publication.
- SCAN provides a consultation service to general practice and general practitioner. Within the SCAN service, the CNS will report clinically to an Advanced Nurse Practitioner (ANP) or a Consultant Psychiatrist. the ANP will report clinically to a CPsychiatrist.
- Within the SCAN service, all patients remain in primary care. Being seen by the SCAN service does not constitute a referral to the CMHT and the patient remains in primary care. If the SCAN and/or the GP deem that a referral to a CMHT is required, the normal referral process by a GP to the CMHT should be followed.
- The CNS should discuss cases with the GP and receive clinical supervision from a registered ANP (RANP) or from a Consultant Psychiatrist, depending on individual service need.
- A General Adult Consultant Psychiatrist should be allocated time to provide weekly face-to-face supervision and time to develop the service with the local GPs. This will require 0.2 WTE Consultant time per 300,000 population.

Access to Crisis Mental Health Assessment by a Community Mental Health Team (Chapter 8)

- Mental health services should be resourced to ensure that CMHTs can develop effective liaison with General Practice and Primary Care.
- Each CMHT must ensure it has the capacity to respond to urgent referrals of new and existing patients on the same day.
- The development of the SCAN service, as described in Chapter 7, has been shown to reduce referrals to CMHTs.
- Improved liaison between GPs and CMHTs will reduce duplication of work and improve outcomes for patients.

Education, Training and Continuing Professional Development (Chapter 9)

- Mental health professionals delivering the NCPSH should receive competency-based training. Competencies are included under clinical technical expertise, stylistic/ interpersonal, and professional knowledge relevant to the role.
- All mental health professionals delivering the programme should have access to clinical supervision to develop their skills and competencies in the above areas.
- Training is identified by the NCPSH as mandatory (M), recommended (R) and useful (U). All mental health professionals delivering the NCPSH should receive the mandatory training and then build on that training with recommended and finally useful training (Table 9.5).
- The mental health professional's line manager should ensure that regular face-to-face supervision is provided. During this supervision, the clinician's training needs should be identified and a plan made to attend required trainings.
- Education on the NCPSH Model of Care will be provided from the NCPSH office.
- Education programmes from the NCPSH will be designed and delivered using different delivery methods to ensure that training is accessible by clinicians – e.g. seminars, webinars and distance learning.
- Education programmes from the NCPSH should be co-produced and co-delivered by clinicians, people with lived experience of self-harm and family members with lived experience.
- Education programmes provided from the NCPSH should reach a standard approved for CEUs (Continuous Educational Units) by the NMBI (National Nursing and Midwifery Board), and CPD (Continuous Professional Development) from CPsychI (College of Psychiatrist of Ireland, or the ICGP. (Irish College of General Practitioners.)
- Postgraduate education programmes should include specific training on assessment and intervention when working with individuals who experience self-harm and suicidal behaviour. This should include clinician, service user and family member input in collaboration with higher educational institutes.
- CNS should keep a training log of training received.
- Nurse management should audit CNS training received each year so as to identify further training needs as per recommendations from the NCPSH.
- Consultant Psychiatrists who are providing clinical supervision and educational supervision for professionals completing assessments should ensure they have a knowledge and understanding of the NCPSH.
- Further qualitative research should be carried out to elicit more detailed information regarding the education and training needs mental health professionals require in order to deliver the NCPSH effectively from a service user perspective.

Clinical Governance (Chapter 10)

- Clinical governance is a framework through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver.
- The office of the NCAGL is responsible for the development, coordination, and oversight and monitoring of the implementation of the NCPSH.
- The NCPSH identifies the Model of Care and training required for practitioners delivering the NCPSH.
- The Local Area Management Team is responsible for the implementation of the NCPSH in each area.
- Staff implementing the NCPSH are employed by the mental health services and report professionally to their line manager in that service.
- Staff implementing the NCPSH work under the clinical guidance of a Consultant Psychiatrist.
- The role of the Consultant, CNS, NCHD and other mental health professionals working in the ED can be stressful. It is important that they have access to both clinical and managerial supervision and support.

Monitoring and Evaluation (Chapter 11)

- The CNS appointed through NCPSH is responsible for ensuring that data is collected and submitted to the NCP office on each person who presents to the ED or SCAN service. The supervising ADON has a role in ensuring the quality of the data submitted.
- The NCPSH will work with the HSE Office of the Chief Information Officer (OoCIO) and the National Suicide Research Foundation (NSRF) in developing appropriate data collection platforms to optimise the use of data from the Self-Harm Registry and from the NCPSH in improving service delivery.
- The national NCPSH activities will be published annually.
- Data for each service will be available for that service, measuring standards against national metrics.
- The Research and Audit Committee will develop appropriate local, regional and national projects to facilitate the monitoring and improvement of services.
- The PRISM study, a collaboration with NSRF is researching the cost and efficiency of the implementation of the NCPSH.
- Members of local management teams should ensure they obtain feedback on the implementation of the NCPSH from the local Mental Health Engagement and Recovery Forum.
- The development of an appropriate mechanism to provide feedback from people who use the service should continue.

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Rationale, Vision and Objectives

1.1 Rationale

1.1.1 The Model of Care (MOC) for patients presenting to the Emergency Department (ED) following self-harm was first introduced to HSE in 2014. The Model of Care was published in March 2016. The aim of the National Clinical Programme (NCPSH) is to ensure that all patients who self-harm or with suicidal ideation and present to the ED are offered a timely, expert biopsychosocial assessment, including a written Emergency Care Plan (ECP), that next of kin or supportive adults are involved in assessment and management, and all patients are followed up and linked to the next appropriate care.

1.1.2 The Model of Care (HSE March 2016) remains the guidance for the Assessment and Support of Patients Presenting to the Emergency Department following Self-Harm. Since 2016 a number of developments have necessitated updating the original MOC. These developments are discussed further in Section 1.2.2. This update expands on sections of the MOC. It is informed by recent literature evidence and practice evidence received from the services' experience in implementing the Clinical Programme. It also addresses recommendations from a number of recently published policy drivers, reviews and publications (since 2012). These include Sláintecare (DoH 2017), Sharing the Vision (DoH 2020) and a number of service improvement initiatives in HSE mental health services, including A Recovery Framework for Mental Health Services (2019).

1.1.3 The National Clinical Programmes for Mental Health were established in 2010 as a joint initiative between HSE Clinical Strategy and Programmes Division and the College of Psychiatrists of Ireland. The aim of the programmes is to standardise high-quality, evidence-based practice across the mental health services. A working group established in 2010 produced the NCPSH. In 2014 a standard operating procedure (SOP) was developed, and this supported the work of clinical nurse specialists and local clinical leads in delivering this programme. In 2016 the Model of Care, a joint document between the HSE and the College of Psychiatrists of Ireland, was published (HSE 2016). In February 2017 a National Clinical Lead was appointed and reviewed the implementation of the programme. A review of the programme was undertaken in 2017 by the Clinical Lead and published in October 2017 (HSE, 2017).

1.1.4 Figure 1.1 outlines the progress with the NCPSH to date. Since the Model of Care was developed in 2016, the Clinical Programme has been funded to appoint CNS grade nursing staff in 26 adult EDs and three paediatric EDs. The NCPSH is currently operational in 24 of the country's 26 adult Eds that are open 24 hours, 7 days a week, and in one of the Children's Hospitals. An Implementation Advisory Group (IAG), established in 2018 and representing all clinical stakeholders, patient and family member service development advocates, has advised on this update to the Model of Care.

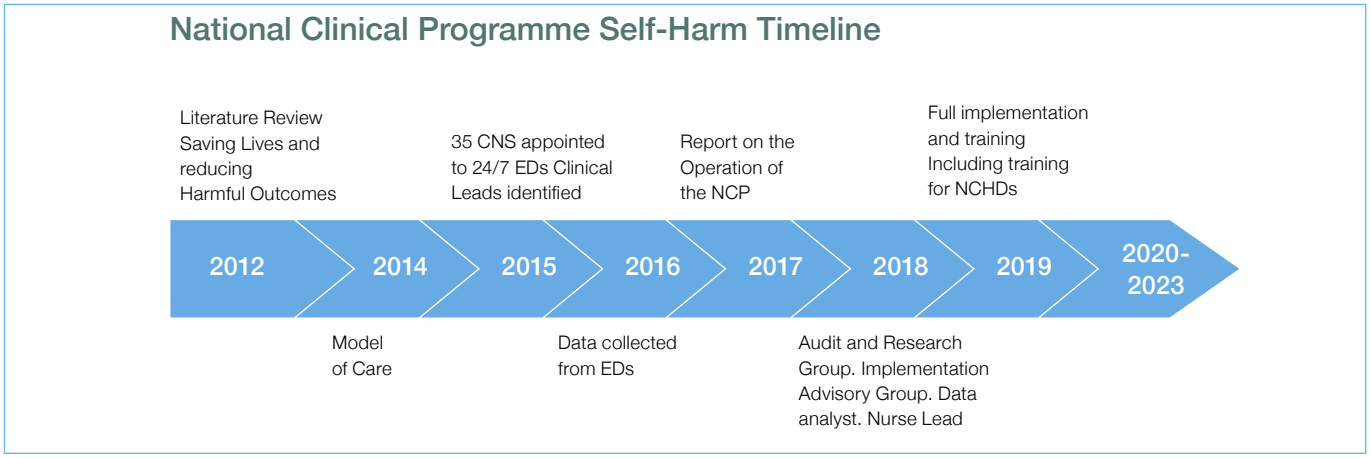


FIG. 1.1 DEVELOPMENTS IN THE CLINICAL PROGRAMME 2012–2021

1.2 Overview

1.2.1 The four Pillars of Intervention for people presenting to the ED following self-harm or with suicide-related ideation include: access to a compassionate, empathic and validating response; a clear clinical pathway to an expert mental health assessment; involvement of next of kin or supportive adults at both assessment and management phase, and follow-up and bridging to next care.

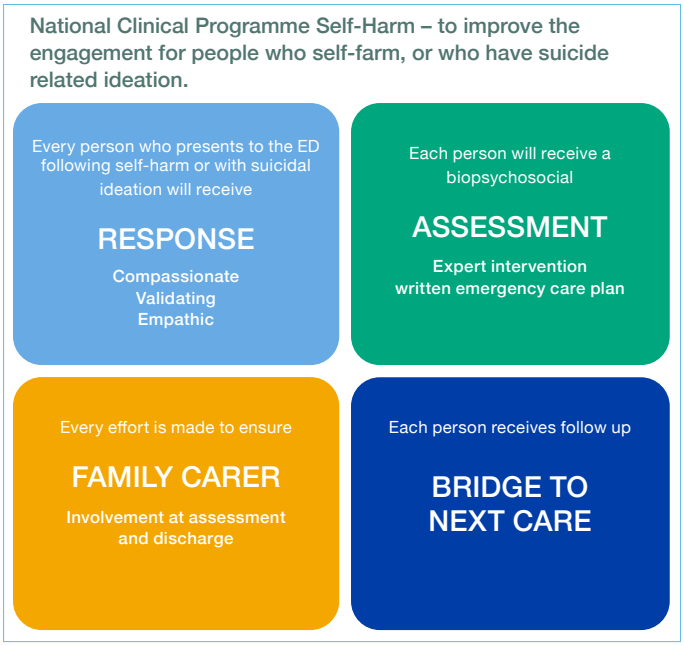


FIG. 1.2 CLINICAL COMPONENTS OF THE NCPSH

Data on all presentations and clinical activities within the Clinical Programme are collected and collated centrally.

Engagement of service users, family members and clinicians who are implementing the Clinical Programme in the development and delivery of the Clinical Programme occurs at all levels of services.

Training, support and supervision of the staff working within the Clinical Programme is central to the effective delivery of the programme.

The programme is delivered in the Emergency Departments (EDs) of Model 3 and Model 4 hospitals that have EDs open 24 hours a day (Figure 1.3).

At a local level the programme is led by Consultant Psychiatrists and delivered by Clinical Nurse Specialists (CNSs) and Non-Consultant Hospital Doctors (NCHDs).

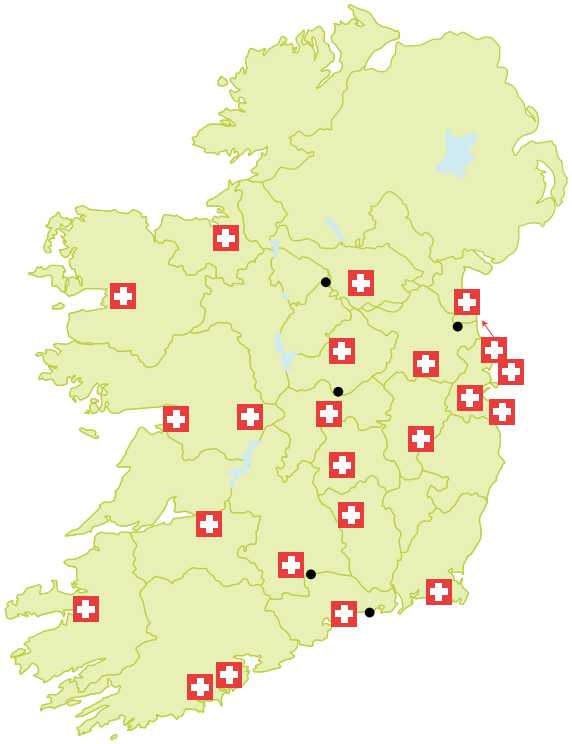


FIG. 1.3 DISTRIBUTION OF EDS THAT HAVE IMPLEMENTED THE NCPSH

1.2.2 This update has been developed by the National Clinical Lead, the Programme Manager, the National Nurse Lead and the Data Manager, with input and advice from the Implementation Advisory Group (IAG) of the Clinical Programme. The IAG includes representatives of individuals and family members with lived experience of self-harm and suicide, along with clinicians from general practice, nursing, psychiatry, psychology and social work (Appendix 1).

1.2.3 Since 2018, the Clinical Programme has been implemented in almost all Model 3 and Model 4 hospitals in Ireland. Regular reviews by the Implementation Advisory Group (IAG) of the factors facilitating and blocking full implementation have resulted in a number of suggested additions to the original Model of Care. The following is a summary of those factors.

Name of the programme: The name of the original MOC, The National Clinical Programme for the Assessment and Management of Patients Presenting to the Emergency Department following Self-Harm, was a misnomer in that it referred to patients presenting to the ED following self-harm. In practice, the MOC identified the need to ensure that people presenting with self-harm or with suicide-related ideation at the ED, at the GP and at Community Mental Health Teams received a standardised approach. The use of the term management does not reflect the collaborative approach to the interventions such people should receive and is no longer considered appropriate in a recovery-focused service. Clinicians working on the NCPSH and researchers working on suicide and self-harm were enrolled to identify a more appropriate name. An online survey was sent to an international network of early-career researchers (netECRs) in the field of suicide and self-harm, including researchers with lived experience. The anonymous survey included a list of potential programme names selected by the NCP team, with the option of a free text option for researchers to suggest further titles. A number of choices were put to the Implementation Advisory Group. They agreed on the title: National Clinical Programme for Self-harm and for Suicide-related Ideation. The use of the term suicide-related ideation refers to thoughts of both suicide and of self-harm.

Suicide-related ideation: The MOC focused on developing a service for people who presented to the ED following self-harm, and also recommended that people with suicide-related ideation be included, but did not identify how this should be delivered. In practice, in 2019 46% of those presenting to the ED and assessed by clinical nurse specialists or NCHDs were presenting with suicidal ideation alone. The MOC stated that the ED was not a suitable place for these presentations. This update now addresses how people with suicidal ideation can be best supported in a non-ED setting.

Safety planning to replace risk assessment tools: Based on best evidence, the MOC advocated against using standalone risk assessment tools when assessing people who self-harm or have suicidal ideation. In practice, many services tend to rely excessively on the use of risk assessment tools. In Chapter 2, 4 and 7, this update will expand on the problems with risk assessment tools and the benefits of introducing safety planning.

Liaison Psychiatry services: The Model of Care advised that, 24 hours a day, 7 days a week, those presenting to the ED with self-harm and suicide-related ideation should all receive the standardised approach of empathic response, expert assessment, family involvement and follow-up, and bridging to next appropriate care. This should be delivered by Consultant Psychiatrists and coordinated through Liaison Psychiatry services. The MOC advised that the local coordination of the programme should rest with the Liaison Psychiatrist, but that a designated General Adult Consultant Psychiatrist should provide where there was no Liaison Psychiatrist service. This update identifies the need for Liaison Psychiatry services in all Model 3 and Model 4 hospitals. (See Chapter 3).

General Adult Psychiatry services: A review of the operation of the NCPSH (HSE 2017) showed that 42% of presentations of self-harm or suicidal ideation occurred outside the hours of Liaison Psychiatry, and the self-harm registry shows that most presentations of self-harm occur outside daytime hours (Griffin et al 2018). Assessments out of hours are carried out by NCHDs, who are supervised by General Adult Psychiatrists. This update identifies the need to resource and support General Adult psychiatry consultants to implement the NCPSH and to ensure that the NCHD working out of hours is appropriately supported (see Chapter 3).

Family/supporter involvement: The importance of involvement of either a family member or supportive friend, both at assessment and in discharge planning, has been emphasised in the MOC. The ongoing need for this emphasis is supported by further literature evidence. Family/supporter involvement is addressed in a number of chapters, including Chapters 2, 3, 4 and 7.

Service to children: Under the MOC, the programme applies to all ages. In practice, it is currently being implemented in only one of the Children's Hospitals. Chapter 4 addresses the challenges for developing the services for children, and makes recommendations for future developments.

Service to groups with specifically identified needs: Certain groups in society show increased vulnerability to suicide and also have special requirements when they present with

suicide-related thoughts or self-harm. Their assessment and needs are discussed in a separate section in Chapter 5.

General practitioners' response to self-harm and suicidal ideation: The MOC states that GPs should be regarded as the first point of medical care for all persons with mental health disorders, including those who engage in self-harm – with the exception of those requiring hospital-based medical care arising from a self-harm episode. This is addressed in Chapter 7.

Access to crisis service in Community Mental Health Teams (CMHTs): The MOC states that each CMHT must ensure it has the capacity to respond to urgent referrals of new and existing patients on the same day. In practice this has not been the case. Additional requirements are identified in Chapter 8.

Training: A comprehensive competency-based training programme has been identified for all staff implementing the Clinical Programme. See Chapter 9.

Governance: A detailed review of role definition, governance and supervision is provided in Chapter 10.

Monitoring and evaluation: Since the NCPSH began, implementation has been monitored and supported by the NCPSH office. Working with the National Suicide Research Foundation, a more detailed evaluation of the implementation is ongoing. This is described in Chapter 11.

1.3 Mission, Vision, Core Values and Principles

1.3.1 Vision of the Clinical Programme

The vision of the NCPSH is:

> *To ensure this clinical programme is embedded into everyday clinical practice so that every individual who presents to General Practice, Emergency Department, Community Mental Health Team or CAMHS following self-harm, or with suicide-related ideation, will receive a timely, expert assessment of their needs, and is connected to appropriate next care. That the individual and their family are valued and supported, by staff who themselves are valued and supported.*

This update of the MOC will align with other national policies, including Connecting for Life, Sláintecare (2017) and Sharing the Vision and its related documentation (DoH 2020) It will also align with HSE documents, including A National Framework for Recovery in Mental Health (HSE 2017b).

1.3.2 Connecting for Life: Ireland's National Strategy to Reduce Suicide, 2015–2020; extended 2020–2025 (HSE NOSP 2020)

Based within the HSE, the National Office for Suicide Prevention (NOSP) oversees the implementation, monitoring and evaluation of *Connecting for Life – Ireland's National Strategy to Reduce Suicide 2015–2020* (DoH 2015). Connecting for Life sets out a vision of an Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health. It achieves this vision though seven strategic goals (Figure 1.4).

The NCPSH aligns with the mission, values and principles of Connecting for Life (CFL), the national suicide prevention strategy 2015–2020. It specifically addresses strategic goals 3, 4 and 5: to focus on priority groups, to provide better access to support, and to ensure high-quality services.

FIG. 1.4 STRATEGIC GOALS OF CONNECTING FOR LIFE, NATIONAL SUICIDE REDUCTION STRATEGY 2020–2025

People who self-harm are recognised as a priority group who require better access to support and high-quality services. Effective data collection will facilitate improved safety planning and research.

Action 4.1.5 of Connecting for Life is to: deliver a comprehensive approach to managing self-harm presentations through the HSE Clinical Care Programme for the Assessment and Management of Patients Presenting with Self-Harm to the Emergency Departments.

The Connecting for Life implementation plan 2020–2022 (NOSP 2020) identifies a number of overarching milestones related to the National Clinical Programme. These include: recruiting staff to ensure the delivery of the programme in all public hospitals, and the delivery of crisis support for people experiencing suicidal ideation through a range of community-based services. It also pointed to the need to work with the Irish College of General Practitioners in developing training and documentation for GPs, to expand training from the Clinical Programme to include Community Mental Health Teams, SCANs (Suicide Crisis Assessment Nurses) and Crisis Assessment Teams, and also to expand the programme to children.

Central to the implementation of Connecting for Life is the development of local Connecting for Life Action Plans. It is recommended that these plans include provision for GP and Emergency Department assessment of self-harm and suicide-related thoughts, as outlined in the Clinical Programme. All clinicians working with the clinical programme should develop a close working relationship with the local Resource Officer for Suicide Prevention (NOSP 2020).

1.3.3 Sláintecare

Sláintecare, the 10-year programme to transform Ireland's health and social care, identifies the need to design models of care based on evidence and patient safety principles. This will ensure that an evidence-based and integrated approach is taken to meeting the needs of patients. The plan is also aimed at strengthening community-based services (DoH 2017).

1.3.4 Sharing the Vision

Sharing the Vision: a Mental Health Policy for Everyone was launched in 2020 to build on the *A Vision for Change* policy. While it focuses on developing a broad-based, whole-system mental health policy for the whole of the population, it also recommends there should be "continued investment in and implementation of the National Clinical Programme for the Assessment and Management of Patients presenting to the Emergency Department following Self-Harm" (DoH 2020).

1.3.5 Programme objectives

- To improve the interventions and support for people who self-harm or have suicide-related ideation
- To reduce rates of repeated self-harm
- To improve access to appropriate interventions at times of personal crisis, ensuring the person receives the right intervention, at the right time, in the right place and by the right person
- To ensure rapid, timely and safe linkage to appropriate follow-up care
- To optimise the experience of families and carers in trying to support those who present with self-harm

1.3.6 Programme remit

The NCPSH refers to all persons who present to their GP or to the ED following an act of self-harm or with suicide-related ideation.

The NCPSH refers to all ages, including children up to 18 years of age, adults, and older adults aged over 65 years.

The NCPSH does not include the assessment and management of physical healthcare needs following self-harm.

02

Literature Review

2.1 Introduction

A review of the evidence base was carried out in 2012 (Cassidy et al 2012) to support the development of the NCPSH MOC. The review included the Guidelines for Self-harm by the National Institute for Clinical Excellence (NICE 2004 and 2011), the Guidelines for assessment and management of patients presenting to ED or to psychiatry inpatient units with a suicide attempt or self-harm, produced by the American Association of Suicidology and the Suicide Prevention Resource Centre (2010), and the Report of the Royal College of Psychiatrists on treatment of self-harm and suicide risk (2010).

This chapter reviews the literature since 2012. The review focuses on key documents and articles in relation to the assessment and support of self-harm and suicide-related ideation. It is informed by the work of the NCPSH Implementation Advisory Group and the NCPSH Research and Audit Group, by discussions with clinicians who are implementing the programme and clinicians who work with people presenting with self-harm and suicide-related ideation. The findings from this literature review and from discussion with clinicians have provided the evidence for the changes recommended in this update. Further focused literature evidence is provided in later chapters on specific areas of care.

Since 2012, recommendations for assessing and managing patients presenting to the Emergency Department (ED) following self-harm have further supported the use of dedicated staff to provide assessment and interventions as outlined in the MOC. Kapur (2015) has demonstrated the value of a comprehensive psychosocial assessment for those who present to the ED following self-harm. In November 2016 NICE published comprehensive evidence-based guidance on urgent and emergency mental health care (NICE 2016). This guidance recommends that, within four hours of arriving in an ED or being referred from a ward, a person should have received a full biopsychosocial assessment and have an emergency and urgent care plan in place, at a minimum be on route to their next location if geographically different, or have been accepted and scheduled for follow-up care by a responding service, or have been discharged because the crisis has been resolved, or have started a mental health assessment. This builds on the recommendations in the Five-Year Forward View for Mental Health: expanding both Crisis Resolution and Home Care Treatment Teams, and providing core liaison service teams for all acute hospitals (NHS 2016a).

Suicide is a major public health problem. In Ireland in 2016, there were 437 deaths by suicide, a rate of 9.2 per 100,000. Figure 2.1 shows that the rate has been reducing since 2012 (CSO Statistics).

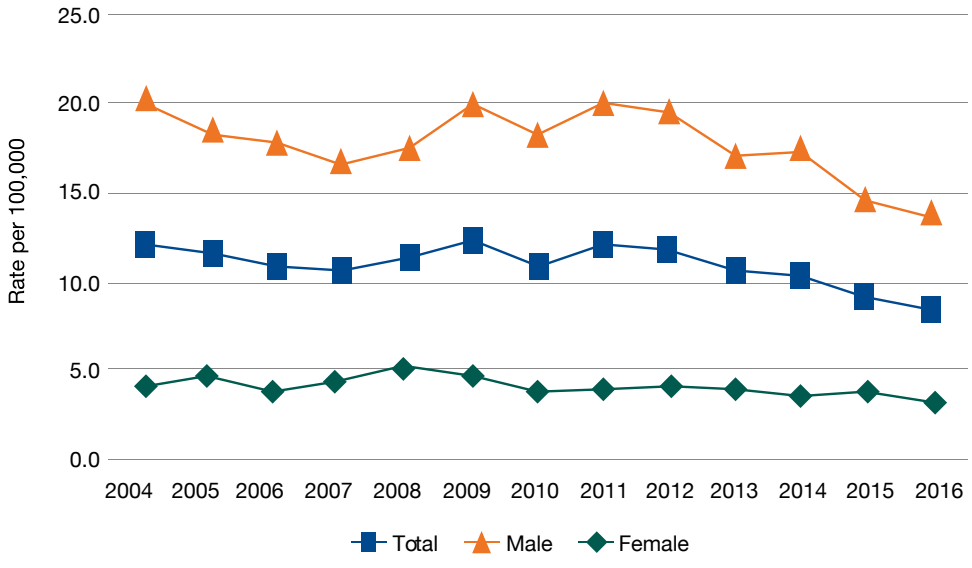
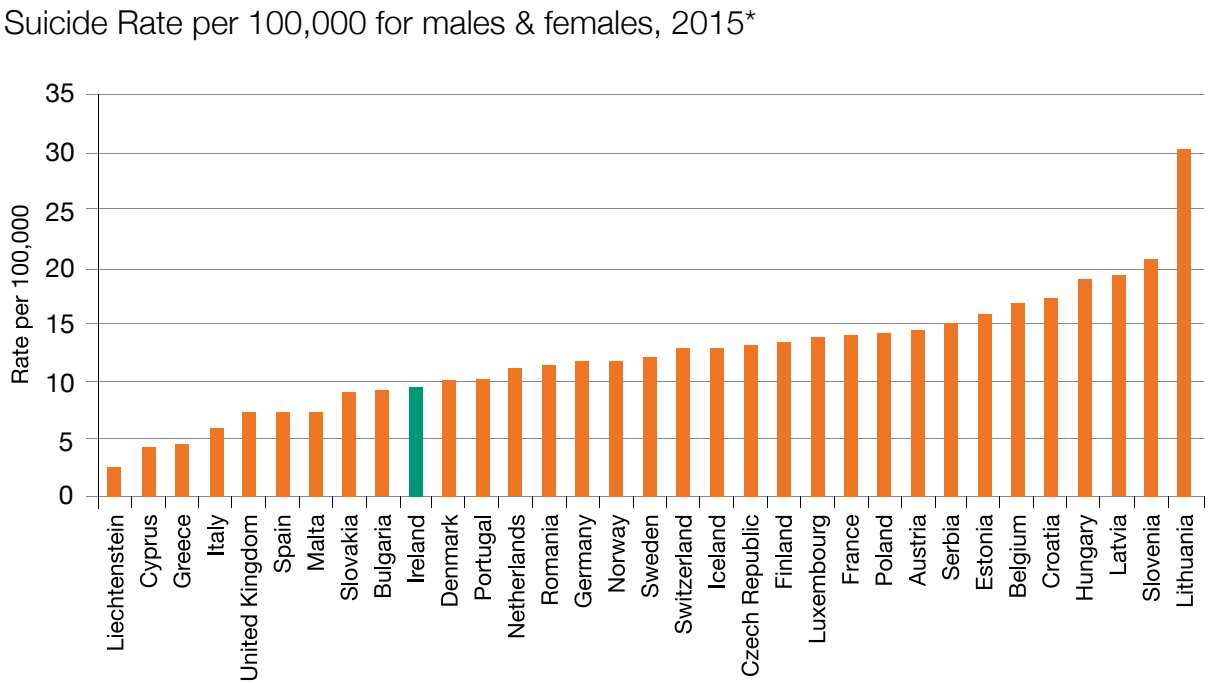


FIG. 2.1 SUICIDES IN IRELAND FOR MALE AND FEMALE PER 100,000 POPULATIONS 2004–2016 (NSRF 2019)

Suicide is the most common cause of death among young Irish men (aged 15–24) and middle-aged men (aged 45–54). Alcohol consumption is implicated in 44% of cases of suicide (Larkin et al 2017) and in 37% of cases of self-harm (Griffin et al 2015).



*Death rate of a population adjusted to a standard age distribution. The standardised death rates used here are calculated on the basis of a standard European population (defined by WHO).

FIG. 2.2 RATE OF SUICIDE AMONG 15–19-YEAR-OLDS IN EUROPE IN 2015 PER 100,000 OF POPULATION

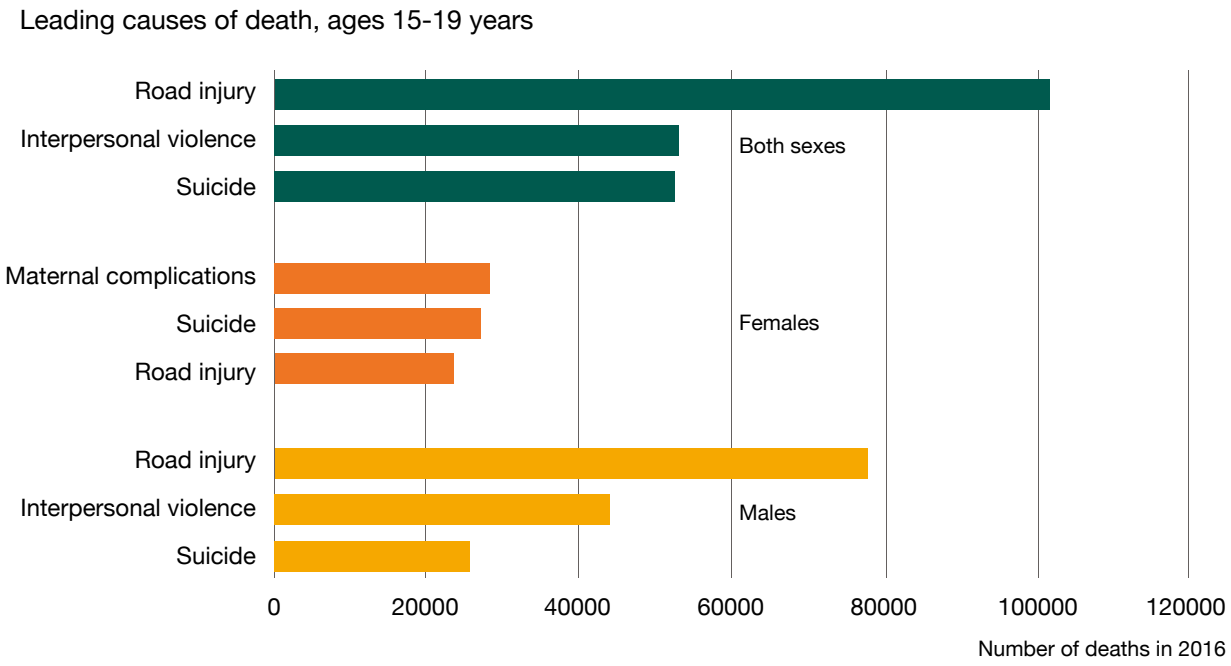


FIG. 2.3 LEADING CAUSES OF DEATH, AGES 15–19, 2016

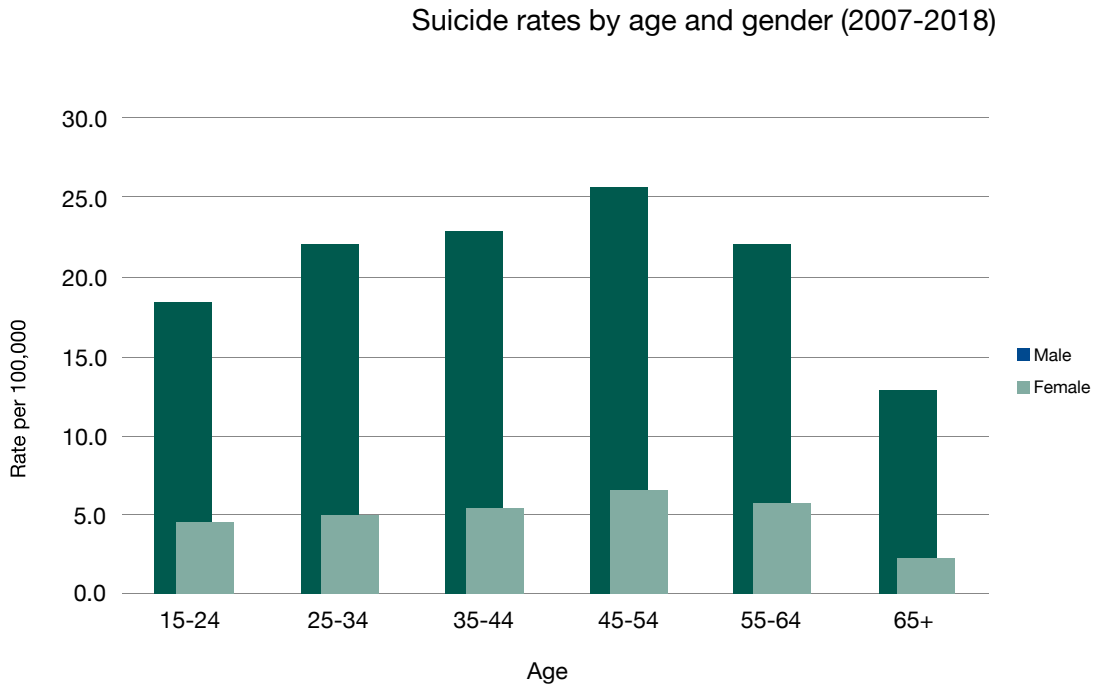


FIG. 2.4 SUICIDE RATES BY AGE AND GENDER, IRELAND, 2007–2018)

In 2021, suicide is the second leading cause of death in young people aged 15-19 years.

Over the last 12 years the suicide rate in Ireland has continued to fall (CSO 2020). Much of this can be attributed to improved economic conditions. However, there is a risk that this improvement will not be sustained, with the impact of Covid-19 (Gunnell et al 2020). Preliminary results indicate there was an increase in self-harm presentations to the ED following the third wave of Covid, and an increase in severity of mental health presentations has been predicted (O'Connor et al 2020). It is essential to ensure that clinicians are adequately trained and supported to address this increase in need.

2.2 Self-harm

Self-harm is defined as intentional self-poisoning or injury of oneself, irrespective of motivation or intent to die (Hawton et al 2012). It is estimated that approximately half of all people who die by suicide have previously self-harmed (Foster et al 1999). Of people presenting to the ED following self-harm, a meta-analysis in 2014 estimated that fatal repeat self-harm occurred in 1.6% of people within one year after their index attempt; incidence was almost double in males compared with females. It was estimated that one in 25 patients who self-harm and present to the ED will go on to die by suicide in the 10 years after their index case (Carroll et al 2014). Among patients who have been discharged from ED following self-harm, the risks of repeated acts of self-harm and suicide among all ages is highest immediately following discharge (Geulayov et al 2018).

People who self-harm are the group with the highest risk of completing suicide. Connecting for Life, Ireland's suicide prevention strategy 2015–2025, targets priority groups such as those who self-harm. It also identifies the need to enhance accessibility, consistency and care pathways, and ensure safe and high-quality services for people vulnerable to suicide (HSE NOSP 2015, 2020).

Ireland has a national registry of self-harm since 2007 (Perry et al 2013). It identifies all those who present to the ED, the nature of the self-harming behaviour, the interventions and the follow-up offered. In 2017 there were 11,600 presentations to ED following self-harm. It is estimated that, for every presentation to the ED, there are five times as many self-harm episodes in the community (Arensman et al 2018).

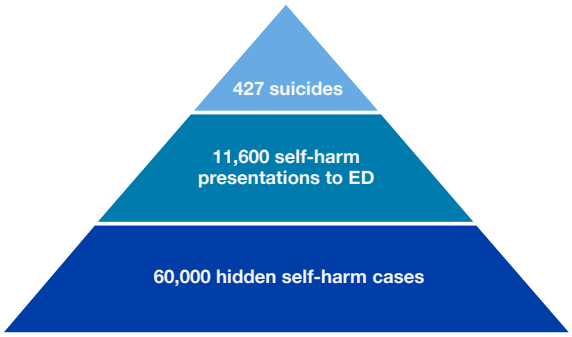


FIG. 2.5 THE ICEBERG MODEL OF SELF-HARM (ADAPTED, ARENSMAN ET AL 2018)

In 2014 67% of people presenting to the ED following self-harm received a mental health assessment (NSRF 2014.) In 2019 this number rose to 72% (NSRF 2019). Assessment was most common following attempted hanging and attempted drowning. Those with alcohol taken or who were self-cutting were less likely to receive an assessment. Of those presenting, 17% in 2014 and 14.5% in 2017 made at least one more presentation to hospital during the calendar year (Griffin et al 2014, 2017).

In recent years psychiatric practice has changed. Referral patterns from GPs have altered (Douglas and Feeney 2016); most people with suicide-related ideation are now being referred directly to community mental health teams rather than for inpatient treatment. Those who are referred for inpatient care are likely to be those that GPs or family members consider most at risk, but, as stated above, this assumption is not always reliable. Ireland has the lowest number of psychiatric beds per 100,000 population in the EU, with just under 34 beds per 100,000 population, while the EU average is 72 beds (Eurostat 2018).

A Vision for Change (DoHC 2006) recommended the development of Community Mental Health Teams and specialist health teams, but recruitment difficulties and lack of investment has resulted in deficits in both inpatient and community facilities (Kelly 2019). Very few services in Ireland have home-based treatment teams that provide intensive home treatment to people who might otherwise be admitted to hospital (O'Keeffe and Russell 2019).

2.3 Risk assessment and safety planning

The aim of the Clinical Programme is to improve engagement with people who self-harm or present with suicide-related ideation and thereby reduce recurrence of self-harm and reduce suicide. Before the introduction of the Clinical Programme, the focus of the initial contact was often on assessing immediate risk and only intervening with those who were considered to be at high risk (Griffin et al 2013). While there is evidence that the introduction of the Clinical Programme has improved the ED experience for many using the service, there is also evidence that mental health services continue to put emphasis on the use of risk assessment tools and checklists at the expense of developing effective therapeutic alliances that instil hope and improve future engagement (Doyle et al 2020, Cully et al 2020).

It has long been recognised that it is not possible to predict suicide (Pogorny 1983). Suicide risk is not binary, and the categories of high, medium and low-risk that are often used in clinical practice are arbitrary. We also know that suicide risk is dynamic, with risk changing from one assessment to the next. Standalone risk assessment tools have been found to be ineffective in assessing individuals with suicide-related behaviour (NICE 2011). They should not be used to predict future suicide or repetition of self-harm, or to determine who should or should not be offered treatment (NICE 2011). It has been clearly demonstrated by meta-analyses of their use that about half of people who die by suicide have been identified as being of low risk (Large et al 2011) and that none of the scales provides sufficient evidence to support their use (Chan et al 2016). In addition, the use of these scales, or over-reliance on identifying risk factors in clinical practice, may provide false reassurances to clinicians, and are therefore potentially dangerous (Chan 2016). Also, almost all the risk assessment tools used in the UK, many of which are also used in Ireland, have not been tested or validated and have simply been devised by the services themselves (Quinliven et al 2014). Further studies confirmed that even validated scales are not useful in predicting repeat self-harm or suicide (Quinliven 2017).

A national review of the assessment of clinical risk in UK mental health services (NCISH 2018) made a number of observations, including that risk assessment tools should not be seen as a way of predicting future suicide-related behaviour. It advised that risk is not a number and risk assessment is not a checklist. It noted the growing consensus that risk tools and scales have little place on their own in preventing suicide, and stressed that, instead, the emphasis should be on building relationships and gathering good-quality information, and that staff should be comfortable in asking about suicide-related thoughts. The authors suggested that clinicians should be trained in how to assess, formulate and manage risk; that families and carers should have as much involvement as possible in the risk process, and that management of risk should be personalised and individualised.

Qualitative data also illustrates the fact that clinicians and service users do not find risk assessment scales helpful. A tick box or checklist approach to assessment may be experienced as alienating and hamper therapeutic engagement (Stewart 2018; Doyle et al 2020). Cully et al (2020) explored patients' experiences of engagement with healthcare services following self-harm presentation to a hospital emergency department. Positive experiences of care included 'supportive and compassionate relationships' and 'timely and comprehensive follow-up care'. This resulted in establishing trust and encouraged help-seeking behaviour and adherence to psychotropic intervention. Conversely, 'superficial and unsupportive relationships' and 'care lacking continuity and comprehensiveness' left some participants feeling isolated, contributing to inhibited help-seeking and resistance to psychotropic treatment. Furthermore, those who described unsupportive relationships more frequently reported repeated self-harm, alcohol misuse and hopelessness at follow-up (Cully et al 2020).

Cully et al (2020) further supports the significance of therapeutic engagement in developing hope, decreasing helplessness and reducing the likelihood of future self-harm and suicide-related behaviour. It is therefore necessary that clinicians working with people who experience self-harm and suicide-related behaviour use interventions that instil hope and allow those who experience self-harm to have a greater sense of agency in their recovery.

People who experience self-harm and suicide-related ideation often describe feelings of sadness, depression,

despair, helplessness, worthlessness, loneliness, guilt, despair and hopelessness (Radcliffe 2015; Pariante et al 2013; Subu 2006). It is the feelings of helplessness, hopelessness and despair that can lead to self-harm and suicide-related behaviour. It is imperative that clinicians involved in assessing people presenting with self-harm and suicide-related ideation, along with completing a full biopsychosocial assessment, instil hope and facilitate a sense of agency so that people believe there is something they can do to help such individuals to move forward, thereby directly addressing hopelessness and helplessness.

There is adequate evidence and training available for mental health practitioners to use safety planning interventions (Stanley and Brown 2018; STORM 2015). An eight-step safety plan has been in use in a number of Irish services, and is described in detail in the Review of the Operation of the Clinical Programme (HSE 2017).

As outlined in Stanley and Brown (2018), safety-planning intervention as part of a CBT intervention aimed at reducing suicide risk has been shown to be effective. It involves helping patients to identify what triggered the crisis, use skills to tolerate distress or regulate emotions, and, should the crisis not be resolved, how to access emergency care. The therapeutic interventions would look to ensure the safety of the patient by removing access to lethal means; initiate self-monitoring of the suicide-related thoughts, feelings and behaviours; target symptoms that are most likely to interrupt day-to-day functioning, as well as hopelessness and sense of isolation; reinforce the commitment to treatment and solidify the therapeutic relationship. Certain modifications have been found helpful for people seen in the Irish services.

Staff and service users have reported finding that focus on protective factors is more useful than focusing on reasons for living. A strengths perspective and solution-focused safety planning concentrates on identifying coping strategies and problem-solving as well as harnessing family and social supports. The therapeutic aim is to empower and target where possible the sense of hopelessness. The collaborative nature of developing a safety plan also ensures a sense of agency and self-efficacy, thereby addressing the sense of helplessness that people who experience self-harm and suicide-related ideation often describe.

The safety plan would show what coping strategies, external supports and triggers the service user has identified. Evidence recommends that the clinician and service user generate the plan together, and that the service user's own words are used in the written document. The collaborative nature of this intervention is essential to developing an effective safety plan (Stanley and Brown 2012, Shaffer and Pfeffer 2001).

The clinical alliance is the essential vehicle for delivering a potentially life-saving series of clinical interventions (Jobes 2009). To nurture this alliance, the practitioner takes the stance of working with the suicidal person to help resolve the problems and pain that drive the suicidal wish, rather than working against the person's plans for suicide. The practitioner validates that the person's emotions, behaviours, wishes and fears are understandable in the context of their experience. The validation is evidence of empathy. Through the safety planning, the person becomes the co-author of the safety plan that instils hope and agency.

Higgins et al (2015) state that risk assessment is only effective if it is followed by a safety plan. There is often a disconnect between the risk assessment process and the development of a safety plan. Gilbert et al (2011) and Woods (2013) found that, despite risk assessments being completed by nurses, the safety planning step was omitted or the strategies identified to support the person's safety did not correspond to the risk identified.

The co-production of a safety plan, following the identification of risk, is a critical step in meeting the objective of supporting the person and the clinician to maintain safety, while promoting the potential and priorities of the service user. It is the responsibility of the clinician to address the hopelessness, helplessness and despair that an individual presents with, following self-harm or with suicide-related ideation. Crisis theory also identifies this as an opportune time to bring about effective change.

> *It is timely that the NCP advises a shift in emphasis from using risk assessment tools to using collaborative safety planning. This is in keeping with the recovery ethos and supported by empirical evidence. The NCP recommends that all training curricula and clinical*

practice focus on assessment of need, and includes safety planning to address that need. Standalone and locally developed risk assessment tools should not be used. Clinical risk assessment processes should be improved, with emphasis placed on building relationships and on gathering good-quality information on the current situation, on past history and on the current social circumstances to inform a collaborative approach to management using safety planning.

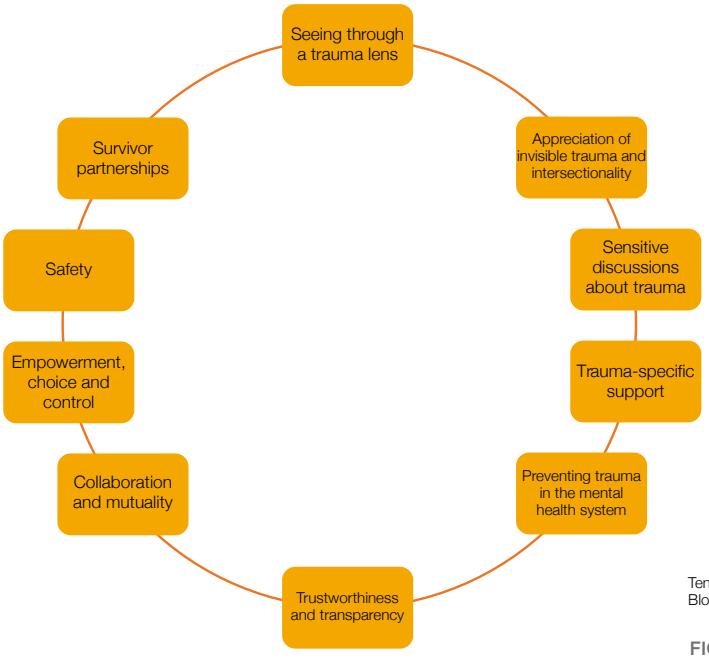
2.4 Trauma-informed approach

Research has consistently found that people using mental health services have experienced high rates of trauma in childhood or adulthood, and that these rates are higher than in the general population (e.g. Mauritz 2013). Furthermore, having a trauma history is associated with poorer outcomes for survivors, including a greater likelihood of attempting suicide, self-harming, longer and more frequent hospital admissions and higher levels of prescribed medication (e.g. Read 2007; Mauritz 2013). Sweeney et al (2018), in a comprehensive review of the subject, recommended that all mental health services adopt a trauma-informed approach. Many of the principles outlined by Sweeney et al, as outlined in Figure 2.6, overlap with the principles and values used in the NCP.

Trauma-informed approaches are based on a recognition and comprehensive understanding of the widespread prevalence and effects of trauma. This leads to a fundamental paradigm shift from thinking 'What is wrong with you?' to considering 'What happened to you?'

Rather than being a specific service or set of rules, trauma-informed approaches are a process of organisational change aiming to create environments and relationships that promote recovery and prevent retraumatisation. The skilled and supervised clinician should undertake an expert biopsychosocial assessment while using a trauma-informed approach.

The NCP should be delivered using a trauma-informed approach. Practitioners should ensure that they are informed on trauma-informed approaches.



Ten key principles of trauma-informed approaches (adapted from Elliot 2005; Bloom 2006; Substance Abuse and Mental Health Services Administration 2014).

FIG. 2.6 TEN KEY PRINCIPLES OF TRAUMA-INFORMED APPROACHES Adapted from Elliot 2005; Bloom 2006, and Substance Abuse and Mental Health Services Administration (2014) by Sweeney et al (2018).

2.5 Staff Supervision

2.5.1 Personal supervision

The role of the CNS, NCHD, Consultant and other mental health professionals working within the ED can be stressful. It is important they have access to both clinical and personal support. This minimises the risk of burnout or of developing compassion fatigue, both of which have been associated with poorer clinical outcomes (Hunsaker et al 2015).

Supervision of staff leads to improved management and care planning. Trauma-informed supervision involves a facilitated reflective group that recognises the impact of secondary traumatic stress (Applegate and Shapiro 2005). Sommer (2008) suggests that the specially trained supervisor should be alert to changes in workers' behaviour with and reactions to clients, intrusions of client stories in workers' lives, signs of burnout and feelings of being overwhelmed, signs of withdrawal in either relationships with clients or in the supervisory relationship, and signs of stress and an inability to engage in self-care. Sommer and Cox (2005) reported that trauma-sensitive supervision should include time for talking about the effects of the work and related personal feelings; directly address vicarious traumatisation, and use a collaborative, strengths-based approach.

Cultivating the practice of reflecting on one's own emotional responses to a client is an integral aspect to trauma-informed supervision. Negative reactions to suicidal individuals in counter-transference are well documented (Maltsberger and Buie 1996). The reactions of clinicians towards patients may result in feelings of incompetence, hopelessness, demoralization, hostility and/or withdrawal from emotional involvement with the client (Hunter 2015).

Balint groups are named after the psychoanalyst Michael Balint. In the late 1950s Balint and his wife began holding psychological training seminars for GPs in London. The group met on a weekly basis, encouraged doctors to discuss cases, and in a safe and supportive environment others were invited to respond to what they had heard.

Since publication on this work (Balint 1957), the Balint approach has flourished and has encouraged the development of reflective practice among GPs and psychiatrists.

Another approach to improving practice, which is used in psychotherapy, is the process of Self-Practice/Self-Reflection (SP/SR). It is a form of personal practice for cognitive behaviour therapy (CBT) that continues a long tradition of experiential group work for psychotherapists (Freeston et al 2019). SP/SR, originally proposed by James Bennett-Levy (2001), involves trainee cognitive behaviour therapists applying the CBT model to themselves and then reflecting on what they have learned by doing this, including reflections on the content, on the process and on how the theory relates to their experience. The rationale for this approach is that it is experiential and, therefore, provides insights that are unlikely to be gained from other training methods. SP/SR outcome studies indicate that the benefits to therapists include greater empathy (Davis et al 2015), enhanced conceptual skills (Haarhoff et al 2011) and improved confidence (Spendelow and Butler 2016). This approach could also be used for clinicians delivering the NCP in self-harm, giving them not only technical knowledge and expertise but also a direct lived experience of, for example, developing their own safety plan so they can develop further understanding and empathy when working with service users who experience self-harm.

- To ensure continued working in a genuine, empathic and compassionate manner, all services should ensure that practitioners have access to reflective practice and regular supervision, at a minimum every month, and increased at times of greater stress.

2.5.2 Clinical supervision

Every CNS, NCHD or health and mental health professional will work under the clinical leadership of a Consultant Psychiatrist. Each case must be discussed with a Consultant Psychiatrist. The timing of that discussion depends on the training and experience of the mental health professional.

One of the core clinical focus competencies of a CNS is to perform a nursing assessment and initiate care and treatment modalities within agreed interdisciplinary protocols to achieve patient-centred outcomes (NCNM 2008). In the NCPSH, the recommended protocol must include discussion of all patients with a senior decision-maker such as a Consultant Psychiatrist, Higher Specialist Psychiatric Trainee or Advanced Nurse Practitioner.

Non-consultant hospital doctors (NCHDs) provide assessments and interventions out of hours or within Community Mental Health work under the clinical supervision of a named Consultant Psychiatrist (CPsychI 2020). It is essential that NCHDs in psychiatry have exposure to a range of emergency assessments and are properly supervised to deliver the Clinical Programme (HSE 2017). NCHDs carrying out such emergency assessments should be in training with the College of Psychiatrists of Ireland (CPsychI 2020), while those in non-training NCHD posts should receive CPD-accredited training in delivering the NCPSH and evidence-based care (Irish Medical Council 2016). This is further addressed in Chapters 9 and 10.

> *It is recommended that all practitioners in their first six months in practice discuss a case with a consultant before they discharge the patient. Every mental health professional will also receive clinical and professional supervision from a clinician experienced in the area of self-harm.*

2.6 Brief contact interventions

Evidence has shown that offering a therapeutic assessment is associated with reduction in repeated self-harm and improved engagement with services (Kapur 2013). Interventions associated with improved outcomes include a written safety plan (Stanley and Brown 2018), input by next-of-kin or a supportive friend (Shea 2011), and follow-up and linkage to next care (WHO 2014, Ribnet 2019). Brief contact interventions such as post-discharge telephone calls have been shown to offer social support, improve suicide prevention literacy and assist in learning alternative behaviours (Milner et al 2016).

In 2016 a Cochrane review (Hawton et al 2016) found evidence that cognitive behavioural therapy (CBT) and dialectical behaviour therapy (DBT) led to a reduction in suicide rates in those who had previously self-harmed. This review noted the paucity of well-conducted randomised controlled trials.

NICE guidelines on the short-term treatment and management of self-harm are under revision (NICE 2004, 2011, 2020). These guidelines emphasise the importance of treating people who self-harm with the same care, respect and privacy as any patient. Healthcare professionals should take full account of the likely distress associated with self-harm. The latest update emphasises that people who repeatedly self-harm may have different reasons for self-harming on each occasion and therefore each episode needs to be treated in its own right. This is in keeping with recommendations from people with lived experience, with the aim of ensuring that reasons for self-harming are adequately explored (Palombini et al 2020).

Doyle et al (2020) published a qualitative review of service users' experiences in the ED following self-harm. It covered a period from 2013 to 2018 and thus included many EDs in which the National Clinical Programme was not implemented. Positive experiences related to a perception that the individual assessing was relaxed and unhurried and had a good understanding of the patient's needs. A number reported that their physical needs were dealt with but their emotional needs were ignored.

Similar experiences have been described in other jurisdictions. MacDonald et al (2020), in a systematic review of patients' experience, found three overarching themes in the literature: the construction and negotiation of the patient identity; the nature and quality of treatment perceived, and the perceived impact of treatment experiences on future self-harm disclosure and help-seeking. They found that across the treatment pathway, and irrespective of the level of suicidal intent, participants felt that their authenticity and legitimacy were questioned. This experience added to the sense of being a burden and reinforced the sense of worthlessness. Many patients referred to discrimination and in some cases hostility. They noted a focus on managing physical symptoms rather than addressing emotional needs. Where patients were offered individualised treatment that focused on the emotional experience of the self-harm, this legitimised their experience and made them more hopeful for the future. Finally, the review showed that those patients who had negative experiences in the ED were less likely to engage with mental health services in the future; in contrast, when emotional needs were met patients were ready to accept referrals to appropriate services. A significant theme throughout the review was the notion of feeling processed, in accordance with the regime within EDs, and a checklist approach to symptoms.

In other jurisdictions, including the UK, most self-harm assessments are commonly carried out by Clinical Nurse Specialists who specialise in liaison psychiatry or self-harm. A large study of almost 4,000 ED patients confirmed that psychiatrists and mental health nurses carry out similar risk assessments on patients following an episode of self-harm (Murphy et al 2010). Psychosocial assessment following self-harm is not necessarily profession-specific, and a service led by experienced nurses can be cost-effective for a health service (Russell and Owens 2010). The value in training multidisciplinary professionals to develop skills for working in suicide prevention has also been demonstrated (de Beurs et al 2015). Multidisciplinary approaches have the advantage of developing services from the perspective of multiple stakeholders, which is likely to be of benefit in relation to the complex needs of individuals presenting with self-harm (Carter et al 2016).

From both a clinical and financial perspective, Consultation-Liaison Psychiatry services are recognised nationally and internationally as being most effective for providing care to patients with mental health needs in acute hospital settings (Parsonage et al 2012). A central aspect of the work of Liaison Psychiatry services includes the assessment and management of patients who present to the ED with self-harm, and the training and support of ED staff in providing care to this group. The contribution of Liaison Psychiatry in achieving considerable savings of £4 per £1 spent and improving quality of care has recently been recognised (Tadros et al 2013.)

In the UK, the Liaison Psychiatry services are mostly provided by mental health trusts but serve acute hospitals. Some are provided by acute hospitals. In Ireland, there is a similar mixed picture, with some services funding a liaison team through the acute hospital, while in others funding is provided by the mental health service. Staffing arrangement has been described for optimum provision of care, with staffing levels and skills mix tailored to local factors, including size and complexity of the hospital, case mix and other local mental health services (RCPsych 2013). Reviews of services in the UK have identified the need for effective communication between primary care and liaison services and between liaison services and community mental health teams (Parsonage 2012, Aitken et al 2018).

A Liaison Psychiatry service provides assessment and management within the ED during the day; out-of-hours services are guided by the on-call Consultant Psychiatrist. Kapur et al (2016) noted the importance of the quality of the assessment in improving engagement with next appropriate services. Follow-up and bridging to next care has not been a component of traditional mental health services in the ED. Services would often signpost to next appropriate care without offering interim support. Stanley et al (2018) have shown that uptake of next-care appointments almost doubled when individuals were offered a written safety plan and a follow-up phone call (Stanley et al 2018).

In recent years there is increasing evidence supporting the use of safety planning in reducing repeat self-harming and suicide (Stanley and Brown 2012, 2018). Specific training in the use of safety planning is now incorporated into training on management of suicidality (Gask et al 2006, Arensman et al 2020).

Repeated studies have shown that people who have self-harmed or who present with suicide-related ideation want to share in the decision-making about their future care, with reasonable attention paid to their personal preferences (Claasen et al 2014). This can be achieved by providing each patient with a co-produced care plan.

A meta-analysis of randomised controlled trials on strategies to prevent death by suicide found three trials where WHO Brief Intervention and Contact was shown to result in a significant reduction in the numbers who died by suicide (Riblet et al 2019). A French study analysing the impact of telephone follow-up calls concluded that phone follow-up of outpatients after a suicide attempt is a protective factor against repeated suicide attempts (Exbrayer et al 2017).

> *People who present to health services following self-harm or suicide-related ideation should receive brief interventions in the form of empathic, validating, compassionate and trauma-informed response; a timely expert biopsychosocial assessment and intervention, including a written emergency safety plan, and follow-up and linkage to next appropriate care.*

2.7 Response to suicide-related and self-harm ideation

While it has been known for some time that people who self-harm have an increased risk of future death by suicide, recent evidence also points to increased risk for those who present with suicide-related ideation (Griffin et al 2019a). This evidence points to the need to standardise and improve responses for people who present with suicide-related ideation. People with suicide or self-harm ideation present to the ED although good practice would recommend they be assessed in the community. Many can be adequately supported by primary mental health services and will not require a referral to a specialist mental health service. This has been shown in Ireland with the Self-Harm Intervention Project (Gardner et al 2015). If they do require specialist mental health input, this can be from a mental health nurse, a CMHT or a central crisis assessment team (Dueweke et al 2018). In the UK, individual services provide a suite of responses for people in a crisis, including a 24-hour helpline, staffed by mental health professionals and open to patients and GPs, and a helpline for use 9–5 Monday to Friday, for people already known to services. GPs can receive a same-day crisis assessment for new patients and, in the rare cases where none of these services is available, the person is advised to attend the ED (NHS 2016a).

McGarry (2019) describes the development of specific self-harm and unscheduled care teams in Belfast, emphasising the need for separate services. He suggests that home-based treatments and 24/7 services are for people known to the service, and that they prevent the admission to hospital of people suffering from severe mental illnesses such as schizophrenia, bipolar disorder and severe depression. Others have also suggested that there is a need for a separate service for those with anxiety disorders and substance misuse, and those who have self-harmed in the absence of severe mental illness or are in crisis due to relationship difficulties (Onyett et al 2006).

In Ireland, information on access to such non-ED unscheduled care is sparse. A recent review of Suicide Crisis Assessment Nurses (SCANs) found that they were present in only eight of the country's 16 mental health services, and within these a SCAN service was only present in some sectors (Griffin et al 2019).

In the South East, the Self-Harm Intervention Project (SHIP) has been in place since 2004. Trained psychotherapists offer specialised non-crisis counselling to people who have self-harmed and to people with suicide-related ideation (Gardner et al 2015). The SHIP programme is provided within the context of a range of services, including SCAN, Community Mental Health Teams (CMHT), community counselling and other community supports. Services have been encouraged to develop 24/7 services for people known to the mental health services (HSE 2018a) and some services are using home-based teams to manage these crises (O'Keeffe and Russell 2019). Some services are providing crisis assessment teams (Feeney and Rossiter 2020), while a number of CMHTs provide same-day assessments, as described in Walsh et al (2013). *A Vision for Change* recommended establishing consultation liaison services with GPs, as described by Wright and Russell (2007).

Talking therapies such as a Counselling in Primary Care (HSE 2018) have been developed. These have no formal liaison with CMHTS but tend to refer people with suicide-related ideation to them. Collins et al (2020) describe a primary care psychology service in a rural Irish county that accepts walk-ins, self-referrals and health and social care referrals. It operates a stepped-care model of service provision whereby the least intensive form of intervention to meet the service user's needs is offered. This leads to a high volume of low-intensity interventions being provided and a smaller volume of high-intensity interventions. The various steps include brief assessment/consultation/signposting, guided self-help and brief (up to six sessions) CBT-informed psychological intervention. Assistant and trainee psychology students, supervised by a psychologist, provide the service. Input can be stepped up to provide senior psychologist input, or referral to secondary care mental health services (Collins et al 2020). Along with describing the service, this study also found that most of the individuals using the service wished to have a timely, positive interpersonal experience that addressed their individual concern. These factors were considered more important than the specific type of intervention offered.

Doyle et al (2020), in their qualitative review of 50 people who had presented to the ED following self-harm or with suicide-related ideation, found that a number of people presenting with suicide-related ideation experienced the ED environment as being unsuitable. They found it noisy and stressful, and

the long delay between registering and being assessed was particularly difficult. Individuals reported feeling they were in the wrong place and yet they were not aware of anywhere else to present when they had suicide-related thoughts.

Douglas and Feeney (2016) reported on the change in referrals to mental health services in the 30 years up to 2013. There has been a reduction in the proportion of referrals concerning psychosis and an increase in the proportion deemed urgent and that were concerned with suicidal risk. Suicidal ideation was mentioned in 14% of referrals in 1983 and in 50% of referrals in 2013.

Since the establishment of the Clinical Programme in 2015, over 40% of patients assessed have presented to the ED with suicide-related ideation only, while 60% presented following self-harm (HSE 2020). As resources in CMHTs are reduced, access to non-scheduled care from CMHTs has reduced, and, in the absence of other services, GPs are forced to refer individuals to the ED (Carey et al 2021). A small number of services in the country offer assessments in the approved centre, obviating the need for such patients to spend often long hours waiting in ED. Most services request that all patients attend ED first, where they are assessed by a mental health professional. Over 40% of these assessments are made out of hours by a non-consultant hospital doctor in psychiatry (HSE 2017).

While it is often quoted that over 90% of patients with mental health problems are managed in Primary Care, studies in Ireland, France and the UK have found that GPs refer between 60% and 80% of patients who have self-harmed to hospital (Fitzsimons 1997, Le Point 2004, Saini et al 2016). The complex and busy environment of ED is not the optimal environment for patients with mental illness or undergoing a psychosocial crisis. The ED is a place for undifferentiated presentations for all health conditions.

A Vision for Change (DoHC 2006) recommends that in-patient admission be coordinated and customised for each service user by the CMHT. The Mental Health Commission in its Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre (MHC 2009) stipulates that a) every approved centre have a protocol in place for dealing with urgent referrals from EDs and from primary care and b) every approved centre have in place a protocol for dealing with individuals who self-present or who present in the company of a relative, parent or guardian. The code recommends that admission should be planned, with individuals first assessed by primary care and then referred to a CMHT and that a person who presents as urgent or is a self-referral should be assessed as soon as practicable.

Non-ED crisis assessment services should be developed by all mental health services in Ireland.

2.8 Family/supporter interventions for people who self-harm or who have suicide-related thoughts

In the NCPSH Model of Care (HSE 2016) the need for family involvement has been clearly described. Once, Twice, Three times – STOP (O'Carroll 2012) – is used to emphasise the need to ensure response to suicide-related ideation or behaviour should be swift and follow national guidelines, two parties should be involved, the suicidal person and a nominated family member and a triangle of care and support for the person should include the health care providers, the person at risk and the family or supportive friend.

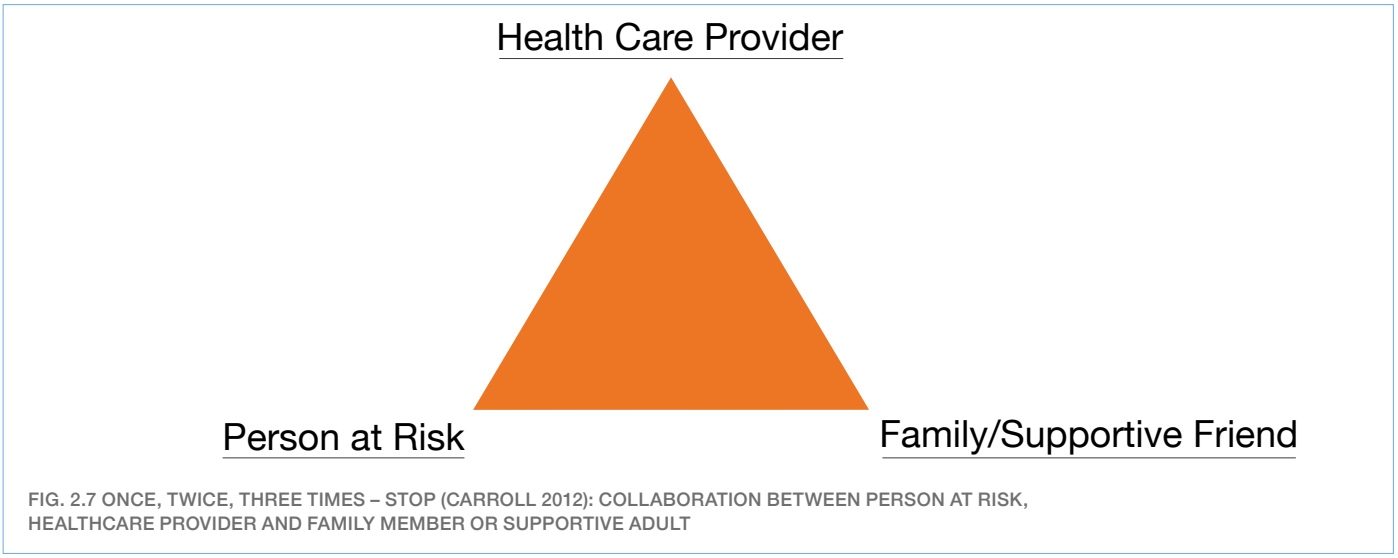


FIG. 2.7 ONCE, TWICE, THREE TIMES – STOP (CARROLL 2012): COLLABORATION BETWEEN PERSON AT RISK, HEALTHCARE PROVIDER AND FAMILY MEMBER OR SUPPORTIVE ADULT

Since 2012 further evidence has accumulated on the need to involve family members at both assessment and discharge planning. Family members are often the first to be contacted following a suicide attempt or an act of self-harm, whether they interrupt a deliberate act of self-harm or accompany the person to hospital and are involved in subsequent hospital care (Frey and Fulginiti 2017). According to Fulginiti et al (2016), the person with suicide-related thoughts generally confides in a family member, placing them in the position of reacting to and learning about the suicide-related behaviour. Hence, family members can be a valuable resource for healthcare professionals in providing collateral information to assist with risk assessment and care planning (Cerel et al 2008, Sellin et al 2017). It is noted that often people who are suicidal may not have family support; in that case, they may nominate a supportive friend to take the place of a family member. Anything that applies to a family member can also apply to a supportive friend. It is recognised that suicidal people do not always share their true intentions. Even in the context of the deepest clinical engagement, the actual intent to die may not be revealed (Shea 2011).

From a broad perspective of mental health, the positive effect that family support has on the person with mental illness is well documented (Fadden and Heelis 2011, Taylor et al 2015). Frey and Fulginiti (2017) found that family reaction to suicide-related behaviour is interpreted by the suicidal person as an indication that they are either a burden on the family or are supported by and belong within their family. The positive or negative reaction of the family member has a direct effect

on the person's recovery and whether they feel they can reveal their suicide-related thoughts and behaviour to a family member (Frey et al 2016). Similarly, Chiang et al (2015) found that positive reactions from family members towards the suicidal relative have positive outcomes in terms of enhanced relationships between them, thus enabling the family member to identify suicide-related behaviour and get help.

Although family intervention has been proven to be effective from the broader mental health aspect, specific research into its effect on self-harm and suicide prevention is limited (Frey and Cerel 2015, Prabhu et al 2010). Dialectical behaviour therapy, a treatment for people with emotional dysregulation and self-harming behaviour or suicide-related thoughts, includes family intervention from the perspective that the family can provide support and comfort to reduce inner tension in times of crisis (Fruzzetti et al 2006). This programme, known as Family Connections, has been developed in Ireland by DBT Ireland (Flynn et al 2017) and there are plans to develop it further. Families receiving very basic advice on keeping environments safe and validating an individual's distress has also been shown to provide support (Grant et al 2015).

Families have expressed their own need for emotional support, feeling burdened by the person's at-risk behaviour. Feelings of confusion, feeling lost and being excluded from the person's professional healthcare have been described by family members (Stewart et al 2018, Sellin et al 2017). This in turn causes isolation and a feeling of being powerless; they struggle to share everyday life with the suicidal person (McLaughlin et al 2016). In a study that surveyed 465 patients and 254 family members/friends who accompanied the suicidal person to an ED, 220 patients reported that a family member was with them in the ED (Cerel et al 2006). In response to a question about what was particularly helpful or hurtful, family members reported that receiving information about the care of their loved one was highly valued and that better communication of discharge plans and information on supports for families was needed. Lakeman (2010) cautions that, if the carer's needs are not addressed, their capacity to care for someone can be reduced. McLaughlin et al (2014) also identify the risk of burnout for these family members.

Prominent in the literature is the issue of confidentiality: the patient's right to instruct healthcare staff to withhold information from family, and the challenge of providing the family with sufficient information to enable them to provide the best support (McLaughlin et al 2016). Family members can experience a feeling of exclusion when confidentiality is viewed as a barrier to gathering important information from the family (Tillman et al 2017).

In an Irish study Wilson et al (2015) found that 56.3% of carers responding to an evaluative questionnaire stated that they have specifically encountered difficulties accessing information from the treating mental health team. The main reasons given were lack of patient consent (46.2%) and the unavailability of staff speak with relatives (46.2%).

In another Irish qualitative study of family members of patients who presented to the ED following self-harm, Dennehy (2020) found that relatives' paramount concern was their relative's safety. They wished to be involved at all stages of their relative's care. Many arrived at the hospital in shock and believed that hospital admission was needed to keep their relative safe. They all requested support and information if they were taking their relative home (Dennehy 2020).

Professor Patricia Casey has explored the issue of confidentiality in detail (Casey 2016). Recognising the importance of both providing information to carers and gathering information in order to make a full assessment of a newly referred patient or one who is acutely ill, she outlines the ethical dilemma that can arise when a patient refuses to agree to the gathering of information or the sharing of relevant information with carers. The quandary is between beneficence (doing good by respecting the patient's wishes) and non-maleficence (doing no harm by failing to collect or disclose vital information.) Part of the solution is the recognition that confidentiality is not absolute. This is recognised in the Professional Conduct and Ethics for Registered Medical Practitioners (Irish Medical Council 2019). Confidentiality can be broken against the wishes of the patient so as to protect the person, another person or the public, or when instructed by the courts. Failure to interview family members for collateral history could, Casey argues, in certain circumstances be construed as negligent. She points to the fact that those who are intent on suicide may

deliberately conceal this from the doctor and others may exaggerate symptoms for gain; in these cases, collateral information is mandatory to confirm the veracity of the history. The confidentiality rule does not extend to refusing to take telephone calls or neglecting to respond to communication from carers expressing concern. Listening is not precluded by confidentiality, even when a patient with capacity refuses consent to share information. In these circumstances, not only must the doctor listen to carers' concerns; if they are grave enough, the doctor should act on those concerns.

Casey concludes that managing confidentially should not be cast as a competition between patients and carers. Experience within the NCPSH has found that, when patients who self-harm or have suicide-related ideation are given time and an understanding of the importance of involving family members or a supportive adult in care, almost all patients will agree to this (HSE 2017).

The European Federation of Families of People with Mental Illness (EUFAMI) in a 2019 position statement in suicide prevention described the need to ensure that families are involved in the treatment and recovery process following a suicidal attempt by a family member. They make a number of recommendations on training and support for families (EUFAMI 2019).

The National Office of Suicide Prevention (NOSP) has produced a booklet for families or supportive friends to use in this situation, *Would you know what to do if someone told you they were thinking of suicide?* (HSE NOSP 2016).

While family support is important, there is also a need to be aware of the possibility of abuse within the family. Intimate-partner violence – defined as 'behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours' (WHO 2013) – has been shown to be associated with a number of mental and physical health problems (Dillon et al 2012). A number of studies have reported an association between the lifetime experience of intimate-partner abuse and increased self-harm, suicide-related ideation and suicidal attempts among women (Himelfarb et al 2006, Roche et al 2007, Sato-Dilorenzo and Sharpe 2007).

Intimate-partner violence and coercive control has also been shown to be associated with a range of mental health problems, including depression, post-traumatic stress disorder (PTSD), suicide-related ideation, substance misuse, functional symptoms, and the exacerbation of psychotic symptoms (Howard et al 2010a). Indeed, research has shown that there is a strong association between domestic abuse and mental disorder, with evidence of bidirectional causality (Trevillion 2014).

Mental health service users are at increased risk of domestic abuse, but their experiences are often undetected by mental health professionals (Howard et al 2013). Alongside the identified barriers to disclosure for victims of domestic abuse, Rose et al (2011) found that a major barrier to disclosure is that healthcare professionals do not ask service users about such matters. There are a myriad of reasons for this, including lack of confidence among staff, the focus on symptoms, and domestic abuse not being a priority in assessing and treating mental health difficulties (Howard et al 2010b).

There is evidence that women are more likely to disclose domestic abuse to a healthcare professional than to the police; women are assaulted an average of 35 times before they report domestic violence to the police (Yearnshire 1997). However, qualitative research in primary and secondary care has found that women may not disclose unless they are asked (Feder 2009, Rose 2011). Research shows that around 15% of women and 6% of men in Ireland have experienced severe domestic violence. Emerging evidence suggests that, globally and in Ireland, domestic violence has risen since the outbreak of Covid-19 (Doyle J 2020).

Domestic abuse is under-detected in services internationally, with only 10–30% of recent violence asked about and disclosed in clinical practice (Howard 2010b). Similar findings have been reported for primary care (Feder 2009). Findings from a recent Irish study, 'The Prevalence of Domestic Abuse amongst Service Users Attending an Adult Mental Health Service', found that 73% of participants had never been asked by a professional if they had experienced domestic abuse (O'Connor et al 2021).

Disclosure of domestic violence is facilitated by a good service user-professional relationship and is likely to be facilitated further by domestic violence training of professionals. Routine enquiry increases detection but needs to be introduced in the context of comprehensive training, and only where referral and care pathways have been developed (Waalen et al 2000). It is necessary to develop and evaluate clear care pathways, involving professions with specialism in this area such as social workers and domestic abuse agencies, to address this under-detected but potentially life-threatening issue. All clinicians should be aware of this and the need to provide each patient with personal time and space to be interviewed alone.

Gathering information from family members and supportive adults and providing family members and supportive adults with support is central to the NCPSH. Every effort should be made to provide the patient with a clear understanding of the value and importance of both gathering information from and sharing information with family members or a supportive friend. Confidentiality is paramount but there are situations where it can be breached. Even in situations where it is not appropriate to breach confidentiality, listening to family members/carers is important and is not precluded by confidentiality. Providing support for family members/carers is also important.

All clinicians should ensure that all patients are given the time and space to be interviewed alone. Before requesting family or supportive friend input, clinicians need to understand the relationship the patient has with their family member, being aware of the possibility of intimate partner or family abuse.

2.9 Summary and recommendations

- People who present following self-harm or with suicide-related ideation are at increased risk of dying by suicide in the future. Evidence supports the use of interventions in improving engagement with mental health services and reducing repeat self-harming.
- It is timely that the NCP advises a shift in emphasis from using risk assessment tools to using collaborative emergency safety planning. This is in keeping with the recovery ethos and is supported by empirical evidence. The NCP recommends that all training curricula and clinical practice focus on assessment of need, and include safety planning to address that need. Standalone and locally developed risk assessment tools should not be used. Clinical risk assessment processes should be improved with emphasis placed on building relationships and on gathering good-quality information on the current situation, on past history and on the current social circumstances to inform a collaborative approach to management, using safety planning.
- The NCP should be delivered using a trauma-informed approach. Practitioners should receive training on trauma-informed approaches.
- People who present to health services following self-harm or suicide-related ideation should receive brief interventions in the form of empathic, validating, compassionate and trauma-informed response; a timely expert biopsychosocial assessment and intervention, including a written emergency safety plan, and follow-up and linkage to next appropriate care.
- Non-ED crisis assessment services should be developed by all mental health services in Ireland. These include Crisis Assessment Teams and the use of Suicide Crisis Assessment Nurses (SCANs) to work with GPs.
- To ensure continued working in a genuine, empathic and compassionate manner, all services should ensure that practitioners have access to reflective practice and regular supervision, at a minimum every month, and increased at times of greater stress.
- All presentations should be discussed with a Consultant Psychiatrist. The timing of that discussion depends on the skill and experience of the mental health practitioner. It is recommended that all practitioners in their first six months in practice discuss a case with a consultant before they discharge the patient. Every mental health professional will also receive clinical and professional supervision from an experienced clinician in the area of self-harm.
- Gathering information from family members and supportive adults and providing family members/ supportive adults with support is central to the NCPSH. Every effort should be made to provide the patient with a clear understanding of the value and importance

of both gathering information from and sharing information with family members or a supportive friend. Confidentiality is paramount but there are situations where it can be breached. Even in situations where it is not appropriate to breach confidentiality, listening to family members/carers is important and is not precluded by confidentiality. Providing support for family members/carers is also important.

» All clinicians should ensure that all patients are given the time and space to be interviewed alone. Before requesting family or supportive friend input, clinicians need to understand the relationship the patient has with their family member, being aware of the possibility of intimate partner violence or family abuse.

03

Update on Services for People who Present to the Emergency Department following Self-Harm or with Suicide-related Ideation

3.1 Consultant Psychiatrist clinical supervision

Clinical Nurse Specialists (CNSs), other equally qualified mental health professionals and Non-Consultant Hospital Doctors (NCHDs), all of whom receive clinical guidance and supervision from Consultant Psychiatrists, deliver this programme. During the day this supervision is provided by Consultant Liaison Psychiatrists and out of hours by the on-call Consultant Psychiatrist. Consultant General Adult, Later Life and Child and Adolescent Psychiatrists also provide clinical guidance.

FIG. 3.1 CLINICAL COMPONENTS OF THE NCPSH

3.1.1 General adult, child and adolescent and older-life psychiatry services

It is the responsibility of all Consultant Psychiatrists to ensure that the NCPSH is fully implemented. Out of hours, all patients assessed by the CNS or NCHD should be discussed with the Consultant Psychiatrist on call. The timing of this discussion will depend on the experience of the CNS or NCHD. A core competency of all psychiatrists is the assessment and management of risk and need in those who have self-harmed. As educational supervisors and tutors of psychiatrists in training, all Consultant Psychiatrists should understand the NCPSH, including the values and evidence underpinning the NCPSH (as described in Chapters 1 and 2). The National Clinical Programme clearly states that the ED is not a suitable place for people who do not have emergency physical health needs, and that urgent or emergency mental health needs should be managed

outside the ED. Mental health crises take weeks, even months to develop; if community and specialist mental health services offer sufficient early intervention, emergency presentations can often be avoided.

All Community Mental Health Teams (CMHTs) should ensure that each of their patients has a crisis management plan in place, and that there is access to crisis assessments for both patients known to their services and new patients (*A Vision for Change*, DoHC 2006). The assessment of and intervention for any associated self-harm or suicide-related ideation should be delivered in a non-ED setting, unless there is an immediate physical injury or need, while meeting the standards outlined in the NCPSH.

The GP is the first point of contact for patients who self-harm or have suicide-related ideation. Such patients who present to their GPs should only be referred to the ED where there is an immediate physical need. The pathway of care for these patients is described in detail in Chapter 7.

3.1.2 Adult Liaison Psychiatry Services

The specialist Liaison Psychiatry team, including a consultant, non-consultant hospital doctors and psychiatric liaison nurses, provides mental health assessment and intervention for patients in the acute hospital setting. The current funding streams do not include out-of-hours cover, and so the specialist Liaison Psychiatry team are the first point of psychiatric contact for patients who present to the ED following self-harm or with suicide-related ideation during working hours only.(NCCMH 2016). These services have been well developed in the UK but not in Ireland (HSE 2016). For the last four decades in Ireland, the model in place has been that all patients who self-harm and present to the ED are referred to a psychiatrist for assessment and linkage to next appropriate care.

The NCPSH recommends provision of this service by suitably trained clinical nurse specialists (CNSs) or equally trained mental health professionals, and out of hours by

non-consultant hospital psychiatrists (NCHDs). The CNS is responsible for implementing the NCPSH, including providing assessments and follow-up for all patients, including those who are assessed out of hours by NCHDs. The recommended staffing is one CNS per 200 presentations of self-harm to the ED per annum. It is important that such CNSs are members of a Consultant-led Liaison Psychiatry multidisciplinary team and receive clinical supervision from a Consultant Liaison psychiatrist during working hours and from the on-call Consultant Psychiatrist if working extended hours (e.g. 8pm to 8am).

A Vision for Change (DoHC 2006) recommends having one multidisciplinary liaison psychiatry team, which should include at a minimum a consultant psychiatrist; a non-consultant hospital doctor; 2 clinical psychologists; 5 clinical nurse specialists, including 2 specialist behaviour nurse therapists or psychotherapists and 2 secretaries/administrators per regional hospital, or roughly 1 per 300,000 population, for every acute admitting hospital in Ireland. In 2006 there were 9 liaison psychiatry teams nationally. In 2021, there are 16 adult liaison teams – 7 in Dublin, 2 in Cork, 1 in Limerick, Galway, Drogheda, Cavan, Waterford, Sligo and Mayo. Letterkenny has funding agreed since 2015, but to date has been unable to recruit a consultant liaison psychiatrist. The number for Mullingar, Portiuncula and Kerry is 0.5 consultant liaison psychiatrist per acute hospital.

This leaves seven EDs that do not have input from a consultant in liaison psychiatry. CNSs and NCHDs provide assessments and each case is discussed with a General Adult Consultant Psychiatrist – either a Sector Consultant or the on-call Consultant. A designated Consultant Psychiatrist provides clinical governance. Experience has shown that the programme is well delivered by CNSs and NCHDs, with no significant difference between services that have fulltime Consultant Liaison Psychiatrists and those that do not (HSE 2017). Ongoing managerial support from the National Clinical Office has shown anecdotal evidence of a reduction of stress in CNSs following the introduction of a Liaison Psychiatrist, and an increased burden on CNSs working without a Consultant Liaison Psychiatrist at times of particular stress, such as during the Covid-19 pandemic. The programme now recommends that all services have input from a Consultant-led Liaison Psychiatry team.

3.1.3 Liaison mental health services for children

A Vision for Change also recommends that Child and Adolescent Liaison mental health services be provided for 300,000 catchment areas. Along with the full multidisciplinary teams in each of the three national children's hospitals, these services would provide liaison services to paediatric and general services. *A Vision for Change* recognised four categories of problems that require referral to child and adolescent liaison services: children and adolescents with chronic physical illness; those with chronic and medically unexplained somatic symptoms that have perpetuating and precipitating psychogenic factors; those who overdose and engage in deliberate self-harm and present to the hospital; and those with mental health disorders and coexisting physical illness.

This programme recommends that a child and family who present in crisis to an ED receive an assessment by a mental health professional who has timely access to clinical supervision by a CAMHS consultant on the phone.

Children in the three Dublin liaison services receive an immediate assessment following referral. In Tallaght and Crumlin, a small number of children, who are first presentations and deemed not to require further input from the community CAMHS team, will be followed up by the CAMHS liaison team. In Dublin EDs 16 and 17-year-olds present to adult acute hospitals. Mental health staff who assess these children do not currently have access to CAMHS consultant supervision. This programme recommends access to timely (before the patient leaves the ED) CAMHS consultant supervision over the phone, at a minimum.

In Limerick the community CAMHS has been developed over the past 19 years. The crisis nurse in ED will assess children at night, and the community CAMHS will provide assessments within 24 hours. The team uses a transdisciplinary approach, with one team member available for urgent assessments each afternoon. This person provides assessments in the ED during the day. This process has developed in the absence of a liaison CAMHS service. When a liaison CAMHS service is introduced, the ideal would be to continue to provide a team member for emergency assessments, who can carry out joint assessments with the ED-based liaison team member. This can facilitate separate

family and child assessments and also ensure there is access to a mental health professional who can follow up the child if required, along with a mental health professional who is working in the ED.

In Galway, the CAMHS consultants provide support and advice for the NCHDs or liaison staff who assess children. There is a rota system, and they provide on-call services to a number of hospitals in the area. There can be a delay in assessment during the day, while teams are in clinics. Individuals who are assessed will be linked with CAMHS within 24 hours.

In Dublin, funding has been secured to provide a CNS, working in the CAMHS team as a crisis intervention specialist. As part of this post, there would be a commitment to provide inreach to the ED in the local area. The Children's University Hospital, Temple Street and North Dublin could be used as a pilot, with joint meetings arranged to agree job description, clinical governance, training, policies and procedures.

3.2 Emergency Medicine Programme and the NCPSH

3.2.1 Interface between the NCPSH and the Emergency Medicine Programme

It is important to consider this NCPSH in the context of the ongoing transformation of healthcare services in Ireland, including fundamental restructuring of the emergency services.

The Emergency Medicine Programme (EMP), launched in June 2012, is the blueprint for emergency care in HSE, covering all aspects of governance and management of care and supporting standardised workforce models, processes, metrics and guidelines. Since 2012 there have been further developments in managing urgent and unscheduled care (Acute Medicine Programme and EMP 2020). These developments focus on the use of ED for emergency and undifferentiated presentations. A presentation with a problem clearly defined as the remit of a particular speciality can be referred directly for a non-ED assessment, such as the acute floor. This will apply in all medical specialties including psychiatry.

The overarching aim of the EMP is to improve the safety and quality of patient care in EDs and to reduce waiting times for patients.

Key initiatives of the EMP include:

a. The definition and development of Emergency Care Networks within a National Emergency Care System. The networks of EDs will be fully integrated with pre-hospital and hospital-based services, ensuring a standardised approach to the delivery of high-quality emergency care.

b. Increased consultant-provided care in EDs

c. Developing clinical guidelines

d. Developing roles for nurses including staff nurses, clinical nurse specialists, advanced nurse practitioners, therapy professionals, medical social workers and other members of the multidisciplinary team

e. Implementing new clinical governance structures and processes to ensure clear authority, accountability and responsibility across the emergency care system

f. Integrating implementation of the Emergency Medicine Programme with all relevant programmes, particularly the Acute Medicine, Surgery, Critical Care, Paediatrics, Medicine for the Elderly and Diagnostic Imaging

g. Achievement of 6/9-hour ED time targets, from time of presentation to admission or discharge of patients

The overarching aim of both Clinical Programmes is to improve the safety and quality of patient care in EDs and to reduce waiting times for patients. Both programmes recommend ensuring clarity of communication between the ED staff and the mental health staff who are providing psychiatric services. The aim should be to improve access to mental health when needed, and to ensure that all patients have access to medical care. Within each ED, we advise that the ED staff and the mental health staff – to include both liaison and general adult psychiatrists who provide out-of-hours mental health service – hold regular meetings (at a minimum three monthly) to promote development of collaborative work practices. They provide a forum to address issues such as developing shared protocols around referrals, behaviour causing disturbance, patient transfer, admissions and clinical responsibility.

Examples of the interface of this NCPSH with the Emergency Medical Programme include:

1. Equity of access for all patients, whether presenting to the ED with predominantly physical or with mental healthcare needs. This includes all patients requiring care following self-harm.
2. The use of a mental health decision tool at the point of ED triage (Post-Triage Mental Health Triage Tool) (HSE 2017a). This has been introduced in some EDs. Further training and support is required to ensure it is used in all EDs.
3. The development of good working relationships between ED and mental health services.
4. Adherence to the 6 and 9-hour time targets (allowing for fitness for assessments in certain situations – e.g. where drug or alcohol intoxication is present).
5. Mental health staff provide training for ED staff on mental health and self-harm awareness. This training should be developed and delivered in collaboration with people with lived experience.
6. The NCPSH recommends that all patients who present receive a timely expert biopsychosocial assessment of needs. In some cases those presenting may be reluctant to wait for such an assessment. It is the responsibility of the ED, working with the mental health staff, to develop a clear protocol on contacting these patients' GP and ensuring they have an opportunity to link with next appropriate care.
7. ED staff and mental health staff should work with NOSP in developing 'distress' or 'support ' cards for people in mental health distress, similar to those developed for persons presenting following a head injury. These cards would be useful to support individuals and family members in accessing next appropriate care.
8. ED and mental health staff working in the ED should obtain feedback on the experience of people who use the service. This can be facilitated through the Mental Health Engagement and Recovery Forums that are now present in each CHO.

3.2.2 Assessment rooms suitable for patients requiring a mental health assessment

The Model of Care (HSE 2016) recommends that all EDs have a suitable room for assessment of people who require a mental health assessment. This recommendation is aligned with Irish and UK best practice (DoH Design Council 2011, IAEM 2006). This room should provide a calming atmosphere and be equipped for assessments of patients whose mental illness increases their risk of harm towards themselves or others (NICE 2004).

The Psychiatric Liaison Accreditation Network (PLAN) has identified standards suitable for this assessment room. PLAN is an initiative of the UK's Royal College of Psychiatrists' Centre for Quality Improvement, in partnership with the Royal College of Physicians, Royal College of Nursing, College of Emergency Medicine and the mental health charity Mind (RCPsych 2020). Patient and carer representatives are integral to the setting of quality standards and accreditation of services. These standards developed in the UK have been recommended for adoption in Irish EDs (McCraith Report 2014, College of Psychiatrists of Ireland 2018, National Clinical Programme Model of Care 2016.) A national audit of assessment rooms found high compliance with these standards (Jeffers et al 2020).

Is located within the main emergency department
Has at least one door, which opens outwards and is not lockable from the inside
Has an observation panel or window which allows staff from outside the room to check on
the patient or staff member but which still provides a sufficient degree of privacy
Has a panic button or alarm system (unless staff carry alarms at all times)
Only includes furniture, fittings and equipment that are unlikely to be used to cause harm
or injury to the patient or staff member. For example, sinks, sharp-edged furniture, lightweight chairs, tables, cables, televisions or anything else that could be used to cause harm or as a missile are not permitted
Is appropriately decorated to provide a sense of calmness
Has a ceiling which has been risk-assessed
Does not have any ligature points

TABLE 3.1 STANDARDS FOR ED ROOMS FOR ASSESSING PATIENTS PRESENTING WITH MENTAL HEALTH PROBLEMS

3.2.3 Assessment of patients with mental health needs only

The complex and busy environment of ED is not the optimal environment for assessing patients with mental illness or psychosocial crisis. ED is a place for undifferentiated presentations for all health conditions. *A Vision for Change* (DoHC 2006) recommends that in-patient admission be coordinated and customised for each service user by the CMHT. The Mental Health Commission in its Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre (MHC 2009) stipulates that a) every approved centre have a protocol in place for dealing with urgent referrals from EDs and from primary care and b) every approved centre have in place a protocol for dealing with individuals who self-present or who present in the company of a relative, parent or guardian. The code recommends that admission be planned, with individuals first assessed by primary care and then referred to a community mental health team, and that a person who presents as urgent or as a self-referral should be assessed as soon as is practicable.

People with lived experience of self-harming or suicide-related ideation do not find the ED suitable for assessment (Doyle et al 2020). GPs do not find it a suitable environment (Carey et al 2021) and there is also evidence that patients assessed in the ED, rather than in the community, are more likely to be admitted to an approved centre when compared with people assessed in a community (non-ED) mental health setting (Gibbons 2012).

The experience of the Covid-19 pandemic has required many services to develop non-ED crisis assessment units in order to protect patients and staff from contracting Covid-19. This took the form of telephone triage, stand-alone crisis assessment hubs, or assessments within the approved centre.

In keeping with *A Vision for Change* and the Code of Practice of the Mental Health Commission, all services should develop acute assessment facilities outside of the ED.
If a patient with a well-differentiated mental illness and with no physical health needs presents to the ED, there should be a policy in place to ensure that person is redirected to a more appropriate place of assessment. This is consistent with all other differentiated medical presentations to ED, and with a parity of esteem approach.

It is the responsibility of the mental health services to provide an alternative to the ED for crisis assessments. A clear written policy should be in place in each ED describing how a person can be safely transferred to such a service. Barry et al (2020) have described service initiatives introduced during the Covid-19 pandemic, many of which include non-ED crisis assessment facilities. These should be continued in the post-Covid period.

3.2.4 Assessment of patients with both physical and mental health needs

For patients with both physical and mental health needs, both NCPSH and EMP promote the use of parallel assessments, whereby a mental health professional can work alongside ED staff or medical staff in meeting patients' needs. Access to mental healthcare should follow the same principles as access to any other hospital specialty and be guided at all times by the needs of the patient.

Timings of mental health assistance should be based on both the needs of the patient and the referrers rather than rules around whether the patient is able to participate in a full psychiatric assessment, often erroneously called 'medical clearance'. Even prior to interview, liaison psychiatry staff can give advice on the basis of past records, take collateral history from family or carers, support patients, advise clinical teams and plan appropriate timing for mental health interview. Mental health practitioners, usually clinical nurse specialists or non-consultant hospital doctors, should have received specific training and appropriate supervision. Mental health practitioners should discuss all presentations with a Senior Psychiatrist (Consultant or Higher Specialist trainee) or an Advanced Nurse Practitioner. The timing of that discussion depends on the training and experience of the mental health practitioner.

Interventions aimed at discouraging help-seeking are not effective, can be counter-productive and harmful, and should not be used. There is no place for inaccurate terms such as 'medically cleared', which have been used in the past to defer mental health assessments. These should be replaced with terms such as 'fit for assessment', 'fit for review' or 'fit for discharge' that can bring about an improvement in collaborative working and will improve the quality of the service the patient receives. The psychiatry service has an important role in guiding ED staff around management of patients who may lack capacity.

For parallel assessments to work effectively, patients whose care includes input from mental health teams while in the ED must remain under joint care of both the ED team and the psychiatry team. Liaison Psychiatry services do not have access to inpatient beds. If a decision is made to admit a person to the approved centre, the mental health services must continue to provide input until they leave the ED. Joint ownership will ensure that the patients' medical needs are addressed along with collaborative interdisciplinary working between mental health and ED staff in addressing patients' healthcare needs, including the management of safety needs and risks.

Alexander et al (2020) provide a detailed description of introducing process mapping from lean management into an Irish ED to improve the flow of patients with mental health problems. They found that process mapping addressed delays in patient flow, role confusion, duplication of work and communication difficulties. The process they describe would be an asset to any ED consultation liaison service.

3.2.5 Timely, expert, biopsychosocial assessment

Each person who presents following self-harm or with suicide-related ideation should receive a timely, expert biopsychosocial assessment. This assessment should be conducted by a clinical nurse specialist, social worker or non-consultant hospital doctor.

As well as being a thorough assessment of the individual's needs, this assessment should form a therapeutic connection. Collateral information should be obtained, with a person's permission, from family members, GPs and mental healthcare records.

Following this intervention, an emergency safety plan should be co-produced by the mental health professional in collaboration with the patient, and if possible with a family member or supportive adult. The patient should be given a copy of the emergency safety plan, a copy should be sent to their GP, and a copy should be retained in their notes.

CNSs employed by the mental health service and receiving clinical guidance from a Consultant Psychiatrist complete assessments during the day. They should be incorporated into the appropriate clinical governance of the mental health service. Ideally this is as part of the Consultant-led Liaison Psychiatry service. One CNS per 200 presentations per annum is funded through the NCPSH. This allows the CNS to complete the clinical role of providing assessments and follow-up phone calls, including for those assessed out of hours, along with their role in teaching, research and audit and supervision.

Appropriately trained Mental Health Social Workers (MHSWs) employed by the mental health services and receiving clinical guidance from a Consultant Psychiatrist can complete assessments. MHSWs are registered practitioners with CORU, Ireland's multi-profession health regulator. They must also engage in continuous practice development and hold a Level 8 or above on the NQAI framework. Social work in mental health seeks to address

the social and environmental factors affecting the individual's and family's mental health, working in partnership with the person and their family/support person. MHSW inform care planning on multidisciplinary teams in mental health, ensuring a psychosocial aspect and perspective to client care. MHSWs are ideally placed to provide individual assessment and also to add to the interdisciplinary working of the liaison team.

The NCPSH should be delivered 24/7. A patient presenting out of hours should have access to the same four clinical components of the NCPSH: they should receive an empathic, compassionate, trauma-informed and validating response; they should receive a timely, expert biopsychosocial assessment and intervention, including a written emergency safety plan; every effort should be made to involve family in assessment and safety planning, and the patient should be followed up and bridged to next appropriate care. The CNS will provide the follow-up phone call within 24 hours, but it is the responsibility of each assessing clinician, including the NCHD out of hours, to provide the Emergency Safety Plan, to send a letter to the GP within 24 hours and to send information and notes, as appropriate, to the next appropriate care. The CNS on duty the following day should be informed of the assessment.

On-call and crisis psychiatry is becoming very challenging for psychiatrists in training. Over one-third of trainees surveyed reported dissatisfaction with their experience on call, reporting poor training, overwork and lack of suitable facilities to see patients (O'Donovan et al 2020). It is the responsibility of the clinical director to ensure that the NCHD is supported to carry out all aspects of the NCPSH. This includes training, consultant supervision and, in some of the busier services, ensuring there is extra staff to provide support where required. A recent report of service innovations during Covid-19 provides helpful recommendations for services, including in the post-Covid period (Barry et al 2020).

NCHDs are invited to the training offered twice yearly for CNSs and mental health professionals delivering the NCPSH. The College of Psychiatrists of Ireland in collaboration with the NCPSH office has developed an e-module on the NCPSH (CPsychI 2021). NOSP, the NCP office and CPsychI continue to collaborate on delivering training.

3.3 The role of emergency safety planning in mitigating suicide risk

The risk of suicide is raised in any person who self-harms or presents to hospital with suicide-related ideation. The aim of the Clinical Programme is to introduce practices that mitigate this risk.

Self-harm and talking about suicide leads to understandable anxiety and distress among individuals and family members. The assessing mental health clinician needs to provide compassionate support and develop a therapeutic rapport in order to complete an expert assessment. Many individuals and their families will have an expectation that hospital admission may be required. In practice, most individuals will be treated within the community. Hospital admission will only be required for a very small percentage of people – those presenting with symptoms of psychosis or extreme agitation or hopelessness caused by mental illness.

Most people will not present an immediate risk of suicide, and yet on any actuarial assessment of risk they would have a high score, simply by virtue of having made a previous suicidal attempt or presenting with suicide-related ideation. We know that risk assessment tools cannot predict suicide (Chan 2016). We also know that, in the UK, most risk assessment tools used in services have not been tested or validated (Quinliven 2014) and it is likely that the same applies in Ireland. We also know that a preoccupation with risk assessment tools is often used to manage organisational risk and is not in the patient's best interest. Patients complain of feeling processed or partaking in a tickbox exercise when their risk is being assessed. Along with the expert biopsychosocial assessment, patients also want hope and support (Doyle et al 2020).

Brief interventions, such as follow-up phone calls, safety planning, cognitive behavioural therapy and dialectical behavioural therapy, have been shown to have benefit (Milner et al 2016, Stanley and Brown 2018). Knowledge of these different interventions is required to instil hope and explain future treatment plans. These should address the helplessness, hopelessness and despair the individual experiences, and at the same time acknowledge that during this crisis the person will be most open to change.

The brief treatment and crisis intervention model most frequently used in social work practice is the Albert Roberts Seven-Stage Crisis Intervention Model, which has similarities with safety planning. This model facilitates the clinician's effective intervening by emphasising rapid assessment of the client's problem and resources, collaborating on goal selection and attainment, finding alternative coping methods, developing a working alliance, and building on the client's strengths (Roberts 2005). Stages in the model include: assessing safety and lethality, rapport-building problem identification; addressing feelings, generating alternatives, developing an action plan, and follow-up. Building rapport is essential throughout this process. Here the therapeutic core conditions, as outlined by Carl Rogers' person-centred approaches, are used: genuineness, empathy, acceptance and caring, thus instilling hope and trust.

Evidence described in Chapter 2 shows it is now timely that the NCPSH advise a shift in emphasis from using risk assessment tools to using collaborative emergency safety planning. This is in keeping with the recovery ethos and supported by empirical evidence. The NCPSH recommends that all training curricula and clinical practice focus on assessment of need and include safety planning to address that need. Standalone and locally developed risk assessment tools should not be used. Clinical risk assessment processes should be improved with emphasis placed on building relationships and on gathering good-quality information on the current situation, on past history and on the current social circumstances to inform a collaborative approach to management using safety planning.

While the original Model of Care suggested that each person should have an Emergency Care Plan, now, in keeping with recovery principles, we advocate the use of Emergency Safety Planning, focusing on building a therapeutic relationship with the individual. We also emphasise the importance of including the family member or supportive adult, as shown in Figure 3.1.

The following suicide risk mitigation plan should be followed for each person presenting to the ED.

a) Ensure that the person receives an empathic, compassionate and validating response in the ED. This has been shown to improve trust and foster openness to receiving appropriate help.

b) Provide a timely, expert biopsychosocial assessment, ensuring that a family member or supportive friend is contacted to provide collateral information. If the patient does not give permission for this, every effort should be made to persuade them of the value of such input. A comprehensive biopsychosocial assessment will identify an individual's needs and strengths and point to the most appropriate next care.

c) This assessment is a therapeutic intervention in itself, providing support and validation, along with expert direction and the instillation of hope. Genuineness, empathy and acceptance are central to this.

d) Following the assessment, and where possible using family or supporter input, a collaborative emergency safety plan should be developed by the patient and the mental health clinician.

e) This emergency safety plan is aimed at co-producing, with the individual and their family member, a written plan for the following 24 hours. It should include how to provide a safe environment, who to contact in an emergency and what the next professional contact should be, while addressing what the individual needs to do, what the family member needs to do and what the service needs to do.

f) The case should be presented to the Consultant Psychiatrist on call. The clinician ensures that care is transferred to next appropriate care. The timing of this discussion with the Consultant Psychiatrist depends on the skill and experience of the clinician. The clinician ensures that the CNS in self-harm is aware of the case and the future care arrangements. It is the responsibility of the assessing clinician to ensure that the safety plan is completed, a letter is sent to the GP and, if required, notes are sent on to the next service.

g) Within the following 24 hours, the person should be contacted by phone by the CNS in self-harm to review the safety plan and confirm any further appointments.

h) In some cases, 2 or 3 follow-up appointments may be required, to facilitate engagement in next appropriate care.

Patient's Name: **Date of Birth:**
Mental Health Professional (MHP) Name:
ESP completed in collaboration by the MHP and the patient: **Yes ❑ No ❑**
Family member/supporter has been part of the care plan: **Y ❑** N ❑

	RESPONSES	**ACTIONS**
Keep safe	Individual Family member/supporter GP /SCAN	*(e.g. Remove firearms, tablets, means of self-harm. Stay with relatives/supportive friend. Identify internal/personal coping strategies.)*
Emergency numbers		*(Include numbers for Samaritans 116123; daytime numbers for CMHT and GP; and for supportive family members or friends who can be contacted in an emergency.)*
Mental Health Support		*(e.g. Name of place and phone number for next appointment; plan for what the next communication will be with the patient.)*

Patient has requested family member is not included: **Y ❑** N ❑
Family member given a copy of *Would you know what to do if someone told you they were suicidal? (NOSP)*: Y❑N❑
Copy of the ESP given to the patient: **Y ❑** N ❑
Signed (MHP)
Signed (Patient – *optional*)

FIG. 3.2 EXAMPLE OF AN EMERGENCY SAFETY PLAN

3.4 Family/supportive friend intervention

An important objective of the Clinical Programme is to enhance the experience of families in supporting their relative. This includes the mental health professional taking collateral information from family members, providing advice on suicide prevention and, with patient consent, informing family members of the care plan. If the patient is discharged home, the CNS provides brief follow-up support, up to three times, by phone or in person to the patient and the family member between ED assessment and the time they reach the next point of care – for example, the GP, mental health team or a counselling service. Underpinning this model is the triangle of care of the person at risk, the family member and the healthcare professional.

and support to family members and to take any collateral history a family may wish to give. Specific training on confidentiality is required for all staff, including ED staff.

The Emergency Safety Plan should be produced with the individual and their family member/supportive adult. This is a written plan for the following 24 hours. It should include how to provide a safe environment, whom to contact in an emergency and what the next professional contact will be. It should address what the individual, family members/ supportive friend and the service need to do.

Family members or supportive friends will require support in their own right. It is appropriate that clinicians provide time for family members or supportive adults to be interviewed alone.

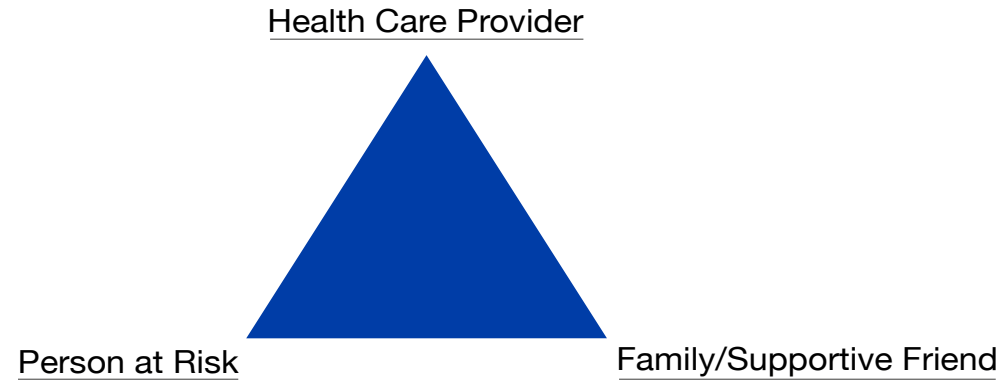


FIG. 3.3 ONCE, TWICE, THREE TIMES – STOP (CARROLL 2012). COLLABORATION BETWEEN PERSON AT RISK, HEALTHCARE PROVIDER AND FAMILY MEMBER OR SUPPORTIVE ADULT

Gathering information from family members and supportive adults and providing them with support is central to the NCPSH. Every effort should be made to provide the patient with a clear understanding of the value and importance of both gathering information from and sharing information with family members or a supportive friend. Listening to family members/carers can be essential and is not precluded by confidentiality. While confidentiality is paramount, there are situations where the level of risk requires that a family member or carer must be contacted for further information. Clinicians can provide support for family members/carers without breaching patient confidentiality. ED staff should be able to access a mental health professional to provide advice

However, it is also important to be aware of the risks of possible abuse by family members. A number of studies have reported an association between the lifetime experience of intimate partner abuse and increased self-harm, suicide-related ideation and suicidal attempts in women (Dillon et al 2012). All clinicians should be aware of this and the need to provide each patient with personal time and space to be interviewed alone.

3.5 Summary and recommendations

- The mental health services should ensure that the NCPSH in the ED is delivered 24 hours a day 7 days a week.
- The four clinical components – an empathic response, an expert assessment and intervention, family/supporter involvement, and follow-up and bridging to next care – should be offered to all patients who present following self-harm or with suicide-related ideation.
- The NCPSH is led by Consultant Psychiatrists and delivered by a CNS, MHSW or NCHD.
- It is the responsibility of the Clinical Director to ensure that the NCHD is supported to carry out all aspects of the NCPSH. This includes training, consultant supervision and, in some of the busier services, ensuring extra staff to provide support where required.
- On-site liaison mental health services should be provided by one multidisciplinary Liaison Psychiatry team, as recommended in *A Vision for Change*. This includes all Model 4 and Model 3 hospitals.
- Access to liaison mental health services should be provided in all hospitals. In smaller hospitals this would include a 0.5 WTE Consultant Psychiatrist providing clinical leadership to a smaller team.
- In the interim, in those acute hospitals where Liaison Psychiatry services are not available, the area mental health service should fund appropriate Consultant Psychiatrist time to provide coordination of the mental health service available for patients presenting to the ED following self-harm or with suicide related ideation.
- Child and Adolescent Liaison mental health services should be provided by one multidisciplinary liaison psychiatry team, as recommended in *A Vision for Change*. This may be on-site services in the larger hospitals and in-reach provided by community-based CAMHS teams.
- The Area Mental Health service should fund appropriate Consultant Child and Adolescent Psychiatrist time to coordinate the mental health service available to children in the ED and general hospital who present with suicide-related ideation or self-harm.
- All Consultant Psychiatrists should ensure they have a working knowledge of the NCPSH and that all patients, including those presenting out of hours, receive all clinical components.
- The mental health team should provide regular training for ED staff on mental health and suicide awareness.
- The Post Triage Mental Health Triage tool should be introduced in each ED. Training is required for ED staff.
- Parallel assessments addressing both mental health and physical health needs should be usual practice.
- Joint responsibility between ED teams and the mental health teams for patients in the ED will provide improved outcomes.
- Regular meetings between the ED staff and the mental health staff providing consultations in the ED should occur to address issues related to assessments, admissions and clinical responsibility of patients.
- ED staff and mental health staff working in the ED should use attendance at the local HSE Mental Health Engagement forum in order to obtain feedback from people who use the service.
- Connecting for Life Local Implementation Plans should include input from mental health staff working in the ED and in SCAN service.
- In keeping with *A Vision for Change* and the Code of Practice of the Mental Health Commissions that all services develop acute assessment facilities outside of the ED.
- Each patient presenting to the Emergency Department following self-harm should be treated with respect and compassion. They should receive an empathic, compassionate, trauma-informed and validating response.
- Each ED should ensure there is high-quality, dedicated accommodation for the assessment of patients with mental problems.
- Each mental health service should ensure there is a clear pathway to transfer patients to a non-ED facility for mental health assessment, where there is no physical health problem and the need for mental health care is clearly differentiated.

- Each patient should be seen in a timely manner by ED staff and by mental health practitioners (usually CNSs or Psychiatrists).
- The interview should focus on developing a therapeutic alliance to instil hope and trust. Genuineness, empathy, acceptance and caring are central to this.
- Standalone and locally developed risk assessment tools should not be used. Clinical risk assessment processes should be improved with emphasis placed on building relationships and on gathering good-quality information on the current situation, on past history and on the current social circumstances to inform a collaborative approach to management using safety planning.
- Each presentation should be discussed with a senior Psychiatrist (Consultant or Higher Specialist Trainee) or Advanced Nurse Practitioner. The timing of that discussion depends on the training and experience of the mental health practitioner.
- An Emergency Safety Plan should be co-produced by the patient, a family member or supportive adult and the mental health clinician.
- This Emergency Safety Plan is aimed at co-producing, with the individual and their family member, a written plan for the following 24 hours. It should include how to provide a safe environment, who to contact in an emergency and what the next professional contact should be, while addressing what the individual needs to do, what the family member needs to do and what the service needs to do.
- The Emergency Safety Plan should include a safe environment, emergency numbers and plans for next care appointment.
- Every effort should be made to involve a family member or trusted adult in assessment and in safety planning.
- Family member/supportive friend should co-produce the emergency safety plan, along with the patient and the mental health clinician.
- Family members/supportive friend should be supported in supporting their loved one, including being given a copy of Would you know what to do if someone told you they were thinking of suicide?
- Confidentiality is paramount but there are situations where it can be breached, such as risk to the individual. Even in situations where it is not appropriate to breach confidentiality, listening to family members/carers is important and is not precluded by confidentiality.
- Support for family members/carers can also be provided without breaching confidentiality.
- ED staff should be able to access a mental health professional to provide advice and support to family members and to take any collateral history a family may wish to give.
- Specific training on confidentiality is required for all staff including ED staff.
- All clinicians should be aware of the possibility of intimate partner violence and the need to provide each patient with personal time and space to be interviewed alone.

Training and governance are discussed in more detail in Chapters 9 and 10.

04

Child and Adolescent Services for Children with Self-harm and Suicide-related Ideation

4 .1 Literature review

Self-harm, defined as intentional self-poisoning or injury of oneself irrespective of motivation or intent is a widespread behaviour among adolescents (Hawton et al 2012). A recent review of 172 adolescent community samples reported a mean lifetime prevalence of 16.9%, as well as a concerning trend of prevalence rates increasing in recent years (Gilles et al 2018). Engagement in self-harm typically begins between 12 and 13 years old, peaks around 15 and 16 years and decreases in older adolescence and adulthood (Moran et al 2012). There is evidence that adolescents and young adults who engage in non-suicidal self-injury are at increased risk of subsequent suicidal ideation, suicide attempts and death by suicide (Castellvi et al 2017). In an Irish study (Griffin et al 2018), rates of self-harm among adolescents increased over a 10-year period from 2006 to 2016, and the age of onset of self-harming was lower than previously, with the increase more pronounced among females and those aged 10 to 14 years.

Ireland had the 7th highest rate of suicide for 15-19 year-olds in the 28 European Union countries in 2014 (Eurostat Comparison Data 2015); in 2018 the rate was recorded as 15th highest (Eurostat 2018) despite the fact that rates in Ireland have not changed. In the SEYLE (Saving and Empowering Young Lives in Europe) study on European adolescents, McMahon et al (2017) gathered information on their lifestyle and mental health, and identified measures that effectively improve adolescent mental health and reduce suicidal thoughts. In Ireland, 1,112 adolescents from 17 schools in the Cork and Kerry region participated in the SEYLE study. While the majority of the Irish sample reported high levels of wellbeing and low levels of risk behaviours, 23.7% had anxiety symptoms suggestive of a possible disorder and 13.8% had depressive symptoms suggestive of disorder. Serious suicidal thoughts were reported by 7.0% of the adolescents and 3.6% reported having attempted suicide at some time in their lives. Rates of suicidal thoughts and behaviour were very similar for boys and girls.

The SEYLE trial identified one school-based intervention, Youth Aware of Mental health (YAM), which was associated with a significantly lower number of subsequent suicide attempts and suicidal ideation compared to the control intervention (Wassermann et al 2015). YAM is a brief, universal mental health awareness programme that was delivered in the classroom over a four-week period. It includes role-play sessions, interactive lectures and workshops. The programme aimed to improve the mental health literacy and coping skills of young people, to raise awareness of risk and protective factors associated with suicide, and to enhance young people's knowledge of mental health issues such as depression and anxiety. The use of YAM confirms the role of coping strategies on suicidal ideation (Kahn et al 2020).

A stated objective in the Department of Education and Skills Action Plan for Education (2017) is 'to improve services and resources to promote wellbeing in our school communities to support success in school and life' (DES 2017). The end-of-year review noted: 'The theme of wellbeing is evident in the curriculum at all levels, early years, primary and post-primary'. Successive Education Action plans have continued to promote wellness; this is further supported in *Wellbeing Policy Statement and Framework for Practice* (DES 2019). Support continues from the National Educational Psychological Services (NEPS) (DES 2010). CAMHS provides more specialist services. Ahern (2018) has shown the cost-effectiveness of introducing school-based programmes.

In 2017 the NSRF reported that self-harm was rare among 10-14-year-olds, but the incidence of self-harm increased rapidly over a short age range. The rate for female self-harm is significantly higher than the male rate among 15-19-year-olds.

Griffin et al (2018) have analysed self-harming behaviour in 10 to 25-year-olds over a 10-year period.

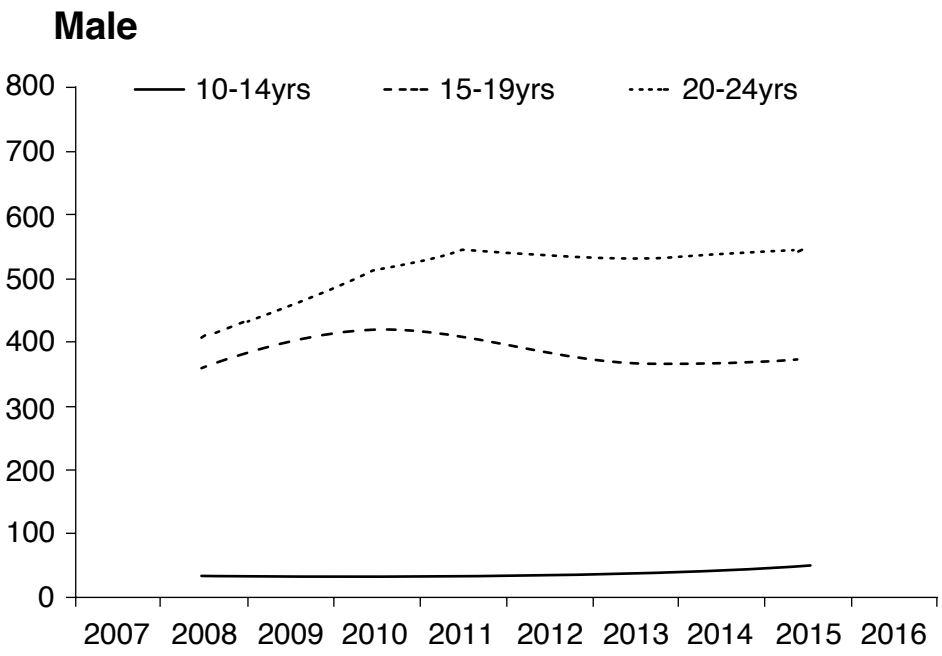


FIG. 4.1 RATE OF SELF-HARM IN IRELAND 2007–¬2016 – MALES (GRIFFIN ET AL 2018)

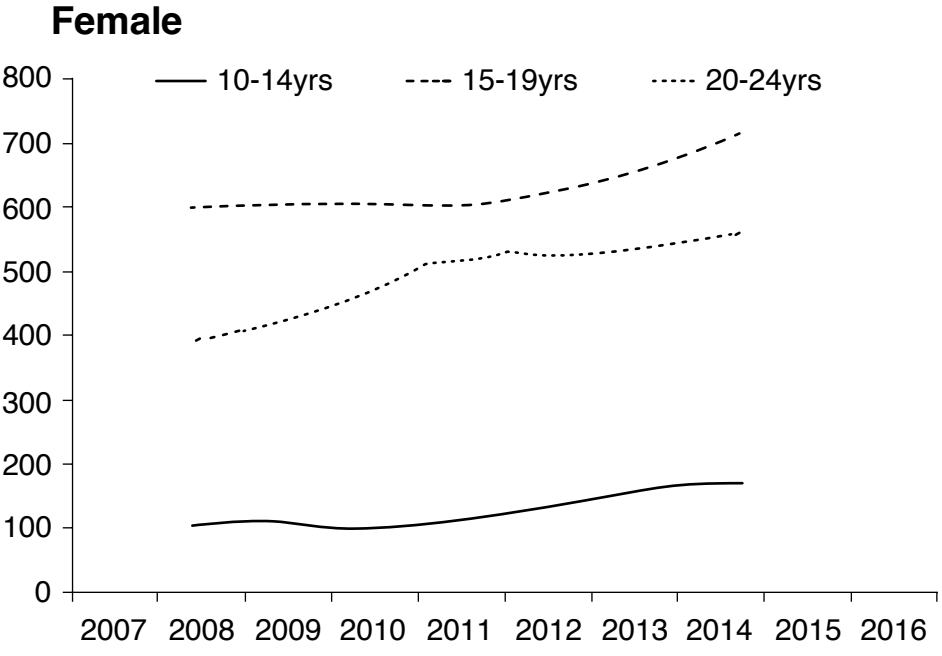


FIG. 4.2 RATE OF SELF-HARM IN IRELAND 2007–2016 – FEMALES (GRIFFIN ET AL 2018)

These numbers are rising. In 2019 in Ireland, 561 children aged 10 to 14 years presented to Irish EDs following self-harm (Griffin et al 2019a). In the same period, 2,202 young people aged from 15 to 19 presented. Presentations in Dublin accounted for 40% and 42% of presenting cases. Outside Dublin, numbers presenting to the ED in these age groups are below one per week and in some services are below one per month. Anecdotal evidence shows that schools, GPs and CAMHS are reporting an increase in minor self-harming behaviour that is not presenting to the ED. This is significant considering that Bennardi et al (2016) has shown the increased suicidal risk in children and young people who engage in self-harm behaviour.

Fitzgerald et al (2020) found a 526% increase in mental health presentations to one of the Irish paediatric EDs over a 10-year period, from 2006 to 2016. A detailed analysis of presentations in 2014 found that the most common presenting complaint was for suicidal ideation at 34.7% (n=103), followed by self-harm at 31% (N=92). Lynch et al (2017) found that, in another paediatric hospital in Dublin over a six-month period, 52% (n-44) engaged in self-harm behaviour, and that almost half of those presenting (46% n=50) were known to CAMHS services.

Presentations to hospitals of self-harm and suicidal ideation in Ireland are just the tip of the iceberg (McMahon 2014). Using coronial and Self-Harm Registry records and a community survey of adolescents, McMahon et al found that, for every boy who died by suicide, 16 presented to hospital and 146 reported self-harm in the community. For every female suicide, 162 girls presented to hospital with self-harm and 3,296 reported self-harm in the community.

Supporting children who self-harm and those with suicide-related thoughts is complex and will not be managed by general practice or the ED alone.

In the UK, the Thrive Framework (Wolpert et al 2019) provides a set of principles for creating coherent and resource-efficient communities of mental health and wellbeing support for children, young people and adults. In Ireland, the Youth Mental Health Task Force Report (DoH 2017a) provides a similar framework for Ireland.

The NICE guidelines recommend that all children or young people who have self-harmed should normally be admitted overnight to a paediatric ward and assessed by a mental health professional the following day, before discharge or further treatment and care is initiated. Alternative placements may be required, depending on the age of the child, circumstances of the child and their family, the time of presentation to services, child protection issues, and the physical and mental health of the child. This might include a child or adolescent psychiatric inpatient unit where necessary (NICE 2011). It is also recommended that training for staff who work with children who self-harm should follow the same principles as for adults who self-harm, but should also include a full assessment of the family, their social situation, and child protection issues. The need to admit all children who self-harm to a paediatric ward is no longer fully supported. A recent meta-analysis of therapeutic interventions for self-harm and suicidal ideation in adolescents indicated that currently available treatments were effective in treating self-harm and suicidal ideation, including treatment as usual in child and adolescent mental health services (Kothgassner 2020). Specific interventions such as DBT-A and family-centred therapy showed small to moderate effects compared with treatment as usual, but these differences were statistically significant and clinically important. The authors suggested using a stepped care model, with expensive and poorly available treatments targeted at young people who need them most. As with adults, Hawton et al (2015), on completing a systematic review of interventions for children and adolescents, pointed to the need for further studies.

Ougrin et al (2018) have compared the effectiveness of an intensive community-supported discharge service versus treatment as usual. They reported a reduction in repeat self-harming with intensive community support, and suggested that this may be an alternative to hospital admission.

In the UK there are examples from individual services that have used the Thrive Framework to change how they support children in crisis. These services include crisis admission avoidance services (Hope NHS Surrey and Borders Partnership Trust) and CAMHS crisis, liaison and intensive home treatment (Tees, Eske and Wear Valleys Trust).

In Ireland, a number of services are available for children, as outlined in the National Clinical Programme for Paediatric Healthcare (HSE 2020) (Figure 4.3).

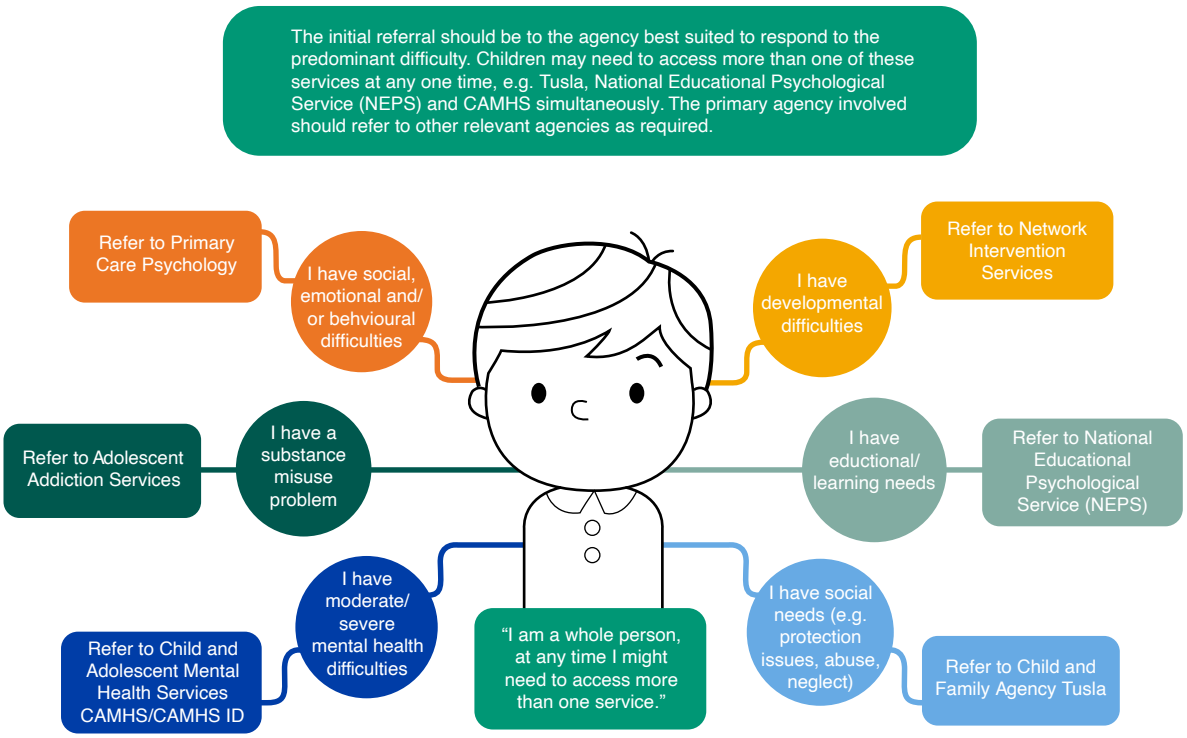


FIG. 4.3 GUIDELINES FOR GPS AND PRIMARY CARE TEAMS REFERRING CHILDREN AND ADOLESCENTS WITH SOCIAL/EMOTIONAL/BEHAVIOURAL/DEVELOPMENTAL DIFFICULTIES

Despite recommendations in *A Vision for Change* (DoHC 2006) on expanding both liaison and community child and adolescent services, in practice this has not happened. A review by Professor Fiona McNicholas noted the increasing numbers of children presenting to EDs either with suicidal ideation or following self-harm (McNicholas 2018). She put a case for increasing the child psychiatrist-led liaison teams, as recommended by *A Vision for Change*. It recommends having two child and adolescent community mental health teams (CMHT) for a 100,000 population, while one child and adolescent CMHT should also be provided in each catchment area of 300,000 to provide liaison cover. It also recommends that these liaison teams develop clear links with primary and community care services and identify and prioritise the mental health needs of children in each catchment area.

McNicholas (2018) outlined the current challenges in CAMHS services. She described CAMHS as fragmented, over-stretched and under-resourced, with staffing levels well below recommended levels. In 2019, there were 2,700 children on a waiting list, with 14% of these waiting longer than 12 months (McNicholas 2019). CAMHS understaffing is not limited to funding issues, but also to recruitment challenges in all professionals groups. McNicholas quoted national print media concerning staff burnout, consultant resignations and services being viewed as 'untenable', while clinicians reportedly perceived themselves to be placed in 'ethically compromising situations' by virtue of inadequate resources. This seems understandable given the reverse trend in overall budget funding for mental health services. The budget for mental health services has decreased from 13% of the overall health spend in 1984 to the current 6% (DoH 1984, HSE 2020a).

A Joint Committee on the Future of Mental Health Care (Oireachtas Report 2018), established in 2017, took evidence from practitioners and families regarding the state of CAMHS (Ombudsman for Children 2018). It produced a concerning report detailing inadequacies in provision of care. The essence of the report was that children were being 'abused' through neglect in the provision of adequate mental health services (Oireachtas Report 2018). Timely access to both community outpatient and in-patient CAMHS was recognised as problematic. Even for cases known to CAMHS, lack of out-of-hours services required many to attend EDs at times

of crisis 'because there was nowhere else to go'. For some, crisis presentations resulted in inappropriate admissions to adult mental health wards.

In the absence of sufficient community and specialist services, McNicholas (2018) suggested that EDs may be the most appropriate places to manage crises, noting that a rapid mental health assessment allows onward referrals to the appropriate services and interventions, maximising health gains and reducing the risk of deterioration while sitting on an inappropriate list. Assessments are often conducted on the same day, and, if admission is required, it is brief. This model may be of value in some areas, but the key issue is to ensure that all children who self-harm or who present with suicidal ideation receive a timely biopsychosocial assessment. The location of this assessment will depend on local resources.

Other child psychiatrists have noted the benefits of one professional from the CMHT visiting the child in the paediatric hospital, either on the same day or within 24 hours. The Model of Care for Paediatric Healthcare (HSE 2020b) identifies the need for timely access to liaison psychiatry and CAMHS for high-quality, safe emergency care.

Discussions with both community-based and liaison child and adolescent psychiatrists have identified a number of challenges to providing this high-quality and safe emergency care. In Dublin, ED assessments take up an increasing amount of the paediatric liaison team's time, accounting in some cases for 80% of the workload. Many presentations are already known to community CAMHS (cCAMHS). Liaison teams provide a quick response to ED presentations. In the Children's University Hospital, Temple Street, about 40% are admitted overnight. This number is higher in Crumlin and Tallaght, where there is no psychiatric liaison service after 5pm, and a limited service at weekends. Referral to next appropriate care can be a challenge; not all children require input from a cCAMHS team, and thus hospital-based teams need knowledge of all community-based services. Increasingly, GPs are referring children to EDs in order to bypass waiting lists in CAMHS, or because services in primary care do not have the training or staffing to support young people who self-harm (Lynch et al 2017). Outside Dublin, where teams are resourced based on recommendations from *A Vision for Change*, children will be seen by cCAMHS teams within 24 hours. Where teams are poorly resourced, they do not provide advice to ED or mental health staff and cannot provide immediate CAMHS appointments. As a result children can be waiting a number of days for a mental health assessment (HSE 2017).

There is no dedicated CAMHS liaison team outside Dublin. A Consultant Liaison Child Psychiatrist has been appointed in Cork and is awaiting appointment of a team. In many services children requiring assessment in the ED wait until cCAMHS can offer assessment. Even where cCAMHS teams are well-resourced, there is a difficulty providing staff to assess emergencies in the ED, due to geographical spread. *A Vision for Change* recommended that the CAMHS teams prioritise the mental health needs of children in the catchment area; this would include the needs of children in a general hospital.

Children with mental health and intellectual disability, those with complex neurodevelopmental disorders and children in care present a number of challenges in management and require multiagency input.

4.2 Service requirements

All children who self-harm or present with suicidal ideation should have access to all four components of the Clinical Programme, as described in Chapter 1. They should receive an empathic, compassionate and validating response; they should receive a timely expert biopsychosocial assessment, including a written, collaboratively developed emergency safety plan; all efforts should be made to involve family members in both assessment and in safety planning, and the children should be followed up and linked to next appropriate care, through telephone and if required in person support.

The Model of Care (2016b) states the following in regard to children up to 18 years:

> *Timely access to Mental Health Services must be available at all times for children attending the ED with a mental health crisis. Each major ED should have defined access to assessment by Child and Adolescent Mental Health Services (CAMHS) through a simple referral procedure. This should be dedicated Liaison CAMHS*

supported by the on-call CAMHS. This service should be accessible 24/7 via a single point of contact. The service responsible for assessment of children up to the age of 18 in the ED should be explicit. Consent should be obtained for mental health assessment from the parent or guardian.

Children aged 16 and 17 years who have engaged in self-harm are assessed in an adult ED setting. Those under 16 years are assessed in paediatric ED in Dublin. Of note, the requirement for 24/7 accesses to emergency generic social work cover is of highest relevance to this age group. It is essential there should be access to social work services in all emergency departments, including out of hours and weekend cover.

The NICE guidelines recommend that all children or young people who have self-harmed should normally be admitted overnight to a paediatric ward and assessed by a mental health professional the following day before discharge or further treatment and care is initiated. Alternative placements may be required, depending on the age of the child, the circumstances of the child and their family, the time of presentation to services, child protection issues, and the physical and mental health of the child; this might include a child or adolescent psychiatric inpatient unit where necessary (NICE 2016). It is also recommended that training for staff who work with children who self-harm should follow the same principles as for adults who self-harm, but should also include a full assessment of the family, their social situation, and child protection issues (NICE 2011). Admission to a paediatric ward may not always be necessary, particularly if intensive support is available to the family (Kothgassner et al 2020).

In Dublin, where a consultant-led multidisciplinary liaison team is in place in each of the paediatric hospitals, each child will receive a response from a liaison team. Since 2018 funding has been allocated to each of the three Dublin paediatric hospitals for a CNS to deliver the clinical programme. Along with ensuring each child receives a timely, expert assessment, family are involved at assessment and safety planning. The role of the CNS is to ensure there is bridging and linkage to appropriate next care. To date, a CNS has been appointed in one of the three paediatric hospitals. Measures are in place to recruit CNSs for the other two paediatric hospitals.

Outside Dublin, CAMHS services have a responsibility to ensure each child who presents to the ED following self-harm or with suicidal ideation also receives all four components of the clinical programme.

Access to social work 24/7 is not always available. This continues to present challenges in supporting children and families out of hours.

The National Youth Mental Health Task Force (DoH 2017) recommended appointing a National Lead for Youth Mental Health and a lead for CAMHS in each CHO to coordinate the provision of services and address gaps in service provision. It also recommended the establishment of an expert group to review the services delivered from 0–25 years. The Higher Education Authority launched the National Student Mental Health and Suicide Prevention Strategy (DES 2020). These initiatives will further support the full implementation of the NCP for children.

Each CAMHS service can learn from the implementation of the Clinical Programme in Adult ED and ensure that every child presenting to the ED receives a compassionate response and a timely, expert assessment, followed by a written Emergency Care Plan, family involvement and linkage to appropriate next care. Effective links between primary and secondary care and with voluntary and HSE-funded agencies should form a central part of this learning.

The Suicide Crisis Assessment Nurse (SCAN) service that has been developed for adults will in time be appropriate for children. At present the focus should be on building CAMHS community-based teams and ensuring that each ED has the resources to provide a timely, expert assessment and support for each child who presents.

There is considerable experience in UK-based CAMHS teams of developing crisis responses for children and adolescents who self-harm. With adequate staffing, CAMHS teams in Ireland will be able to implement many of these innovations.

4.3 Summary and recommendations

- Supporting children who self-harm and those with suicide-related thoughts is complex and requires more than can be addressed through the NCPSH.
- The recommendations of the Youth Mental Health Task Force Report (2017) need to be implemented. Full staffing of community child and adolescent mental health teams is required. CAMHS teams should be encouraged to develop crisis supports for children.
- Full multidisciplinary Liaison Psychiatry services for children should be developed in line with recommendations from *A Vision for Change*.
- A CNS funded through the NCPSH should be available in each of the three Dublin paediatric hospitals, to provide liaison between the mental health staff in the ED and the community-based CAMHS teams and other community-based services.
- The Area Management Teams of the mental health services should ensure that all components of the NCP are implemented for children presenting to the ED and to CAMHS services following self-harm or with suicidal ideation.
- Training in skills for assessing and supporting children and their families, as identified in the NCPSH training schedule, should be made available to all staff working in CAMHS teams.
- The development of a National Lead and a lead for CAMHS in each CHO, as recommended in the Youth Mental Health Task Force Report (2017), would facilitate the full implementation of the NCPSH for children.
- The Higher Education Authority has developed a framework for suicide prevention for students in higher education. Staff working with children and young adults should have a working knowledge of this framework (HEA 2020).
- Development of SCAN in primary care should be considered and developed once appropriate CAMHS community and liaison psychiatry services have been established.

05

Groups with Specifically Identified Needs

All people who self-harm or present with suicidal-related ideation have an elevated risk of suicide. However, a number of groups and communities have a particular vulnerability to and increased risk of suicidal behaviour, and they also have specific needs when they present to services. People may be in more than one of these groups.

5.1 Substance misuse

At least 50% of self-harm episodes are carried out under the influence of alcohol or illicit substances. Acute intoxication is associated with more violent methods of self-harm and suicide for both men and women, particularly among younger and middle-age groups. In addition, elevated self-harm and suicide rates are found in patients who are dependent on alcohol or other substances (Kaplan 2013).

Stigmatising and discriminating against people who use drugs is not limited to the general public; it can directly affect clinical care (Kelly et al 2010).

GPs should be trained in the recognition and treatment of substance misuse and in the provision of brief advice and feedback. The role of harmful drinking patterns contributing to self-harm behaviour should be recognised. There should be a corresponding focus on brief intervention and a low threshold for referral to local alcohol services.

The current strategy, 'Reducing Harm, Supporting Recovery: A health-led approach to drug and alcohol use in Ireland 2017–2025', identifies how the needs of this population can be met. Each local drugs task force is tasked with providing a health-focused and harm-reduction response to drug and alcohol use in Ireland. Use of SAOR (Screening, Ask and Assess, Offer Assistance and Referral), screening and brief intervention for problematic alcohol and substance use in ED settings has indicated that fewer than 10% of those screened needed onward referral to specialist addiction services (O'Shea et al 2017).

All staff carrying out a mental health assessment should have skills in carrying out opportunistic screening and interventions for those at risk, including training in SAOR. The biopsychosocial assessment of all patients who present to ED following self-harm must include a comprehensive assessment of potential misuse of alcohol and other substances. This should include a screen for alcohol and drug use, using a screening tool such as AUDIT and DUDIT (Higgins-Biddle and Bador 2018, Berman et al 2002), discussing options with the patient and referring to specialist services where appropriate. Signposting alone is not effective. Every effort should be made to provide a time and date for an appointment with a specialist service, if a referral is deemed appropriate.

A number of interventions are required to improve the response to people with alcohol and substance misuse. In the larger EDs there is a need to employ an addiction specialist/mental health professional. This is a nurse or other health and social care mental health professional who specialises in intervening with those engaged in alcohol and substance misuse. These professionals will be funded through the Primary Care Addiction Programme and will improve the engagement with mental health services. They also have a role in educating the ED staff.

There is a need to address the needs of those with co-morbid mental illness and alcohol or substance misuse. The HSE Dual Diagnosis Clinical Programme will support this.

There is a need to improve access to addictions services at a primary care level. This is relevant for next appropriate care following review in the ED, and also for GP referrals.

5.2 Homeless population

Homeless people, in particular rough sleepers, are vulnerable to physical and mental health problems and are high users of ED services. They have increased rates of alcohol and other substance misuse, higher rates of mental health difficulties and elevated rates of self-harm and suicide. However, they are least likely to have access to appropriate mental health services (CPsychI 2011).

Using data from the national Self-Harm Registry, the age-standardised incidence rate of self-harm was 30 times higher among homeless people compared with domiciled people in Ireland (Barrett et al 2018). Homeless people had significantly higher odds of being male, of self-cutting and of having a psychiatric admission. They were also found to have

higher odds of repetition of self-harm within 12 months of first presentation.

Dunne et al (2012) profiled the users of the specialist mental health service for homeless people in Cork and found users of the specialist service were more likely to have a history of self-harm compared with those attending a general adult mental health service (54% vs. 21%). They also found that those using the specialist service had a higher prevalence of schizophrenia (50% vs. 34%), personality disorder (37% vs. 11%) and substance dependence (74% vs. 19%).

Glynn et al (2017), in addressing the problem of premature death and self-harm among the homeless in Ireland, recognised that we have a care system that is failing one of its most vulnerable groups. Addressing these issues will require a multifaceted approach. While a housing-led strategy is required, Glynn also identified an urgent need to adequately resource and coordinate those services which aim to address all of the other factors (social and health inequalities, mental ill-health and addiction) which lead people into and prevent them from exiting homelessness.

In September 2018, the 'Housing First National Implementation Plan 2018–2021' was launched by the Minister for Housing, Planning and Local Government and the Minister for Health (Dublin Regional Housing Executive 2018). This plan recognised the critical need for a joined-up approach between government departments, local authorities, the HSE, homeless service providers and voluntary housing bodies. It is a model, first developed in the US in the 1990s, that looks at housing individuals and providing wraparound support to them in a flexible, assertive, outreached modelled approach. Housing First is currently being piloted in Dublin, Cork, Waterford, Limerick and Galway.

The specialist mental health teams for the homeless work with people who have mental illness and severe and complex social needs, and are homeless. Specialist homeless teams, local CMHTs and addiction services in inner Dublin are under-resourced (CPsychI 2011). The mental health services provide for all those with severe and complex mental health and social care needs; if adequately resourced, that support could extend to provide for those with significant mental health and social care needs in the inner city. Fully resourced teams would also work more flexibly with each other. There would still be a need to develop a separate service for those who are in a suicidal crisis but have minor or no mental health needs. There are also specialist services in Galway, Cork, Waterford and Limerick; homeless people use EDs, CMHTs and the specialist services.

While homeless people have a right to mental health services along with the rest of the population, it is also important to provide additional services that acknowledge the logistical difficulties they experience. Homeless people who are suicidal, but whose mental health and social care needs are not severe and complex, are best supported by other community-based services. The Dublin Simon Community has established a specific counselling service for homeless people who are suicidal, with support staff and counsellors trained in Collaborative Assessment and Management of Suicidality (CAMS) (Dublin Simon 2018). This has been part-funded by NOSP. They have recently developed the Suicide Specific Treatment Track (SSTT), an abridged form of CAMS that is used effectively by support workers who are supervised by trained counsellors (Dublin Simon Community, personal communication 2021). The aim of this service is to provide support to individuals in the most appropriate place; for most, this is in a day centre or hostel where they are accessing other services. There is anecdotal evidence that this service is reducing the numbers referred to the ED, ensuring that people are more appropriately supported. The service has identified the need for input from a mental health professional in relation to a small group of clients.

GP services supporting people who are homeless link with support services and counselling services (Safety Net 2020). If the person does not have a severe mental illness and requires a mental health assessment, they are referred to the ED.

Patients who are homeless and present or are referred to the ED, either following self-harm or with suicidal ideation, may not always wait to be seen by a mental health professional. Following mental health assessment they require considerable support in ensuring they are linked to appropriate next care. This may require offering two or three follow-up appointments until this link is made. Collaborative

working between the clinical nurse specialist in self-harm, other clinicians and groups working with homeless people is required.

Dedicated mental health staff, such as a Suicide Crisis Assessment Nurse or equally qualified mental health professional, would be well placed to provide a liaison role and support for GPs and homeless services working with people who are in a suicidal crisis but do not have a severe mental illness and therefore do not obtain input from either the specialised mental health teams for homeless people or the local CMHTs. A Suicide Crisis Assessment Nurse (SCAN) would provide a comprehensive biopsychosocial assessment and identify the most appropriate next care. In some cases it would be appropriate to provide up to three follow-up sessions. They would also provide a liaison role between primary care, homeless services and secondary care services. They would refer the most complex cases to the specialist mental health team for homeless people or to the local CMHTs. The CNS would develop links and work alongside other agencies for homeless people. (Governance is discussed further in Chapter 10).

The mental health service would employ the SCAN. They would receive professional supervision from their line manager and clinical supervision from a Consultant Psychiatrist, either from one of the specialist mental health teams for homeless people, or from a CMHT.

Chapter 7 describes the role of a SCAN professional in more detail. For the rest of the population, it is recommended that there be one SCAN professional for every 75,000 population. In relation to the homeless population in any area, the SCAN professional would work as part of the specialist team mental health team for the homeless and be available to also provide other input within the team.

The combination of the Simon Community's Suicide Specific Treatment Track and the use of SCAN should be piloted in Dublin, with a view to extending this to other parts of the country.

5.3 People who identify as LGBTQI+

Members of the lesbian, gay, bisexual, transgender, queer and/or questioning, intersex, asexual and two-spirit (LGBTQIA2S+) community have been shown by national and international research to have increased risk of suicidal behaviour (Higgins et al 2016, Russell et al 2016, King et al 2008), and have been identified as a priority group in Connecting for Life. There is a high rate of self-harm and suicidal ideation in lesbian, gay, bisexual and transgender groups. Internationally, the rate has been estimated to be between four and eight times higher among LGB and transgender young people compared with heterosexual and cisgender peers (Haas et al 2011). While, as a broad group, sexual and gender minorities have high levels of suicidal ideation and behaviour, among transgender people these rates are even greater (Richards and Barker 2013, Bauer et al 2013, Mottman et al 2010, Grant et al 2011).

Many of the risk factors for self-harm and suicide in the LGBTI+ population overlap with those of non-LGBTI populations, such as depression, alcohol and substance misuse (Hottes et al 2016). There are also unique risks factors to sexual and gender minorities. For example, the experience of abuse, discrimination or harassment due to an individual's gender identity or presentation has been shown to be linked to high levels of attempted suicide (Kelleher 2009, Taliaferro and Meuhlenkamp 2017). It has been suggested that young people may internalise the experiences of public stigma in relation to being LGTBI, and this affects self-perception and beliefs which could increase suicidal behaviour or self-harm (Puckett et al 2017).

Higgins et al in their 2016 study of Irish LGBTI found that 34% reported a lifetime history of self-harm; 60% of people who had self-harmed related their self-harming to their LGBTI identity and their struggle to be accepted by others and society. They emphasised the need to improve the knowledge and skills of professionals and service providers to ensure that practice guidelines and training programmes would be LGBTI-inclusive. Russell et al (2018) highlighted the positive effect that using chosen names and pronouns has on reducing depression and suicide rates among young people. They also emphasised the need to improve the knowledge and skills of professionals and service providers.

All staff carrying out mental health assessments in the ED and in SCAN should receive training in understanding and supporting people with different gender and sexual identities.

5.4 Students in higher education

The college age years are a time of great change and it is also a time when there is a higher risk of manifesting mental health problems; 75% of serious mental health difficulties emerge in the age range 15 to 25 (Kessler et al 2005). Within the student population, 35% of first-year students screened positive for at least one mental health disorder – depression, anxiety or substance use (WHO 2014). Suicide is a leading cause of death in young people (WHO 2014.) The My World Survey in Ireland (Dooley and Fitzgerald 2012) found that the number one health issue for students was mental health. On average, 131 young people under the age of 30 die by suicide in Ireland each year (NOSP 2016).

In both Irish and UK studies, a number of factors have been identified that may increase the risk of mental health difficulties (UUK 2018 and Dooley et al 2019). These include academic pressures, exam and assignment stress, transitions in and out of higher education, financial burdens, managing jobs and academic work, social and cultural pressures (including family, friends and intimate relationships), social media, and broader geopolitical concerns. Some groups of students are at higher risk of developing mental health difficulties; these include those who identify as LGBTQIA2S+, international students, asylum-seekers and refugees, those who experience trauma, online remote students, first-generation students, mature students, those from disadvantaged socioeconomic backgrounds and those from minority ethnic backgrounds.

In September 2020 Ireland launched the National Student Mental Health and Suicide Prevention Strategy (HEA 2020). The National Framework draws from international evidence and calls for an embedded whole-system approach. It provides an opportunity for higher education institutions (HEIs) to review and reflect on their current support for student mental health and actions for suicide prevention. In the whole-system approach, awareness training for all staff and students in recognition and referral for mental health difficulties is prioritised, as is providing students with safe, accessible and well-resourced mental health supports.

Close liaison between CNSs working on the Clinical Programme and GPs, counsellors and psychiatrists within universities is appropriate in dealing with individual cases. All staff should have an awareness of the contents of the Student Suicide Prevention Strategy.

5.5 The Traveller community

Irish Travellers are an indigenous minority group in Ireland, first officially recognised by the Irish Government in March 2017 (Joint Committee on Justice and Equality 2017). They are distinct in their culture, language and value system originating from their nomadic tradition (NiShuinear 1994). The Equal Status Acts (Government of Ireland 2016) defines Travellers as: 'The community of people who are commonly called Travellers and who are identified (both by themselves and others) as people with a shared history, culture and traditions, including an affinity to a nomadic way of life on the island of Ireland'.

Travellers are noted to have a higher rate of suicide than the rest of the Irish population (O'Shea 2011, Pavee Point 2013, Malone et al 2017.) McKey et al (2020) have reviewed the literature on Travellers and suicide, and reported a paucity of research in the area. The largest of the studies examining the health of Travellers is the All-Ireland Traveller Health Study – Our Geels 2010 (AITHS), a community-based survey of all Traveller households on the island of Ireland in 2008 and 2009 (All-Ireland Traveller Health Study Team, 2010). The AITHS included an overall census of 7,042 Traveller families, followed by a random selection of an individual member of the family to answer either a health status or a health utilisation questionnaire. One AITHS paper focused on disparities in fatal and non-fatal injuries in the Traveller population compared with the general public. Findings showed increased intentional injury, including suicide and self-harm in the Traveller population. Men were six times and women four times more likely to have an intentional injury, of which the majority were suicide deaths (Abdalla et al 2013). Malone et al (2017) described suicide in the Traveller community in more detail. McKey and Malone both note that an increase in suicide is common in all indigenous populations, with an increased use of drugs and alcohol noted, although this does not fully explain the increase.

Due to chronic under-usage of mainstream health services (and the attendant obstacles that exist for Travellers accessing healthcare), the Traveller health response seems to focus on ED assessment and input, where the ED is seen as the only resort as well as the last resort for their health (and mental health) needs. On the other hand, the ED is configured to triage and prioritise the most ill, and may not understand the crisis-led life and death culture observed among Travellers, contributing to communication breakdown and mutual mistrust (Beach 2006, McGorrian et al 2012). McKey et al make the point that the ED is an area where cultural competence can affect outcomes, and stigma and discrimination contribute to poor outcomes. A recent study by the European Union Agency for Fundamental Rights (FRA 2020) found that 68% of Traveller men and 62% of Traveller women reported experiencing discrimination.

All staff carrying out mental health assessments in the ED and in SCAN following GP referral should receive training in Traveller cultural awareness.

5.6 Asylum-seekers and refugees

Kavalidou and Albanese (2021) have pointed to the many risk factors for suicide that are seen among asylum-seekers and refugees. They come from a number of heterogeneous groups, and their social, cultural and health needs differ, as do their current legal status and migration experiences. However, Kavalidou and Albanese (2021) propose that the experience of forced migration, pre-migration trauma and entrapment would all pose an increased risk of suicide. They highlight the paucity of studies on self-harm and suicide among asylum-seekers and refugees.

Besides common mental health issues, studies from Australia highlight that prolonged uncertainty and feelings of being trapped among asylum-seekers may lead to suicidal behaviours (Proctor et al 2018). However, there is scarce evidence of suicide and self-harm among refugees and asylum-seekers from other hosting countries (Vijayakumar 2016), although this seems to be due to a lack of studies. A recent systematic review found that unaccompanied minors have an evident risk of self-harm according to the few studies conducted mainly in the UK, Sweden and Belgium (Gargiulo, A 2020). Kavalidou and Albanese (2021) call for further research in this area.

Miller et al (2019) and Im and Swan (2020) have described pointers for ensuring trauma-informed practices in working with young and older refugees.

All staff working with asylum-seekers and refugees should receive training in trauma-informed clinical practices. The national Clinical Programme is well placed to research presentations of asylum-seekers or refuges following self-harm.

5.7 The deaf and hard-of-hearing community

People who are deaf or hard of hearing have an increased rate of mental illness compared with the hearing population (Fellinger et al 2012). They also experience difficulties in accessing mental health care. Turner et al (2007) completed a literature review of suicide in deaf populations. They did not find evidence of increased rates of suicide, but the number of studies was small, and they noted the need for more studies and improved access to specialist mental health services. Mental Health Reform (2015) produced a briefing statement on supporting people from the deaf community who have mental health difficulties. Among other recommendations it recommended that remote interpretation services should be made available in EDs across the country to ensure that people who are deaf are adequately supported should they present in a mental health crisis.

A Vision for Change clearly sets out that mental health services should respond to the mental health needs of minority groups, including the needs of deaf people. The policy recognises that this group of people may have additional needs upon accessing a mental health service; therefore mental health services need to have the necessary understanding and knowledge to meet the care needs of deaf individuals.

More specifically, *A Vision for Change* recommends that effective interpretation services be made available to ensure that deaf people can access mental health services. It recognises that good communication is of crucial importance in service provision and ‘is at the heart of mental health work’. The policy states, ‘Mental health work

requires interpreters who are able to interpret the "idiom" of the individual's distress as well as the actual words used. Interpreters must be able to empathise with the individual's position and children and/or family members of the individual in question should not be used as interpreters'.

Deaf or hard-of-hearing people must have their interview facilitated by an Irish Sign Language (ISL) interpreter. Services should ensure that the phone number and video facility for an ISL interpreter is available for use.

Deaf or hard-of-hearing people who present following self-harm need support in being linked to appropriate next care. While some specialist non-crisis suicide counselling services can provide a service for deaf people, there is a need for specialist mental health services for the deaf community. In 2005 the HSE established a specialist service with a part-time Consultant Psychiatrist and a full-time clinical nurse specialist. Following a break in the service provision following retirement of the Consultant Psychiatrist, it has been restarted and is now provided by Consultant Psychiatrist Dr Aiden Collins and CNS Ms Blessing Obioha. The service is based in the Thomas Mahon Building in the Deaf Village in Cabra, Dublin. It accepts referrals from CMHTs and GPs. Assessments depend on the availability of ISL interpreters (Chime 2021).

5.8 Autistic people

Suicide, self-harm and non-suicidal self-injury are major health concerns for autistic people. Suicidality is exceptionally common, occurring in 66% of autistic individuals (Cassidy et al 2018). Suicide risk is seven times higher in autistic people, contributes substantially to premature mortality in adults on the autistic spectrum (Hirvikoski et al 2016) and is associated with a greater risk of suicide at a younger age (Chen et al 2017) and in autistic females (Kirby et al 2019) compared with non-autistic peers.

Among autistic youth, estimates of suicidality range from 10.9% to 50% (Segers et al 2014, Horowitz et al 2018, Demirkiya et al 2016). Increased rates in comparison with non-autistic children are reported (Hunche et al 2020). Autistic children and/or children with an intellectual disability are disproportionately overrepresented in emergency presentations (20%) in Ireland, and more recently are presenting with high-lethality methods of self-harm, namely ligature use, in comparison with their non-autistic peers (Maguire et al 2020).

Many risk factors associated with suicidality generally are also relevant to autistic adults and youth (Connor et al 2020). Autistic youth may have increased exposure to several risk factors, such as social isolation, peer victimisation, abuse and cyber bullying (Park et al 2020). Park found that autistic traits inherently appear to increase risk and may affect timely detection and intervention. Alexithymia (the inability to identify and describe one's emotions), repetitive behaviours, IQ and adaptive behaviour are implicated in suicide risk in autism (South et al 2020). Theoretically, cognitive rigidity coupled with low mood may act together to reduce coping and problem-solving and increase risk of suicide in autistic people (Culpin et al 2018). This has relevance also in the general population, since autistic traits in childhood predict suicidality in adolescence (Cassidy et al 2014).

There is overwhelming evidence that mental health comorbidities are significant risk factors for suicidality in autistic adults (Rosen et al 2018). However, they are frequently underdiagnosed due to diagnostic overshadowing. The latter refers to non-identification of comorbid conditions in autistic people, which are instead attributed to autism (Rosen et al 2018); 70% of autistic youth experience one or more mental health comorbidities (Simonoff et al 2013), the commonest of which are anxiety, depression and ADHD. However, some studies suggest that mood disorders are less prevalent in suicide attempts by autistic compared with non-autistic people, although this could be related to underdiagnosis of depression (Crane et al 2019). Emotional deregulation could be an underlying factor and target for support.

Autism spectrum disorder (ASD) is often overlooked or misdiagnosed in adult patients, especially in those with other psychiatric comorbidities (Kondo 2015). Five disorders (schizophrenia, psychotic disorder, bipolar disorder, major depressive disorder, and personality disorder) were specifically highlighted as misdiagnosed psychiatric diseases or comorbidities responsible for unrecognised ASD (Kondo 2015).

Significant systemic and autism-specific barriers to accessing a range of health services generally, including mental health services, have been reported (Jager-Hymen et al 2020). Health professionals, including psychiatrists, report difficulties communicating with autistic patients and understanding their needs, which may negatively affect the quality of mental health and suicide risk assessment provided. In one survey, clinicians reported lower confidence with suicide risk assessment, and rated safety planning as significantly less acceptable for their autistic clients (Unigwe et al 2017). Further research is needed in this area.

Autism-specific social difficulties could be bidirectional in nature and people of different neurotypes may be misunderstanding each other. An increasing number of studies provide converging evidence of non-autistic people misreading social situations with autistic people. For example, non-autistic people interpret facial emotions of autistic people less accurately than do autistic individuals and are less willing to interact with autistic people, overestimate how egocentric autistic people are (Sasson el at 2017) and overestimate how helpful they are to autistic people (Heasman and Gillespie 2019). Non-autistic people are less accurate than autistic people at interpreting the mental states of autistic people (Edey et al 2016), while finding autistic people difficult to read is related to their being perceived unfavourably by non-autistic people (Alkhaldi et al 2019).

Autistic people may communicate through spoken language, augmentive and alternative communication (AAC) devices, pictures, sign language, typing, texting, writing, sounds and movements. Some autistic people are non-speaking while others can temporarily lose access to fluid speech, especially during times of distress. Staff should accept an autistic individual's preferred method of communication.

All staff carrying out assessments on people with suicide-related ideation and self-harm should receive training in understanding autism, awareness of the presentation of co-occurring psychiatric disorders, and how to best communicate with and support autistic people who present with self-harm or suicidal ideation.

Information and resources for practitioners are available on the websites of key advocacy groups, such as:
https://asiam.ie
https://www.autism.org.uk/advice-and-guidance/topics/mental-health/suicide
https://www.autistica.org.uk/what-is-autism/signs-and-symptoms/suicide-and-autism

5.9 ADHD and suicidality

Attention deficit/hyperactivity disorder (ADHD) is associated with an increased risk of both attempted suicide and death by suicide (Impey et al 2012). A large population-based study in Sweden confirmed this association and also found an increase in suicide among close relatives of people with ADHD, suggesting that this association is partly due to shared genetic factors (Ljung et al 2014).

Diagnosis, support and treatment for adults with ADHD in Ireland are inconsistent and underfunded. The HSE recently launched a National Clinical Programme for Adults with ADHD (HSE 2021). Staff working with people who self-harm or with suicide-related ideation should understand the links between ADHD and suicide.

5.10 Older persons

The proportion of the population aged 65 and over is expected to grow from 13% in 2016 to 18% by 2030, creating extra challenges for service providers (Wren et al 2017). While the numbers of patients over 65 presenting with self-harm is more modest than in other age groups, this number is growing and those who do present need special consideration.

Among patients presenting, this age group has the highest associated suicide risk (Troya et al 2019, Morgan et al 2018). NICE (2020) recommended that all acts of self-harm in people older than 65 years of age should be regarded as evidence of suicidal intent until proven otherwise.

It is therefore important that all staff carrying out a mental health assessment on this cohort of patients should have knowledge of the special considerations which will enable them to complete a comprehensive assessment, including epidemiologically based risk factors. Wand et al (2017), in reviewing qualitative studies of self-harm and suicidal behaviour in older people, identified a number of themes which should be explored in any assessment, such as

issues related to loss and regaining control; alienation; disconnectedness and invisibility; meaningless and lack of raison d'être, accumulated suffering and a painful life. Comorbid chronic pain, sensory (hearing/vision) loss and covert substance misuse are important common additional factors to consider among this group.

Among these patients, the perceived lethality of any overdose is often important to carefully explore. Even a seemingly small overdose of one or two tablets can constitute a serious suicide attempt if the individual believes that such an amount could kill them. Any episode of deliberate self-harm in an older person needs to be taken particularly seriously.

For patients presenting with acute confusion, it is important to consider that they may have taken an unintentional or intentional overdose. Collateral, and paying special attention to emerging cognitive issues in addition to the issues mentioned above, is very important to ensure complete assessment in this cohort.

Following assessment in ED or by SCAN, there should be clear guidelines in each area regarding access and referral pathways to mental health services for older people. Psychiatry of Later Life (POLL) community mental health teams are usually community-based, with close links to primary care. Establishing and building trusted, consistent lines of communication between SCAN/ self-harm programme staff and local POLL services will ensure efficient, timely care for patients who need further expert assessment and management.

5.11 People with physical illnesses including chronic pain

Research on suicide prevention indicates that people with chronic physical illnesses are at a higher risk of suicide-related outcomes (including suicidal thoughts, behaviours and deaths by suicide). Clinical focus has been given to populations with multiple health conditions, defined as multimorbid (Hawton et al, 2003, Nock et al 2010, Scott et al 2010). Heart disease, chronic obstructive airway disease (COPD), stroke, cancer and asthma have all been associated with increased risk for suicide (Juurlink et al 2004, Webb et al 2012). A large primary care-based study in the UK suggested that the rate of suicide was significantly elevated in people with a range of physical illnesses, especially in women. The presence of depression largely explained the elevated risks, although not in women with cancer or coronary heart disease (Webb et al 2012). Connecting for Life (DoH 2015) recognises people with chronic physical illness as a priority group.

Although the co-occurrence of mental health conditions, such as depression along with other Axis I disorders and alcohol abuse, have been seen as significant clinical factors for predicting future self-harm and suicide (Tuisku et al 2012), physical illness multimorbidity seems to also increase suicide risk, taking into account the mediating effect of depression (Anguiano et al 2012, Scott et al 2010).

Based on the interplay of physical and mental illness, mental and physical illness multimorbidity has more recently been described as a risk factor for suicidal thoughts. Patients with neurological disease are at particular risk from self-harm and completing suicide. Multiple sclerosis (Arciniegas & Anderson 2002) and epilepsy have been linked to increased suicide risk, accounting for 10% of all epilepsy deaths in one study (Bell et al 2009). Suicidal ideation is increased in cases of Parkinson's disease (Kummer et al 2009). Among neurodegenerative disease, suicide rates in Huntington disease remain the highest (Druss and Pincus 2000); completed suicide is reported to be as high as 13% (Cummings 1995). A report of the Neurological Alliance of Ireland in 2014 indicated that the needs of people with advanced neurological conditions were not being met by existing palliative care and neurology services (Weafer 2014). The College of Psychiatrists of Ireland have also described the deficits in neuropsychiatry services nationally and pointed to the need to increase neuropsychiatric service provision (College of Psychiatrists 2016).

Individuals with chronic pain are at least twice as likely to report suicidal behaviours or to die by suicide. Racine (2018) found evidence that chronic pain itself, regardless of type, is an important independent risk factor for suicidality. Pain-related factors such as sleep problems, poorer perceived mental health, concurrent chronic pain conditions, and more frequent episodes of intermittent pain, were all found to be predictors of suicidality. Pain characteristics (e.g. type, duration, intensity/severity) and physical status (e.g. pain interference, disability) were not related to suicide risk. Racine (2018) identified particular psychosocial factors

(e.g. mental defeat, pain catastrophising, hopelessness, perceived burdensomeness, thwarted belongingness) as being associated with suicidality outcomes. A large number of these factors are amenable to change through targeted intervention, highlighting the importance of comprehensively assessing chronic-pain patients at risk for suicide, while also incorporating a suicide prevention component into chronic-pain management programmes.

All staff delivering the NCPSH should have an understanding of the impact that physical illness has on physical illness. The benefit of developing fully staffed multidisciplinary teams in liaison psychiatry has been highlighted (Buzkova et al 2019, Parsonage 2012).

5.12 People who present frequently to the ED, after self-harm or with suicide-related ideation

The national Self-Harm Registry (Griffin et al 2018) has consistently shown that between 20% and 23% of all presentations to the ED following self-harm are for repeat acts. Ness et al (2016) reviewed over 90 people who had presented to mental health services 15 times or more over a four-year period. They found that this group made up less than 1% of all presentations to the ED for self-harm, and repeated the need to educate both ED and mental health staff of this fact. Of the frequent attenders, the majority tended to present in clusters, interspersed with long periods of non-attendance. Some of these are people with untreated mental illness. Mental health assessments need to focus specifically on signs of mental illness.

It has also been shown that presentations of people who repeat self-harm change over time; therefore, a comprehensive assessment of need is required on each presentation (Witt et al 2019). People who present to the ED on more than one occasion in a short period of time need particular attention. Okore et al (2011) found that individuals who attended frequently made up 5.3% of all patients who attended ED for psychiatric care, and accounted for 19% of all admissions. They also found that people who frequently presented were younger and had higher rates of schizophrenia and psychiatric admissions. They recommended targeting these patients with effective community-based strategies such as home-based treatments, which could improve quality of life and reduce the cost of care.

The latest NICE update (2016) specifies that people who repeatedly self-harm may have different reasons for self-harming on each occasion and therefore each episode needs to be treated in its own right. This and other recent literature emphasises the need to complete assessments each time a person presents (Palombini et al 2020).

A number of people repeatedly self-harm due to emotional dysregulation, resulting in distress for themselves and others. They are at particularly high risk of dying by suicide. Staff require specific expertise in ensuring that such people receive a compassionate, empathic and trauma-informed response, while at the same time both staff and the patients themselves accept that they need support to change their behaviour. They may benefit from skilled support and acknowledgment from staff, a trauma-informed assessment and Safety Plan, with onward referral to specialist services such as dialectical behaviour therapy (Flynn et al 2017a) and mentalisation therapy.

A very small number of patients self-harm frequently.
A specific care plan should be developed between the individual, their treating community mental health team and the mental health staff providing input into the ED, specifying the input the patient requires should they present to the ED. This care plan should be available to the ED staff to optimise care on re-presentation. In rare occasions, this care plan may advise that the patient's physical needs be addressed in the ED, but, where their mental health needs and a pathway of psychiatric care for such presentations are already clearly defined, the patient does not need to stay for the purpose of a further psychiatric assessment. The patient's treating community mental health team will be informed of each of these presentations to ED. At any time, if the ED staff have a particular concern for the individual, or there is a change in the patient's mental health presentation, this plan can be overridden and the ED staff can request a mental health assessment in the ED. A decision not to offer a mental health assessment in the ED or in SCAN should be exceptional and never taken without such a collaboratively developed care plan.
A mechanism to identify patients who frequently attend should be in place in the ED and patient-specific care plans developed based on assessment of need for each individual. Psychiatry/ED/social work staff should work together to identify and support these patients and to create agreed

care plans, which should be available to the CMHT and GPs as well as within the ED. It is important that this plan be developed collaboratively with the patient. Nothing in the plan should prevent the patient from receiving a compassionate and empathic response if they present to the ED or to SCAN.

5.13 Summary and recommendations

- A number of identified groups who present to the ED or to the GP following self-harm or with suicidal ideation require enhanced input from the mental health professional to ensure they are linked to appropriate next care.
- These groups include those with substance misuse, those who are homeless, asylum-seekers, members of the Travelling community, deaf people, the LGBTQIA2s+ community, people with chronic health conditions, autistic people and older people.
- All staff carrying out a mental health assessment in the ED or in SCAN should have skills in carrying out opportunistic screening and interventions for those at risk of alcohol and substance misuse, including training in SAOR (Screening, Ask and Assess, Offer Assistance and Referral).
- Each ED and GP should have clear policies and pathways for accessing onward referral to relevant local addiction services.
- Each ED should have access to onsite addiction specialists. This needs to be developed through the Primary Care Addictions Programme and the Dual Diagnosis Clinical Programme.
- People who are homeless benefit most from mental health services that are delivered alongside other services, such as daycare or shelter. A SCAN practitioner in crisis mental health care would be ideally placed to provide clinical expertise to teams working with the homeless population.
- A SCAN or equally qualified mental health professional should be available to work with the homeless population who present with self-harm and suicidal behaviour, providing biopsychosocial assessment and intervention. In addition, the SCAN would liaise between the specialist mental health services for the homeless and the secondary care mental health service.
- All staff carrying out mental health assessments in the ED and in SCAN should receive training in understanding gender and sexual identities.
- All staff carrying out mental health assessments in the ED and in SCAN should receive cultural awareness training in addressing the mental health needs of Travellers, asylum-seekers and refugees.
- All staff carrying out mental health assessments in the ED and in SCAN should receive training to better support the varying needs of autistic people and those with ADHD. Staff must accept the different communication methods used by some autistic individuals.
- All staff will ensure that reasonable accommodation and access are provided for people with disability.
- Non-English-speakers must have their interview facilitated by appropriate interpreters/translators. Services should ensure that their phone number and video facility is available for use.
- Deaf or hard-of-hearing patients must have their interview facilitated by an Irish Sign Language interpreter. (ISL) Services should ensure that the phone number and video facility for an ISL interpreter is available for use. Information on specialist mental health services for the deaf and hard of hearing community are available at www.chime.ie.
- All staff carrying out mental health assessments in the ED and in SCAN should receive training to better support people with physical illnesses, including chronic pain.
- A mechanism should be put in place to identify people who frequently present in the ED following self-harm. These people require particular attention and collaborative care planning to include all agencies involved in their care.

06

Bridging and Linkage to Next Appropriate Care

6.1 Overview

Each patient should be followed up and bridged to next appropriate care. This is achieved through communicating with the patient's GP, phoning the patient within 24 hours of discharge from the ED or SCAN service, and maintaining contact with the patient until they have been in contact with the next appropriate care.

To achieve this, a clear record of all patients presenting to the ED, including those presenting out of hours, should be kept, and within the SCAN service a record of all referrals should be kept. The clinical lead holds responsibility for ensuring that the clinical programme is implemented. It is the responsibility of all Consultant Psychiatrists working in a service to ensure there is an integrated approach to care. Each Consultant Psychiatrist on call has a responsibility to provide clinical supervision for the clinical nurse specialist or the NCHD. The Consultant should ensure that all cases presenting should be discussed with the CNS the following morning. It is then the responsibility of the CNS to provide the follow-up and linkage to next care. Consultant Psychiatrists as a group should ensure that all cases have been appropriately followed up.

The assessing mental health professional, CNS, MHSW or NCHD is responsible for the collaborative development of an Emergency Safety Plan and for sending a letter to the patient's GP immediately following assessment. This should be sent by secure e-link. A copy of the Emergency Safety Plan should accompany this letter. If there is any delay in sending the letter, the GP should be informed by telephone.

The CNS or MHSW should phone the patient within 24 hours of discharge from the ED or SCAN service. If it is known that the patient will be contacted by a home-based treatment team or a community mental health team within 24 hours, and that this team will accept responsibility for providing the telephone call, this can be recorded in the data. There will be rare situations where a telephone call is not appropriate. If the CNS does not make contact with the patient on the first call, it is recommended that they make at least two further calls on at least two separate days. The GP and next appropriate service should be informed if the CNS has been unable to contact the patient.

Where required, the CNS or MHSW will continue to provide telephone support until the person has been linked with appropriate next care. This follow-up provides an opportunity to support family members also.

In some cases it will be appropriate for the CNS, MHSW, NCHD or consultant to provide brief follow-up support. This would usually involve a maximum of three contacts, providing further expert advice to the GP and supporting the patient in engaging with next appropriate care.

6.2 Next appropriate care and community supports

Following a full biopsychosocial assessment with family involvement and completion of a written Emergency Safety Plan, the individual should be followed up and linked to appropriate next care. This may include mental health services and services in the voluntary and community sector.

It is beyond the scope of this model of care to develop next appropriate care; however, it is important that there be a clear pathway to next appropriate care. Examples of appropriate next care will include specialist non-crisis time: limited counselling for self-harm and suicidal ideation, crisis cafés, social prescribing, and community counselling and psychological supports. It is recommended that the NCPSH CNS and the SCAN ensure there is a list of such local supports within the ED or GP surgery. They should liaise with the local HSE resource officers for suicide prevention in compiling such a list.

Sharing the Vision (DoH 2020) recommends putting a number of new services in place, including Crisis Resolution Teams, Crisis Houses, Assertive Outreach Teams and Home-based Supports.

All CHO areas should ensure there is access to a non-crisis self-harm and suicide specialist counselling service. Trained and supervised psychotherapists should staff this service and they should ensure there is an effective communication to and from other health agencies. The Self-Harm Intervention Service (SHIP) provides such a service in the South East (Gardner et al 2015). Some non-governmental organisations (NGOs) have developed similar services.

Crisis cafés have been identified in a number of countries as offering psychosocial crisis supports (Consumers of MH Report 2019; Harbour Café, Certitude 2020; The Living Room, Heyland et al 2013). The model in all these services provides a place for a person in crisis to receive psychosocial support following a mental health assessment. Links are formed with GPs, local mental health teams and EDs, with individuals referred to the crisis cafés from these services.

Crisis cafés, as described in these reports, do not provide an alternative to the ED; they provide an extra service along with the resourced mental health teams. A comprehensive review of crisis cafés and their feasibility in an Irish setting has been conducted by a number of NGOs, Waterford Institute of Technology and employees of the HSE (Kilkenny Crisis Café Feasibility Study 2020). This study outlines how a number of agencies can work together in supporting individuals in a crisis. They describe the development of a peer-led and non-clinical approach to crises. Crisis cafés can provide much-needed psychosocial support but they do not provide biopsychosocial assessment of risk and need, and thus do not replace a skilled assessment provided by a qualified mental health professional such as a SCAN, CMHT or the mental health professional in the ED. For this reason, we have not included crisis cafés on the list of pathways to care from GPs. They form part of the next appropriate care for some individuals.

Social prescribing is a means of enabling GPs and other healthcare professionals to refer patients to a link worker – to provide them with a face-to-face conversation during which they can learn about the possibilities and design their own personalised solution to provide social support. This service provides links to social activities and should not be confused with social work input. People with social, emotional or practical needs who often use services provided by the voluntary and community sector are empowered to find solutions that will improve their health and wellbeing. A recent evaluation (HSE 2020c) found that social prescribing is increasing in Ireland, with 18–20 funded projects and a continuing expanding All-Ireland Social Prescribing Network. The self-harm CNS and SCAN should link with any local social prescriber and identify a resource of suitable community agencies that can offer ongoing support. This should be available to all mental health professionals completing assessments, including those working out of hours.

The NCPSH recommends that the local Connecting for Life Action Plans include a list of available next appropriate care. Liaison between staff implementing the NCPSH and the resource officers for suicide prevention (NOSP 2021) will facilitate this.

6.3 Summary and recommendations

- The responsibility for ensuring that all patients receive effective follow-up and linkage to next appropriate care rests with all consultants who provide on-call clinical supervision.
- Each service should ensure there is a procedure in place to ensure handover of details of all patients who present out of hours.
- Each patient's GP should receive immediate communication by secure Healthlink on the patient's presentation and emergency safety plan. If this is not possible, a phone call should be made to the GP within 24 hours.
- All patients, including those assessed out of hours, should receive a follow-up phone call from a clinical nurse specialist, or equally qualified mental health professional employed through the NCPSH, within 24 hours of discharge from the ED or SCAN. In rare cases, this may not be clinically appropriate and this fact should be recorded in the notes.
- In some cases it will be appropriate for the CNS, MHSW, NCHD or consultant to provide brief follow-up support. This would usually be to a maximum of three contacts, providing further expert advice to the GP and supporting the patient in engaging with next appropriate care.
- Each CNS and SCAN professional should liaise with the resource officers for suicide prevention in their area and develop a list of community supports in that area.
- In developing Connecting for Life Action Plans, NOSP should ensure that there is input from the CNS, SCAN and the NCPSH office.

07

Pathway of Care for Persons presenting to their GP following Self-harm or with Suicidal Ideation

7.1 Introduction

The Model of Care (HSE 2016) states that GPs should be regarded as the first point of medical care for all persons with mental health disorders, including those who engage in self-harm, with the exception of those requiring hospital-based medical care arising from a self-harm episode. This chapter outlines supports required to ensure that the National Clinical Programme (NCPSH) can be delivered for patents presenting to their GP.

Previous chapters provide further information, including the aim and rationale of the NCPSH (Chapter 1), an extensive Literature Review (Chapter 2), Services for those presenting to the ED (Chapter 3), Child and Adolescent services (Chapter 4), Services for groups with specific needs (Chapter 5), and Follow-up and Linkage to next care (Chapter 6). The following chapters look at Community Mental Health Services (Chapter 8), Training (Chapter 9), Governance and Supervision (Chapter 10) and Monitoring and Evaluation (Chapter 11).

7.2 Literature review on self-harm/suicidal ideation and general practice

It is estimated that around half of all people who die by suicide have previously self-harmed (Foster et al 1999). People who self-harm are a group with the highest risk of dying by suicide (Hawton et al 2012). Recently it has been shown that people who present with suicidal ideation are also at increased risk of dying by suicide (Griffin et al 2019). Ireland has a registry of self-harm since 2007 (Perry et al 2013). This registry identifies all who present to EDs, the nature of self-harming behaviour, and the interventions and follow-up offered. In 2017 there were 11,600 presentations to ED following self-harm. It is estimated that, for every presentation to the ED, there are five times as many self-harm episodes in the community (Arensman et al 2018) (see Fig. 7.1).

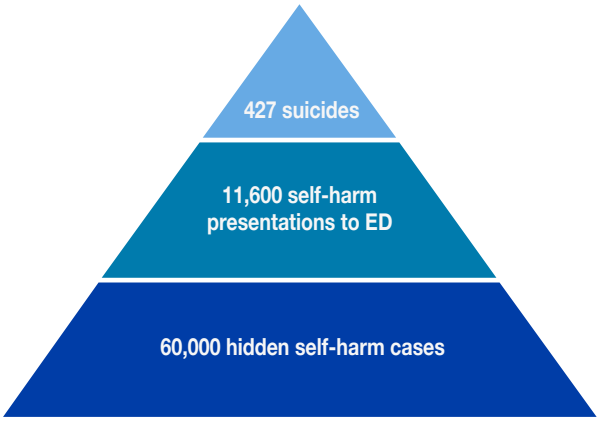


FIG. 7.1 THE ICEBERG MODEL OF SELF-HARM (ARENSMAN ET AL 2018)

General practitioners play a central role in the recognition of suicidal behaviours and in the interventions with patients. Data from the UK show that in the year prior to suicide, 60% to 70% of people have been seen by their GP and almost half of people engaging in a serious suicide attempt have been seen in the previous month (Windfuhr et al 2016). Some studies have found that over 90% of patients with mental health problems are managed in primary care. Studies conducted in Ireland, France and the UK have found that GPs refer 60% to 80% of patients who have self-harmed to hospital (Fitzsimons 1997, Le Point 2004, Saini et al 2016).

Evidence has shown that offering a therapeutic assessment is associated with reduction in repeated self-harm and improved engagement with services (Cully et al 2020, Kapur 2013). Interventions associated with improved outcomes include a written safety plan (Stanley and Brown 2018), next-of-kin or supportive friend input (Shea 2011), and follow-up and linkage to next care (WHO 2014, Riblet 2019). Brief contact interventions such as post-discharge telephone calls have been shown to offer social support, improve suicide prevention literacy and assist in learning alternative behaviours (Milner et al 2016).

In 2016 a Cochrane review (Hawton et al 2016) found evidence that cognitive behavioural therapy (CBT) and dialectical behaviour therapy (DBT) showed a reduction in suicide in those who had self-harmed. This review noted the paucity of well-conducted randomised controlled trials, commenting that self-harm is common and suicide rare.

NICE guidelines on the short-term treatment and management of self-harm are under revision (NICE 2004, 2011, 2020). These guidelines emphasise the importance of treating people who self-harm with the same care, respect and privacy as any patient. Healthcare professionals should take full account of the likely distress associated with self-harm.

Psychosocial assessment following self-harm is not necessarily profession-specific. A service led by experienced nurses can be cost-effective for a health service (Russell and Owens 2010). The value in training multidisciplinary professionals to develop skills for working in suicide prevention has also been demonstrated (de Beurs et al 2015). De Beurs suggests that multidisciplinary approaches have the advantage of developing services from the perspective of multiple stakeholders, which is likely to be of benefit for the complex needs of individuals presenting with self-harm.

Repeated studies have shown that people who have self-harmed or who present with suicidal ideation want to share in the decision-making about their future care, with reasonable attention paid to their personal preferences (Claasen et al 2014). They also benefit from receiving support for better managing distress. This can be achieved by providing each patient with a collaborative plan. In recent years there is increasing evidence for the use of safety planning in reducing repeat self-harming and suicide (Stanley and Brown 2012, 2018). Specific training in the use of safety planning is now incorporated into training on management of suicidality, such as STORM and Self-harm Assessment and Management for General Hospitals (SAMAGH; Gask et al 2006, Arensman et al 2020).

In the Model of Care (HSE 2016), the need for family involvement has been clearly described, citing O'Carroll's Once, Twice, Three Times (2012), to emphasise the need to ensure that response to suicidal ideation or behaviour should be swift and follow national guidelines. Two parties should be involved – the suicidal person and a nominated family member or supportive friend – and a triangle of care and support for the person should include the healthcare providers, the person at risk and the family/supportive friend.

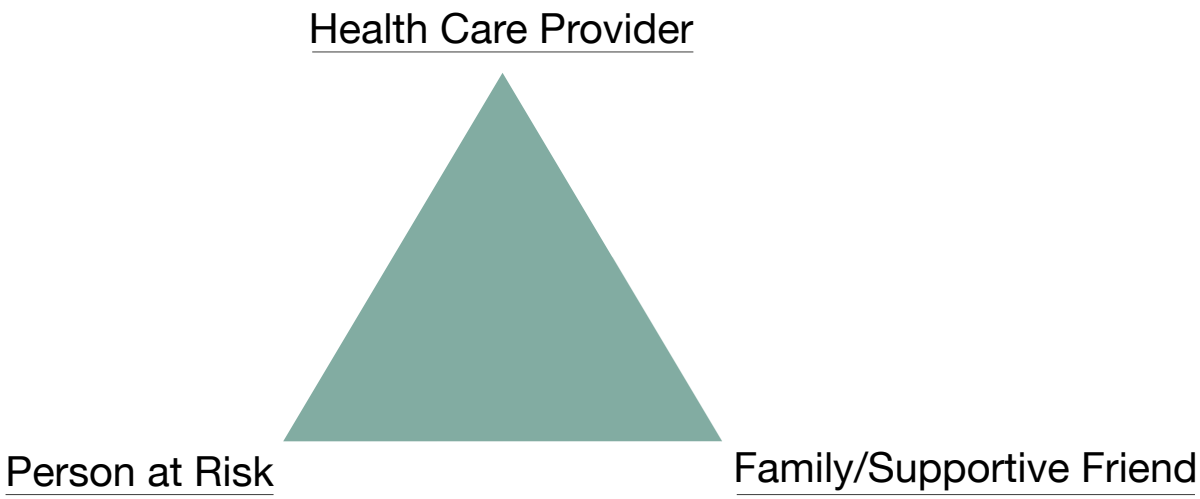


FIG. 7.2 ONCE, TWICE, THREE TIMES – STOP – COLLABORATION BETWEEN PERSON AT RISK, HEALTHCARE PROVIDER AND FAMILY MEMBER OR SUPPORTIVE ADULT

The GP has a key role in supporting both the individual and their family member. Involvement of a family member has also been shown to improve outcome (Taylor et al 2016).

Gathering information from family and supportive adults and providing family members/supportive adults with support is central to the NCPSH. Every effort should be made to provide the patient with a clear understanding of the value and importance of both gathering information from and sharing information with family members or a supportive friend. Confidentiality is paramount but there are situations where it can be breached. Even in situations where it is not appropriate to breach confidentiality, listening to family members/carers is important and is not precluded by confidentiality. Support for family members/carers can also be provided without breaching confidentiality (Casey 2016). Along with family support, clinicians also need to be aware of the risks of family abuse and intimate partner violence. There is an association between intimate partner violence and self-harm and suicidal behaviours (Dillon et al 2012).

The rates of self-harm and suicidal ideation presenting to primary care are rising, but only a minority of patients who self-harm in the community present to healthcare services (Feeney and Douglas 2016). Two-thirds of patients who self-harm present to their GP in the month prior to the self-harm episode and in the month after a self-harm episode (Houston et al 2003). GPs in Ireland report that they have adequate training in the assessment of suicidal behaviour and are open to exploring suicidal ideation and in treating depressive illness (O'Dowd 2006). One Norwegian study found that GPs expressed a high level of perceived competence in managing suicidal patients, but only 38% reported receiving training in the previous five years (Grimholt 2014).

In 2002, Scott et al showed how using a chronic disease model for depression improved the detection and management of depression and suicidal ideation. Factors key to the success of this model were resources to develop a case register, an education and training programme on detection and management agreed by consensus, facilitation of meetings with secondary care staff, and support in developing a practice guideline. An example of effective use of meetings between primary care and secondary care in Ireland is described by Wright and Russell (2007). A combination of these approaches has been used to good effect in another Irish service (McFarland et al 2009).

A systematic review into the GP's role in supporting patients with self-harm behaviour has identified facilitators and barriers to management (Mughal et al 2020). No Irish study was identified in this review but many of the international findings relate to Irish general practice also. Facilitators include training of GPs in brief psychosocial assessments and in assessment of young people; improved communication between primary and secondary care, including the use of co-developed protocols and regular meetings; improved service provision for people who self-harm, including a single point of access for assessment, a mental health nurse, counsellor or psychologist attached to practice; and family involvement. Four themes or barriers to GP management of self-harm were identified, including a) assessment – GPs did not always have the time or confidence to manage people effectively; b) a lack of effective services in primary care; c) poor communication between primary care and secondary care; and d) workload in general practice and geographic boundaries interfering with referral pathways (see Table 7.1).

Facilitators	Barrier
Training of GPs in brief psychosocial interventions; Improved communication between primary and secondary care A single point of access for assessment Mental health nurse, counsellor/psychologist attached to practice	Lack of time Lack of confidence Lack of effective services Poor communication Workload and systems failures

TABLE 7.1 FACILITATORS AND BARRIERS FOR GPS IN MANAGING SUICIDAL BEHAVIOUR (MUGHAL ET AL 2020)

Earlier studies in Ireland have reported similar issues (Whitford and Copty 2005, Jeffers 2010), with GPs requesting access to counselling in primary care, mental health professionals working within general practice, and improved

communication between general practice and secondary mental health services.

A recent presentation to the Oireachtas Joint Committee on Health by ICGP confirmed this (ICGP 2020). General practice provides care for over 90% of mental health conditions without the need for secondary care input and GPs have a pivotal role in providing first and ongoing care for these patients. It needs to be supported in caring for these patients, with greater access to talk therapies, including on-site sessional talk therapy in a general-practice setting, addiction services, improved integration with primary and secondary care, and upscaling of digital technologies in mental health services in particular (ICGP 2020).

GPs want to have immediate access to discussion and advice from a mental health professional. They need a pathway of care that can provide access to a mental health professional urgently – within 24 to 72 hours (Jeffers 2010, Walsh 2013). This will reduce the need for referral to the ED. It will also provide the GP with a meaningful response and help for patients, which is likely to increase their exploration of suicidality.

Doyle et al (2020), in their qualitative review of 50 people who had presented to the ED following self-harm or with suicidal ideation, reported that a number of people with suicidal ideation had found the ED environment to be unsuitable. They found it noisy and stressful, and the long delay between registering and being assessed was particularly difficult. Individuals reported feeling they were in the wrong place and yet they were not aware of anywhere else to present when they had suicide-related thoughts.

People with suicidal ideation or self-harm ideation present or are directed to the ED, although good practice would recommend they be assessed in the community (Carey et al 2021). The Model of Care clearly states that patients in mental health crisis, without physical need, should have direct access to their local community psychiatric teams over a 24-hour period, without recourse to the ED (HSE 2016). Furthermore, it has been recognised that, when mental health services rely on ED as opposed to community services, to urgently assess patients, this results in higher rates of direct inpatient psychiatric admissions, with obvious cost implications (Gibbons et al 2012).

Many people can be adequately supported by primary care mental health services and will not require referral to a specialist mental health service. If people do require specialist mental health input, this can be provided by a mental health nurse, a CMHT or a central crisis assessment team (Dueweke et al 2018). In the UK, individual services provide a suite of responses for people in a crisis, including a 24-hour helpline, staffed by mental health professionals and open to patients and GPs; a helpline for use Mon-Fri 9-5, for people already known to services; GPs can receive a same-day crisis assessment for new patients, and, in the rare cases where none of these services is available, the person is advised to attend the ED (NHS 2019).

McGarry (2019) describes the development of specific self-harm and unscheduled care teams in Belfast, emphasising the need for separate services. He suggests that home-based treatments and 24/7 services are for people known to service and they prevent the admission to hospital of people suffering from severe mental illnesses, such as schizophrenia, bipolar disorder and severe depression. Others have also suggested that there is a need for a separate service for those with anxiety disorders and substance misuse and those who have self-harmed in the absence of severe mental illness, or in crisis due to relationship difficulties (Onyett et al 2006).

In Ireland, information on access to such non-ED unscheduled care is sparse. Most mental health services provide a 7/7 service for patients who are already known to the service, although recruitment continues to be a challenge (HSE 2018a). This is a service that can be delivered by mental health nurses and other health and social care professionals. Current staffing allows only for pre-planned appointments and it cannot provide an emergency service. It is not in place in all services and many service users may not be aware of it. A full review of the operation of the 7/7 services would be useful in identifying gaps in the service. GPs in North Dublin who were surveyed about access to non-ED care indicated that they referred patients to the ED for urgent psychiatric assessment due to difficulty in accessing the CMHT or other community alternatives for crisis mental health presentations, compared with the certainty of a response from the ED. They also felt that the ED setting was not an appropriate environment for such patients (Carey et al 2021).

A small number of services in the country offer assessments in the approved centre, obviating the need for such patients to spend often long hours waiting in ED. Most psychiatric services require all patients to attend ED first, and they will then be assessed in the ED by a mental health professional. Over 40% of these assessments occur out of hours by a non-consultant hospital doctor in psychiatry (HSE 2017). *A Vision for Change* (DoHC 2006) and the Mental Health Commission (MHC 2009) both support using non-ED facilities for assessments.

Suicide Crisis Assessment Nurses (SCANs) who are clinical nurse specialists in mental health provide assessments for GP patients who present with suicidal behaviour. A recent review found that a SCAN was present in only eight of the country's 16 mental health services, and in these a SCAN service was present in some sectors only (Griffin et al 2019). They provide a link between primary care and secondary care, and will reduce the need to refer patients either to ED or to Community Mental Health Teams (CMHTs). Griffin et al (2019) found that only 38% of patients assessed by SCAN were referred to CMHTs. Raymond et al (2020) reported on a SCAN service in North Dublin where only 12% were referred to the CMHT.

The SCAN service is popular with GPs and service users who have accessed it (HSE 2012). Despite this, only 20% of the population have access to a SCAN service. The slow uptake around the country may reflect concerns consultant psychiatrists hold in relation to resources to supervise staff in a new service, and also, in some areas, a reluctance of GPs to change their practice, as evidenced in the 2012 review (HSE 2012). Any expansion of this service will require resourcing in the form of extra Consultant Psychiatrist time as well as extra Clinical Nurse Specialists, and awareness training for GPs on the value of the SCAN service. Clarity on the level of supervision required will also improve uptake of the service. Once a service is established, further education to ensure joint working with GPs to promote the service will be needed. Evidence shows that a SCAN service will reduce the numbers of inappropriate referrals to a CMHT (Raymond et al 2020, Griffin et al 2019).

SCAN services can also be integrated with both primary care and secondary care services. A need has been identified for non-crisis and time-limited specialist counselling for people who self-harm or have suicide-related ideation. One example of this is seen in the South East: the Self-Harm Intervention Project (SHIP), which has been in place since 2004. Trained psychotherapists provide non-crisis, time-limited specialist counselling to people who have self-harmed or have suicidal ideation (Gardner et al 2015). Governance for this programme is through the National Counselling Service of the HSE. The SHIP programme is provided in the context of a range of services, including SCAN, CMHTs, community counselling and other community supports.

A number of non-governmental organisations (NGOs) also deliver non-crisis counselling for people who self-harm or with suicidal ideation. However, SHIP is the only service that has been developed as part of the wider and integrated services in primary and secondary care. As a specialist short-term counselling intervention, SHIP 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, or self-harm and substance misuse, although certain conditions would be considered inappropriate for the brief intervention such as acute psychosis, chronic intractable mental health issues that remain unchanged after two years of psychiatric intervention, severe recurrent depression and borderline personality disorder. SHIP is not appropriate and does not function as a crisis response service. SHIP accepts referrals from health or allied professionals. The number of sessions is agreed between client and counsellor up to a maximum of 12 sessions. Feedback to the referrer is provided when the therapy has ended.

While it is outside the remit of the NCPSH, the availability of non-crisis, time-limited and focused counselling for people who self-harm or are suicidal should be developed as part of a wider range of services, as identified in Fig. 7.3.

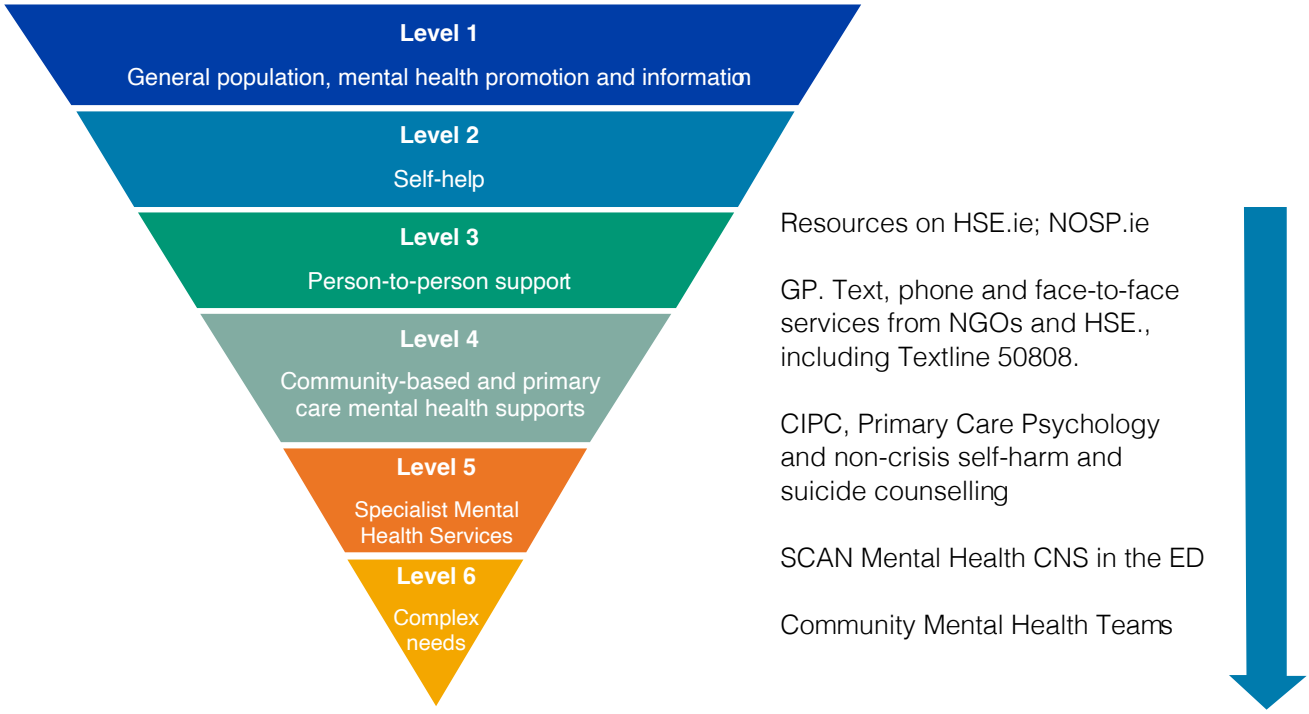


FIG. 7.3 SERVICES REQUIRED FOR SELF-HARM AND SUICIDE-RELATED IDEATION

Psychological services offered in primary care include Adult Primary Care Psychology Services (HSE 2018), Counselling in Primary Care, and Child and Family Psychological Services. Counselling in Primary Care (HSE 2018) is available only to GP patients who are on the General Medical Services scheme. Psychology services are available to all GP patients, but there are long waiting lists (ICGP 2020). GPs also refer patients to local available low-cost or free voluntary counselling provided by NGOs. NOSP has recently developed guidance on governance for voluntary agencies working with people who are suicidal (NOSP 2019a). There are examples around the country of effective collaborative working between primary care psychological and counselling services and secondary care CMHTs. Anecdotal evidence indicates a need to improve this collaboration, and at the same time retain the GP as the gatekeeper to secondary care services. Mental Health CNSs both in the ED and in SCAN services have a role in improving the links between primary care and secondary care mental health services (HSE 2017, Griffin et al 2019).

Collins et al (2020) describe a primary care psychology service that accepts walk-ins, self-referrals, and health and social care referrals in an Irish rural county. It operates a stepped-care model of service provision whereby the least intensive form of intervention to meet the service user's needs is offered. This leads to a high volume of 'low-intensity' interventions being provided and a smaller volume of 'high-intensity' interventions. The various steps include brief assessment/consultation/signposting, guided self-help and brief (up to six sessions) CBT-informed psychological interventions. Assistant and trainee psychology students, supervised by a senior psychologist, provide the service. Input can be stepped up to provide senior psychologist input, or referral to secondary care mental health services. Most individuals using the service wished to have a timely, positive interpersonal experience that addressed their individual concerns. These factors were considered more important than the specific type of intervention offered (Collins et al 2020).

Both the HSE and NGOs provide telephone and text supports for people who are in suicidal crisis. Examples include 50808 text lines; 50808 provides a free, anonymous, 24/7 messaging service, including everything from a calming chat to immediate support. It provide a safe space where the texter is listened to by a trained volunteer. The person and volunteer message back and forth. By asking questions and listening, the volunteer will help the person sort through their feelings until both feel that the person is in a calm safe place. (More information is available at https://text50808.ie/.)

Further examples of mental health support and services available in Ireland are described in Appendix 2.

TABLE 7.2 HSE AND VOLUNTARY MENTAL HEALTH SERVICES IN IRELAND

- General Practitioner
- Counselling in Primary Care (CIPC) / Voluntary no-cost or low-cost counselling
- Psychology in Primary Care / Voluntary no-cost or low-cost psychology services
- Child and Family Primary Care
- Suicide Crisis Assessment Nurse / Crisis Assessment Teams
- Self-Harm Intervention Project / Voluntary Professional Services offering non-crisis counselling for self-harm and suicide-related ideation
- HSE-funded phone lines and text lines
- Community supports
- Seven days a week mental health support for people known to the mental health service
- Community Mental Health Teams

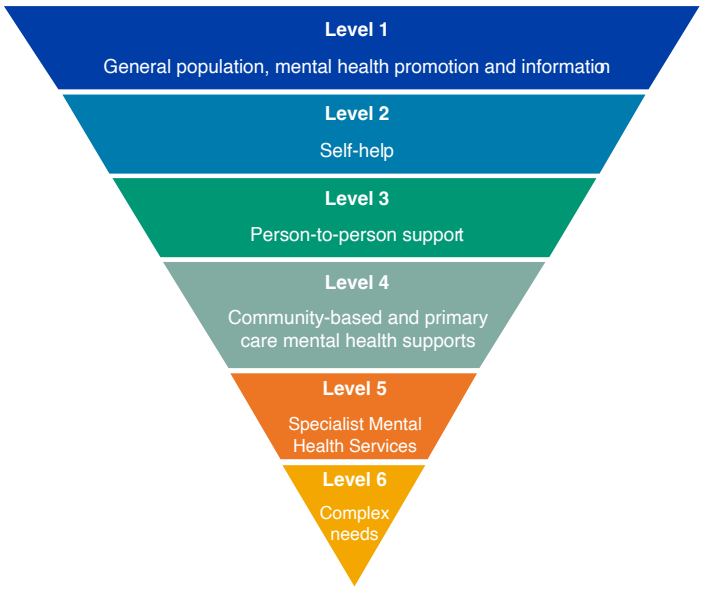


FIG. 7.4 MODEL OF MENTAL HEALTH SUPPORT AND SERVICES IN IRELAND

Douglas and Feeney (2016) have reported on the change in referrals to mental health services in the 30 years up to 2013. Overall, there has been a marked increase in referrals; a reduction in the proportion of referrals concerning psychosis, and an increase in the proportion that were deemed urgent and were concerned with suicidal risk. Suicidal ideation was mentioned in 14% of referrals in 1983 and 50% of referrals in 2013. Since the establishment of the Clinical Programme in 2015, over 40% of patients assessed present to the ED with suicidal ideation only, while the other 60% present following self-harm. Reflecting reduced resources in CMHTs, access to non-scheduled care by CMHTs has reduced and, in the absence of other services, GPs are forced to refer individuals to the ED.

The Connecting for Life Implementation Plan (NOSP 2020) supports the development of Connecting for Life Action Plans in each area. This action plan includes a list of all verified resources and services available in the community, which can support the use of a stepped care approach.

(For a more extensive literature review on self-harm and suicidal ideation, see Chapter 2.)

Summary of literature related to self-harm and suicide-related ideation response by general practitioners:

- Self-harm and suicide-related ideation is associated with an increased risk of death by suicide in the future.
- People who present to their GP with self-harm or suicidal ideation benefit from brief intervention, development of safety plans, and follow-up and linkage to next care.
- At present a high percentage of people presenting to the GP with suicidal ideation or following self-harm are referred to the ED.
- Best practice recommends the development of non-ED crisis assessments in the mental health services or urgent mental health interventions in primary care..
- The SCAN service can provide assessments for GP patients within 72 hours.
- The HSE and NGOs provide a number of telephone and text supports for people in a suicidal crisis.
- The HSE and NGOs also provide specialist non-crisis time-limited counselling for people with suicide-related ideation or self-harm.

7.3 Services required at GP level

7.3.1 Overview

The Model of Care states that GPs should be regarded as the first point of medical care for all persons with mental health disorders, including those who self-harm, with the exception of those requiring medical care arising from a self-harm episode.

The literature review points to the need to develop a specialist service for people who present to their GP following self-harm or with suicidal ideation who do not, at that time, have a primary severe mental illness. They require an empathic response, expert biopsychosocial assessment, family/ supporter involvement and linkage to appropriate next care.

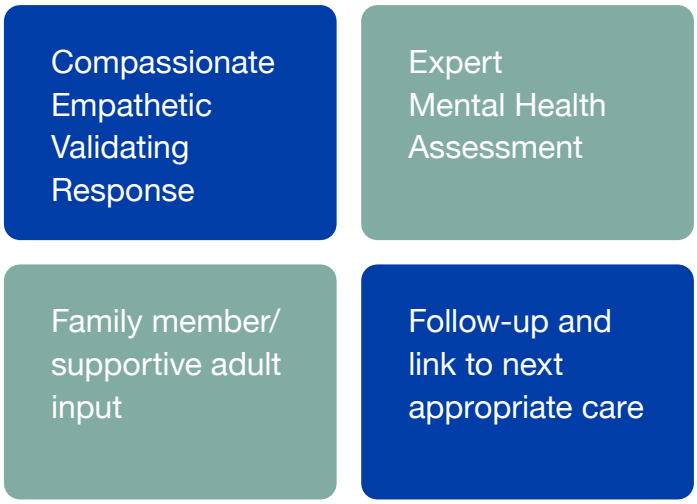


FIG. 7.5 CLINICAL COMPONENTS OF THE NCPSH

The NCPSH was initially introduced for all patients presenting to the ED following self-harm or with suicide-related ideation. It is now recognised that many people with self-harm or suicide-related ideation will present to their GP or primary care, and require a service separate from the ED. There is a need to integrate the services available in the community and in the specialist services.

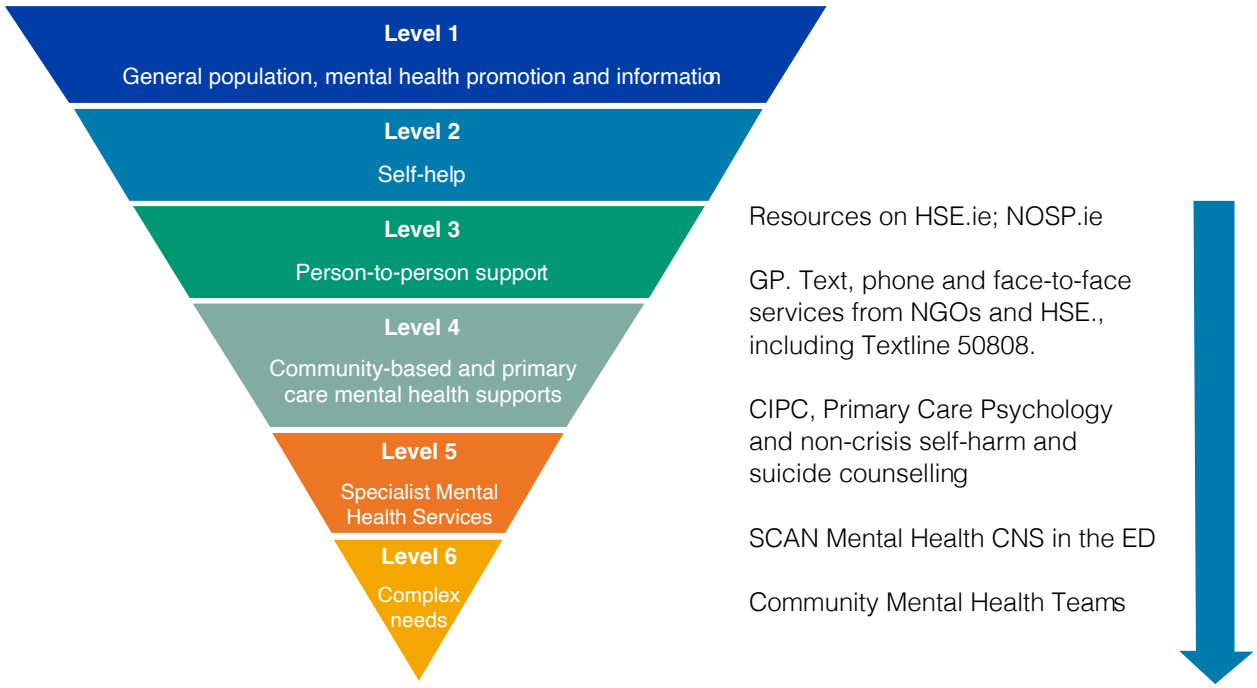


FIG. 7.6 POPULATION, COMMUNITY AND MENTAL HEALTH SERVICES FOR SELF-HARM AND SUICIDE-RELATED IDEATION

A Vision for Change (DoHC 2006) identified the need for liaison and collaboration between primary care and secondary care mental health services. The introduction of SCANs or suicide crisis assessment teams can support this collaboration.

Examples of further collaboration are described in Chapter 8.

7.3.2 Introduction of a new SCAN service

The Suicide Crisis Assessment Nurse (SCAN) was introduced to Ireland in 2007, initially in South Dublin and Wexford. A nurse, at CNS level, was employed by the mental health service to provide assessments of GP patients experiencing a suicidal crisis.

An in-depth evaluation in 2012 described the SCAN service as a valuable, accessible and timely gateway between primary care and mental health services, allowing for expedited admission, referral for ongoing mental health intervention in the community or management in primary care (HSE 2012). Almost all GPs with experience of the SCAN service agreed that it led to better treatment adherence than 'usual care' and clients were more readily agreeable to being referred to the SCAN service.

Following publication of the 2012 report, further SCAN services were introduced in a number of services in Ireland and in 2017 a review of the service was completed for the National Office of Suicide Prevention (NOSP) (Griffin et al 2019). This review found that SCAN services remained in place and worked effectively when there was support and clinical supervision from a General Adult Consultant Psychiatrist (GACP), but those services where there was no clinical supervision from a GACP have not remained in place. One of the strengths of the service is that it is located in primary care. The service is in place in eight services in the country, covering 20% of the population; the review found that 230 GPs were using the service, referring an average of five patients per year, with 30% of practices referring one patient. A total of 72% of patients referred were assessed; the commonest reason for not assessing was the patient not attending for the appointment. Assessments took an average of 2–3 hours and in 69% of cases some engagement was

made with a family member; 40% of those reviewed had alcohol and drug misuse along with suicidal behaviour. Over 95% were given an emergency safety plan (the study does not identify if this was written or verbal), while 38% of patients assessed were referred to a community mental health team.

A separate study of one SCAN service in North Dublin found that 12% of the patients assessed were referred to the CMHT. In this study, the pathway to care from the GP to the SCAN involved the patient remaining under the clinical guidance of the GP. If referral was required to the CMHT this was made by the GP. In other services, referrals can be made directly from the SCAN to the CMHT.

The current SCAN service is delivered by 11 experienced CNSs. Both the Griffin report (2019) and personal communication with the CNSs delivering SCAN show they are delivering a service that is valued by GPs and Consultant Psychiatrists, as well as service users and family members. Whenever the service has been withdrawn or curtailed, there is evidence of an increase in referrals to CMHTs and to the ED (SCAN 2021). The current SCAN staff are experienced and ideally placed to mentor and support the training of new staff commencing a SCAN service. A need for formalised governance structures for the SCAN staff was identified in the Griffin report.

The current SCAN staff follow a standard operating procedure that aligns with the four components of the NCPSH: a compassionate, empathic response for people who have self-harmed or are suicidal; an expert biopsychosocial assessment, including a written emergency care plan; family involvement where possible, and follow-up and linkage to next appropriate care (SCAN 2021).

Consultants in Ceneral Adult Psychiatry are best placed to provide clinical governance to SCAN professionals. In the absence of a SCAN service, the evidence is that GPs refer suicidal patients either to a CMHT or to an ED (Carey et al 2021). We know that the ED is not a suitable place for people who are suicidal but have no physical health needs, and that people assessed in the ED, rather than in a non-ED mental health service, have a higher rate of admission (Gibbons et al 2012). We also know that SCAN services markedly reduce referrals to the CMHT (Griffin et al 2018, Raymond et al 2020).

The introduction of the SCAN service will provide a suitable and appropriate service for a large group of service users, and will reduce the numbers of inappropriate admissions to approved centres as well as inappropriate referrals to CMHTs. Being seen by SCAN does not constitute a referral to the CMHT and the patient remains in primary care. If SCAN and/or the GP deem that a referral to a CMHT is required, the normal referral process by a GP to the CMHT should be followed.

The NCPSH now recommends the development of Suicide Crisis Assessment Nurse service in local areas in all parts of Ireland. As part of this development, the current SCAN staff should:

- be incorporated into the NCPSH
- be trained and supported in submitting data on all cases referred to them
- receive support and oversight from the staff of the NCPSH office, including review of their service and support to implement all aspects of the Clinical Programme
- attend all training and networking days organised by the NCPSH
- have the opportunity to provide input to the Implementation Advisory Group (IAG) and to the Research and Audit Committee

SCAN service provision

- The role of a SCAN service is to provide assessment and support to GP patients who have suicide-related thoughts, who do not have an acute mental illness requiring immediate input from a secondary mental health team and are not at immediate risk of suicide.
- Patients should be seen within 72 hours of referral.
- Assessments should be carried out in general practice if space is available. It is the responsibility of the HSE to ensure that facilities in primary care are available for use in situations where accommodation is not available in general practice.
- The SCAN practitioner should complete a full biopsychosocial assessment; with patient permission should liaise with family or a supportive friend; should

develop a collaborative written emergency safety plan, and provide feedback to the GP.

- Where required, the SCAN practitioner should provide up to three follow-up appointments.
- In all cases, the SCAN practitioner should provide a follow-up phone call within 24 hours of the first assessment.
- The SCAN practitioner should develop a resource of all the mental health supports available in the local area and should be an active member of the Connecting for Life local action plan.
- SCAN practitioners could be a nurse, at clinical nurse specialist level, an Advanced Nurse Practitioner (ANP) or an appropriately trained mental health professional.
- Each service should have a General Adult Consultant Psychiatrist who will act as clinical lead. They will require allocated time of 0.2 WTE to provide supervision for the SCAN CNS and/or ANP.
- The CNS will require clinical supervision from sector consultants following each assessment and also weekly supervision on work practices and learning, which can be provided by the clinical lead.
- An ANP can work with a greater level of personal accountability and responsibility, and does not always require immediate clinical support following each assessment. An ANP can also provide supervision for a CNS, thereby freeing up Consultant Psychiatrist time.
- The development of the SCAN service would be the responsibility of the clinical lead, SCAN CNS and/or ANP.
- SCAN should be available initially for adults over the age of 18 years. Once the model is established, the development of a similar service for children could be explored.
- One SCAN practitioner for roughly 75,000 population will be required. 0.2 WTE General Adult Consultant Psychiatrists are required per 300,000 population. Initially this service should be commenced in areas of greatest need.

In some services it will be more efficient to employ SCAN staff as members of a crisis assessment team, or with the homeless as part of the specialist mental health team for the homeless (Chapter 5). The service provided for GP patients would be the same but the staff would work as part of a crisis assessment team or assessment hub. The governance structures and oversight of such services would be the same as for the SCAN service, with a CNS appointed through the NCPSH and accountable for implementing the NCPSH.

Staff providing a SCAN service

Clinical Nurse Specialists (CNSs)

In a SCAN service or in crisis assessment teams, assessments are carried out by nurses at CNS grade or mental health practitioners of similar qualification. At this grade nurses have at least five years' postgraduate experience in an acute mental health service and have educational qualifications to level 9 (Postgraduate Diploma/ Master's). Other studies have shown the benefits of using nursing assessments both within CMHTs (Walsh et al 2013) and in assessments following self-harm (Russell et al 2010).

Vandewalle (2020) has shown the benefits that the nursing perspective brings to these assessments, with an enhanced working alliance between patients and health professionals. He recommends that nurses be appropriately supported with clinical and managerial input. At CNS level, nurses can complete assessments and discharge of patients following discussion with a senior decision-maker, such as a Consultant Psychiatrist, Higher Specialist Trainee or Advanced Nurse Practitioner.

CNSs would require clinical supervision from the Consultant Psychiatrist clinical lead. The purpose of this supervision would be to support service development, clinical training and case management.

Registered Advanced Nurse Practitioners (RANPs)

Advanced Practice Nursing (RANP) is defined as a career pathway for registered nurses, committed to continuing professional development and clinical supervision, to practise at a higher level of capability as independent, autonomous, and expert practitioners (NMBI, 2017). The RANP manages a specific caseload of patients'/service users, from admission to discharge, completing an episode of care at an advanced level.

RANPs working in the SCAN service would require a level of training, qualification and experience that would enable them to hold personal accountability and responsibility for patients they see. They would work under the clinical supervision of a general adult psychiatrist, but the input required for discussion and management of clinical cases would be similar to that of a senior decision-maker, such as a higher specialist trainee. The RANP would be in a position to provide clinical support for CNSs.

Consultant Psychiatrist

A General Adult Psychiatrist is the most appropriate person to provide clinical governance over a SCAN service and provide oversight for the SCAN professional in providing timely input in an appropriate place.

Funding should be allocated through the NCPSH to allocate 0.2 WTE Consultant Psychiatrists for a population of 300,000. Working with the appointed SCANs, this consultant would implement the NCPSH, ensure that other Consultant Psychiatrists understood the NCPSH, develop enhanced communication with GPs, and provide ongoing leadership and supervision for the SCAN. All General Adult Consultant Psychiatrists have a role in providing clinical advice for SCAN, relating to patients from their sector and patients who are assessed on call.

Commencement of SCAN as an integral part of the NCPSH

- All current SCAN and equivalent practitioners should be supported as staff implementing the NCPSH.
- SCAN practitioners will be required to implement the NCPSH, as identified in the SCAN SOP.
- Data will be collated on all presentations to SCAN services, and submitted to the NCP office on a monthly basis.
- The NCPSH office will review the practice, supervision and work practices of all SCAN practitioners, and support the practitioner and the service in fully implementing the NCPSH.
- Promotion and awareness of the SCAN programme will be developed for Consultant Psychiatrists and GPs. This will be developed by the NCPSH in conjunction with ICGP. Current SCAN practitioners will be invited to participate in this promotion.
- SCAN practitioners will be invited to participate in the work of the IAG and the Research and Audit Committee of the NCPSH.
- SCAN practitioners will be included in all training and network events organised through the NCPSH.
- Key to effective working between GPs and the SCAN service and between GPs and secondary mental health services is effective and timely communication. This can be in the form of a secure email link such as Healthlinks, through telephone discussion or planned regular meetings between general practice and secondary mental health.

7.4 The role of emergency safety planning in mitigating suicide risk

The risk of suicide is raised in any person who self-harms or who presents with suicidal ideation. The aim of the clinical programme is to introduce practices that will mitigate this risk.

Self-harm and talking about suicide leads to understandable anxiety and distress among individuals and family members. The assessing mental health clinician needs to provide compassionate support and develop a therapeutic rapport in order to complete an expert assessment. Many individuals and their families will have an expectation that hospital admission may be required. In practice, most individuals will be treated within the community. Hospital admission will only be required for a small percentage of people – those presenting with symptoms of psychosis or extreme agitation, or hopelessness caused by mental illness.

As outlined in Stanley and Brown (2018), safety planning intervention as part of a CBT intervention aimed to reduce suicide risk has been shown to be effective. It involves helping patients to identify what triggered the crisis, use skills to tolerate distress or regulate emotions, and, should the crisis not resolve, how to access emergency care. The therapeutic interventions would seek to:

- ensure the safety of the patient by removing access to lethal means
- initiate self-monitoring of the suicidal thoughts, feelings and behaviours

Patient's Name: **Date of Birth:**
Mental Health Professional (MHP) Name:
ESP completed in collaboration by the MHP and the patient: **Yes ❑ No ❑**
Family member/supporter has been part of the care plan: **Y ❑** N ❑

	RESPONSES	**ACTIONS**
Keep safe	Individual Family member/supporter GP /SCAN	*(e.g. Remove firearms, tablets, means of self-harm. Stay with relatives/supportive friend. Identify internal/personal coping strategies.)*
Emergency numbers		*(Include numbers for Samaritans 116123; daytime numbers for CMHT and GP; and for supportive family members or friends who can be contacted in an emergency.)*
Mental Health Support		*(e.g. Name of place and phone number for next appointment; plan for what the next communication will be with the patient.)*

Patient has requested family member is not included: **Y ❑** N ❑
Family member given a copy of *Would you know what to do if someone told you they were suicidal? (NOSP*): Y❑N❑
Copy of the ESP given to the patient: **Y ❑** N ❑
Signed (MHP)
Signed (Patient – *optional*)

FIG. 7.7 EXAMPLE OF AN EMERGENCY SAFETY PLAN

- target symptoms that are most likely to interrupt day-to-day functioning
- target hopelessness and sense of isolation
- reinforce the commitment to treatment
- solidify the therapeutic relationship

Certain modifications have been found helpful for people seen in the Irish services. Staff and service users have reported finding that focus on protective factors is more useful than focusing on reasons for living. Strengths-perspective and solution-focused safety planning focuses on identifying coping strategies and problem-solving, and harnessing family and social supports.

A sample emergency safety plan is shown in Fig. 7.7.

7.5 Family member/supportive friend intervention

One objective of the clinical programme is to enhance the experiences of families in supporting their relative. This includes the mental health professional taking collateral information from family members, providing advice on suicide prevention and, with the patient's consent, informing family members of the care plan. If the patient is discharged home, the CNS provides brief follow-up support by phone to the patient and the family member until they reach the next point of care – for example, the GP, mental health team or a counselling service. Underpinning this model is the triangle of care of the person at risk, the family member and the healthcare professional.

Gathering information from family and supportive adults and providing the latter with support is central to the NCPSH. Every effort should be made to provide the patient with a clear understanding of the value and importance of both gathering information from and sharing information with family members or a supportive friend. Confidentiality is paramount but there are situations where it can be breached. Even in situations where it is not appropriate to breach confidentiality, listening to family members/carers is important and is not precluded by confidentiality. Support for family members/carers can also be provided without breaching confidentiality.

As well as encouraging family involvement, GPs and SCANs need to be aware of the possibility of abuse within the family and in particular the risk of intimate partner violence. All patients presenting should be given the time and space for an interview alone.

The Emergency Safety Plan should be produced with the individual and, where appropriate, their family member/supportive adult. This is a written plan for the following 24 hours. It should include how to provide a safe environment, whom to contact in an emergency and what the next professional contact will be. It should address what the individual needs to do, what the family members/supportive friend need to do and what the service needs to do.

7.6 Prioritising need

General practice has for some time identified the inverse care law (Tudor Harte 1971). The areas of most need are often less well served by health services. The NCPSH strongly recommends that resources for a SCAN service be introduced to ensure that those services of greatest need receive the first services.

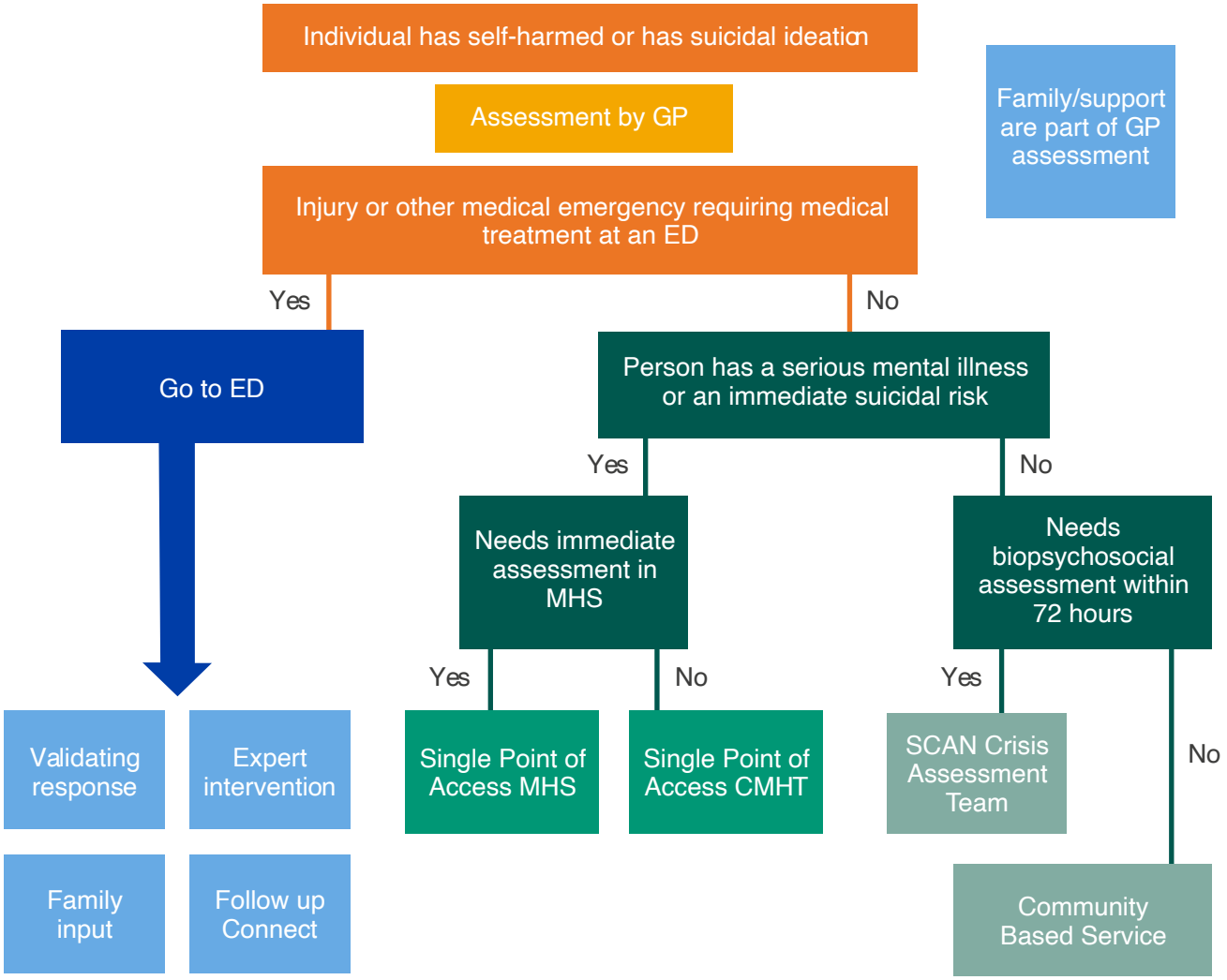


FIG. 7.8 PATHWAY OF CARE FOR PERSON PRESENTING TO GP FOLLOWING SELF-HARM OR WITH SUICIDAL IDEATION

7.7 Examples of local pathways that can be developed

Pathway of care from the GP

Key to effective working between GPs, SCAN and CMHTs is effective communication and collaborative working. The following examples can be used by teams to jointly develop referral pathways. The aim is to ensure that all who have self-harmed or have suicide-related thoughts are directed to the most appropriate service in the first place. The ED is for people who have a medical emergency or an undifferentiated illness. Sending people who do not have a mental illness to the ED to be assessed by a psychiatry-led team is not appropriate. The appropriate service should be available in primary care. If there is no evidence of a serious mental illness, the SCAN service is appropriate. A person with a serious mental illness, who also has suicide-related thoughts or acts, will need to be referred to a psychiatrist-led mental health team. If it's a case of psychiatric emergency, the local mental health service should be contacted through a single point of access. Table 7.3 shows the required pathway of care.

TABLE 7.3 EXAMPLES OF LOCAL PATHWAYS THAT CAN BE DEVELOPED WHEN A PERSON PRESENTS TO THE GP WITH SELF-HARM OR SUICIDE-RELATED IDEATION

Clinical Scenario	Intervention	Useful Contacts
A. The person has intrusive thoughts of wanting to die by suicide and has a means and plan to carry it out. Following GP assessment, it is clear they are at immediate and imminent risk.	**a)** Refer to the local mental health service for assessment for admission. Use the Mental Health Act if the person will not agree to this. **b)** Ensure the person is accompanied at all times until they are safely transferred to the Mental Health Service.	Local Mental Health Service single point of access to discuss assessment for admission.
B. **1.** The person has a serious mental illness, and **2.** has psychotic symptoms or has extreme agitation, or it is not possible to take a full history, and **3.** lives alone or has no family or supportive carer, or **4.** has intrusive thoughts of wanting to die by suicide and has a means to carry it out.	**c)** Contact the Mental Health Service via the Single Point of Access. **d)** In arranging the next assessment, ensure the person is safely linked to the next assessment. An emergency care plan can support this. This will also involve ensuring there is a person with the patient at all times.	Local single point of access for Mental Health Service.
C. **1.** Has a serious mental illness such as moderate or severe depression, Bipolar Affective Disorder, Schizophrenia, Severe Anxiety Disorder, or emotionally unstable personality disorder, and **2.** has fixed thoughts of suicide, and **3.** has supportive family or friend, and, **4.** following assessment and discussion it is clear to the GP the individual's safety can be maintained for 24 hours.	**e)** Complete a collaborative emergency safety plan with the individual and the family/ supportive friend Include – keeping a safe environment, emergency contact numbers and plan for next care. **f)** Contact Community Mental Health Team for assessment within 24 hours.	Local CMHT one point of access for Mental Health Service.
D. **1.** Does not have a major mental illness, **2.** has fixed thoughts of suicide, but no imminent plan, **3.** has supportive family or friend, and **4.** following assessment and discussion it is clear the individual's safety can be maintained for 24 hours.	**g)** Complete a collaborative emergency safety plan with the individual and family. Include keeping a safe environment, emergency contact numbers and plan for next care. **f)** Contact SCAN service for assessment within 24 hours (if SCAN cannot provide this, local Mental Health Service will need to provide an assessment).	Local SCAN service (Some SCAN services will not be able to respond in 24 hours. In these cases SCAN would refer to the CMHT for assessment.)
E. **1.** Has no immediate plans to act on suicidal thoughts. **2.** Has adequate social support. **3.** Is fully cooperative. **4.** Has hope for the future. **5.** Following assessment it is clear the individual's safety can be maintained for 72 hours. **6.** Does not have a major mental illness, or mental illness can be managed by the GP.	**i)** Complete collaborative emergency care plan with the individual and, if they agree, a family member. **j)** Refer to Suicide Crisis Assessment Need (SCAN) service. **k)** SCAN professional to phone within 24 hours, and provide assessment within 72 hours.	Local SCAN service.

Special Circumstances		
F. A person has been assessed by a mental health professional within the last month but now presents with escalating suicide-related thoughts or self-harming.	**a)** Refer to the local mental health service for assessment for admission. Use the Mental Health Act if the person will not agree to this. Or to the local CMHT. **b)** Ensure the person is accompanied at all times until they are safely transferred to the Mental Health Service.	Local Mental Health Service, one point of access for assessment for admission.
G. Suicide-related thoughts or behaviour are accompanied by alcohol and/or other drug use, in the absence of immediate or imminent risk such as in A, in which case interventions for A should be followed.	**c)** Complete a collaborative emergency safety plan with the individual, and, if they agree, a family member. **d)** Follow procedures as in C or D. **e)** Using the SAOR Screening and Brief Intervention for Problem Alcohol and Substance Use, complete a screen for alcohol and other drug use using a screening tool such as AUDIT, DUDIT. Discuss options with the person. **f)** Refer to specialist addiction services where appropriate.	Phone number for local addiction service.

7.8 Follow-up and linkage to next appropriate care

Following a full biopsychosocial assessment with family involvement and completion of a written emergency safety plan, the individual should be followed up and linked to appropriate next care. This may include mental health services and services from the voluntary and community sector.

Chapter 6 described follow-up and linkage to next appropriate care in detail. Follow-up and bridging to next appropriate care is achieved through the SCAN communicating with the patient's GP, telephoning the patient within 24 hours of assessment, and maintaining contact with the patient until they have been in contact with the next appropriate care.

It is beyond the scope of this Model of Care to develop next appropriate care; however, it is important that there be a clear pathway to next appropriate care. It is recommended that all local services develop referral protocols between ED, SCAN, crisis assessment services, CMHTs and community-based non-crisis suicide counselling services. GPs may find that many of these services provide effective supports for individuals before they reach a crisis. Examples of appropriate next care include specialist non-crisis time-limited counselling for self-harm and suicidal ideation, crisis cafés, social prescribing, community counselling and psychological supports. It is recommended that the ED CNS and the SCAN develop clear referral pathways to these services.

The NCPSH recommends that all regions provide access to non-crisis time-limited specialist counselling for self-harm and suicide-related thoughts, and that these services ensure effective communication to and from other health agencies. These services could be developed by the HSE or by NGOs in partnership with the HSE. The Self-Harm Intervention Service (SHIP) in the South East is an example of such a service (Gardner et al 2015). Some non-governmental organisations (NGO) have developed similar services.

Crisis cafés have been identified in a number of countries as offering psychosocial crisis supports (Consumers of MH Report 2019; Harbour Café, Certitude 2020; The Living Room, Heyland et al 2013). The model in all these services provides a place for a person in crisis to receive psychosocial support following a mental health assessment. Links are formed with GPs, local mental health teams and EDs, with individuals referred to the crisis cafés from these services.

Crisis cafés, as described in these reports, do not provide an alternative to the ED; they provide an extra service along with the resourced mental health teams. A comprehensive review of crisis cafés and their feasibility in an Irish setting has been conducted by a number of NGOs, Waterford Institute of Technology and employees of the HSE (Kilkenny Crisis Café

Feasibility Study 2020). This study outlines how a number of agencies can work together in supporting individuals in a crisis. They describe the development of a peer-led and non-clinical approach to crises. Crisis cafés can provide much-needed psychosocial support but they do not provide biopsychosocial assessment of risk and need, and thus do not replace a skilled assessment provided by a qualified mental health professional such as a SCAN, CMHT or the mental health professional in the ED. For this reason, we have not included crisis cafés on the list of pathways to care from GPs. They form part of the next appropriate care for some individuals.

Social prescribing is a means of enabling GPs and other healthcare professionals to refer patients to a link worker – to provide them with a face-to-face conversation during which they can learn about the possibilities and design their own personalised solution to provide social support. This service provides links to social activities and should not be confused with social work input. People with social, emotional or practical needs who often use services provided by the voluntary and community sector are empowered to find solutions that will improve their health and wellbeing. A recent evaluation (HSE 2020c) found that social prescribing is increasing in Ireland, with 18–20 funded projects and a continuing expanding All-Ireland Social Prescribing Network. The self-harm CNS and SCAN should link with any local social prescriber and identify a resource of suitable community agencies that can offer ongoing support. This should be available to all mental health professionals completing assessments, including those working out of hours.

7.9 Training

Training and governance is discussed in detail in Chapters 9 and 10.

7.9.1 Training of GPs

Training, education and continual professional development of GPs takes place through reading, attendance at courses and conferences, and clinical practice.

The ICGP developed the CME Tutor Network to support GP learning. Established in the early 1980s, it has been the most popular form of continuous medial education among GPs in Ireland. Meetings are run in all parts of Ireland and are open to anyone who is working as a GP in general practice in Ireland. A total of 3,195 GPs are currently on the CME mailing list, with more than 10,000 attendances at over 1,200 meetings each year.

The meetings are based on peer-based learning, whereby members share their knowledge and experience. The meetings aim to improve the knowledge base of GPs and also their attitudes and professionalism.

As discussed earlier, GPs have identified specific training needs in relation to supporting individuals with self-harm and suicidal ideation. A systematic review identified the need for training in brief psychological therapies, along with the need to improve communication between the GP and specialist mental health services.

TABLE 7.4 FACILITATORS AND BARRIERS FOR GPS IN MANAGING SUICIDAL BEHAVIOUR (MUGHAL ET AL 2020)

Facilitators	Barrier
Training of GPs in brief psychosocial interventions	Lack of time
Improved communication between primary and secondary care	Lack of confidence
A single point of access for assessment	Lack of effective services
Mental health nurse, counsellor/psychologist attached to practice	Poor communication
	Workload and systems failures

Training in brief psychological therapies is being developed through NOSP and the Irish College of General Practitioners (ICGP). This training will improve GPs' ability to support patients who are in suicidal crisis and enable the GP to use counselling services in primary care in an appropriate manner for all patients. Table 7.5 outlines the learning outcomes of this training.

TABLE 7.5 LEARNING OUTCOMES FOR NOSP/ICGP TRAINING ON COUNSELLING IN PRIMARY CARE

- Understand the role of counselling and psychotherapy in primary care
- Be aware of the different HSE-provided counselling services, and which patients to refer to each service
- Have a basic knowledge of the different forms of counselling available
- Be aware of e-therapies available and the place these therapies have for patients with mental health issues
- Know how to identify patients likely to benefit from therapy and those not currently likely to benefit
- Be trauma-aware in interactions with patients presenting with mental health issues
- Be aware of the clinical governance and risk management issues, the importance of ensuring counsellors are appropriately qualified, and the role of registration bodies and CORU

Specific awareness-building about SCAN will be required as the service is rolled out throughout the country. SCAN nurses and GPs already using the service are ideally placed to support this training.

Training in safety planning and suicide mitigation identified for CNSs and NCHDs, such as STORM training, would also benefit GPs.

The ICGP and the NCPSH should continue to work closely with NOSP in delivering training for GPs in brief interventions.

GPs may also benefit from developing skills in carrying out opportunistic screening and interventions for those at risk of alcohol and substance misuse, including training in SAOR (Screening, Ask and Assess, Offer Assistance and Referral). This training is described further in Chapters 5 and Chapter 9.

7.9.2 Training of SCAN practitioners

Training for SCAN practitioners is described in detail in Chapter 9. All SCANs should attend annual national training seminars organised by the NCP.

7.10 Governance

SCAN practitioners will be funded, recruited and managed by the mental health services.

Each SCAN will require suitable office facilities, ideally alongside a CMHT. Assessments should be carried out in general practice if space is available. It is the responsibility of the HSE to ensure that facilities in primary care are available for use in situations where accommodation is not available in general practice.

7.10.1 Clinical reporting relationship for SCAN service

SCAN provides a consultation service to general practice and general practitioners. Within the SCAN service, the CNS will report clinically to an ANP or a Consultant Psychiatrist. The ANP will report clinically to a Consultant Psychiatrist.

Within the SCAN service, all patients remain in primary care. Being seen by a SCAN does not constitute a referral to the CMHT and the patient remains in primary care. If a SCAN and/or the GP deem that a referral to a CMHT is required, the normal referral process by a GP to the CMHT should be followed.

The CNS should discuss cases with the GP and receive clinical supervision from a registered ANP (RANP) or from a Consultant Psychiatrist, depending on individual service need.

The RANP should receive clinical supervision from a General Adult Consultant Psychiatrist.

Where the supervision is provided by an ANP, that ANP should be allocated time to provide weekly face-to-face supervision, time to establish the service with GPs and, when required, provide input to individual patients.

A General Adult Consultant Psychiatrist should be allocated time to provide weekly face-to-face supervision and time to develop the service with local GPs. This will require 0.2 WTE consultant time per 300,000 population.

7.11 Summary and recommendations

- It is recommended that Connecting for Life Local Action Plans include the provision for GP and ED assessment of self-harm and suicide-related thoughts, as outlined in the Clinical Programme.
- The GP should be the first point of access to people who self-harm or have suicidal ideation.
- Training for GPs should focus on exploring suicidal ideation, identifying local and community-based referral pathways, support family involvement, and brief psychosocial interventions.
- Each general practice should have access to a Suicide Crisis Assessment Nurse service of mental health practitioners. These would be CNSs or equivalent mental health professionals who can address suicide crisis assessment needs. These practitioners will be employed by the mental health services and have access to the clinical support of a Consultant Psychiatrist.
- SCAN should complete interventionist assessments, develop a collaborative safety plan with the patient and a family member or supportive adult, and provide a follow-up phone call and linkage to next appropriate care.
- GPs and secondary care mental health services should aim to develop effective communication, including the joint development of referral protocols, and quarterly meetings to include GP staff, the SCAN service and the CMHT.
- Information on service provision within primary care and community should be available for all GPs.
- All CHO areas should have access to a non-crisis, time-limited, specialist counselling service, with effective communication between health professionals and counsellors within such a service.
- Resources from NOSP, in particular the booklet 'Would you know what to do if someone told you they were thinking of suicide', should be available to all GPs through https://www.healthpromotion.ie/publication.
- SCAN provides a consultation service to general practice and general practitioners. Within the SCAN service, the CNS will report clinically to an ANP or a Consultant Psychiatrist. The ANP will report clinically to a Consultant Psychiatrist.
- Within the SCAN service, all patients remain in primary care. Being seen by the SCAN does not constitute a referral to the CMHT and the patient remains in primary care. If the SCAN and/or the GP deem that a referral to a CMHT is required, the normal referral process by a GP to the CMHT should be followed.
- The CNS should discuss cases with the GP and receive clinical supervision from a registered ANP (RANP) or a Consultant Psychiatrist depending on individual service need.
- A General Adult Consultant Psychiatrist should be allocated time to provide weekly face-to-face supervision and time to develop the service with local GPs. This will require 0.2 WTE consultant time per 300,000 population.

08

Access to Crisis Mental Health Assessment by a Community Mental Health Team

8.1 Urgent referrals to the CMHTs

The Model of Care (HSE 2016) states that each CMHT must ensure it has the capacity to respond to urgent referrals of new and existing patients on the same day. The complex and busy environment of ED is not the optimal environment for assessing patients with mental illness or psychosocial crisis. For those with a severe mental illness, who require input from a CMHT, there is a need for a service outside the ED. The Emergency Medicine Programme emphasises that the ED is a site for assessing undifferentiated health presentations, whether medical or psychiatric, and that patients with known conditions are directed, for example, to acute chest pain clinics, etc, rather than to the ED. As noted in *A Vision for Change*, a fundamental component of mental health care is to clarify arrangements for the provision of 24-hour crisis response capacity. The working-day crisis response service is provided by CMHTs. There is a need to ensure that each team is adequately resourced to respond to urgent referrals of new and existing patients on the same day.

Development of SCAN services, as described in Chapter 7, has been shown to reduce referrals to CMHTs, and provide timely and appropriate assessments for GP patients who have suicidal ideation or who have self-harmed and do not require physical intervention in the ED. The SCAN service is appropriate when suicidal patients do not present an imminent risk or do not have a severe mental illness.

Services have been encouraged to develop 24/7 services for people known to mental health services (HSE 2018). Some services are using home-based teams to respond to the needs of people with acute mental disorders whose needs cannot be met by community interventions of less intensity (O'Keeffe and Russell 2019). A number of CMHTs provide same-day assessments, as outlined in Walsh et al (2013). *A Vision for Change* recommended establishing consultation liaison services with GPs, as described by Wright and Russell (2003).

8.2 Primary and secondary mental health services working together

A Vision for Change noted the need to provide an evidence-based, flexible model of working together for the configuration of primary care and mental health services. It described the use of the Consultation Liaison model and the need to develop close links between the primary care team and the mental health team in order to reduce rather than increase referrals of milder mental health problems, selectively encourage referral of serious mental illness and enhance GPs' skills in detecting and managing mental illness (Fig. 8.1). *A Vision for Change* noted that this recommendation on developing a close relationship between primary care and mental health teams had been made in *Planning for the Future* in 1984, but had not been followed up to any significant extent in a formal way. While communication between primary care and specialist mental health teams has improved in many areas, there is room for improvement. Where such liaison has been developed, improved patient outcomes have been reported (Wright and Russell 2007, McFarland 2010.) This aligns with Sláintecare and current policies of introducing integrated care pathways.

As discussed in detail in Chapter 7, a number of services are available at primary care and secondary care level (Fig. 8.2).

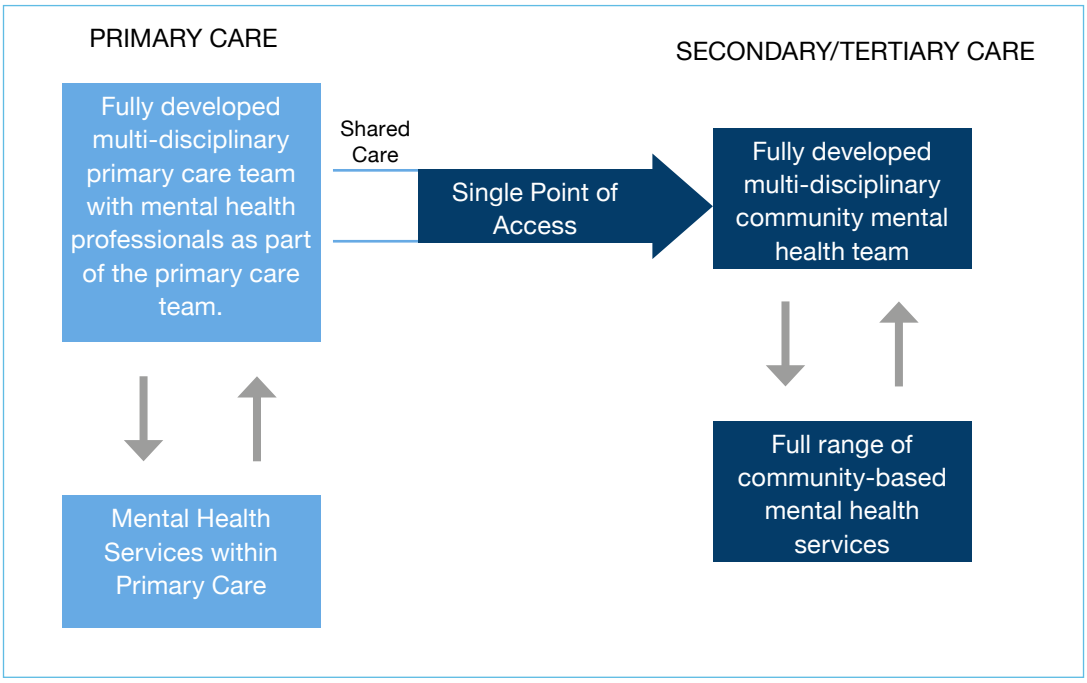


FIG. 8.1 MODEL FOR SHARED MENTAL HEALTH CARE (A VISION FOR CHANGE, DOHC 2006)

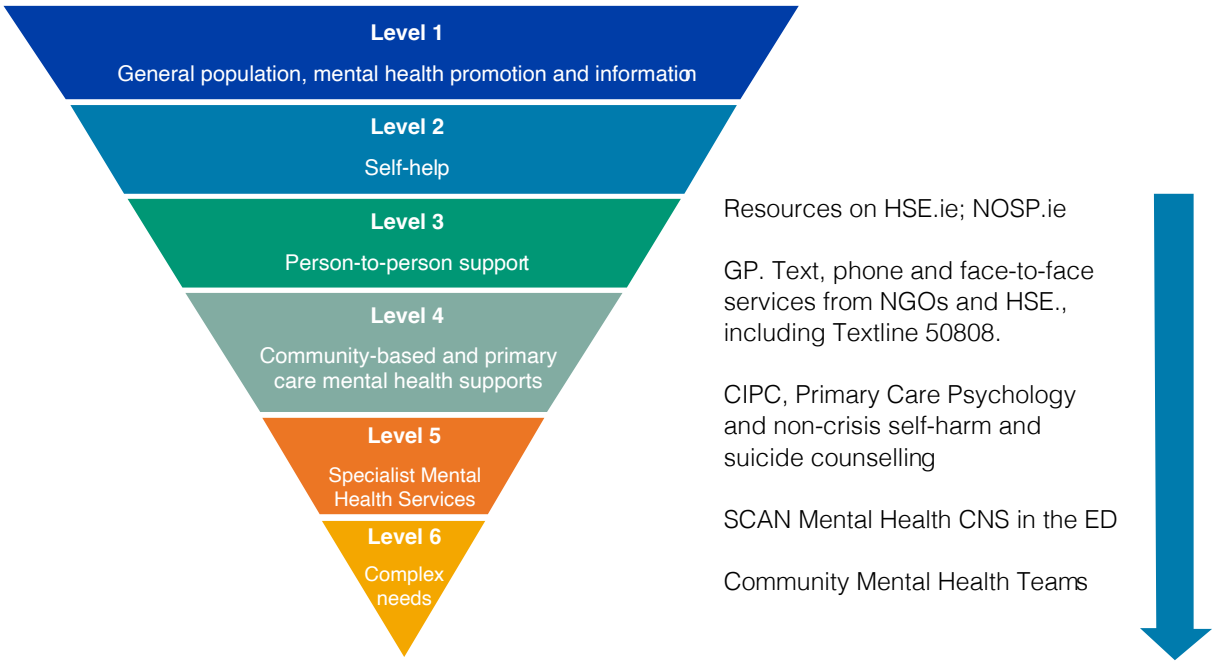


FIG. 8.2 SERVICES FOR SELF-HARM AND SUICIDE-RELATED IDEATION

Effective communication between the GP and the mental health service can ensure that this service works efficiently.

Table 8.1 gives examples of ways of improving communication between GPs and specialist mental health teams, as advised in Planning for the Future (DoH 1984), *A Vision for Change* (DoHC 2006) and Sláintecare.

The GP is best placed to act as gatekeeper between primary care and secondary care. Regular clinical meetings between the Consultant-led CMHTs can support the development of referral protocols and offer opportunities for training. These meetings can build effective and mutually supportive working relationships, and have been shown to reduce the numbers of inappropriate referrals, improve the integration of care pathways and lead to better patient outcomes (Wright and Russell 2003, McFarland et al 2010).

TABLE 8.1 RECOMMENDATIONS ON IMPROVING LIAISON BETWEEN GPS AND CMHTS

- Improve communication between GP referrers and CMHTS.
- Develop protocols on referrals, documentation and how to deal with a crisis, co-produced by GPs and the CMHT
- Identify a team member to provide liaison between the GP and the CMHT.
- Provide GPs with a SPA (single point of access) person. This SPA can be a team co-ordinator or a nominated MDT member who would be the specific contact person for referrals. All referrals and requests for advice would be discussed with the SPA person, rather than with individual members of the team.
- Provide GPs with the contact details of the CMHT SPA member and/or central email and postal address for all referrals.
- Arrange regular clinical meetings between consultant psychiatrists and GPs.

Urgent mental healthcare does not fit neatly into primary or secondary care. Along with a stepped care approach, there is a need for co-produced integrated pathways of care. The two professional groups that hold clinical responsibility for urgent mental health care are the GP and the Consultant Psychiatrist. This Model of Care update provides a template for management of self-harm and suicide-related ideation. Identifying where a person is best treated continues to rest with the GP and Consultant Psychiatrist. There is a need for a forum of the relevant stakeholders to develop integrated pathways of care that can align with the recommendations in this Model of Care.

8.3 Summary and recommendations

- Mental health services should be resourced to ensure that CMHTs can develop effective liaison with general practice and primary care.
- Each CMHT must ensure it has the capacity to deal with urgent referrals of new and existing patients on the same day.
- The development of the SCAN service, as described in Chapter 7, has been shown to reduce referrals to CMHTs.
- Improved liaison between GPs and CMHTs will reduce duplication of work and improve outcomes for patients.
- There is a need for a forum to develop integrated pathways of care that can align with the recommendations in this Model of Care. This forum should be led by the Department of Health and the HSE, and include all relevant stakeholders.

09

Education, Training and Continuing Professional Development

9.1 Background

The overall aim of the NCPSH is to reduce repetition of self-harm, which is associated with increased risk of completed suicide. Mental health professionals, including clinical nurse specialists (CNSs), have been allocated to emergency departments (EDs) and SCAN services across the country to deliver the programme. All CNS/mental health professionals have received training in assessing and managing self-harm. The programme recommends that each CNS/mental health professional be supervised by a named Consultant Psychiatrist who will act as clinical lead. It is the responsibility of the clinical lead and the CNS/mental health professional to ensure that the programme is delivered.

Ireland's national strategy to reduce suicide, Connecting for Life (2015–2020), sets out a vision of 'an Ireland where fewer lives are lost through suicide and where communities and individuals are empowered to improve their mental health and wellbeing'. The National Office for Suicide Prevention (NOSP) has developed a National Education and Training Plan. It recommends that all mental health service staff receive training in suicide and self-injury mitigation training (NOSP 2019). Education should focus not just on knowledge acquisition but move beyond to include competency in psychotherapeutic interventions, recovery and social inclusion (Higgins et al 2010). This understanding aligns with the NCPSH, which identifies developing competency in technical expertise, stylistic or interpersonal factors and professional knowledge relevant to the role.

The Nurse and Midwifery Act (2011) states that there is a need for nurses of all disciplines to maintain their competencies through continued professional development. The work in implementing the Clinical Programme warrants the development of a separate education and training plan. To develop the education and training plan, a training needs analysis of current training available was conducted. The aim of the self-harm NCPSH education and training plan is to ensure that every mental health professional working in the NCPSH has the required technical (clinical) and stylistic (interpersonal) and professional expertise required so as to ensure that the components of the NCPSH are delivered by mental health professionals effectively and with interpersonal warmth and empathy.
Competence is usually defined as the integration of knowledge, skills and attitudes. Professionals require background knowledge relevant to their practice, but what marks out competence is whether the person has the ability to draw on and apply knowledge in different situations, the skills and ability to use them in different situations, and the appropriate attitude and set of values.

TABLE 9.1 NCP SELF-HARM COMPETENCY MAP

Generic Competences	Technical Knowledge	Stylistic/Interpersonal	Professional Knowledge
» Knowledge of Mental Health Disorders/Presentations » Knowledge of Psychosocial Interventions » Knowledge of Psychopharmacology » Knowledge of Factors that Contribute to Self Harm and Suicidal Behaviour	» Biopsychosocial Assesment/ Mental Health Assessment » Collateral History Taking » Formulation » Safety Planning » Risk Mitigation eg. Storm » Care Planning » Pharmacotherapeutics » Psychosocial Interventions » Psychotherapy	» Communication Skills » Engagement and Therapeutic Competences » Psychotherapeutic Interventions eg. CBT; DBT; CFT; Trauma Informed Approaches » Clinical Supervision/Peer Supervision Competences » Staff Training Competences Including: Train the Trainers Self-Awareness Training for Emergency Staff; Clinician Connections; & Samagh)	» Organisational Policies/ Protocols/Guidelines » Effective Records, Reports and GDPR » Data Protection for Health and Socialcare Professionals » Information Governance » Healthcare Professionals and Law eg. Mental Health Act » Knowledge Related to Capacity; Consent; Confidentiality; Safeguarding » Audit » Research » Ethics and The Law

9.2 Education and training needs analysis

An education and training needs analysis (https://www.hse.ie/eng/about/who/cspd/ncps/self-harm-suicide-related-ideation/) was conducted between September 2019 and October 2020 to ascertain the current training undertaken by clinicians delivering the Self-harm NCPSH.
The aim of this education and training needs analysis was to:

- identify the education and training needs of mental health professionals delivering the NCPSH on assessing and supporting patients presenting to the ED following self-harm in the Republic of Ireland
- provide recommendations on evidence-based education and training to inform the skills and knowledge required for mental health professionals to effectively deliver the National Clinical Programme

The objectives of the education and training plan were to:

- identify what post-registration education and training needs mental health professionals require to deliver the Self-harm NCPSH effectively and competently
- Identify and recommend relevant postgraduate and CPD training programmes for mental health professionals delivering the Self-harm NCPSH
- Identify the training and education needs of mental health professionals delivering the NCPSH

A mixed-methods approach was used to identify the education and training needs of mental health professionals involved in the delivering the Self-harm NCPSH. Consultation took place, from September 2019 to October 2020, between the NCPSH office and clinical nurse specialists; the College of Psychiatrists; the area directors of Mental Health Nursing, and assistant directors of Mental Health Nursing delivering the Self-harm NCPSH. A questionnaire was used to collect quantitative data completed by CNSs.

The Self-harm NCPSH education and training needs analysis and subsequent plan identifies the technical knowledge and expertise (clinical); stylistic or human-factor knowledge and expertise (interpersonal), and the professional knowledge (professional) relevant to the role. It identifies the postgraduate training required and continued professional development trainings relevant to assessing patients presenting to the ED with self-harm and/or suicidal ideation.

TABLE 9.2 COMPETENCIES REQUIRED FOR PROFESSIONALS COMPLETING ASSESSMENTS FOLLOWING SELF-HARM/SUICIDAL IDEATION

Clinical	Technical skills Expert knowledge
Interpersonal	Stylistic and human-factor knowledge and expertise
Professional	Ethics and conduct

Technical expertise relates to the relevant knowledge (knowing what makes someone more likely to harm themselves) and skills (knowing how to identify someone's needs and strengths) to perform a particular task or tasks. It does not suggest experience, social skills or attitude. Stylistic strategies relate to the clinician's style and form of communication with the patient. Style has to do with tone, intensity, speed and responsiveness. A clinician's style can communicate attitudes such as condescension and arrogance versus respect and affection. This relates to the clinician having a 'real' relationship with the patient that is compassionate, genuine and responsive to their needs (Linehan 1993). Professional and legal knowledge relevant to the role relates to the knowledge required by clinicians to undertake their role safely and competently.

9.3 Training of other health professionals

9.3.1 ED staff

A training programme has been developed in University College Cork (UCC) to train mental health CNSs in training ED staff on suicide and mental health awareness (Arensman and Coffey 2010). It is the responsibility of the clinical lead and the CNS to ensure that all ED staff receive training on suicide and mental health awareness. Ambulance staff and security staff should also receive mental health awareness training, tailored to their needs.

9.3.2 Psychiatric trainees

Doctors in basic specialist training in psychiatry provide clinical cover for the ED out of hours, or when the CNS is not available. They receive supervision of clinical management

from a Consultant Psychiatrist. They also receive regular clinical supervision from their educational supervisor, also a Consultant Psychiatrist.

Psychiatric trainees receive training and supervision in line with the curriculum and regulations of the College of Psychiatrists of Ireland (CPsychI 2019). Competencies are included under two domains: clinical and professional (Table 9.3). The national training programme provides an induction bootcamp that includes instruction on the NCPSH. The College of Psychiatrists facilitates training through the use of online learning, lectures and conferences. All local services provide training for psychiatric trainees on assessment and support of individuals who are in suicidal crisis. It is the responsibility of the local clinical lead in the NCPSH, both in the ED and in the SCAN service, to ensure that the consultant supervisors and the psychiatric trainees have a working knowledge of the NCPSH.

TABLE 9.3 COMPETENCIES FOR TRAINEE PSYCHIATRISTS (CPSYCHI 2019)

Curriculum Domain	Competencies
Clinical	Biopsychosocial assessment; physical examination and medical management; collateral history-taking; Communication; Formulation; Risk assessment and management; Care planning; Pharmacotherapeutics; Psychosocial interventions; Psychotherapy.
Professional domain	Behaviour, Governance, Team working, Audit, Research teaching, Ethics and the law.

9.3.3 Social work training

Mental health social workers are registered practitioners with CORU. They must also engage in continuous practice development and hold a Level 8 or above on the NQAI framework. Social work in mental health seeks to address the social and environmental factors affecting the individual's and family's mental health, working in partnership with the person and their family/support person. The social workers inform care planning on multidisciplinary teams in mental health, ensuring a psychosocial aspect and perspective to client care.

Along with the clinical and professional competences outlines in Table 9.2, social workers bring additional competencies, as outlined in Table 9.4.

TABLE 9.4 ADDITIONAL COMPETENCIES OF MENTAL HEALTH SOCIAL WORKERS

Clinical case management	Responsibility for coordinating care for a caseload of service users, ensuring appropriate psychosocial supports, providing therapeutic interventions and psychoeducation to individuals and families, and liaising with community services as required.
Psychosocial assessment	Psychosocial issues affecting the individual and family. Working systemically with service users, families/significant others and the wider community.
Mental health assessments	Biopsychosocial Assessment. Mental health social workers may also train as authorised officers (S.9 of Mental Health Act 2001). This involves mental health assessment and managing care in the community or making a recommendation for an involuntary admission.
Role of advocate/ inter- agency work/mobilisation of resources	Encourage individuals to advocate for themselves and/or also advocate on their behalf where needed. Social workers aim to build on people's strengths and skills. They have particular skills in advocating with other service providers in the area of housing, social welfare and mobilising community supports, to ensure that service users and their families obtain maximum resources and services where possible, recognising the impact of social and environmental factors on a person's wellbeing and that of their family.
Trauma-informed care	Working through a trauma-informed lens. Social workers are trained in client-centred, solution-focused, strengths-based counselling interventions, which is part of their core training. Many mental health social workers have additional training in, for example, Cognitive Behavioural Therapy, Dialectical Behavioural Therapy and Behavioural Family Therapy, and some may also be dual qualified as fully accredited psychotherapists and family therapists.

Family-focused practice	Involving families and carers/support persons in the delivery of care for the service user. Also specialised family work with families with more complex needs, and often working with families and individuals in crisis. Social workers also provide specialist interventions (therapeutic work and advocacy) in cases where individuals experience intimate partner violence, and with marginalised groups in society.

9.3.4 Training of GPs

Training for GPs is organised through the CME Tutor Networks by the ICGP.

The CME Tutor Network was established in the early 1980s. Since its inception it has been the most popular form of continuous medial education among GPs in Ireland. Meetings are run in all parts of Ireland and are open to anyone who is working as a GP in General Practice in Ireland. A total of 3,195 GPs are currently on the CME mailing list, with more than 10,000 attendances at over 1,200 meetings each year.

The meetings are based on peer-based learning; members share their knowledge and experience. The meetings aim to improve the knowledge base of GPs and also their attitudes and professionalism.

As discussed in Chapter 7, GPs have identified specific needs in relation to supporting individuals with self-harm and suicidal ideation. A systematic review identified the need for training in brief psychological therapies, as well as to improve communication between the GP and specialist mental health services.

Training in brief psychological therapies is being developed through NOSP and the Irish College of General Practitioners (ICGP). This training will improve GPs' ability to support patients who are in suicidal crisis and enable them to use counselling services in primary care in an appropriate manner for all their patients. Table 7.5 outlines the learning outcomes of this training.

Specific awareness training on the SCAN service will be required as the service is rolled out throughout the country. SCAN nurses and GPs already using the service are ideally placed to deliver this training.

Training in safety planning and suicide mitigation identified for CNSs and NCHDs, such as STORM training, will also be of benefit to GPs.

The ICGP and the NCPSH should continue to work closely with NOSP in delivering training for GPs.

9.4 Training plan

Table 9.5 identifies the mandatory, recommended and useful training for mental health professionals working in the NCPSH, both within the ED and in the SCAN service. The biannual training organised through the NCPSH will provide mandatory and recommended training that is unique to the NCPSH, along with opportunities to network and spread learning between services. This training is provided for all disciplines, availing of the value of interdisciplinary education. It is up to line managers to support the mental health professional in completing training. Training will be through lectures and experiential learning, including shadowing a more experienced clinician. Ongoing clinical and personal supervision will further enhance learning.

Prerequisites for the appointment of a CNS include a Postgraduate Diploma or MSc in Mental Health Nursing (3rd level institutes), and at least five years' postgraduate experience. Social workers require a higher diploma and skill and experience at a senior social worker level.

TABLE 9.5 SUMMARY OF TRAINING NEEDS OF MENTAL HEALTH PROFESSIONALS IN SELF-HARM

Length of experience working with patients experiencing self-harm	0-24 months	24 months +
Mandatory [M]	» NCPSH biannual training days (2-day training) [M] » Biopsychosocial assessment [M] » STORM training [M] » Effective Records, Reports and GDPR [M] » Data Protection for Health and Social Care Professionals [M] » Information Governance » Training on working with groups identified with specific needs such as Traveller Community, LGBTQ+, addictions, autistic people [M] » Mental Health Act [M] » Basic Life Support (BLS) [M] » Moving & Handling [M] » Prevention & Management of Aggression & Violence (PMAV) [M] » Fire Training [M] » Children First [M] » Student Mental Health Nurse Preceptorship training [M]	» NCPSH biannual training days (2-day training) [M] » Train the Trainers Self-Awareness Training for Emergency Staff [M] » Clinician Connections (delivered by National DBT Project) [M] » Self-harm Assessment and Management for General Hospitals programme in Ireland (SAMAGH) [M]
Recommended [R]	» Clinical Audit training [R] » Care of the Vulnerable Adult [R] » Healthcare Professionals and the Law [R] » Individual Clinical Supervision [R] » Screening and Brief Intervention (Project for Alcohol and Substance Use (SAOR) [R] » Healthcare Professionals – Children and the Law [R] » Mindfulness Skills training [R] » Essential Guide to a Coroner's Inquest [R] » Understanding Digital Health – eMental Health	» Clinical Audit training [R] » Dialectical Behaviour Therapy (DBT) [R] » Healthcare Professionals – Children and the Law [R] » Mindfulness Skills Training [R] » Essential Guide to a Coroner's Inquest [R] » Understanding Digital Health – eMental Health » Care of the Vulnerable Adult [R] » Healthcare Professionals and the Law [R] » Screening and Brief Intervention (Project for Alcohol and Substance Use (SAOR) [R] » Individual Clinical Supervision [R] » National Health Communications » Programme Workshop Module 1, 2 and 3 [R] » Motivational Interviewing Level 1 [R] » Models of clinical supervision including: Peer group clinical supervision for nurses & midwives; Self-Practice/ Self-Reflection/Trauma-informed Approaches. [R]
Useful [U]	» ASIST (Applied Suicide Intervention Skills Training) [U] » SafeTalk ('suicide alertness for everyone') [U] » Understanding Self-Harm Awareness Training Programme [U] » Brief Solution-focused Therapy [U]	Postgraduate Diploma/MSc in CBT (UCC, TCD, Queen's) [U] Master's in Human Factors in Healthcare, RCSI [U]
Clinical supervision	Clinical supervision – regular supervision from consultant psychiatrist/clinical lead [M]	Clinical supervision – regular supervision by consultant psychiatrist /clinical lead [M]
Management supervision/	Management supervision – regular	Management supervision – regular
Support	Supervision by assistant director of nursing [M]	Supervision by assistant director of nursing [M]

All training is funded through the Nursing and Midwifery Planning and Development Units (NMPDU). Training on the Model of Care will be provided through the NCPSH office.

9.5 Summary and recommendations

- Mental health professionals delivering the NCPSH should receive competency-based training. Competencies are included under clinical technical expertise, stylistic/interpersonal, and professional knowledge relevant to the role.
- All mental health professionals delivering the programme should have access to clinical supervision to develop their skills and competencies in the above areas.
- Training is identified by the NCPSH as mandatory (M), recommended (R) and useful (U). All mental health professionals delivering the NCPSH should receive the mandatory training and then build on that training with recommended and finally useful training (Table 9.5).
- The mental health professional's line manager should ensure regular face-to-face supervision is provided. During this supervision the clinician's training needs should be identified and a plan made to attend required trainings.
- Education on the NCPSH Model of Care will be provided from the NCPSH office.
- Education programmes from the NCPSH will be designed and delivered using different delivery methods to ensure that training is accessible by clinicians – e.g. seminars, webinars and distance learning.
- Education programmes from the NCPSH should be co-produced and co-delivered by clinicians, people with lived experience of self-harm and family members with lived experience.
- Education programmes provided from the NCPSH should reach a standard approved for CEU (Continuous Educational Units) by the National Nursing and Midwifery Board (NMBI) and Continuous Professional Development (CPD) from the College of Psychiatrist of Ireland (CPsychI) or the Irish College of General Practitioners (ICGP).
- Postgraduate education programmes should include specific training on assessment and intervention when working with individuals who experience self-harm and suicidal behaviour. This should include clinician, service user and family member input in collaboration with Higher Educational Institutes.
- CNS should keep a training log of training received.
- Nurse management should audit CNS training received each year so as to identify further training needs as per recommendations from the NCPSH.
- Consultant Psychiatrists who are providing clinical supervision and educational supervision for professionals completing assessments should ensure they have a knowledge and understanding of the NCPSH.
- Further qualitative research should be carried out to elicit more detailed information regarding the education and training needs mental health professionals require in order to deliver the NCPSH effectively from a service user perspective.

10

Clinical Governance

10.1 Overview

Clinical governance is a framework through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver (HIQA 2012). Service providers are accountable for continually improving the quality of their clinical practice and safeguarding high standards of care by creating an environment in which excellence in clinical care flourishes. This includes mechanisms for monitoring clinical quality and safety through structured programmes; for example, clinical audit (HIQA, 2019). Clinical governance helps ensure that people receive the care they need in a safe, nurturing, open and just environment, arising from corporate accountability for clinical performance. The benefit of clinical governance rests in improved patient experiences and better health outcomes in terms of quality and safety (HIQA, 2012). Healthcare providers must have formalised governance structures with clear accountability and responsibility arrangements (HIQA, 2019). Governance also ensures the establishment of learning systems so that all experience within a service is shared and used to improve patient/service user care. Good governance supports strong relationships between frontline staff, patients and senior leaders in an organisation (HSE, 2016a).

The Model of Care for the NCPSH adopts the clinical governance standards set out in the following documents:

- Quality Framework for Mental Health Services in Ireland (Mental Health Commission 2007)
- Achieving Excellence in Clinical Governance: Towards a Culture of Accountability (HSE 2012)
- The Code of Governance Framework for the Corporate and Financial Governance of the HSE (HSE 2015)
- Checklist for Quality and Safety Governance, HSE Clinical Strategy Programme Division (CSPD) and the Quality and Patient Safety Division (QPSD 2014)
- Framework for Improving Quality in our Health Service (HSE 2016)
- HSE Best Practice Guidelines for Mental Health Services (HSE 2017c)
- HSE (2019) Date Protection Policy

10.1.2 Legal and ethical considerations

There are statutory requirements of particular relevance for mental health service provision in Ireland. The NCPSH Model of Care will operate under the following legislation and frameworks so that it fulfils the legal and ethical obligations and ensures that the clinical needs, rights and safety of service users are respected by the National Clinical Programme.

- The Mental Health Act 2001 and associated Regulations, Rules and Codes of Practice
- The Data Protection Act (1998 and 2003)
- The Medical Practitioners Act 2007
- The Nurses and Midwives Act 2011
- The Assisted Decision Making (Capacity) Act (2015) (once commenced)
- The Children First Act (2015)
- European Convention on Human Rights
- UN Convention on the Rights of Persons with Disabilities
- European Union General Data Protection Regulations (GDPR) (2018)

10.2 Clinical governance structure for the NCPSH

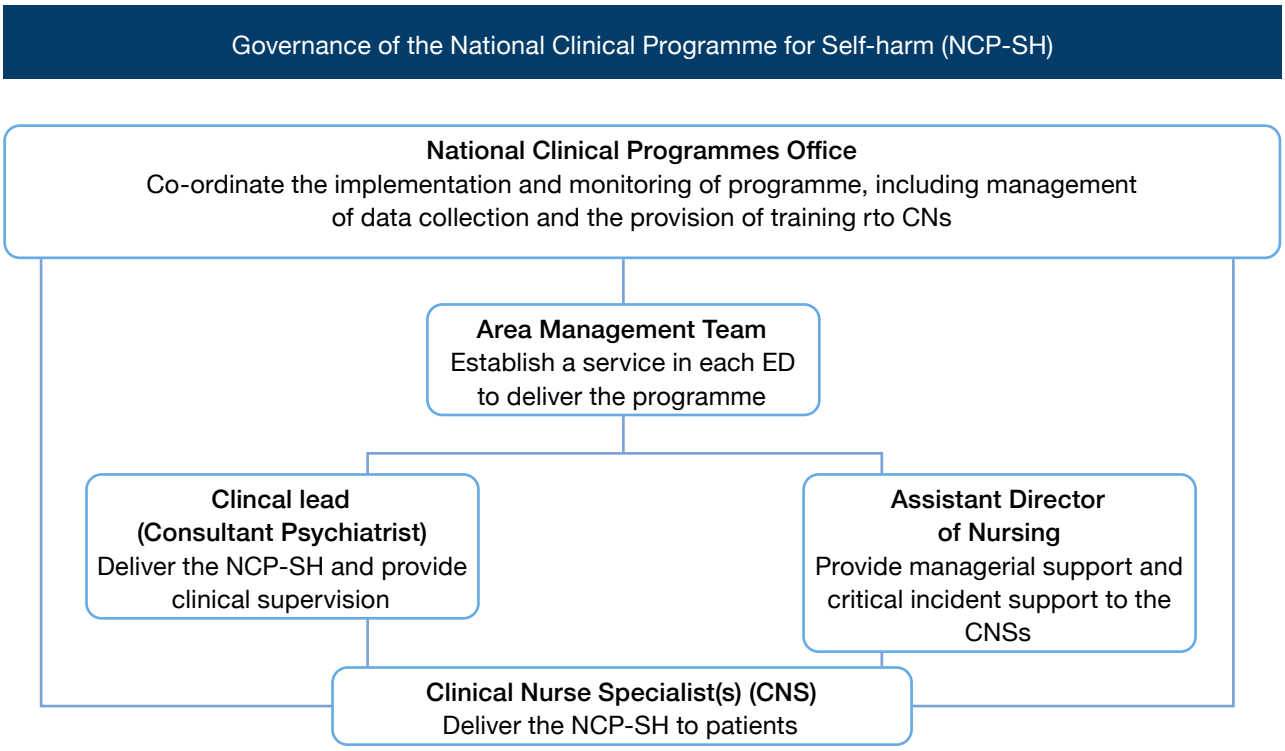
10.2.1 Summary

The National Clinical Programme (NCP) includes a number of measures to ensure that the key pillars of clinical governance facilitating quality, safety and effective service provision are developed and maintained. The HSE National Clinical Programme Office and HSE National Mental Health Service will monitor the services on a regular basis to support and review progress towards the identified standards, identify issues of concern and lead out on future developments. The full implementation of the NCPSH is also a key priority for Connecting with Life (NOSP 2020) and for Sharing the Vision (DoH 2020).

TABLE 10.1 SUMMARY OF NCPSH GOVERNANCE COMPONENTS TO ACHIEVE QUALITY AND SAFETY

Knowledge and Skills	Management teams ensure they have the knowledge and skills for driving quality care.
Leadership and Accountability	At all levels, activities and services are measured and management teams drive quality and safety.
Information	Information is used to measure, monitor and oversee quality and safety of care.
Culture	A learning environment focused on improving quality of care is promoted. Use of clinicians, service users and family members in driving this learning is supported.
Relationships	The NCPSH supports strong relationships that partner with service users, family members and staff in primary care and secondary care and with voluntary and community agencies.
Quality Improvement	A quality improvement plan is in place, based on the Model of Care and learning from clinicians, managers, service users and family members.

FIG. 10.1 SUMMARY OF NCPSH GOVERNANCE (GRIFFIN ET AL 2021)



10.3 Management structure and responsibilities

To support the clinical governance, a project management structure has been developed at both national and Community Healthcare Organisation (CHO) levels, with the following roles and responsibilities.

10.3.1 National Clinical Programme Office

The office of the National Clinical Advisor and Group Lead (NCAGL) has oversight over the development, implementation and monitoring of the clinical NCPSH. Within this, the NCPSH office requires a programme manager, a clinical lead, a lead nurse and a data manager. As the programme expands, hours of work for these key personnel will increase and should be reviewed annually.
Overall the team will have responsibility for:

- Oversight and governance of the implementation of the NCPSH nationally
- Supporting services to deliver on NCPSH objectives
- Supporting and implementing national training plans in accordance with the Model of Care (MOC)
- Managing, reviewing and reporting on data collected monthly at each site nationally
- Working with an Implementation Advisory Group of clinicians, managers, individuals and family members with lived experience of self-harm to review, evaluate and update the MOC
- Collaborating with and reporting to the National Office of Suicide Prevention in delivering Connecting for Life
- Collaborating with the National Suicide Research Foundation in improving the quality of data collected and in evaluating the MOC
- Working with relevant stakeholders in the HSE in embedding the NCPSH into day-to-day operations
- Collaborating with clinicians, people with lived experience, researchers, universities, professionals and training colleges in delivering training and in conducting research and audit in the NCPSH

10.3.2 CHO Area Management Team responsibility

The CHO Area Management Team have responsibility for:

- Recognising the importance of this programme in improving service provision for the CHO population, and providing leadership and support to ensure implementation
- Identifying a clinical lead to implement the programme in the ED
- Appointing a clinical lead to implement the SCAN service – funding for 0.2.WTE Consultant Psychiatrists per 300,000 population is provided through the NCPSH
- Appointing a CNS or suitably qualified mental health professional to deliver the NCPSH – funding for 1 CNS per 200 ED presentations of self-harm per annum one SCAN practitioner per 75,000 population and 0.2 WTE Consultant Psychiatrist per 300,000 is provided through the NCPSH
- Designing, setting up, recruiting, managing and overall governance of the NCPSH services in their region
- Ensuring that all line managers are aware of the requirements of the NCPSH for their staff
- Having systems in place locally for accurate, comprehensive and timely data collection to facilitate audit and evaluation locally and nationally
- Allocating resources to provide supervision and training requirements
- Facilitate staff in the area to receive supervision and training as required
- Collating and feeding back to the National Clinical Programme Office on key performance indicators
- Working with the National Clinical Programme office in implementing the Clinical Programme
- Establishing a Clinical Forum to ensure that the Clinical Programme activities are well integrated with other activities of the mental health service
- Ensuring that all line managers for clinicians have a working knowledge of the NCPSH, and that line managers support the full implementation of the NCPSH

- Ensuring that local CHO Connecting for Life plans include the NCPSH

10.3.3 Clinical leads, Advanced Nurse Practitioners, Clinical Nurse Specialists, Social Workers

Clinical leads, ANPs, CNSs and Social Workers:

- Deliver the NCPSH in accordance with the NCP
- Deliver awareness training on suicide and self-harm to ED staff and GPs as appropriate
- Attend supervision and training as identified in the Education and Training Plan
- Record and submit monthly data on time in accordance with NCPSH requirements, using the agreed format
- Provide leadership, education and training in issues related to self-harm
- Monitor and ensure best practice in their area of expertise through audit and research
- Maintain a database of staff trained in particular interventions

10.4 Professional reporting relationship

To implement the Clinical Programme, CNSs and other suitably trained mental health practitioners will be appointed to work in the EDs or with GPs to provide mental health input for patients who present following self-harm or with suicidal ideation.

- The professional reporting relationship for CNSs, whether working in EDs or in the SCAN service is to the HSE Area Director of Nursing or designated Assistant Director of Nursing, Mental Health Services.
- The professional reporting relationship of ANPs is to the HSE Area Director of Nursing, Mental Health Services.
- The professional reporting relationship for other mental health professionals is through their professional line management structure.
- The professional reporting relationship of the NCHD is to their educational supervisor.
- The professional reporting relationship of the Consultant is to the Executive Clinical Director.

10.5 Clinical reporting relationships

It is the responsibility of the Clinical Director of each service to ensure that the NCPSH is implemented.

10.5.1 Clinical reporting relationship for staff delivering the NCPSH in the ED

There are a number of variants of governance arrangements, as outlined below. They are based on the principle of a CNS or mental health professional of equivalent skill and training working within the ED, reporting on clinical matters to a named consultant psychiatrist.

a. **CNS or other mental health professional (MHP) working in a HSE service with a Consultant Psychiatrist-led liaison service.** The CNS or MHP work as members of the liaison psychiatry team and report on clinical matters to the Consultant Psychiatrist on that team.

b. **CNS or MHP working in a non-HSE hospital where there is a Consultant Psychiatrist-led Liaison service.** The CNS or MHP is part of the liaison psychiatry team and reports on clinical matters to the Consultant Psychiatrist on that team. In this situation there must be a close working relationship between the Area DON of Mental Health and the DON of the acute hospital to ensure a smooth professional working relationship for the CNS or MHP.

c. **Acute Model 3 or Model 4 hospital with no consultant-led liaison service.** This should only be an interim situation, as the Model of Care recommends that all Model 3 and Model 4 hospitals have access to a Consultant Psychiatrist-led Liaison service. There should be a named and funded HSE consultant in adult psychiatry to whom the CNS or MHP report on clinical matters. The introduction of an ANP would reduce the required clinical commitment from the Consultant Psychiatrist; it would allow the CNS to report to the ANP while the ANP would report to the Consultant Psychiatrist, as required.

d. **Acute hospitals with injury units and medical assessment units.** These hospitals have low numbers presenting; people who present following self-harm or with suicidal ideation should receive all four

components of the NCPSH, with a biopsychosocial assessment by the on-call non-consultant hospital doctor in psychiatry, and clinical supervision from the on-call Consultant Psychiatrist.

10.5.2 Clinical reporting relationship for SCAN service

SCAN provides a consultation service to general practice/ general practitioners. Within the service, the CNS reports to an ANP or consultant psychiatrist. The ANP reports to a Consultant Psychiatrist.

a. Within the SCAN service, all patients remain in Primary Care.

b. The CNS should discuss cases with the GP and also receive clinical supervision from a registered ANP (RANP) or Consultant Psychiatrist, depending on individual service need.

c. The mental health professional should discuss cases with the GP and receive clinical supervision from a Consultant Psychiatrist.

d. The RANP should receive clinical supervision from a General Adult Consultant Psychiatrist.

e. Where the supervision is provided by an ANP, that ANP should be allocated time to provide weekly face-to-face supervision, time to establish the service with GPs and, when required, provide input on individual cases.

f. Where the supervision is provided by a General Adult Consultant Psychiatrist, that Consultant Psychiatrist should be allocated time to provide weekly face-to-face supervision and time to develop the service with the local GPs. This will require 0.2 WTE consultants per 300,000 population.

10.6 Roles and responsibilities of staff in relation to the NCPSH

10.6.1 Role of the clinical lead in the ED

The clinical lead has overall responsibility for ensuring all patients who present to the Emergency Department will receive all 4 components of the Clinical Programme. The clinical lead is a Consultant Psychiatrist who has one dedicated session a week to provide clinical supervision to the Clinical Nurse Specialist (CNS) and/ or mental health professional appointed through the Clinical Programme.

10.6.1.1 Where the clinical lead is a Consultant Liaison Psychiatrist (CLP), the CNS/mental health professional will be part of the liaison team.

- The Consultant will provide clinical cover and supervision for the CNS/ mental health professional appointed to the programme.
- The clinical lead and CNS/mental health professional will ensure that the programme is at all times implemented; provide education and training for NCHDs and ED staff, and record and collate data as required by the NCPSH office.
- The clinical lead will support the CNS/mental health professional in ensuring they receive support and training to implement the programme.
- The clinical lead will provide support to the area management team in developing local policies and procedures for the programme.
- Particular attention needs to be paid to the need for the clinical lead to have time for personal reflection, supervision and scheduled work. In some services, this may require that general adult psychiatrists provide clinical cover for one day a week.

10.6.1.2 Where there is no Consultant Liaison Psychiatrist (CLP), the clinical lead will be a named Consultant Psychiatrist in general adult psychiatry. The service should ensure that the consultant has time dedicated to implementing the clinical programme and to providing clinical supervision for the CNS/ mental health professional. In these circumstances:

- The day-to-day clinical cover will be provided by the consultant on call or the sector area consultant.
- The clinical lead will meet with the CNS/mental health professional for at least one-hour face-to-face supervision once a week. This supervision time will be used to support the CNS/mental health professional in implementing the programme, to review the week's work, to problem-solve and to ensure that training needs are met.

- The CNS/mental health professional and clinical lead will record and collate data as requested by the NCPSH office.
- The clinical lead and local management team are responsible for ensuring that local policies are developed to implement the programme. The clinical lead is advised to link with a regional liaison consultant who can provide direction and guidance on developing these policies.

10.6.1.3 Where the clinical lead is a Consultant Liaison Psychiatrist or a General Adult Psychiatrist the following applies:

- The clinical lead should work with the clinical director in ensuring that NCHDs in psychiatry receive appropriate training in assessing and managing those who present following self-harm, or with suicidal ideation. They should also ensure that NCHDs are familiar with the clinical programme and that there be good communication between the CNS/mental health professional and the NCHDs.
- Where the programme is delivered in the ED, the clinical lead and CNS/mental health professional are responsible for providing education to the ED staff.
- Good governance requires regular (e.g. quarterly) ED-mental health service meetings to optimise communication and risk management. These meetings should include representatives from Liaison Psychiatry, General Adult Psychiatry and Management.
- The clinical lead can work with the clinical director in ensuring that there is good collaboration between the staff working in the ED and other mental health staff. This will facilitate integrating this clinical programme with the day-to-day practice of all mental health teams.
- It is the responsibility of the ECD to ensure that the clinical lead is resourced to provide time to deliver the NCPSH. The CNS/mental health professional and clinical lead are invited to the national training days organised by the NCPSH office.

10.6.2 Role of the clinical lead for the SCAN service

The clinical lead is a General Adult Psychiatrist who has two dedicated sessions a week (0.2 WTE) to provide clinical supervision to SCAN professionals and provide overall leadership for the development of the programme. The clinical lead has overall responsibility for ensuring the full implementation of the SCAN service.

The clinical lead and local area management team are responsible for ensuring the programme is implemented, including ensuring a Consultant Psychiatrist or other senior clinical decision-maker is available to provide clinical support to the SCAN professional.

The clinical lead and SCAN professional will provide education and training on SCAN for local GPs.

10.6.3 CNS working in self-harm in the ED

The Clinical Nurse Specialist in Self-Harm postholder is professionally and operationally accountable to the Area Director of Nursing or designated Assistant Director of Nursing, Mental Health Services.
On day-to-day clinical matters the CNS will report to the local named clinical lead for the Clinical Programme. They will liaise and consult with the relevant Consultant Psychiatrist pertaining to clinical matters, as required.

10.6.4 Role of the SCAN or mental health professional (MHP) working in SCAN service

This could be a CNS or other suitably qualified MHP.
The SCAN postholder is professionally and operationally accountable to the Area Director of Nursing or designated Assistant Director of Nursing, Mental Health Services/Head of Discipline, respectively.

On day-to-day clinical matters, the SCAN postholder will report to the local named clinical lead for the Clinical Programme. They will liaise and consult with the relevant Consultant Psychiatrist about clinical matters, as required.

They will report to the GP about clinical matters as required.

10.6.5 Registered ANP (RANP) working in general practice

The RANP in self-harm postholder is professionally and operationally accountable to the Area Director of Nursing, Mental Health Services.

The RANP will report to a named clinical lead in the mental

health services. They will liaise and consult with the relevant Consultant Psychiatrist about clinical matters, as required.

10.6.6 Role of the non-consultant hospital doctor (NCHD) in psychiatry

The Model of Care advises that, where possible, mental health services should ensure there is at least one CNS or equally qualified MHP available to provide assessments in the ED from 8am to 8pm, seven days a week. This may not be possible in all hospitals. When a CNS/MHP is not available, the assessments are provided by the NCHD in psychiatry, usually the on-call NCHD.

It is the responsibility of the clinical director to ensure the following:

- The NCHD in psychiatry has a working knowledge of the National Clinical Programme.
- Each patient assessed by the NCHD should be discussed with a Consultant, the Sector Consultant and Consultant on call or the Liaison Consultant. The timing of this discussion depends on the skill and experience of the NCHD. For NCHDs in their first six months working in psychiatry, all presentations should be discussed with a consultant before the person is discharged from the ED.
- All services should ensure there is immediate telephone access to a Consultant Psychiatrist for all NCHDs, both during working hours and out of hours.
- The workload of the NCHD should allow them to attend in a timely manner to each person who has self-harmed or presents with suicide-related ideation.
- Their knowledge and workload should ensure that each patient receives a comprehensive biopsychosocial assessment, that family or supportive adult input is obtained and that a written collaborative emergency care plan is developed with the patient.
- The NCHD is aware of the responsibility to inform the patient's GP of the outcome of the presentation. Information should be sent to the GP by secure elink such as Healthlink or by telephone within 24 hours of the patient's discharge.
- The NCHD is aware of the responsibility to inform the CNS the following day of all patients who presented out of hours. The CNS will provide a follow-up phone call where this is clinically appropriate. All other follow-up arrangements should be made by the NCHD, such as ensuring that information is sent to the CMHT and the GP.

10.7 Facilities and administrative support

In each ED, facilities must be available for the safe and therapeutic assessment of all patients. Standards should follow those recommended by the College of Psychiatrists of Ireland (see Chapter 3.)

Each CNS/mental health practitioner will require suitable office facilities, located close to the ED.

Each SCAN will require suitable office facilities, ideally alongside a CMHT. Assessments should be carried out in general practice if space is available. It is the responsibility of the HSE to ensure that facilities in primary care are available for use in situations where accommodation is not available in general practice.

Each CNS/MHP will require the administrative support of 0.2 WTE secretarial supports.

Each CNS/MHP will need access to a computer/laptop to submit data on each patient and to access online training opportunities.

10.8 Personal and clinical supervision

10.8.1 Personal supervision

The role of the consultant, CNS, NCHD and other mental health professionals working in the ED can be stressful. It is important they have access to both clinical and managerial supervision and support. This minimises the risk of burnout or of developing compassion fatigue, both of which have been associated with poorer clinical outcomes (Hunsaker et al 2015).

In delivering the Clinical Programme, CNSs benefit from daily clinical input from a Consultant Psychiatrist, and also from discussing all cases with a Consultant Psychiatrist. The

timing of this discussion depends on the experience and expertise of the practitioner.

Each CNS or MHP should have access to monthly formal face-to-face meetings with their administrative supervisor, i.e. ADON or senior MHP respectively. Along with reviewing clinical work, the ADON should ensure that all data is submitted and that the CNS is attending required training sessions. It is up to the immediate supervisor to identify if the CNS/MHP requires any further psychotherapeutic supervision.

Twice a year, when public health permits, the NCPSH office arranges a two-day training meeting. This provides important training and also allows networking between CNSs.

Supervision of staff leads to improved management and care planning. Supervision will be informed by trauma-informed approaches.

Trauma-informed supervision involves a facilitated reflective group that recognises the impact of secondary traumatic stress (Applegate and Shapiro 2005). Etherington (2000) suggests that the specially trained supervisor should be alert to:

- changes in workers' behaviour with and reactions to clients
- intrusions of client stories in workers' lives
- signs of burnout and feelings of being overwhelmed
- signs of withdrawal in either relationships with clients or in the supervisory relationship
- signs of stress and an inability to engage in self-care

Sommer and Cox (2005) reported that trauma-sensitive supervision should include time for talking about the effects of the work and related personal feelings; directly address vicarious traumatisation, and use a collaborative, strengths-based approach.

Cultivating the practice of reflecting on one's own emotional responses to a client is an integral aspect to trauma-informed supervision. Negative reactions to suicidal individuals in 'counter-transference' are well documented (Maltsberger and Buie 1996). The reactions of clinicians towards patients may result in feelings of incompetence, hopelessness, demoralisation, hostility and/or withdrawal from emotional involvement with the client (Hunter 2015). Balint groups are named after the psychoanalyst Michael Balint; in the late 1950s Michael and his wife began holding psychological training seminars for GPs in London. The group met on a weekly basis, encouraged doctors to discuss cases, and in a safe and supportive environment others are invited to respond to what they have heard. Since the publication of the work (Balint 1957), the Balint approach has flourished and has encouraged the development of reflective practice among GPs and psychiatrists.

Another approach, which is used in cognitive behavioural psychotherapy (CBT), is the process of self-practice/self-reflection (SP/SR), a form of personal practice for CBT that continues a long tradition of experiential group work for psychotherapists (Freeston et al 2019). SP/SR, originally proposed by James Bennett-Levy (2001), involves trainee cognitive behaviour therapists applying the CBT model to themselves and then reflecting on what they have learned by doing this. The reflections involve reflections on the content, the process and how the theory relates to their experience.

The experiential nature of this approach provides insights that are unlikely to be gained from other training methods. SP/SR outcome studies indicate that the benefits to therapists include greater empathy (Davis et al 2015), enhanced conceptual skills (Haarhoff et al 2011) and improved confidence (Spendelow and Butler 2016). This approach could also be used for clinicians delivering the NCPSH in self-harm, giving them direct lived experience of, for example, developing their own safety plan so they can develop further understanding and empathise when working with service users who experience self-harm.
There is scope to develop SP/SR groups nationally. Training should be developed and delivered to clinicians to facilitate SP/SR groups supported by the NCPSH.

10.9 Summary and recommendations

- Clinical governance is a framework through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver.
- The office of the NCAGL is responsible for the development, coordination, and oversight and monitoring of the implementation of the NCPSH.
- The NCPSH identifies the Model of Care and training required for practitioners delivering the NCPSH.
- The Local Area Management Team is responsible for the implementation of the NCPSH in each area.
- Staff implementing the NCPSH are employed by the mental health services and report professionally to their line manager in that service.
- Staff implementing the NCPSH work under the clinical guidance of a Consultant Psychiatrist.
- The role of the consultant, CNS, NCHD and other mental health professionals working in the ED can be stressful. It is important that they have access to both clinical and managerial supervision and support.

11

Monitoring and Evaluation

11.1 Data collection and auditing

Ongoing audit will be pivotal in monitoring and implementation of the NCPSH. The NCPSH CNS, both in the ED and in SCAN, will have a lead role in coordinating data collection through which the programme outcomes can be monitored and evaluated. The NCPSH National Office will ensure regular training for CNS and their line managers on data collection. Line managers will have a lead role in data quality assurance.

11.2 National metrics

Since 2017 detailed data have been collected from presentations to the ED. The following metrics are being collected:

TABLE 11.1 NATIONAL DATA COLLECTED FROM EDS AND SCAN SERVICE

Time of presentation	Hour, day and month
Patient demographics	Age, ethnic background, gender, referred to ED by …, employment status
% of those presenting assessed	National metric: 95% of people presenting following self-harm or with suicidal ideation will receive a biopsychosocial assessment.
Past mental health history and past suicidal ideation and self-harming behaviour	
Type of presentations	Details on type of self-harm, or no self-harm and suicidal ideation only
Staff who provided mental health assessment	CNS, SCAN or trainee psychiatrist (NCHD)
Interventions received	National metrics: 95% of those assessed to receive a full biopsychosocial assessment 95% of those assessed to receive a written emergency safety plan. 85% have a collateral history from a family member or supportive adult. 100%: the GP is sent a letter within 24 hours.
Family member/ supportive care involvement	National metrics: 85% have a family member or supportive adult involvement in discharge planning.
Referral to next appropriate care	

Follow-up and bridging to next care	National metrics: 85% receive a follow-up phone call within 24 hours of discharge from the ED.
Time to next CMHT appointment	
Patients discharged from ED	National metrics: 95% of patients assessed within 2 hours of referral to the mental health service. 100% assessed within 6 hours of referral to mental health service. 95% of all patients are discharged from ED or admitted in <6 hrs. 100% of all patients are discharged from ED or admitted in <9hrs.

The NCPSH will work with the HSE Office of the Chief Information Officer (OoCIO) and the National Suicide Research Foundation (NSRF) in developing appropriate data collection platforms to optimise the use of data from the Self-Harm Registry and from the NCPSH in improving service delivery.

11.3 Monitoring and evaluation through clinical audit and research

The Commission on Patient Safety and Quality Assurance (2008) identified clinical audit as an essential component of clinical governance, stating that it 'constitutes the single most important method which any healthcare organisation can use to understand and assure the quality of the service that it provides' (DoHC 2008). The National Clinical Programme Office will further develop and maintain a standardised database system.

The NCPSH has established an Audit and Research Group for Assessment and Management of Self-Harm in the ED. This group includes representatives from academia and clinical practice. The purpose of the group is to support the development of local, regional and national audit practice within the NCPSH. It also supports the development of local, national and regional research within the NCPSH.

The NCPSH maintains a standardised database system. The recommended metrics outlined in the Model of Care will enable clinicians, teams and the NCPSH to track progress and inform the effectiveness, quality and efficiency of service provision. Key performance indicators will be collected nationally to assist oversight and governance at the national level. This will support audit and evaluation at local, regional and national levels, with prompt feedback to the services being provided. A key to data collection is the availability of IT systems and provision of administrative support and training to collate data in a timely manner at both CHO and national levels.

Each year the Research and Audit Committee facilitate the completion of an in-depth national audit. These audits use national data along with local audits to evaluate service delivery. To date, audits have been completed on Standards in ED Assessment Rooms, Standards of Emergency Care Plans, and Frequency of Follow-up Phone Calls (Appendix 3).

11.4 Monitoring and evaluation through research

The NCPSH supports practice-related research and is mindful of its obligations to ensure that any research conducted is both ethical and respectful of service users and providers. Research may inform and contribute to the improvement of the NCPSH. Research will include service evaluation. The NCPSH office works closely with universities, clinicians and the National Suicide Research Foundation in developing research projects relevant to the NCPSH.

The National Suicide Research Foundation (NSRF) has been collecting data on every episode of self-harm presenting to Irish EDs since 2005 (Perry et al 2013). Funding has been granted through the Health Research Board to fund a collaborative evaluation of the Clinical Programme through

PRISM ('Providing Improved Care for Self-Harm; A mixed method study of intervention, implementation and economic outcomes from a National Clinical Programme study'). Led by principal investigator Dr Eve Griffin, this study (Griffin et al 2021) will apply a mixed-methods approach using a sequential explanatory design, which will comprise two stages; quantitative data will inform qualitative data collection and data analysis, along with subsequent integration of both quantitative and qualitative data (Tashakkori and Teddlie 2010). Stage 1 will be a natural experiment (Craig et al 2017) which will use data from the National Self-Harm Registry (Joyce et al 2020) to examine the effectiveness and cost-effectiveness of the NCPSH in relation to hospital-presenting self-harm. Implementation fidelity in this study will be conceptualised as adherence: how far those responsible for delivering an intervention actually adhere to the core components of the programme (Carroll et al 2007). Measures of implementation fidelity will be included in the primary evaluation study, as a mediator between the intervention and observed intervention outcomes. Stage 2 will be primarily a qualitative study. It will begin by describing the implementation of the NCPSH and will identify implementation strategies adopted by hospitals. As fidelity is the primary facet of implementation to be examined, the determinants (barriers and facilitators) contributing to achieving fidelity across hospital sites will be examined, using the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al 2009).

11.5 Evaluation and monitoring from people who use the service

People with lived experience of self-harming and family members who have been bereaved by suicide provide regular feedback to the NCPSH through the Implementation Advisory Group and the Research and Audit Committee. Individual services have completed service user evaluation studies, the results of which have been presented at annual training days for clinical leads and CNSs.

A pilot project using Your Voice Matters was introduced to two services in 2020. Your Voice Matters is a nationally available patient experience framework tool that allows service users and/or their families to describe in their own words their story of a recent instance of engaging with health and social care service(s). These experiences are then considered further using a number of questions represented in triad (triangle), dyad (sliding scale) and multiple-choice question form, focusing on key elements of person-centred, co-ordinated care, including empathy and respect, shared decision-making, communication and values.
A working group from the Research and Audit Committee developed a tailored Your Voice Matters survey. Over a three-month period, a paper and online version of this was given to all patients assessed within the service in two pilot sites. Responses could be sent anonymously in a stamped addressed envelope or online. Despite the use of information flyers, putting the code for the online survey onto the emergency care plan and encouragement from the assessing staff, no replies were received over the three-month period. This poor response may have been linked to the timing of the survey, October 2020 to February 2021 during the Covid-19 pandemic. It is also possible that people who have been through an assessment following self-harm are not in a position to complete a detailed survey immediately following that assessment. Evaluation within a six-month or year period may be more appropriate.

The use of HSE Mental Health Engagement and Recovery Forums, which are located in each CHO, are a useful mechanism for people who use the service to provide feedback to the local management team. Members of the management team should ensure they obtain feedback on the implementation of the NCPSH from the local forum.

The NCPSH office and the Research and Audit Committee should continue to explore further means to obtain feedback from people who present to services following self-harm or with suicide-related ideation.

11.6 Summary and recommendations

- The CNS appointed through NCPSH is responsible for ensuring that data is collected and submitted to the NCP office on each person who presents to the ED or SCAN service. The supervising ADON has a role in ensuring the quality of the data submitted.
- The NCPSH will work with the HSE Office of the Chief Information Officer (OoCIO) and the National Suicide Research Foundation (NSRF) in developing appropriate

data collection platforms to optimise the use of data from the Self-Harm Registry and from the NCPSH in improving service delivery.

- The national NCPSH activities will be published annually.
- Data for each service will be available for that service, measuring standards against national metrics.
- The Research and Audit Committee will develop appropriate local, regional and national projects to facilitate the monitoring and improvement of services.
- The PRISM study, a collaboration with NSRF, is researching the cost and efficiency of the implementation of the NCPSH.
- Members of local management teams should ensure they obtain feedback on the implementation of the NCPSH from the local Mental Health Engagement and Recovery Forum.
- The development of appropriate mechanisms to provide feedback from people who use the service should continue.

Appendix 1. Members of NCPSH Advisory Groups

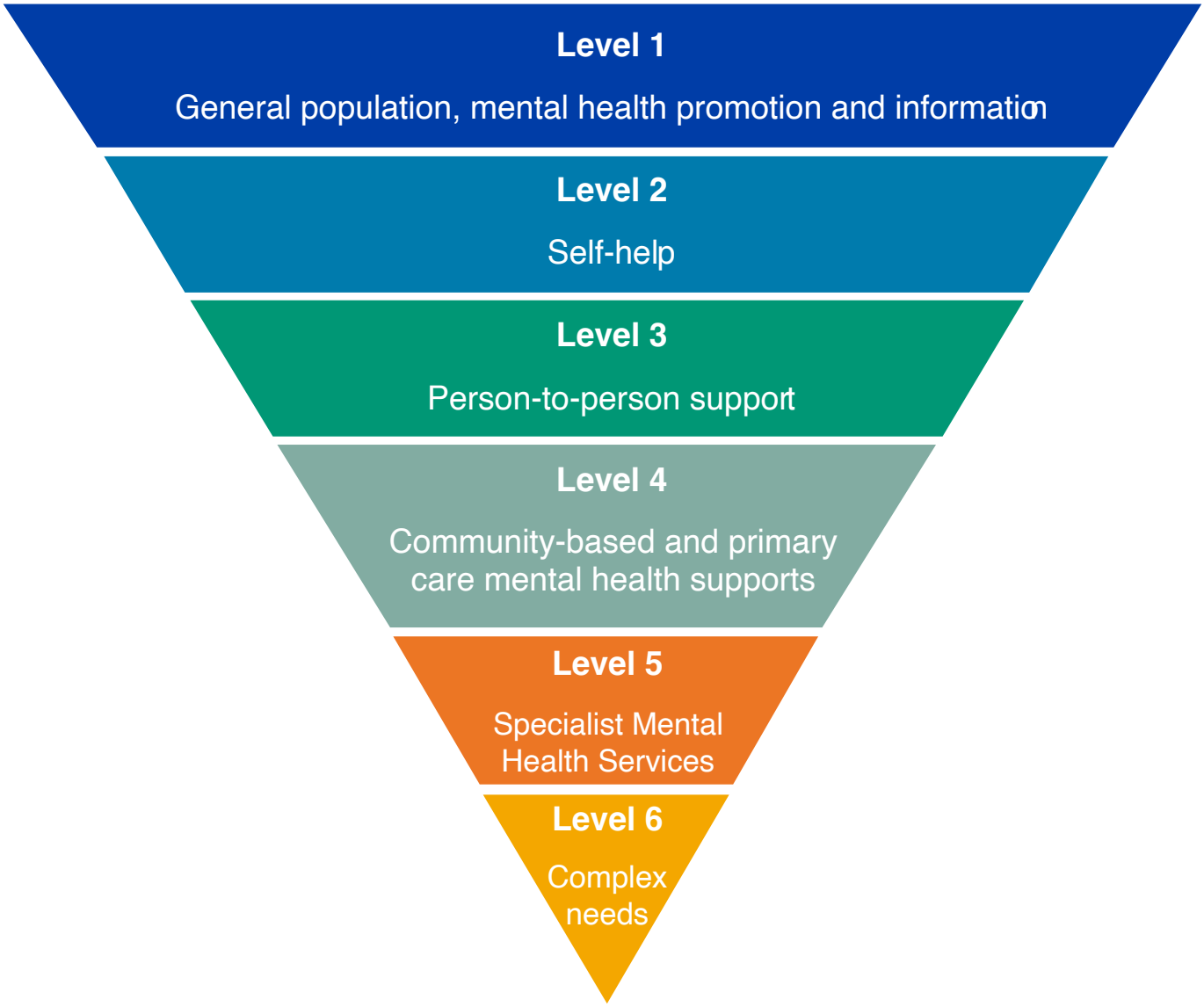
Implementation Advisory Group

Dr. A. Jeffers (Chair), National Clinical Lead
Dr. James O'Mahony, National Nurse Lead
Ms. Rhona Jennings, Programme Manager
Dr. Katerina Kavalidou, Data Manager
Dr. Brian Osborne, ICGP Mental Health Lead
Ms. Ciara Acton, HSE Mental Health Operations
Ms. Antoinette Barry, Mental Health Head of Service
Ms. Danni Burke, Peer Worker Service Development Advocate
Mr. Derek Chambers, HSE Connecting for Life Lead
Dr. Padraig Collins, Principal Primary Care Psychologist
Dr. Leonard Douglas, Consultant in Psychiatry of Later Life
Ms. Aisling Duffy, HSE Mental Health Engagement and Recovery Office
Ms. Teresa Harte, Clinical Nurse Specialist in SCAN and the NCPSH
Dr. Eric Kelleher, Consultant Liaison Psychiatrist
Mr. Ned Kelly, Area Director of Nursing Adult and CAMHS CHO4
Mr. Peter Livingstone, Clinical Nurse Specialist in NCPSH
Dr. Siobhan MacHale, Consultant Liaison Psychiatrist
Dr. Gerry McCarthy, Emergency Medicine Programme Clinical Lead
Dr. Brendan McCormack, Executive Clinical Director
Ms. Eileen Ní Shúilleabháin, Principal Mental Health Social Worker
Dr. Natasha Nor, Consultant General Adult Psychiatrist
Ms. Siobhan O'Carroll, Family Member Service development Advocate
Dr. Anne-Marie Waldron, Clinical Director, North Dublin CAMHS

Research and Audit Committee

Dr. Anne Jeffers (Chair), National Clinical Lead
Dr. James O'Mahony, National Nurse Lead
Ms. Rhona Jennings, Programme Manager
Dr. Katerina Kavalidou, Data Manager
Professor Ella Arensman, UCC and National Suicide Research Foundation
Dr. Helen Barry, Consultant Liaison Psychiatrist
Dr. Catherine Corby, Consultant Liaison Psychiatrist
Dr. Paula Corcoran, UCC and National Suicide Research Foundation
Ms. Marie Cotter, Clinical Nurse Specialist in the NCPSH
Professor Anne Doherty, UCD and Consultant Liaison Psychiatrist
Professor Louise Doyle, TCD School of Nursing and Midwifery
Ms. Kate Gaffey, Clinical Nurse Specialist in the NCPSH
Dr. Eve Griffin, UCC and National Suicide Research Foundation
Dr. Aine Horgan, School of Nursing & Midwifery University College Cork
Dr. Sutha Jain, Higher Specialist Trainees in Liaison Psychiatry
Dr. Erica Maguire, Higher Specialist Trainee in Liaison Psychiatry
Professor Kevin Malone, UCD and St Vincent's University Hospital, Dublin
Professor Fiona McNicholas, UCD and Consultant in Child and Adolescent Liaison Psychiatry
Ms. Michelle O'Donoghue, Clinical Nurse Specialist in the NCPSH

Appendix 2. Mental Health Support and Services in Ireland



Service/Support	Type	More Information
Yourmentalhealth.ie	Website, information, signposting	www.yourmentalhealth.ie
Keep Well	Campaign, website, information, signposting	www.gov.ie/en/campaigns/healthy-ireland
Minding Your Mental Health (multilingual)	Online videos	www.translateireland.ie
Union of Students in Ireland	Website, information, signposting	www.mentalhealth.usi.ie
College of Psychiatrists in Ireland	Online videos	College of Psychiatrists in Ireland
SpunOut.ie	Website, information, resources and signposting	www.spunout.ie
Mental Health Ireland	Telephone, website, information, resources and signposting	01 2841166 Minding our mental health during Covid-19
Inclusion Ireland	Website, information, resources and signposting	www.inclusionireland.ie
Aware	1800 804848, supportmail@aware.ie, www.aware.ie	
BeLonGTo Youth Services	Website, information, peer support, signposting	www.belongto.org
Age Friendly Ireland	www.agefriendlyireland.ie	

Level 1 General population

General population, mental health promotion and information services for all

Service/Support	Type	More Information
Minding your Wellbeing	Online programme	Minding your Wellbeing Programme
Stress Control	Online programme	HSE Health and Wellbeing
HSE Eating Disorder Self Help App	Mental Health App	HSE Eating Disorder Self Help App
MindShift App (by Anxiety Canada)	Mental Health App	MindShift on the App Store MindShift from Google Play
HeadSpace App	Mental Health App	HeadSpace from the App Store HeadSpace from Google Play
Clear Fear App	Mental Health App	Clear Fear from the App Store Clear Fear from Google Play

Level 2 Self-help

The resources at this level provide people with advice and guidance around activities they can engage in themselves.

Service/Support	Type	More Information
Samaritans	Telephone Email	116 123 jo@samaritans.ie www.samaritans.ie
Text50808	Text	Text HELLO to 50808 www.text50808.ie
Grow Mental Health Recovery	Peer support	www.grow.ie, 1890 474 474
Wellness workshops from Suicide or Survive	Online workshops	www.suicideorsurvive.ie
HSE Mental Health Recovery Colleges	Peer support	HSE Recovery Education
Shine	Telephone, email	phil@shine.ie www.shine.ie/covid-19
LGBT Ireland	Telephone, email, instant messaging	1890 929539 info@lgbt.ie, www.lgbt.ie
Childline	Telephone, email, text, instant messaging	Text 50101 1800 666666 www.childline.ie
Bodywhy	Telephone, email, online	01 2107906 alex@bodywhys.ie www.bodywhys
Exchange House	Telephone, online	01 8721094 www.exchangehouse.ie
Barnardo's	Telephone	1800 910 123, 01 4732110 www.barnardos.ie
Alone	Telephone	0818 222024 www.alone.ie
Alzheimer Society of Ireland	Telephone	1800 341341 helpline@alzheimer.ie

Level 3

Person-to-Person Support

Service/Support	Type	More Information
Traveller Counselling Service	Telephone, online	www.travellercounselling.ie
Together 4 Cancer Concern	Telephone	1800 200700 HSE National Cancer Control Programme
Practitioner Health	Telephone, email	confidential@practitionerhealth.ie, www.practitionerhealth.ie
Connect	Telephone	1800 477477 www.connectcounselling.ie
Minding Creative Minds	Telephone, online	www.mindingcreativeminds.ie
MyMind	Online counselling	hq@mymind.org, www.mymind.org
Turn2Me	Online counselling, online support groups	www.turn2me.ie
Jigsaw	Telephone, email, online	1800 544729 help@jigsaw.ie, www.jigsaw.ie
Pieta	Telephone, text, counselling	1800 247247 Text HELP to51444 www.pieta.ie
Irish Hospice Foundation	Telephone	1800 807077 www.hospicefoundation.ie

Level 4
Community-based and primary care mental health services*

Services at this level are delivered by people with a suitable qualification and include counselling services that can be accessed directly by members of the public.

* The difference between level 3 supports and level 4 relates to the accreditation or professional qualification of people delivering the services at level 4. Supports at level 3 are delivered by peers or trained volunteers.

Appendix 3. Clinical Audit conducted by the NCPSH

3a) An audit of assessment rooms for mental health assessments in Ireland's emergency departments

This audit was published in the Irish Journal of Psychological Medicine.

Jeffers, A., Jennings, R. & O'Mahony, J. (2020). An audit of assessment rooms for mental health assessments in Ireland's emergency departments. *Irish Journal of Psychological Medicine*, 1-6.

The following are extracts from that publication.

Objectives. To audit compliance of mental health assessment rooms in Irish adult emergency departments (EDs) which are open 24 hours on 7 days a week with standards identified by the Psychiatric Liaison Accreditation Network (PLAN).

Methods. A self-audit tool was sent via email to Clinical Nurse Specialists and Consultant Psychiatrists in Ireland's 26 Adult EDs that are open 24 hours on seven days a week. Results were collated and are presented ensuring anonymity.

Results. A response rate of 100% was achieved. Full or substantial compliance with PLAN standards was recorded in 73% of services. In seven services, the rooms used for mental health assessments were unsuitable when measured against the PLAN standards. A number of services identified the presence of ligature points within the rooms.

Conclusion. The Health Service Executive (HSE) National Clinical Programme for the Assessment and Management of patients presenting to the ED following self-harm is committed to achieving 100% compliance with PLAN standards in all services. Recommendations include introducing formal ligature risk assessments and risk assessments of the use of the assessment rooms. The Chief Executive Officers of all hospital groups were informed of the results of the audits and advised on recommendations for each hospital ED.

Table 1. Psychiatric Liaison Accreditation Network Criteria

- The assessment room should be located within the Emergency Department:
- Have at least one door that opens outwards and cannot be locked from the inside. Whilst not mandatory,
- PLAN highly recommends assessment facilities should have 2 doors to provide additional security.
- Have an observation panel or window allowing staff outside the room to check on the patient or staff member, and at the same time ensure privacy from the public is maintained. A common and effective approach is to use obscured toughened glass with a small clear section or built in adjustable blinds.
- Have a panic button. (Or staff use personal alarms.)
- Only include furniture, fittings and equipment which are unlikely to cause injury to the patient or staff member.
- Avoid the following– sinks, sharp-edged furniture, lightweight chairs, tables, cables, televisions or anything else that could be used as a missile.
- Does it have a suspended ceiling made of tiles, or does it include any fittings through which a ligature could be looped?

Table 2. Compliance with Psychiatric Liaison Accreditation Network standards

Standard	Full Compliance	Substantial Compliance	Not Compliant
	12	7	7

Table 3. Compliance with individual Psychiatric Liaison Accreditation Network Standards

Standard	Compliant	Not Compliant
The room is located within the ED	25	1
At least one door is opening outwards and is unlockable	22	4
There is an observation panel/window that provides privacy	22	4
There is an alarm or panic button available to staff	23	3
Furniture cannot be used to cause harm.	17	9
There are no ligature points 15 1 1	15	11
Decoration provides a sense of calmness	16	10

Table 4. Risk assessments of ceiling and use of the room

Has the ceiling been risk assessed	Yes	11	No	15
Has there been a formal risk assessment of the use of the room		8		18

Table 5. Characteristics of rooms that are non-compliant with Psychiatric Liaison Accreditation Network standards

No. of Hospitals	Compliance	Non-compliance
3	Room is located within the ED. Alarm is available	One door, which does not open outwards. No observation panel. Furniture is light and mobile. Several ligature points in the room.
2	Room is located within the ED Door opens outwards. Observation panel is present. Alarm is available.	Furniture is light and mobile There are multiple ligature points including sinks and oxygen portals The room is not available, used for medical cases
1	Room is located within the ED	Doors do not open outwards Light mobile furniture Multiple ligature points
1	Door opens outward Observation panel is in place Alarm is available. No ligature points.	Located outside the ED adjacent to reception area, Staff could be isolated Furniture is light and mobile

3b) An Audit of the Emergency Care Plan within the National Clinical Programme for patients who present to the Emergency Department following Self-Harm

Introduction

When the Clinical Programme commenced in 2014 services were advised to develop Emergency Care Plans. The Standard Operating Procedure stated that a written Emergency Care Plan (ECP) that addresses clinical needs and risks should be formulated and documented. The patient, and wherever possible their carer/next-of-kin, should be involved in the determination of this. A copy of this written ECP should be offered to every patient and family member/carer unless clinically inappropriate, and should be sent by secure fax and/or secure email (health-mail) (depending on local arrangements) to the patient's GP surgery. Patients who are not registered with a GP should be supported in registering.

The Model of Care (2016) states that an **Emergency Care Plan (ECP)** that addresses short-term and medium-term needs and risks should be formulated and documented. The patient, and wherever possible their carer/next-of-kin, should be involved in the determination of this. An ECP with clear, written information on how to access services, including specific contact details and telephone numbers of next step care e.g. clinic, day service and named mental health team clinician, in particular for out-of-hours presentations. The family member/carer/ significant other should be involved in this. The patient and the significant other should be advised on what to do should a further crisis occur.

The Review of the Operation of the Clinical Programme (2017) reported: Almost all services reported developing ECPs. They ranged from writing routine appointments and emergency numbers on a blank piece of paper, to providing a highly structured safety plan which included a modification of Stanley and Brown's safety plan in the first person, known as My 8-Step Safety Plan (Stanley and Brown, 2012).

> *A safety plan document is created collaboratively by a patient and clinician and typically consists of written strategies and sources of support that patients can use to alleviate suicidal urges or other safety crises. A commonly used model is Stanley and Brown's Safety Planning Intervention (SPI), which includes six components: (1) recognize warning signs of an impending suicidal crisis, (2) employ internal coping strategies, (3) utilize social contacts as a means of distraction from suicidal thoughts, (4) contact family members or friends who can help resolve the crisis, (5) contact mental health professionals, and (6) reduce the potential use of lethal means (Stanley & Brown, 2012). A cohort comparison trial of suicidal ED patients in US veteran's hospitals found that Safety Planning and phone follow-up reduced suicidal behaviours and increased treatment engagement in the intervention condition. (Stanley et al 2018.)*

The SPI is presented as a strategy to illustrate how to prevent a future suicide attempt, and identifies coping and help-seeking skills for use during times of crisis.

This audit measures what items are included in ECPs and how well ECPs are being completed. In some services the focus is on the treatment offered and in others the focus is on treatment and maintaining safety. Following this first phase of the audit cycle – new standards will be developed and in 6 months a re-audit will audit against these standards.

Methodology

In September 2019 all CNSs and Clinical Leads within the Clinical Programme were sent an Audit Tool and requested to complete an Audit on 10 Emergency Care Plans (ECP) by choosing consecutive notes from the previous two months until 10 ECPs were audited. Inclusion Criteria: All people who were discharged from hospital after they receive a mental health assessment following presentation at the ED

following self-harm or with suicidal or self-harm ideation. This is a retrospective Emergency Care Plan audit. A small number of services who scored 100% compliance on almost all items were contacted to discuss the value of including specific items in a national template.

Results: 22 of 24 services completed the Audit. 1 service has not introduced Emergency Care Plans and the other service was unable to complete the audit.

The following are the National results. For each items the mean % compliance was calculated and is shown in column 2. The number of hospitals that scored 100% on each item is shown in column 3. The number of hospitals that either scored 0% or rated the item as Not/Applicable is shown in column 4.

No	Item Audited	Nat. Aver	No. of Hosp 100%	No. of Hosp. 0 % or n/a
1	There is a written ECP in the patient's notes.	87%	13/22	0/22
2	The ECP was completed by a CNS	66%	6/22	1/22
3	The ECP was completed by an NCHD	34%	1/22	6/22
4	The date of assessment is on the ECP	97%	18/22	0/22
5	There is evidence (either in the notes or on the ECP) that the ECP was written in collaboration with the patient	93%	15/22	0/22
6	The development of the ECP has input from the family/ Chosen adult. (Evidence in the notes or on the ECP).	65%	4/22	0/22
7	The ECP is signed by the assessing mental health professional (MHP)	89%	17/22	2/22
8	The name of the MHP is written legibly on the form	90%	15/22	1/22
9	There is evidence in the notes the individual was given a written copy of the ECP	73%	9/22	1/22
10	The ECP details the individual discharge plan.	88%	17/22	1/22
1 1	The ECP details triggers for Self-Harm/Suicidal/Self-Harm Ideation	52%	6/22	6/22
12	The ECP identifies warning signs for Self-Harm/Suicidal/ Self-Harm Ideation	52%	5/22	7/22
13	The ECP identifies internal coping strategies.	53%	8/22	6/22
14	The ECP identifies ways to keep the environment safe.	62%	8/22	4/22
15	The ECP identifies time and date for next care appointment	34%	0/22	5/22
16	The ECP identifies supportive family/friends.	65%	6/22	3/22
17	The ECP identifies contact numbers for emergency support.	88%	14/22	0/22
18	The ECP states the patients will receive a follow up phone call within 24 hours.	49%	3/22	4/22
19	All items on the ECP were completed	77%	12/22	3/22
20	There is evidence in the notes that a copy of the ECP was sent to the patient's GP.	54%	7/22	9/22

Discussion

Personalised collaboratively developed risk management planning has been identified by the National Confidential Inquiry into Suicide in the UK as one of the factors in reducing suicide (NCISH 2016).

This audit was completed to identify a baseline of what services in Ireland are including in an Emergency Care Plan, and also to support development of a national template with a set of minimum recommendations.
A number of items w
ere present in over 85% of ECPs audited, and it is recommended that any national recommendations would include these items. These items were: having a copy of the written ECP in the patient's notes; each ECP should contain the date, the legible name and signature of the mental health professional; there should be evidence in the notes that the plan was developed in collaboration with the patients and details of the discharge plan. 88% of the ECPs included contact numbers for emergency contacts, it is agreed that services should ensure all numbers recommended are for reliable and available services.

That the development of the ECP had input from the family was present in 65% of ECPs. In 4 services this item was present in 100% of the ECPs audited, and there were no services that did not have at least one ECP with it included. While it may not always be possible to involve family members, the NCP does recommend that every possible effort is made to involve family or a supportive adult. A booklet Would you know what to do if someone told you they were suicidal? had been developed by the National Office of Suicide Prevention. An item could be included identifying if family have been included, and if this booklet was given to the family.

In 73% of ECPs there was evidence that a copy of the ECP had been given to the patient. It is recognised that not all patients wish to take written material with them. An item identifying that the patient was offered a copy of the ECP, and whether they took same could be included.

Only 62% of ECPs recorded an item on keeping the environment safe and 4 services did not have this item on any ECPs. While not the only intervention in suicide prevention, reducing access to means is an effective way of reducing suicide, preventing impulsive action and giving the person an opportunity to stop and seek help. Identifying means to keep the environment safe such as removing firearms and reducing available tablets is effective, particularly if the person has identified a plan to use these items. Raising this topic may lead to anxiety in family members, this is understandable and family members should be supported in sharing their concerns, at the same time supported in helping provide a safe environment. It is recommended that a general item "Staying Safe" would be included in a national template. This could include having a safe environment.

Whilst 88% documented having Individual discharge plans, only 34% documented including time and date of next care appointment. Many CNSs have identified difficulty in obtaining time and date for next care appointment, it can be argued that having this is one of the most effective measures in ensuring engagement with next appointment, and therefore should be included in national recommendations. Compliance with this will depend on greater cooperation from community, addiction and mental health teams. `Triggers, warning signs and internal coping strategies were each recorded as present in just over 50% of ECPs. 5 services recorded all in 100% of ECPs, but 6 services did not record any of these on any ECP.

The 5 services that recorded all 3 in 100% of cases were contacted for further explanation. They reported including them from recommendations on safety planning, (Stanley and Brown 2012). They commented that internal coping strategies were helpful, but they felt triggers and warning signs do not contribute to this short term emergency care plan, and including them often involved unnecessary repetition for the patient. One CNS, who has trained in DBT, encourages use of personal strategies such as distraction and self-soothing. Stanley and Brown, comment on the value for the patient in identifying their own coping strategies in improving self-efficacy. This is also an opportunity to include personal resources or strengths. This would suggest the national template should include internal coping strategies/personal resources as part of staying safe, but leave out triggers and warning signs.

Only 49% of ECPs referred to receiving a follow-up phone call from the CNS the following day. The NCP recommends that all patients, except where it is not clinically appropriate, should receive a follow up phone call within 24 hours. The combinations of having a Safety plan and receiving a follow up phone call has been shown to reduce the incidence of repeat self-harm and improve engagement with services (Stanley and Brown 2018.) As not everyone receives this call, it may be appropriate to recommend it as an individual item included in Next Mental Health Care section.

In 54% of ECPs is it documented that a copy of the ECP is sent to the patient's GP. In 9 services the ECP was never sent to the GP. This point was raised at a meeting with the ICGP. GPs reported valuing seeing a copy of the ECP. Some GPs reported they would use see a place for using ECPs in General Practice, particularly for sharing information form out of hours services. The national template should include a section identifying that a copy was sent to the patients GP.

Based on these results the following example is recommended as minimum standard for all services

- A written Emergency Care Plan should be completed on each patient.
- ECPs should have the date, the patients name, the Mental Health Professionals name and signature.
- There should be evidence, either on the ECP or in the patient's notes that the ECP was completed in collaboration with the patient.

There should be a place on the Care Plan to state if family have been part of the care plan, if the patient has asked family be excluded, and if the person and family were given a copy of or a link to Would you know what to do if someone told you they were suicidal?

The patients should be given a written ECP, and this fact should be recorded in the notes. Keeping Safe should be included in the ECP. Place and phone number of next care appointment should be included.

The ECP should identify Emergency numbers, including national numbers that are recognised as being reliable and available, supportive family/friends.

The ECP should include a section on Mental Health Care – this should include discharge plan, and all effort should be made to include time and date of next care appointment. In some cases this will include the fact the person will receive a phone call from the CNS the following day.

A copy of the ECP should be sent to the patients GP and this should be documented in the notes.
Agreed at Research and Audit Committee and Implementation Advisory Group on 5.12.19.

Example of an Emergency Safety Plan

Patient's Name: **Date of Birth:**
Mental Health Professional (MHP) Name:
ESP completed in collaboration by the MHP and the patient: **Yes ❑ No ❑**
Family member/supporter has been part of the care plan: **Y ❑** N ❑

	RESPONSES	**ACTIONS**
Keep safe	Individual Family member/supporter GP /SCAN	*(e.g. Remove firearms, tablets, means of self-harm. Stay with relatives/supportive friend. Identify internal/personal coping strategies.)*
Emergency numbers		*(Include numbers for Samaritans 116123; daytime numbers for CMHT and GP; and for supportive family members or friends who can be contacted in an emergency.)*
Mental Health Support		*(e.g. Name of place and phone number for next appointment; plan for what the next communication will be with the patient.)*

Patient has requested family member is not included: **Y ❑** N ❑
Family member given a copy of *Would you know what to do if someone told you they were suicidal? (NOSP)*: Y❑N❑
Copy of the ESP given to the patient: **Y ❑** N ❑
Signed (MHP)
Signed (Patient – *optional*)

c) Audit of Follow-up phone calls

Audit of follow up phone-call for patients assessed by Clinical Nurse Specialists and by NCHDs out of hours.

Introduction

For individuals presenting to the ED following self-harm, the period after discharge from hospital is marked by heightened vulnerability for further suicide attempts/behaviour. Effective care following presentation can significantly reduce risk. The National Clinical Programme for Self-Harm (NCPSH) identifies four areas for improving care including recommending that all patients who self-harm and present to the ED receive a compassionate, empathic approach from a mental health clinician; receive an expert biopsychosocial assessment with a written emergency care plan; have family/carer involvement, and are followed up and linked to appropriate next care. One aspect of the follow-up and link to next care is the recommendation that 'where clinically appropriate, patients discharged from the ED following a presentation with self-harm, including those seen out of hours, should be offered a telephone call within 24 hours from a Specialist Nurse (Registered Psychiatric Nurse) to offer support and discuss the care plan further' (HSE 2016c).

Among patients who have been discharged from hospital following self-harm, the risks of repeated acts of self-harm and suicide among all ages is highest immediately following discharge (Geulayov et al 2018). Brief contact interventions such as post-discharge telephone calls have been shown to offer social support, improve suicide prevention literacy and assist in learning alternative behaviours (Milner et al 2016).

National NCPSH data for 2019 for all patients who were assessed following self-harm or with suicidal ideation found that only 39.5% of those who were assessed received a follow-up phone call. Of CNS-assessed patients, 51.4% received a follow-up phone call and of NCHD-assessed patients the percentage was 27.7% (HSE 2020, Delivering Specialist Mental Health Services). While this gives an overall percentage, it does not give any breakdown on what presentations were more likely to receive a follow-up phone call, or on the outcome of the phone calls. Also, large variations between hospitals are shown in the national statistics, with the percentage receiving a follow-up phone call ranging from 2% to 90%.

A more in-depth audit of follow-up phone calls was conducted to identify and analyse the factors contributing to such national variation. The results of this audit will further inform practice and data collection.

Method

A Clinical Nurse Specialist in each service was asked to complete an Audit of 10 consecutive presentations to the ED following self-harm or with suicidal ideation. This audit identified the number receiving a follow-up phone call, the reason why a phone call was not given, the timeframe within which the phone call was made; whether the patient had self-harmed or had suicidal ideation; whether the patient was assessed by a CNS or an NCHD, and if contact was made with the patient. The audit also identified the time the person presented, whether alcohol of substance misuse was a factor, and the lethality of the suicidal attempt.

Results

Results were obtained for 17 out of 24 services. The mean rate of follow-up phone calls for the 7 services that did not complete the audit, as shown by the national NCPSH data in 2020, was no less than the mean for all the hospitals. There was a slightly higher rate, but the numbers are too small to indicate any significant difference (Table 1).

Table 1 Rates of follow-up phone calls for hospitals (NCPSH data 2020)

Services	Mean rate of follow-up phone calls
7 services that did not complete the audit	45.1%
All hospitals in 2019	39.5%

Table 2 Results of audit of follow-up phone calls from 17 hospitals Text in top-right cell unreadable

No. of hosp.	No. of phone calls made	Reason for no phone call	Timeframe for call	No. of calls for patient who self-harmed	No. of calls for patient with suicidal ideation only	No. of calls for CNS assessed patient	No. of calls for NCHD assessed patients	No of calls for which contact was made	% of all w required a c receiving a f up phone ca
1	4	1a) 5 e)	4 in 24 hrs.	3 of 8 (37%)	1 of 2 (50%)	2 of 6 (33 %)	2 of 6 (33 %)	2 of 4	22%
2	2	3 b)	1 in 24 hrs. 1 in 72 hrs.	1 of 6 (17%)	1 on 4 (25%)	2 of 3 (66%)	0 of 7	1 of 2	14%
3	7	1a) 2 e)	5 in 24 2 In 72	4 of 7 (57%)	3 of 3 (100%)	4 of 6 (67%)	3 of 3 (100%)	7 of 7	78%
4	5	3 a) 1b)	3 in 24 2 in 72	5 of 8 (62%)	1 of 2 (50%)	3 of 3 (100%)	2 of 2 (100%)	2 of 5 (40%)	40%
5	3	1a) 5b) 1e)	2 in 24 1 in 72	2 of 7 (29%)	1 of 3 (33%)	3 of 4	0 of 0	3 of 3	75%
6	5	5 a)	5 in 24	3 of 7 (43%)	2 of 3 (66%)	2 of 2	3 of 3	5 of 5	100%
7	7	2 b) 1 e)	7 in 24	4 of 6 (66%)	3 of 4 (75%)	7 of 9	1 of 1	3 of 7	37.5%
8	8	1a) 1 b)	8 in 24	3 of 5	5 of 5	5 of 5	3 of 3	8 of 8	100%
9	7	3 a)	7 in 24	4 of 5	3 of 5	5 of 5	2 of 2	6 of 7	(86%)
10	10	0	10 in 24	6 of 6	4 of 4	7 of 7	3 of 3	7 of 10	(70%)
1 1	9	1a)	8 in 24 1 in 72	6 of 7	3 of 3	9 of 9	0	8 of 9	(90%)
12	8	2 a)	8 in 24	2 of 2	6 of 8	7 of 7	1 of 1	8 of 8	(100%)
13	6	1a) 1b) 2e)	6 in 25	5 in 7	1 in 3	6 of 8	0	6 of 6	(75%)
14	2	3a) 2 b) 3e)	1 in 24 1 in 72	1 of 3	1 of 7	2 of 4	0 of 1	2 of 2	(40%)
15	9	1e)	8 in 24 1 in 72	4 of 5	5 of 5	9 of 9	0	9 of 9	(100%)
166	2	3 a)	2 in 72	2 of 4	0 of 6	2 of 2	0 of 1	2 of 2	(66%)
		4 b) 1 e)							
177	7	2a) 1 e)	4 in 24 2 in 72 1 in aweek	1 of 2	6 of 8	7 of 8	0	7 of 7	(87.5%)

Key to column 3. Reason for no phone call: a) Admitted to approved centre; b) Phoned by CMHT team; c) Medical records not available; d) CNS on leave; e) Other.

Of the 17 hospitals that completed the audit only one hospital delivered a follow-up phone call in each of the 10 presentations audited. When the presentations who did not require a follow-up phone call (e.g. the person was admitted to an approved centre or received contact from a home-based treatment team or a community mental health team) were removed, 4 services delivered phone calls to 100% of people who required them, and the range was from 14% to 100%, with 12 services delivering a follow-up phone call in 66% or more cases, with a mean of 86%. 52 presentations overall were either admitted to an approved centre, or the person was contacted by a CMHT the following day. This left 118 presentations from a total of 170 where a follow-up phone call was required. 101 phone calls were delivered, giving an overall percentage mean of 86%. Two hospitals found only half of the calls made contacted the patient, resulting in a 22% and 14% rate for giving a call when it was required. For 2 hospitals this rate was between 35% and 40%, for 1 it was 66%, and for the 11 remaining it was over 70% (Table 2).

Table 3 Patient age and follow-up call

Patient Age Range	F/u call YES	F/u call N	Admitted	Total	Contact not made with the patient
16-yr	41 (84%)	5	4	50	3
25-34 yr	21 (87.5)	3	6	40	1
35-44 yr	28 (85%)	5	4	37	5
45-54 yr	23 (79%)	4	3	30	2
55-yr	15 (100%)		2	17	
65-74 yr	2 (100%)			2	
75+			3	3	
Unknown			1	1	

These results show that, while numbers are lower, those over 55 yrs. were more likely to receive a call. It was noted in a number of centres that up to 4 calls could be made to a person. In others, one call was made and no comment was given as to why another call was not made.

Table 3 Alcohol a factor and follow-up call

Alcohol a Factor	F/u call YES	F/u Call NO	Admitted	Total	Contact not made with patient
Yes	69 (85%)	1 1	7 (8%)		12
No	5 5 (90%)	6	18 (36%)		2
Unknown	1		2		

It was noted in a number of services that people were called up to 5 or 6 times and still contact was not made.

Table 4 Suicidal act/suicidal ideation

SA or SI	F/u call YES	F/u call NO	Admitted	Total	Contact not made
Suicidal Act	73	8	14		9
Suicidal Ideation	47	8	9		3
Unknown		1	1		

There were a higher number of presentations for suicidal acts compared with suicidal ideation. There was almost no difference between the two groups on the numbers where contact was made.

Table 5 Severity of suicidal act/lethality

Severity	F/u call YES	F/u call NO	Admitted	Total	Contact not made
Low	63	10	2		5
Moderate	37	6	8		5
Severe	7	1	8		2
N/A	13	9	6		

While those with more severe attempts have a lower number of contacts made, it was noted that, in some cases of moderate or severe lethality, no contact was made despite 4, 5 or 6 phone calls being made.

Of the 17 people for whom a follow-up call was appropriate and it did not occur, 12 were out of hours and assessed by an NCHD, and 5 were assessed by a CNS.

Discussion

This audit showed a marked variation in the use of the follow-up calls across services in Ireland, but the rates were higher and the mean percentage of 86% is much higher than the NCPSH data rate of 39.5%. Also, 13 of the 17 hospitals had a rate of over 50%, with 11 having a rate of over 70%. This discrepancy can be explained by the reasons for not offering a phone call. Another mental health team, such as a home-based or a community team, contacted a large number within 24 hours, and yet in the national statistics this group would have been recorded as not receiving a phone call. This has identified a need to collect data in the national statistics on numbers receiving a call within 24 hours, to include those who are contacted by another mental health team.

A number of people were not contactable, despite the CNS making a number of calls. Age, alcohol use or severity of suicidal behaviour were not factors as to whether the person was contactable or not. This has demonstrated that no standard has been identified in the NCPSH for how many attempts at follow-up phone call should be made. Following discussion with the Implementation Advisory Group of the NCPSH, it has been agreed that best practice would be to call each person on at least two occasions on at least 2 days, and if the person still cannot be contacted their GP and the next appropriate care is informed. This remains a clinical decision. It identifies a minimum standard and it is then a clinical decision if more attempts are warranted.

As is seen with the NCPSH national data, those assessed by a CNS had a higher rate of follow-up phone calls.

Conclusion

This audit has shown a high rate of compliance with the requirement under the NCPSH to provide a follow-up phone call for each person who presents to the ED following self-harm or with suicidal ideation. It has found that an apparent low compliance with national standards, seen from NCPSH data, reflects the fact there is no place in the NCPSH to submit data on phone calls delivered by other mental health teams. There is a greater rate of follow-up calls for those assessed by a CNS compared with those assessed by an NCHD. Based on this audit, the NCPSH has introduced a change on how data on follow-up phone calls are collected. Also, CNSs are now advised to use clinical judgement to determine how often to attempt to make contact with a patient, but at a minimum they should attempt at least on two occasions on two different days. Training to ensure that NCHDs are aware of the need to provide the CNS with information on assessments they complete continues. This should increase the numbers of NCHD-assessed patients receiving a follow-up phone call.

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Health Service Executive (HSE)
Mental Health National Clinical Programmes,
Dr. Steevens' Hospital, Steevens' Lane,
D08 W2A8, Dublin 8, Ireland

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