POLICY BRIEF

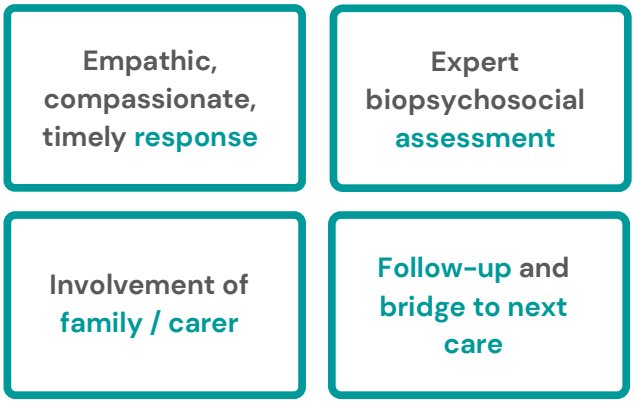
21st January 2025

Evaluating the implementation of the National Clinical Programme for Self-harm and Suicide-related Ideation in emergency departments

The National Clinical Programme for Self-harm and Suicide-related Ideation (NCPSHI) was introduced in Irish public hospital emergency departments (EDs) in 2014.

While the components of care recommended in the NCPSHI broadly align with other guidelines for managing self-harm, the approach of the programme within the ED offered some unique features:

- The programme was primarily delivered by clinical nurse specialists (CNSs) with support from a Clinical Lead (consultant psychiatrist) within each hospital area.
- Dedicated staff were employed to deliver the programme within the hospitals and to oversee implementation from a national perspective.
- The programme required collaboration between mental health and medical professionals in the ED.
- The NCPSHI includes people presenting with suicidal ideation as well as self-harm.



KEY FINDINGS AND POLICY IMPLICATIONS

The introduction of the NCPSHI was associated with improvements in care, particularly for hospitals with no prior liaison psychiatry service. This underscores the need for continued resourcing of dedicated specialised professionals to respond to those presenting to ED with self-harm. This includes supporting the involvement of Non-Consultant Hospital Doctors who deliver the NCPSHI out-of-hours.

In early implementation, barriers to implementation in some hospitals included lack of a designated assessment room, limited access to consultant input and supervision, and poor collaborative relationships between ED and liaison psychiatry staff. Addressing these barriers is key to the success of the NCPSHI.

The perceived value of the NCPSHI model and the national programme team helped to drive implementation forward. Resourcing of a national team to coordinate evidence-based implementation, as well as training of clinical staff, support networks and outcome monitoring is pre-requisite for implementation of such a national model.

Varied availability of timely next care from community providers remains an ongoing challenge, suggesting a need for further resourcing of community teams as well as greater systems of collaboration between liaison and community psychiatry teams.

Study Design

The **PRISM Study (PRoviding Improved care for Self-harM)** was a mixed-methods study of intervention, economic and implementation outcomes of the NCPSHI. The objectives of the first two phases of the study were:

Phase 1: Examine impact on self-harm repetition and provision of care

Phase 2: Identify factors affecting implementation of the NCPSHI

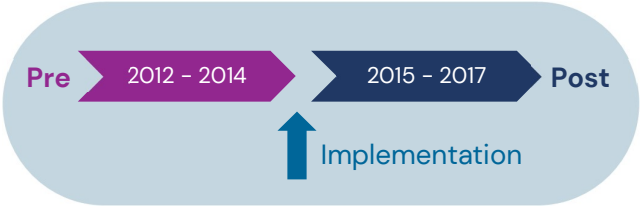
Phase 1

- Data from the National Self-harm Registry Ireland
- Analysis of changes in individual risk and trends from pre (2012-2014) to post (2015-2017) implementation

Phase 2

- Interviews (n=30) with staff involved in implementation of the NCPSHI
- Thematic analysis using an implementation framework

The study included the 15 hospitals who begun implementing the programme by January 2015.



These hospitals were grouped according to their pre-existing liaison psychiatry services.

Designated liaison psychiatry service (7 hospitals)	Liaison nurse(s) (4 hospitals)	No designated staff (4 hospitals)

Phase 1: Impact of the NCPSHI on self-harm repetition and care outcomes

Self-harm repetition

- For presentations involving people with a history of self-harm, signs of a reduction in repetition were observed following the introduction of the NCPSHI for hospitals with no pre-existing designated staff (Table 1).
- For presentations involving people without history of self-harm, an increase in repetition was found in hospitals with pre-exisiting liaison nurse(s).
- Analyses using individual and hospital level data indicated similar patterns.

Table 1. *Change in self-harm repetition by hospital group*

	Designated liaison psychiatry service		Liaison Nurse(s)		No designated staff	
	Pre-post (%)	Adj. IRR (95% CI)	Pre-post (%)	Adj. IRR (95% CI)	Pre-post (%)	Adj. IRR (95% CI)
Self-harm history	32-36%	1.09 (0.98-1.21)	31-32%	0.99 (0.71-1.46)	35-30%	0.85 (0.67-1.09)
No self-harm history	7-8%	1.04 (0.93-1.17)	**5-8%**	**1.48 (1.13-1.94)**	8-7%	0.88 (0.71-1.10)

Care outcomes

- Most improvements in outcomes were detected in hospitals with no pre-existing liaison psychiatry staff. Post-implementation, these hospitals had reduced rates of non-assessment, increased rates of mental health referral and fewer medical admissions.
- For hospitals with a designated pre-existing liaison psychiatry service, post-implementation there was evidence of a significant reduction in self-discharge i.e. reduced likelihood of people leaving the hospital without a recommendation.
- For hospitals with liaison nurses in situ pre-implementation, there were mixed impacts. The individual analysis showed an increase in rates of non-assessment post-implementation. However, the hospital level analysis indicates that this increase reflected the attenuation of an increasing trend prior to implementation in these hospitals, which was followed by a 20% reduction and a trend change at the introduction of the NCPSHI.

Table 2. *Change in care outcomes by hospital group*

	Designated liaison psychiatry service		Liaison Nurse(s)		No designated staff	
	Pre-post (%)	Adj. IRR (95% CI)	Pre-post (%)	Adj. IRR (95% CI)	Pre-post (%)	Adj. IRR (95% CI)
Non-assessment	27 - 27	1.00 (0.94-1.06)	34 - 42	**1.21 (1.10-1.33)**	32 - 25	**0.78 (0.71-0.87)**
Mental health referral	45 - 46	0.99 (0.94-1.03)	29 - 31	1.15 (0.98–1.35)	42 - 59	**1.39 (1.26-1.53)**
Medical admission	19 - 20	1.05 (0.99-1.12)	40 - 36	**0.92 (0.83-0.97)**	28 - 24	**0.91 (0.83-1.00)**
Self-discharge	18 - 15	**0.85 (0.79-0.92)**	14 - 14	1.01 (0.87–1.16)	13 - 13	1.01 (0.87-1.16)

Phase 2: Factors affecting implementation of the NCPSHI

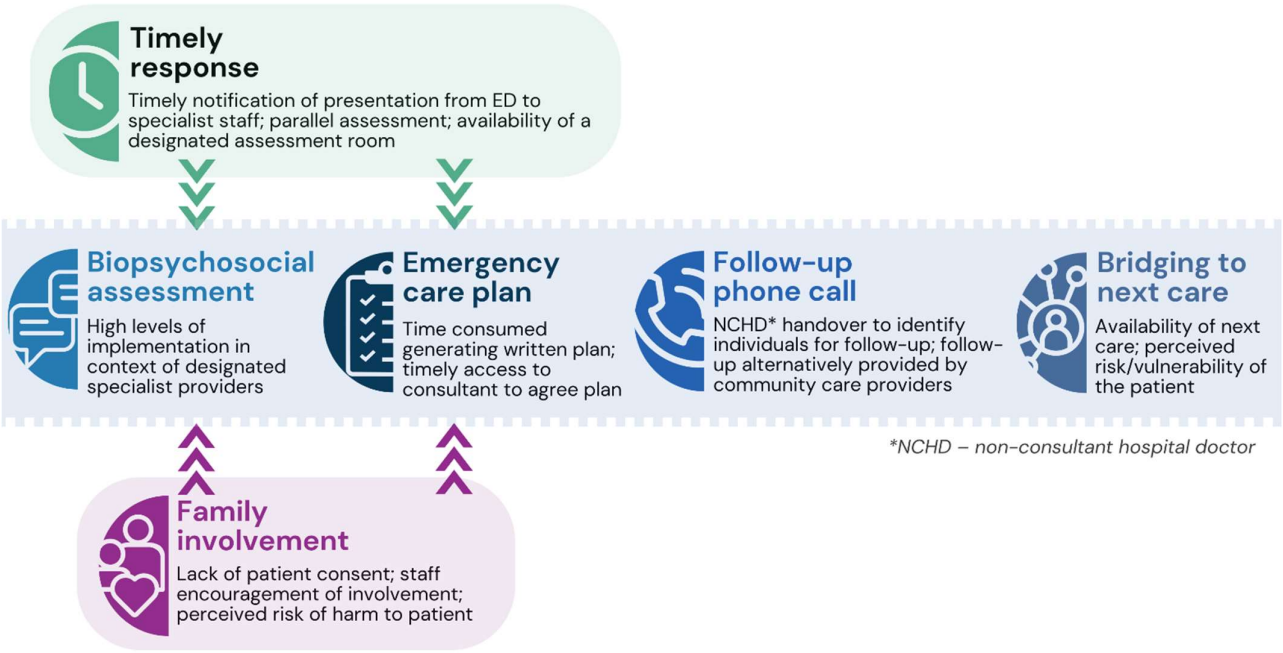
Eight overarching factors were identified to influence implementation as barriers or enablers. Some of these factors changed over time.

Primary area	Theme	Key Findings
The innovation (NCPSHI)	**National standardised guidance for Eds**	Model of care perceived as **enabling** a standardised, consistent approach, "tightening up" of practices with a "clear beginning and end".
Inner setting (hospital)	**Designated space and operational support**	Limited access to an assessment room was a **barrier** that improved over time for most hospitals. *"We've used the [audit] to bring about change or upgrades to our assessment room in the A&E Department to make sure that that's fully compliant"* (Consultant Psychiatrist)
	Timely access to clinical input and supervision	Having dedicated consultant leads **enabled** timely decision-making while lack of dedicated NCPSHI consultants in some hospitals in the early years **hindered** timely decision-making; availability of clinical supervision was not consistent.
	Navigating tensions in the ED through collaborative relationships	Development of formal and informal connections between NCPSHI and ED staff **enabled** implementation. These relationships improved over time. *"I just think nurture the relationship that you have with the emergency department really"* (CNS)

Primary area	Theme	Key findings
Individuals	**Nurse Specialist training and networking**	Ongoing training opportunities and learning from other sites **enabled** CNSs to develop competence and feel supported in role. *"Definitely talking to other people, finding out what they were doing in other areas […] also there were national meetings which were fantastic because you got a feel for what was going on around the country"* (CNS)
Outer setting (community, primary care etc.)	**Varied availability of next care**	Delays in accessing next care was a commonly reported **barrier** across hospitals, which varied across community teams/catchments. There have been some improvements over time.
Process	**Adaptability of programme delivery**	Flexibility in how to organise a work across liaison team was an **enabler** in some hospitals and **barrier** in others where there was limited planning/consultation.
	Nationally led implementation strategies	The national programme team had led implementation strategies at the national level that **enabled** implementation, though a lack of clear mechanisms for implementation through operational pathways was reported as a **barrier.**

Factors influencing each care component

We also examined the factors that affected the implementation of each care component along the care pathway (figure below). While experience of implementing most components of care was similar across the hospital groups, hospitals with pre-existing **designated liaison psychiatry services** had greater systems of parallel assessment in the early years of implementation to support a timely response to people presenting to the ED. This links with our observed finding of reduced self-discharge in these hospitals.



Policy, practice and research implications

Support relationships between liaison psychiatry and ED staff.

- Continue train-the-trainer approaches for CNSs to provide training to ED staff on presentations of self-harm and suicidal ideation.
- Promote collaboration and share examples of good practice in relation to parallel assessment.

Foster inclusion of all members of liaison psychiatry team, including NCHDs.

- Provide accessible training opportunities for NCHDs.
- Ensure availability of proformas for biopsychosocial assessment and care planning.
- Improve handover systems to prevent missed follow-up.

Ensure availability of a designated assessment room.

- Continued audit of available rooms.
- Advocate for designated assessment room using audit data.

Provide continued support for CNS role.

- Ensure ongoing specialised training and preparation for role as champion of the NCPSHI at hospital level.
- Provide continued opportunities for networking as part of the NCPSHI events.
- Continued use of working groups to identify challenges to the CNS role and suitable supports.
- Ensure resources exist to provide clinical supervision to address variation in supervision access.

Examine optimal approaches to improving transition to and availability of next care.

- Strengthen resources in community teams to improve timeliness of response.
- Support networking between ED and community teams, including locally agreed care plans across community and acute care providers.
- Strengthen evidence-base around impact of emergency care plan and disseminate.

Support family/carer involvement in assessment and care planning.

- Clarify benefits of family involvement and best practice around involving family/carers.
- Clarify protocols for lack of patient consent.
- Provide training to staff and information resources for patients and family/carers.

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RELEVANT PUBLICATIONS

Griffin, E., McHugh, S. M., Jeffers, A., Gunnell, D., Arensman, E., Perry, I. J., Cully, G., McElroy, B., Maxwell, M., Chang, S., Ruane-McAteer, E., & Corcoran, P. (2021). Evaluation of the impact and implementation of a national clinical programme for the management of self-harm in hospital emergency departments: Study protocol for a natural experiment. *BMJ Open, 11*(12), e055962-e055962. **(Link)**

Cully, G., Corcoran, P., Gunnell, D., Chang, S. S., McElroy, B., O'Connell, S., Arensman, E., Perry, I. J., & Griffin, E. (2023). Evaluation of a national clinical programme for the management of self-harm in hospital emergency departments: Impact on patient outcomes and the provision of care. *BMC Psychiatry, 23*(1), 917-917. **(Link)**

O'Connell, S., Cully, G., McHugh, S.M., Maxwell, M., Jeffers, A., Kavalidou, K., Lovejoy, S.A., Jennings, R., Russell, V., Arensman, E., & Griffin, E. (2021). Factors affecting implementation of a national clinical programme for self-harm in hospital emergency departments: a qualitative study. *BMJ Quality & Safety*. **(Link)**

Support

This briefing refers to self-harm and suicide. This content may be understandably distressing to read and may trigger painful thoughts or memories for some. Any readers particularly affected by this content are advised to link with a supervisor, allied supports available or supports listed below:

- Samaritans: For confidential, non-judgmental support freephone 116 123, email jo@samaritans.ie or visit www.samaritans.ie
- Pieta: A range of suicide and self-harm prevention services. Freephone 1800 247 247 anytime day or night. Text HELP to 51444 (standard message rates apply). Visit www.pieta.ie for more information.
- Text About It: A free 24/7 text service, providing everything from a calming chat to immediate support for people going through a mental health or emotional crisis. Text HELLO to 50808, anytime day or night. Visit www.textaboutit.ie for more information.
- Childline: Children and Adolescents can access 24-hour support freephone 1800 66 66 66, free text "support" to 50101 or live chat at www.childline.ie
- Yourmentalhealth.ie: Visit www.yourmentalhealth.ie for information on how to mind your mental health and to find a support service in your area. Call the HSE Your Mental Health Information Line on 1800 111 888 for information on mental health services in your area.