Review of the Operation of the Programme 2017

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

National Clinical
& Integrated Care Programmes
Person-centred, co-ordinated care

HSE Mental Health Services

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

Review of the Operation of the Programme

October 2017

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contents

List of Content

Every individual who presents to the Emergency Department following an act of self-harm or with suicidal ideation will receive a timely, expert assessment of their needs, and be connected to appropriate next care. The individual and their family are valued and supported, by staff who themselves are valued and supported.

Vision

This report is for all who are responsible for delivering the Clinical Programme. It uses examples of good practice from services around the country to inform the further implementation of the programme.

Acknowledgements

I would like to thank the Clinical Nurse Specialists and Clinical Leads who gave so generously of their time and expertise in informing me of the operation of the programme. At all times, the emphasis from the clinicians has been on improving the experience of the patient, and this has been captured in the report and recommendations.
Thanks go to Dr Ian Daly who initially championed the need for a dedicated service for those presenting to the Emergency Department following self-harm. The College of Psychiatrists and Directors of Nursing were instrumental in ensuring that the programme was delivered.

I would also like to thank Dr Siobhan MacHale, Professor Eugene Cassidy and Dr Margo Wrigley who, along with Programme Manager Rhona Jennings have developed and implemented the programme. Their ongoing commitment to the training and support of staff continues, and they can be very proud of their work. Thanks to Fiona O'Riordan for input and advice on data management. Others helped in providing training for staff, including Professor Ella Arensman, members of the NMPDU (Nursing & Midwifery Planning & Development), Directors of Nursing and patients, in particular Laura Louise Condell, of the College of Psychiatrists REFOCUS committee.

Finally, I would like to thank Ms Siobhan O'Carroll for her dedication to the development and implementation of the programme. Her contribution has ensured that the programme has remained focused on the needs of the family and the patient.

Foreword by Dr Anne Jeffers, National Clinical Lead

This clinical programme has been designed to improve outcomes for all patients presenting to the Emergency Department following self-harm or with suicidal ideation. Since taking up the post of National Clinical Lead in February 2017, it has been my privilege to visit each emergency department in the country and review its operation. I have been constantly impressed by the dedication and commitment of the Clinical Nurse Specialists and the Consultant Clinical Leads who are delivering this programme.

The model of care developed by the original working group is an excellent example of a well-defined, specific and measurable programme. It ensures that care is standardised and standards are improved. Because of this clinical programme, each individual who has suicidal behaviour or thinking and who presents to the Emergency Department can now receive a timely, expert biopsychosocial assessment; their next of kin will be involved at the assessment stage and be given advice on suicide prevention; the individual will be given a written care plan; their GP will be contacted, and the person will receive support and linkage onto next care.

This report reviews qualitative and quantitative data from each of the emergency departments in Model 3 and 4 hospitals in the country. It identifies good practice points from around the country. It makes recommendations on how this clinical programme can be embedded into day-to-day practice. Services are encouraged to use the good practice points in implementing the recommendations.

I look forward to working with the Mental Health services and the Emergency Department services in using this review to further improve the standard of care delivered to each person who presents to the ED following self-harm.

Dr Anne Jeffers

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

Foreword by Dr Phillip Dodd National Clinical Advisor and Clinical Programmes Group Lead-Mental Health

The National Clinical Programme for the Assessment and Management of people presenting to the Emergency Department following Self-Harm provides an example the benefits of an integrated approach to support people who are at risk of both repeated self-harm and of suicide. The funding of 35 Clinical Nurse Specialists to provide expert biopsychosocial assessments began in 2014, and now with the programme up and running in 24 of 26 Adult Emergency Departments in the country, it is timely to review its operation.

As Vision for Change (HSE, 2006) is currently under review, this report comes as a critical time, with the potential to significantly inform the process of mental health policy review.

This review has captured the work completed by the Clinical Nurse specialists and the Clinical Leads, the support that they have received and the challenges that they have faced. Throughout the report, there are clear examples of the dedication and commitment of staff to the improvement of the patient journey from the ED to next appropriate care.

This report contains a lot of positive findings. There are accounts of improved attitudes and training of ED staff in mental health; accounts of excellent working relationships between ED and Mental Health Staff; examples of excellent supervision and support of the Clinical Nurse specialist being provided, as are examples of excellent integration of this clinical programme with the day to day mental health services. Family involvement is occurring and clinicians are using emergency care plans to formulate care. Follow up to next care is occurring in some services and the review makes recommendations on how this can occur in all services.

The review identifies examples of good practice and all services can use these examples to improve the implementation of the programme in their service.

Training and support of the Clinical Nurse specialist has been paramount for the National Clinical Programme Office. Data collection has also been prioritised and this report gives full year 2016 data from 16 services.

The next step in the implementation of this programme is the further training and education of psychiatrists in the delivery of the programme. There is also a need to improve interdisciplinary working and HSE Mental Health Division will work closely with Executive Clinical Directors, Heads of Mental Health and Area Directors of Nursing in supporting this development.

I would like to sincerely thank Dr Anne Jeffers and Ms Rhona Jennings for the dedication, initiative, commitment and skill that they have shown in the completion of this Review, but also for their general sincere commitment to the development of high quality, integrated clinical care.

Dr Phillip Dodd

National Clinical Advisor and Clinical Programmes Group Lead - Mental Health

Executive Summary

- The National Clinical Programme (NCP) for the Assessment and Management of Patients presenting to the Emergency Department (ED) following self-harm was introduced to the first ED in 2014.
- The aim of the NCP is to ensure that all patients who present to the ED following self-harm or with suicidal ideation will receive a prompt biopsychosocial assessment, their next of kin will receive support and advice on suicide prevention, the patient will be linked with the next appropriate care, and both the patient and their general practitioner will receive a written plan of care.
- Funding for 35 clinical nurse specialists (CNSs) was made available and in 2015 the NCP was delivered in 16 services. Full data is available for 2016. In 2016 a further five services began implementing the NCP. In 2017, 24 of the 26 adult EDs in the country have a CNS delivering the NCP.
- This review uses the quantitative data submitted in 2016, along with detailed interviews completed on all sites between March and July 2017 by Dr Anne Jeffers, National Clinical Lead.
- A key performance indicator of the NCP is a reduction in the numbers leaving the ED before receiving a biopsychosocial assessment. This is achieved through improving the training of ED staff, improving the environment in which patients are assessed, and ensuring that patients with mental health needs are assessed in a timely manner.
- In 2016, out of 6,928 presentations of patients who had self-harmed or who were expressing suicidal ideation, 90% received a biopsychosocial assessment from an expert mental health professional.
- All CNSs have been offered training in raising awareness and skills for ED staff working with patients with mental healthcare needs. In three EDs, this training has been formally delivered. It is recommended that all CNSs be supported in delivering this training.
- Twelve of the 29 (26 Adult, 3 Paediatric) EDs in the country have a dedicated, suitable room for the assessment of patients with mental health needs. It is recommended that all EDs be provided with a suitable room.
- It is recommended that all patients receive parallel assessments, which has been shown to reduce waiting times to assessment
- In 2016, of 6,239 presentations where the patient received a biopsychosocial assessment, 32% were assessed by the CNS, 42% by the NCHD and 22% by a liaison nurse. The NCP recommends that all patients receive a biopsychosocial assessment from a CNS, a psychiatrist or a non-consultant hospital doctor (NCHD) in psychiatry.
- It is estimated that one CNS per 200 presentations per annum is needed to deliver the NCP. This would provide CNS cover from 8am-8pm, 7 days a week, and ensure that the CNS can follow up on patients assessed out of hours by the NCHD. It would also provide essential time for support and supervision of the CNS.

- The report highlights examples of excellent practices around the country; Good Practice Points are noted throughout the report. In implementing the report's recommendations, services are encouraged to put these points into practice.

- Support and supervision are essential to ensure that staff remain healthy, and to prevent compassion fatigue and burnout. This review makes recommendations on the support, supervision and training of NCHDs, CNSs, liaison nurses and consultant psychiatrists.

- In each service, the NCP is delivered by the CNS and a clinical lead, who is a consultant psychiatrist. The success of this NCP relies on true interdisciplinary working between the CNS and the clinical lead. The report makes recommendations to help ensure that the clinical leads are supported in their role.

- A total of 61% of presentations in 2016 included the patient's next of kin in assessment and management. It is recommended that this number be increased to 100%.

- Each patient assessed is given an Emergency Care Plan. Examples of best practice are identified.

- Communication with the GP is paramount. In only 61% of presentations was a letter sent to the GP within 24 hours of discharge. It is recommended that the proportion be increased to 100% for those who have a GP.

- Each patient should receive a follow-up phone call within 24 hours of discharge from the ED. A phone call was received in only 47% of presentations. It is recommended that all patients, including those who present out of hours and are assessed by the NCHD, should receive a phone call from the CNS within 24 hours of discharge from the ED.

- Each patient should be linked to next care. Recommendations are made on how this can be achieved.

- In many services, it was clear that out-of-hours NCHDs were completing biopsychosocial assessments but did not fully comply with the NCP. Recommendations are made to ensure compliance. Extra training will be provided for NCHDs.

- A high number of patients without physical health needs have been presenting to the ED. They would be better assessed by a Community Mental Health Team (CMHT). Recommendations are made as to how the Executive Clinical Director (ECD) can work with CMHTs and the clinical lead so as to address this.

- Children are not included in the work of this NCP. There is good evidence that, in the three Dublin paediatric hospitals, the Paediatric Liaison Psychiatry team already provide most components of the NCP. Better liaison with the community is required, and this can be achieved by appointing CNSs with training in Child and Adolescent Psychiatry through the NCP. Improvements in providing a timely assessment are required countrywide.

- In 2018, Audit and Research networks will be developed. These will include CNSs and clinical leads who are delivering the NCP.

Recommendations

Lead Responsibility	Recommendation	Timeframe
Mental Health Division Senior Management Team	Funding will be provided through the National Clinical Programme to ensure CNSs can be available from 8 am - 8pm seven days a week, and provide assessment and follow up, including follow up to patients who are assessed by the NCHD. One CNS per 200 presentations per annum will be allocated.	2018
	To fund CNS posts in each of the children's hospitals along with extra sessions for CAMHS teams in Galway, Cork and Limerick.	2018
	To secure funding to resource CAMHS teams as recommended by a Vision for Change.	2018/2019
National Clinical Advisor and Clinical Programme Group Lead in Mental Health	To report via the National Clinical Advisor and Clinical Programs Group Lead in Acute Hospitals, to the CEOs hospital groups, outlining the requirements in order to comply with the NCP standards.	2017
Programme Manager/Clinical Lead	To review with National Suicide Research Foundation (NSRF) how the training on Increasing Awareness of Suicide and Self-Harm among Emergency staff could be delivered to ED staff in shorter modules.	Q4 2017
	To ensure the course on Increasing Awareness of Suicide and Self-harm among Emergency Healthcare staff is available for all CNS. To ensure refresher training is available on an annual basis. To ensure CNS is supported in ensuring the formal training is delivered in all EDs.	Q4 2017 2017/2018
	To develop an interactive data collection form in collaboration with Office Chief Information Officer and ensure this is available for use from January 2018.	Q4 2017
	To work closely with the Paediatric Psychiatric Liaison teams and community CAMHS teams in implementing the NCP for children.	Q1 2018
	To establish audit and research networks. These networks will include CNSs and Clinical Leads from the NCP.	Q1 2018

Lead Responsibility	Recommendation	Timeframe
Executive Clinical Director	Local Mental Health Services will develop a policy on whether patients presenting out of hours are assessed in the Emergency Department or in the Department of Psychiatry. In both places, the patient will receive prompt support from a mental health nurse while awaiting an assessment by the NCHD. The NCHD will be supported by having immediate access by telephone to a senior decision maker, such as a Consultant or Senior Registrar, and the patient and family should receive support from the NCHD and mental health nurse.	
	Ensure appropriate Consultant Psychiatrist or Senior Registrar resources are in place to facilitate regular clinical supervision.	
	Address delays in accessing crisis care in the CMHTs resulting in both inappropriate presentations to the ED of patients who do not have physical health needs, and in difficulties in the referral pathway from ED to CMHTs.	
	Ensure all staff, including Consultant Psychiatrists, providing out of hours clinical care are familiar with the NCP.	
	Assessments will be completed by CNS or NCHDs with senior clinical decision maker such as Consultant and Senior Registrar available to discuss on the telephone immediately following assessment. Arrangements will be made, either with ED staff or mental health staff to ensure the NCHD has nursing support.	
	All patients presenting out of hours will benefit from a team approach. The patient will be supported by a nurse and NCHD. The NCHD will have access by telephone to a senior decision maker such as Consultant or Senior Registrar.	
	To develop a forum with the General Adult Psychiatrists, the Clinical Lead and the CNS to ensure the NCP is delivered, all staff, including the clinical lead, are appropriately supported and the patient journey is improved.	
Directors of Nursing Mental Health	All members of the local NCP team will have input into the recruitment of CNS. The DON will ensure the opinion of the Clinical lead and other CNSs working to the NCP is obtained before advertising and interviewing for these posts.	
	To establish and facilitate regular clinical supervision for each CNS	
Clinical Lead/CNS	To ensure quarterly meetings are held with ED staff to review the operation of the NCP.	
	To develop a joint policy between ED staff and Mental Health staff to ensure that all patients who have self-harmed but who leave before receiving a biopsychosocial assessment receive assertive follow-up.	

Lead Responsibility	Recommendation	Timeframe
Clinical Nurse Specialist (CNS) and NCHDs	All patients, including those presenting out of hours will be seen following triage by both ED staff and mental health staff. A joint decision will then be made on how the patient is best supported and assessed.	
	All practitioners will strive to raise family or supporter involvement to 100%. All family members spoken to will be given time to discuss their concerns and will be given verbal and written information on suicide prevention.	
	All patients, including those who are assessed out of hours, will receive an Emergency Care Plan or Safety Plan, which includes names and numbers for people to contact in a crisis along with names and numbers for next-care appointments. A copy of this plan will be sent to the patient's GP, and a copy kept in the ED file.	
	All patients, including those who are assessed out of hours, will receive a follow-up phone call from a nurse specialist within 24 hours to offer support and to review the Emergency Care Plan.	
	For all patients, including those seen out of hours, a short note will be sent to the GP immediately after assessment. This will state the reason for referral, the outcome of the assessment and the follow up. This note should be accompanied by a copy of the Emergency Care Plan.	
	Bridging Strategies will be employed for every patient assessed. For some, who are seen immediately by next care this involves one phone call. For others, it may be a phone call at weekly intervals until they are seen at next care. For a tiny percentage, bridging may involve face to face appointments.	

Full implementation of the Clinical Programme: Future Plans for Programme Office:

Issue	Recommendation	Date
Ensure the NCP is implemented in each of the 26 Adult EDs	Continue to liaise with clinical staff and management	On-going
Standard Operating Procedure is due for review	Review using recommendations from this report	Q4 2017
Improve the data collection	Introduce an interactive data sheet	Q1 2018
Implementation of the NCP for Children	Develop implementation plan	Q1 2018
Creation of audit and research networks	Identify ADON leads	Q4 2017
	Establish working groups	Q4 2017
	Provide training session and identify work plan	Q1 2018.
Long term oversight and governance of the assessment and management of patients presenting to the ED following self-harm	Mental Health Division and National Clinical Programme develop a transition plan	Q3 2018

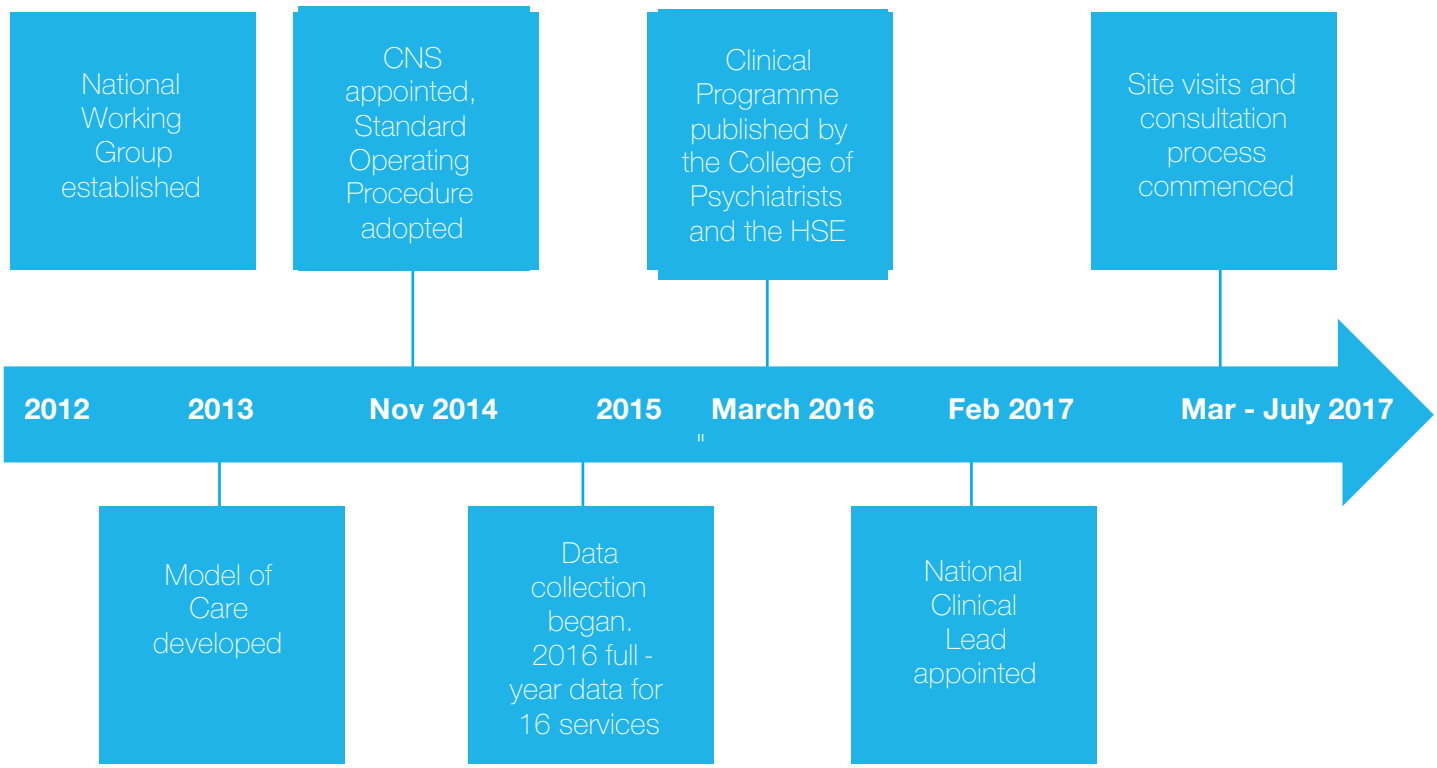
Introduction

The Clinical and Integrated Care Programmes (ICPs) are essential in operational delivery and reform. The Mental Health Division recognises the potential for these programmes to improve integration of services, access and outcomes. It is committed to actively support the development and implementation of the priority work streams of the programmes.

The National Clinical Programme for Mental Health was established in 2010 as a joint initiative between HSE Clinical Strategy and Programmes Division and the College of Psychiatrists of Ireland. The overarching aim of the programmes is to standardise high-quality, evidence-based practice across the mental health services.

The National Clinical Programme (NCP) on the assessment and management of patients presenting to the Emergency Department (ED) following self-harm is one of the first clinical programmes in mental health. In 2010 a working group was established and in March 2012 a subgroup of this working group published 'Saving Lives and Reducing Harmful Outcomes: Care Systems for Self-Harm and Suicidal Behaviour' (Cassidy et al, 2012).[1] This paper reviewed the evidence base for the existing guidelines on the assessment and management of self-harm in the ED, and determined national guidelines for assessing and managing those presenting following self-harm to Irish emergency departments. This paper informed the work of the working group, who went on to produce the NCP. 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 programme was endorsed by the College of Psychiatrists in Ireland (HSE 2016). In February 2017 a National Clinical Lead was appointed to review the implementation of the programme. This report is the result of this review.

Figure 1: National Clinical Programme for Mental Health – timeline



[1] The full title is: 'Saving Lives and Reducing Harmful Outcomes: Care Systems for Self-Harm and Suicidal Behaviour: National Guidelines for the Assessment and Management of Patients Presenting to Irish Emergency Departments following Self-Harm'.

The NCP is part of an overall strategy, and specifically addresses the care and treatment required for people who present to the emergency departments (EDs) of acute hospitals following an episode of self-harm or with suicidal ideation. It aims to provide a standardised specialist response to all such persons and, by so doing, to reduce the numbers leaving the ED without assessment, link people with appropriate care, and involve families and support as appropriate. The overall aim is to reduce repetition of self-harm which is known to be associated with an increased risk of completed suicide. The NCP is consistent with Connecting for Life, the Suicide Prevention Strategy 2015–2020 in targeting approaches to reduce suicidal behaviour and improve mental health among priority groups, to enhance accessibility, consistency and care pathways, and ensure safe and high-quality services for people vulnerable to suicide (NOSP 2015).

Clinical nurse specialists (CNSs) have been allocated to emergency departments across the country to deliver the programme, working with the teams and staff already in place. All CNSs have received training in assessing and managing self-harm. The programme recommends that each CNS be supervised by a named Consultant Psychiatrists who will act as clinical lead. It is the responsibility of both the clinical lead and the CNS to ensure that the programme is delivered.

Since 2015, data has been collected to capture the clinical experience of patients who present to the ED following an act of self-harm or with suicidal ideation. This data is collected by the CNS and sent to the NCP office each month. Between March and July 2017, each ED in the country was visited by the National Clinical Lead for the NCP. At each site, the CNS and clinical lead were interviewed. These interviews, used in conjunction with the data, have enabled a full review of the operation of the NCP.

Remit of the National Clinical Programme (NCP)

The NCP relates to:

- All individuals who present to emergency departments following an act of self-harm, or with suicidal ideation – it addresses the biopsychosocial assessment of the patient's level of need and risk at the time of presentation until discharge from the ED, and linking the person to follow-up care after discharge
- Patients admitted to Clinical Decision Units under the care of consultants in emergency medicine and those admitted to medical and surgical inpatient beds because of the severity of self-harm
- Patients of all ages, including children up to 18 years, adults, and older adults aged over 65 years

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

NCP objectives

To reduce the numbers of people leaving the Emergency Department (ED) prior to receiving a biopsychosocial assessment

To improve the assessment and management of all individuals who present to the ED following self-harm or with suicidal ideation

To reduce rates of repeated self-harm

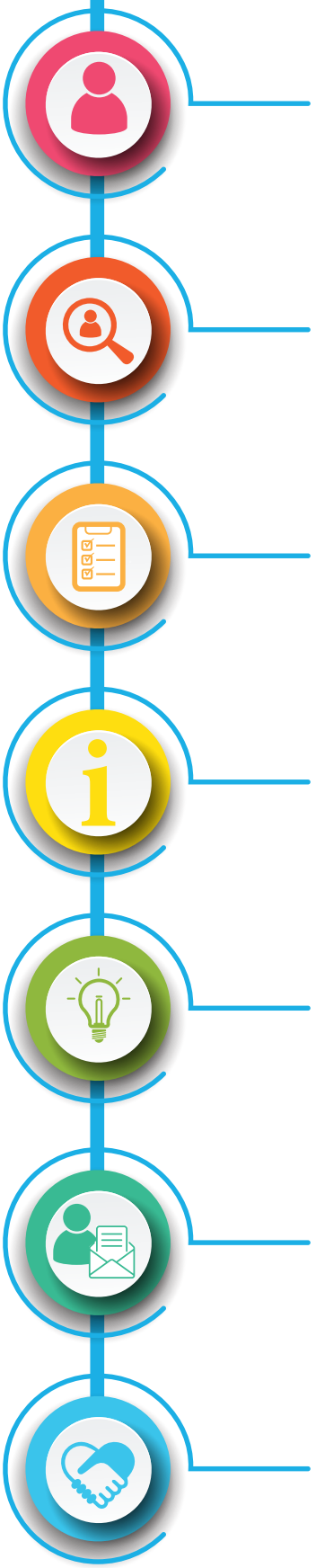
To improve access to appropriate interventions at times of personal crisis

To ensure rapid and timely safe linkage to appropriate follow-up care

To optimise the experience of families and carers in trying to support those who self-harm

These objectives are to be achieved through improving the patient journey. This report reviews the operational issues in ensuring that the patient journey is improved.

The Patient Journey



The patient presents to the Emergency Department (ED) following self-harm or with suicidal ideation.

The patient is triaged; the CNS from the NCP (MHCNS) or on-call non-consultant hospital doctor (NCHD) is informed of the patient's presentation, at the same time as the patient is referred for physical care.

The MHCNS/NCHD assesses the situation, identifies whether the person is fit to be assessed, and agrees a management plan with the ED staff.

The MHCNS/NCHD gathers information from the GP, Mental Health services and patient's next of kin (NoK). ED staff and NoK are given support by the MHCNS/NCHD. When the patient is fit for full assessment, the MHCNS/NCHD carries this out, in a safe and private environment. All sources of information are included in completing the assessment of needs and risks.

The MHCNS/NCHD provides information for the patient and NoK on suicide prevention, identifies the most appropriate next care, includes this in an Emergency Care Plan (ECP), and informs the patient they will receive a follow-up phone call from the MHCNS the next day.

Once assessment is complete the MHCNS/NCHD gives a copy of the ECP to the patient, and sends a letter and copy of the ECP to the patient's GP.

The MHCNS: phones the patient the next day to provide support and review the ECP, ensures that the patient has dates for next appointments, contacts the patient prior to next appointment to encourage attendance,

Programme recommendations

To ensure the delivery of objectives and to improve the patient journey, the NCP recommends that:

1. (i) Emergency Department healthcare staff receive training in awareness of suicide and self-harm and skills for working with patients with mental health needs.

   ii) Each ED has a dedicated, safe and private room for the assessment of patients with mental health needs.

2. Each ED has access to a trained and supervised mental health professional at the level of clinical nurse specialist (CNS) or non-consultant hospital doctor (NCHD) to provide timely biopsychosocial assessment and follow-up to patients who self-harm.

3. CNSs appointed through the NCP receive supervision, training and support through a consultant clinical lead and nursing management.

4. All patients are actively encouraged to nominate a family member who can provide information, and are advised on suicide prevention before the patient is discharged.

5. All patients are given a written Emergency Care Plan (ECP) prior to discharge.

6. The patient's GP is informed of the presentation and provided with a copy of the care plan within 24 hours of discharge.

7. All patients receive assertive follow-up regarding their next-care appointment.

8. Each CNS collects data on patients assessed through the NCP and submits this data to the NCP office each month.

Each of these areas is addressed in detail in this report. The report is based on data collected from 16 services in 2016, along with information collected during visits to 30[2] services in the country (see Table 1).

[2] ED services were visited. 26 Model 3 Hospitals with Adult EDs; 3 Paediatric Hospitals; 1 Model 2 Hospital.

Methodology:

This report uses both quantitative and qualitative data to review the operation of the NCP.

Since CNSs were first put in place, a detailed data sheet has been completed for each patient who has presented to the ED. The CNS submitted this data to the national clinical programme office at the end of each month. For 2016, there is complete data from 16 services. This data was collected on an Excel sheet and provided information on: the numbers of patients seen; demographic details; the nature of their self-harming behaviour; the proportion receiving a biopsychosocial assessment; the staff member who completed the biopsychosocial assessment; next of kin involvement and follow up to next care.

Between March and July 2017, Dr Anne Jeffers, as National Clinical Lead visited each service and completed detailed interviews with each CNS appointed through the NCP and with the Clinical Lead. The local Executive Clinical Director or Director of Nursing were informed of the visits and given an opportunity to meet if they wished, however it was evident early in the assessments that the staff who were most informed on the service were the Clinical Lead and the CNS and this report is based on the detailed interviews with them. 30 services, which include 26 Emergency Departments, 3 Paediatric Emergency Departments and 1 Urgent Care Centre, were visited.

A semi structured interview was developed using a combination of the standard operating procedure developed for the programme (SOP 2014), data available from the National Suicide Research Foundation (NSRF 2015) and data submitted to the NCP office. The standard operating procedure covered areas such as Target patient group; Governance issues; CNS role; CNS working arrangements; Assessments; Emergency Care Plan; Next of Kin Involvement; Assertive Follow-up to next care; Documentation; Supervision; Training; In all 30 services visited there was prior information available from the NSRF 2015 report. This provided the numbers presenting following self-harm along with the percentage leaving the ED prior to receiving a biopsychosocial assessment. In 16 services detailed data was available on the NCP.

The interviews with the CNS took on average 90 minutes. They began with an open discussion on the role, support and supervision of the CNS and then discussed the data in detail, with the emphasis on enquiring what, in their opinion would improve the implementation of the NCP. The interviews with the Clinical Lead took 30 minutes and provided an opportunity to assess the level of support the Clinical Lead had and to assess what was required of the wider mental health service to ensure full implementation of the NCP.

In six services an ADON or DON provided further valuable information which has also been included in the report.

The information from each service is used in a general anonymous manner in informing this report. Examples of good practice have been identified and are used throughout this report to provide information for all services in the further implementation of the service. Individual reports have been sent to each service.

Quantitative results

Table 1: 2016 data submitted from 16 emergency departments (EDs)*

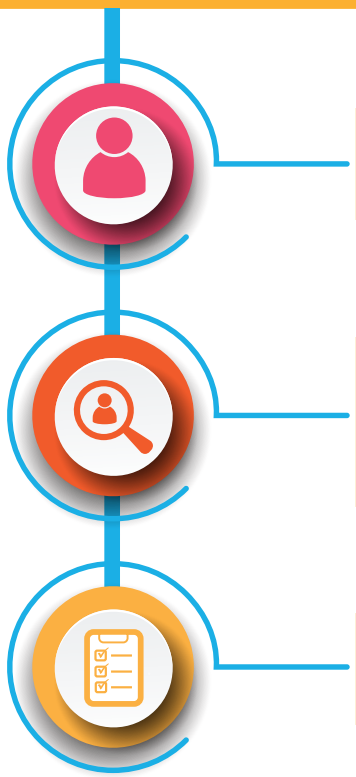
Number presenting to ED following self-harm or with suicidal ideation	6,928
Number receiving biopsychosocial assessment	6,239
Number not assessed	689 (9.9%)
Age (years)	
0 – 15	191
16/17	325
18/19	524
20 – 29	1,979
30 – 39	1,585
40 – 49	1,180
50 – 59	792
60 – 64	225
>65	257
Time of presentation	
Monday – Friday, 9am – 5pm	2,205
Monday – Friday, 5pm – 9pm	1,029
Monday – Friday, 9pm – 9am	1,800
Sat and Sun, 9am – 5pm	540
Sat and Sun, 5pm – 9pm	291
Sat and Sun, 9pm – 9am	590
Bank holiday	299
Time within which patients are assessed	
Assessed within 6 hours of being fit to be assessed	6,099
Assessed within 69 hours of being fit to be assessed	140
Assessed 9 hours after being fit for assessment	40
Number of episodes of self-harm	
1st episode within 12 months	4,406
2nd episode within 12 months	1,049
3rd or more episodes within 12 months	794

Self-harm act	
Overdose	2,781
Cutting	797
Hanging	221
Shooting	3
Poisoning	47
Drowning	110
Alcohol	668
Other	277
Suicidal ideation only	2,546
Number of patients assessed	6,239
Patient assessed first by:	
Clinical Nurse Specialist (CNS)	2,029 (32%)
Non-Consultant Hospital Doctor (NCHD)	2,691 (42%)
Liaison Nurse	1,421 (22%)
CNS and NCHD jointly	217
Next-of-kin involvement	
In assessment	4,183 (67%)
Given advice on suicide prevention	3,831 (61%)
Follow-up of patients assessed	
Letter sent to GP within 24 hours	3,814 (61%)
Phone call to the patient	2,932 (47%)
Place of next care	
Community Mental Health Team	3,520
Admitted to Approved Centre	1,144
General Practitioner (GP)	1,132
Addiction Services	1,100
Other (incl. stat. counselling)	567
Voluntary Counselling Agency	496
Child and Adolescent Mental Health Service	430
Psychiatry of Old Age	92

Money Advice and Budgeting Service (MABS)	29
Mental Health in Intellectual Disability Service	19
Forensic Mental Health Service	17
Days to next appointment	
<24 hours	875
1-3 days	1,071
7-7 days	854
7 – 14 days	458
15 – 21 days	94
>21 days	72

* CNSs appointed through the NCP submit data on each patient presenting to the ED. They aim to ensure that all presentations are included in this data, but in a number of centres this data may be incomplete. Presentations out of hours are thought to be under-recorded. Where out-of-hours presentations are recorded, details on interventions offered may not always be available.

The Patient in the Emergency Department



Patient Journey

The patient presents to the Emergency Department following self-harm or with suicidal ideation.

The patient is triaged, the CNS from the NCP (MHCNS) or on-call non-consultant hospital doctor (NCHD) is informed of the patient's presentation, at the same time as the patient is referred for physical care.

The MHCNS/NCHD assesses the situation, identifies whether the person is fit to be assessed, and agrees a management plan with the ED staff.

The first objective of the National Clinical Program (NCP) is to reduce the numbers of people who have self-harmed who leave the Emergency Department (ED) before receiving a biopsychosocial assessment. A key performance indicator (KPI) of the programme is to reduce this number to below 10% for all services, and to below 5% in those services where the percentage leaving was already below 10%. This number is measured annually by the National Suicide Research Foundation (NSRF). The latest NSRF report (2015) found that 13% left before assessment, with a range from 5.5% to 27%.

Data submitted to the NCP indicated that 9.9% of those identified as having self-harmed or having suicidal ideation left the ED before assessment. This number included those admitted to medical or surgical wards; when they are excluded, the percentage not receiving a biopsychosocial assessment is 7.2%. This may be an underestimate in that data may be incomplete (some data from out-of-hours presentations may be missing). Also, the NCP data includes those who present to the ED with suicidal ideation without self-harm, a group who are motivated to remain for a biopsychosocial assessment.

Factors that influence individuals to wait for a complete biopsychosocial assessment include: attitude of the staff, the environment in which they are assessed, and the length of time people have to wait. The NCP addresses each of these.

ED staff training

Emergency Department Healthcare staff should receive training in awareness of suicide and self-harm and skills for working with patients with mental health needs.

Better knowledge of suicidal behaviour has been found to improve staff attitudes to patients, raise their confidence in their ability to manage patients, increase their desire to work with at-risk patients, and contribute to better patient outcomes (Gibb et al, 2010). All CNS appointed through the NCP were offered places on a train-the-trainer programme to increase awareness of suicide and self-harm and skills among emergency healthcare staff. This training has been developed and provided by the National Suicide Research Foundation (NSRF) and University College Cork (Arensman and Coffey, 2010). To date, this training has been formally delivered in three EDs. CNSs have stated they have used information from the course in educating ED

staff. They report using each clinical contact as an opportunity to educate and inform ED staff. The formal training takes three hours to deliver; many ED staff find it difficult to allocate three hours for training. CNSs have also requested refresher training in delivering the awareness training.

Recommendation: The office of the National Clinical Advisor and Clinical Programme Group Lead - Mental Health ensures that the train the trainers skills awareness course available for all CNS The course developers have agreed to review how the training could be delivered to ED staff in shorter modules. The national office ensures that refresher training is available on an annual basis. CNSs are supported in ensuring that the formal training is delivered in all EDs.

Good Practice Point: CNSs in mental health are ideally placed to improve ED staff's awareness and understanding of mental health issues. Each clinical contact can be used as a training opportunity so as to improve patient outcomes.

Dedicated room for assessment

Each emergency department should have a dedicated, safe and private room for assessing patients with mental health needs.

Emergency departments are noisy and busy environments. NSRF data in 2015 indicates that 13% of patients presenting following self-harm leave before a next-care recommendation can be made. A safe therapeutic environment will reduce this number.

Standards for the assessment room have been identified by the Psychiatrist Liaison Accreditation Network (PLAN – RCPsych, 2017). This has been endorsed by the Liaison Faculty of the College of Psychiatrists of Ireland and is incorporated in the Clinical Programme. The assessment room should -

- Be located within the main ED
- Have at least one door opening outwards, which is not lockable from the inside – ideally, assessment facilities should have two doors to provide additional security. All new assessment rooms must be designed with two doors.
- Have an observation panel or window that allows staff from outside the room to check on the patient or staff member, and at the same time ensure privacy
- Have a panic button or alarm system
- Contain only furniture, fittings or equipment that is unlikely to be used to cause harm or injury to the patient or staff member (thus excluding, for example, sinks, sharp-edged furniture, lightweight chairs, tables, cables, TV, or anything else that could be used as a missile)
- Not have any ligature points

The assessment rooms in all 26 adult EDs and in the three paediatric EDs were visited as part of this review. In 12 out of the 29, there was a dedicated assessment room that met all the criteria identified in the NCP. In some of these EDs, the room was not always available for mental health assessments, but instead was used for isolating patients with physical health needs.

Recommendation: The National Clinical Lead will send a report, via the National Clinical Advisor and Clinical Programmes Group Lead in Acute Hospitals, to the CEOs of the remaining 17 hospitals, outlining the requirements to ensure compliance with the NCP.

Triage assessment

Triage on arrival should include a mental health assessment.
Mental Health Triage scales reduce waiting times and reduce the proportion of people who leave before receiving a biopsychosocial assessment (Cooper et al, 2006). The NCP recommends that all patients who self-harm, or who express suicidal ideation, receive an expert biopsychosocial assessment. Prompt referral to mental health staff with ED staff and mental health staff working together provides the best means to ensure that patients do not leave before receiving an assessment.

This review has found that, in each service, CNSs have developed their own means of triaging patients. Most have developed a system whereby they are informed immediately if a person who has self-harmed or who has suicidal ideation presents. In many services, the CNS will immediately visit the patient, offer support to the staff and next of kin, and make a judgement on how soon they can assess the patient. If medical or surgical intervention is required before biopsychosocial assessment, the CNS uses the time available to obtain a history from the next of kin and the person's GP, and to trace any community mental health notes the patient may have. ED staff have identified this approach as being best-practice, with the CNS for the NCP recognised as being part of the ED team working alongside ED staff, rather than taking over the patient care.

Some CNSs have expressed concern that, once they become involved, they are expected to take over care of the patient. Where the programme works well, the CNS and ED staff work closely together in ensuring that the patient and their family receive optimum and timely care and support.

All staff need to be aware of the risk of overlooking medical needs; the ED staff thus retain responsibility for the patient, while the mental health professional provides essential collaborative expertise.

Recommendation: All patients, including those presenting out of hours, are seen following triage by both ED staff and mental health staff. A joint decision can then be made on how the patient can be best assessed and supported.

Good Practice Point: Parallel assessment of all patients who self-harm will reduce the proportion of patients who leave before receiving a biopsychosocial assessment and will also improve the attitude of ED staff to patients who self-harm.

Particular challenges arise in providing a prompt service for people presenting out of hours. Data from the NSRF (2015) indicates that 50% of presentations occur between 7pm and 1am. When a CNS is not available, in almost all services out-of-hours assessments are completed by an NCHD. In some services, the assessments are completed by senior nurses working in the acute inpatient mental health unit; in others, the assessments are completed jointly by the NCHD and a mental health nurse. One service introduced senior mental health nurses to provide cover up to 3am.

Patients and ED staff complain that waiting times out of hours are long, and many point to the fact that the ED at night is not a suitable place for a person in an acute mental health crisis. One such person stated:

> **"I understand that medical professionals are overworked and under-resourced. Because of this I know that even in an emergency I should expect to wait hours to be seen. It's hard to describe what that does to a person. It made me feel simultaneously insignificant and a burden. The way my mental health had deteriorated, I already felt worthless, and this only adds to it." (NCP Training Day April 2016)**

In a number of services around the country, all patients who require a biopsychosocial assessment are sent to the Department of Psychiatry. This occurs immediately following triage if no physical health need is identified. Otherwise, once they are physically treated, they are then referred to the Department of Psychiatry. Once a person is referred to a Department of Psychiatry, they and their family are supported by a mental health nurse while waiting assessment by the NCHD. In this situation the NCHD would also receive support and advice from the mental health nurse. In other services, all patients are assessed in the ED. In these services it has been stated that patients with mental health problems are being stigmatised and discriminated against if they do not go through the ED like all other patients. There is also concern that patients who are assessed in a Department of Psychiatry may be more likely to be admitted, and this admission may not always be appropriate. Patients report feeling totally unsupported if they have to remain for long periods in the ED. This is a time of particularly high risk for patients to leave. In one service, a voluntary group provide support workers to sit in the ED while assessment is awaited. But NCHDs also report that assessments in the ED at night are particularly challenging in that they often have no nursing support and the environment is unsuitable. Some individual services have collected their own data, which shows that patients are twice as likely to be admitted out of hours. This seems to be related to a lack of senior clinical input at the time of assessment rather than to where the person is assessed. In some services, patients who present to ED out of hours are immediately taken to an observation area in the ED. It would also be advisable that a mental health nurse provide support for the NCHD completing out-of-hours assessments. This nurse does not need to be at CNS level as the assessment can be completed along with an NCHD. Where patients present to an ED where there is no access to mental health staff, local arrangements are required to ensure that patients remain safe while awaiting assessment.

Recommendation: Local services will develop a policy on whether patients presenting out of hours are assessed in the Emergency Department or in the Department of Psychiatry. In both places, the patient will receive prompt support from a mental health nurse while awaiting an assessment by the NCHD. The NCHD will be supported by having immediate access by telephone to a senior decision-maker, such as a consultant or senior registrar, and the patient and family will receive support from the NCHD and mental health nurse.

Good Practice Point: Patients and their families presenting with self-harm or suicidal ideation benefit from prompt support from mental health nurses. This reduces the risk of people leaving before assessment and ensures that they benefit from a team approach.

CNSs for the programme have developed close working relationships with ED healthcare staff. Clinical leads work closely with consultants in emergency medicine in ensuring the smooth delivery of the NCP. Those services that have introduced regular quarterly ED-Mental Health service meetings have optimised communication and improved the clinical journey for patients who self-harm.

Recommendation: Each clinical lead and CNS will ensure that quarterly meetings are held with ED staff to review the operation of the NCP.

Staff in the National Clinical Programme

Patient Journey

The MHCNS/NCHD gathers information from the GP, Mental Health services and the patient's next of kin (NoK). ED staff and the NoK are given support by the MHCNS/NCHD. When the patient is fit for full assessment, the MHCNS/NCHD carries this out, in a safe and private environment. All sources of information are included in completing the assessment of needs and risks.

Each Emergency Department has access to a trained and supervised mental health professional at the level of clinical nurse specialist (CNS) or a psychiatric non-consultant hospital doctor (NCHD) to provide timely assessment and follow-up to patients who self-harm.

In 2014, 35 CNS posts were allocated to this clinical programme. Posts were allocated to each ED based on the data from the NSRF registry on self-harm. These CNSs were employed through the Mental Health service and worked in the ED under the supervision of a consultant psychiatrist. Throughout the country, liaison mental health nurses, employed separately from the NCP, have also been delivering the NCP.

Ideally, a CNS should be available from 8am–8pm, seven days a week, and out-of-hours cover should be provided by the NCHD. Each CNS should receive initial training in biopsychosocial assessments and then ongoing training through the NCP office. All CNSs should receive clinical support and supervision from a named consultant lead and from nursing management. Patients assessed by the NCHD out of hours should be followed up by the CNS.

Number of EDs implementing the clinical programme

In 2016, 16 EDs had at least one NCP-appointed CNS in post and full year data is available for these 16 services. In 2017, 24 of the 26 adult EDs had CNSs appointed through the programme, and the programme was commenced in 22 of these EDs. In two EDs, posts have been allocated but governance issues have prevented them being filled. Two EDs have access to liaison nurses (appointed through general mental health funding) who are delivering the NCP.

Table 2: Numbers of EDs implementing the NCP in 2017

EDs with CNS appointed through the NCP delivering programme	EDs delivering NCP using CNS appointed through mainstream mental health funding
22	2

Working arrangements of the CNS

The NCP provides a framework and advises that local services adapt the NCP for their local needs. The working arrangements of the CNSs vary throughout the country. One service uses CNS cover on a 24-hour, seven-day-a-week rota. Two services use a Clinical nurse manager (CNM) from the Acute Mental Health Unit to provide assessments at night-time. One service uses liaison nurses to cover the ED up to 3am. Nine hospitals have CNSs working from 8am to 8pm, and covering seven days a week. Of these, in three services, two CNSs worked 8am to 8pm, and one (the nurse employed through the NCP) worked 8am to 4pm or 9am to 5pm. Eleven services provided cover from 8pm or 9am to 4pm or 5pm, Monday to Friday.

Table 3: Hours of work covered by CNS

Hours covered by CNS	8am-8pm 7 days a week	Combined, 8am-8pm, 7 days and 9am-5pm Mon-Fri	9am- 5pm Mon-Fri	Combined 9am- 5pm Mon-Fri and 3pm-3am, and weekends	CNS available 24 hours, 7 days a week
No. of services	6	3	11	1	3

There were mixed views on the optimum hours of cover by the CNS. A number of people working 9am-5pm agreed that it would be preferable to provide 8am-8pm cover seven days a week. Increased resources would be needed to achieve this.

Some concern was expressed about the provision of clinical cover, as many Monday-Friday 9-5 services had their supervising consultant providing clinical cover at all times. They were not fully confident in the quality of cover provided by the on-call consultant if the CNS was working outside their supervising consultant's hours. In services where consultants on call provided clinical cover outside Monday to Friday 9-5, no problems were reported. In many cases, CNSs and clinical leads reported benefits, believing that other consultants gained a better understanding of the NCP.

The 2016 data from 16 services indicated that 42% of patients presenting with self-harm or suicidal ideation were assessed by NCHDs out of hours. This number was lower where the service had longer hours of CNS cover. Some services reported ED staff keeping people within the ED until the nurse was available the next day. Others described how they followed up everyone who had been seen at night by the NCHD. The point was made that much of the work involves linking the patient with other services, and that this is not possible at night-time. In some of the larger services, the combination of staff working both 8am-8pm and 9am-5pm works well, with one or two CNSs providing cover from 8am to 8pm, seven days a week, and one CNS working 9am-5pm Mon-Friday. In larger services, the ED was always covered, even when staff were on leave. In one of the smaller services, cover was provided for leave, ensuring that a CNS was present in ED every day of the year. The service providing cover until 3am was implemented some years ago following an audit identifying a high number of inappropriate admissions to the mental health unit occurring in the evening and early morning. The service providing 24-hour CNS cover has been developed gradually to meet local need.

Recommendation: Funding will be provided through the National Clinical Programme to ensure that CNSs can be available from 8am to 8pm seven days a week, and provide assessment and follow-up, including follow-up for patients assessed by the NCHD. One CNS per 200 presentations per annum will be allocated.

Good Practice Point: The most effective services use a team approach, providing a CNS supported by a consultant from 8am – 8pm seven days a week, and an NCHD supported by a consultant from 8pm – 8am, and ensuring that the CNS follows up on all cases, including those seen by the NCHD out of hours. Resource requirements to achieve this are one CNS per 200 patients per annum.

Assessment of patient following self-harm or with suicidal ideation

The NCP ensures that all patients receive a timely assessment of needs and risk by a trained mental health professional, who will be a CNS or NCHD. Evidence has been emerging for some years now that assessments of suicidal patients have tended to focus on risk assessment rather than establishing a therapeutic connection with the patient. Concerns have been expressed that assessment models have prioritised risk at the expense of needs (NICE, 2011). The value of using risk-assessment tools has been questioned, with little evidence that suicide can be predicted (Pokorny, 1983; Large, 2011). It is now accepted that risk-assessment scaling should not form the basis of clinical care and that the use of detailed risk assessments should be curtailed, lest they deliver false reassurance for clinicians and managers (Chan, 2016). It is acknowledged that 1% of patients assessed following self-harm will go on to complete suicide within 12 months, but it is not possible to predict who that 1% are (Owens et al, 2002).

The NCP data shows that risk-assessment tools were in use in most services, but all reported that they found them of little use in predicting risk. The difficulties with predicting suicide have long been recognised (Pokorny, 1983), Despite increased use of suicide risk-assessment tools, it has been clearly demonstrated by meta-analyses of their use that about half of people identified as low-risk go on to kill themselves (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 the identification of risk factors in clinical practice, may provide false reassurances, and are therefore potentially dangerous (Chan, 2016). However, there is concern about abandoning risk assessment altogether (Draper, 2012). Draper argues that risk assessments might have limited value in the immediate discharge period, although not much beyond that. This is difficult to measure in a meta-analysis. Over the past 10-15 years, the conceptualisation of suicide risk assessment has graduated significantly in the clinical domain to a more sophisticated and systematic process for learning about the person. Draper suggests that risk assessment is more effective when it focuses on the individual's circumstances (including a range of social, environmental, situational, family and other areas) and involves a series of convergent data-gathering tools (e.g. interviewing family members, significant others, etc.).

Technical competence and an empathic attitude make the patient-clinician relation a trustworthy one. Hawgood and De Leo (2016) suggest that, in this light, risk assessment should be focused on mitigating risk and informing the effective and personalised care of the individual, with the ongoing aim of supporting growth and recovery, and ultimately of enhancing the person's self-stated reasons and desires for living. They developed a data-gathering tool, STARS, as a guidance framework to aid clinicians in this process. This mirrors the work carried out by CNSs and NCHDs in Ireland. All CNSs assess suicide intent; identify what supports the individual has, and how these can be used to mitigate any risk factors. They all emphasise the value of forming a therapeutic alliance with the patient and a family member in supporting risk management.

Good Practice Point: Developing a collaborative, therapeutic relationship with the patient, obtaining information from the person's family, developing a care plan with the patient and family, and bridging to next care is the most effective means of managing risk of suicide.

Evidence about recipients' views of the psychosocial assessment process offers some clear messages. There are copious reports of patient dissatisfaction with any sense of being processed, and with stock questions in particular, which are seen as constituting a superficial assessment (Horrocks et al, 2005). Patients want a space where it is safe to be emotionally distressed, while retaining some sense of privacy. A patient who presented at the national training day for the NCP in April 2017 stated:

"I have sat through enough risk assessments to know the difference between targeted listening and actual listening. I know when someone is only listening out for keywords and phrases to see if I am an active danger to myself or others. People can feel the difference. All I need is to be listened to, to be heard. Not being listened to compounds those feelings of worthlessness and hopelessness, can leave me worse off than before I went in. Being heard, being listened to with compassion and empathy, can literally save lives. In five minutes you can give someone back their hope, their dignity, their humanity. If you only have five minutes with somebody, please make them count." (NCP Training Day April 2017)

People are relieved to have their painful mental state taken seriously. When a nurse or doctor legitimises feelings of distress, it can be a first step in dealing with the intense negative emotions that preceded the self-harm (Hunter et al, 2013). People want openness, warmth and respect, and at the same time acknowledgement of their fragile emotional state.

In the interviews conducted during the services visits, staff reported their efforts to adopt a warm, compassionate and respectful approach. CNSs reported offering cups of tea, creating a relaxed and supportive environment, and giving the patient and family member time to tell their story. While many NCHDs will also take this approach, some assessments can be limited in that the focus is on identifying a diagnosis, identifying risk and offering a binary solution of admission to hospital or discharge. This can result in either needlessly restricting some individuals' freedom and giving unrealistic expectations of hospital admission, or discharging without adequate support in the community. There is evidence from around the country that this is less likely to happen when the NCHD can immediately discuss with a consultant or senior registrar. The NCP identifies a collaborative and respectful assessment, family advice on suicide prevention, an Emergency Care Plan and a follow-up phone call within 24 hours of discharge as an effective means of avoiding these negative outcomes.

The hours of work of NCHDs make follow-up difficult. The most effective approach used is where the NCHD completes the immediate interventions, including giving an Emergency Care Plan (ECP) and a GP letter, but the follow-up phone call and bridging to next care is completed by the CNS. CNSs reported that, once the NCHD has informed the patient that they could expect a phone call from the CNS the following day, the patient welcomed this call. CNSs used the call as a means of reviewing the ECP, and some also spoke with the next of kin. Some CNSs expressed reluctance to phone patients they had not met, but where this was happening no difficulties were reported and CNSs reported that the call was valuable.

All staff completing assessments need to be fully supported. Where an NCHD is completing assessment, it is important that the patient and family be also provided with support from a nurse. There is a need to ensure that a senior decision-maker, such as a consultant or senior registrar, is available by telephone at all times. This will improve the patient journey and ensure that staff are being appropriately trained, supervised and supported. Consultants on call will need a full understanding of the NCP in order to ensure that all patients receive comprehensive care and follow-up.

Recommendation: The Executive Clinical Director will ensure that all staff, including consultant psychiatrists providing out-of-hours clinical care, are familiar with the NCP. Assessments will be completed by CNSs or NCHDs, and a senior clinical decision-maker, such as a consultant or senior registrar, will be available to discuss on the telephone immediately following assessment. Arrangements will be made, with either ED or mental health staff, to ensure that the NCHD has nursing support.

Good Practice Point: An effective team approach – with the NCHD providing the assessment, but the patient and family also receiving support from a nurse, either from the ED or the mental health service, depending on local arrangements –improves the patient journey.

Clinical Nurse Specialist role

While all CNSs reported giving priority to self-harm assessments, in all but eight services the CNS assesses all those who present to the ED with mental health needs. Of the eight services where only those with self-harm or suicidal ideation are seen, four provide follow-up and bridge to next care. People who present with other problems or liaison cases on the wards are seen by NCHDs on call, or by the liaison team. Of the other 16 services, a number reported initially seeing only those who were suicidal or who had self-harmed, but then moved on to see others, including those on the acute wards. For patients, both approaches worked well, once there was a clear referral pathway for ED staff, and patients were seen immediately following referral.

A number of clinical leads and CNSs stated they believed the risk of burnout would be reduced if the work included more than self-harm assessments. There is limited evidence on interventions that can reduce burnout in mental health staff, with most support for effective personal and organisational interventions (Van Brogaert et al, 2013). Where work is valued, the individual is appropriately trained and persistently supported by management, burnout is reduced (Van Brogaert et al, 2013; Hunsaker et al, 2105). In some services, the CNS was seeing all liaison cases, along with those who self-harm, but did not have the time to implement the NCP in full.

Where the CNS is working only with those who self-harm or with suicidal ideation, one CNS per 200 presentations per annum is required.

Good Practice Point: Once all elements of the NCP are implemented, it is up to the local service to agree on who the CNS assesses. In services with a full liaison team, all members of the team, including the NCP CNS, complete assessments on all individuals with mental health needs, the NCP CNS takes responsibility to ensure that the programme is fully implemented, and data is returned to the NCP office.

The data identified the proportion of first assessments completed by each mental health professional. Nationally, 42% were seen by a doctor first, but this varies considerably throughout the country. Where there was 24/7 cover by a CNS, 10% of cases were seen by an NCHD, which occurred when the CNS was busy. Where there was an 8am-8pm CNS service, seven days a week, most recorded seeing 50% to 60% of cases, while the others were seen by the NCHD. The range in the other services was the CNS seeing 20% to 45% of cases.

CNSs are following up on a number of people seen by the NCHDs. Only four centres report they are following up on all those seen by the NCHDs. In some services everyone is followed up; at other sites, only those requested by the NCHD. In those sites where everyone is followed up with a phone call within 24 hours of discharge, the NCHDs are encouraged to inform the person assessed that they will receive a phone call from a nurse specialist the next day. In no service was there evidence that NCHDs were following up patients following discharge, although a number of CNSs reported believing that it was up to the NCHD to complete the assessment and follow-up. This would not be possible with most NCHD rotas and work commitments.

Good Practice Point: The CNS checks who has been assessed by the NCHD out of hours and provides the follow-up phone call within 24 hours. The NCHD informs the patient they can expect a phone call from a nurse specialist, and ensures that the CNS is informed about the patient.

Clinical and personal support and supervision for the CNS

As noted above, the role of the CNS can be stressful. It is important to provide 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). The dedication and commitment of all the CNSs working in this NCP was evident at the service visits, and it is through training, supervision and support that this can be sustained.

All nurses employed through the programme are qualified to CNS level. At this level, nurses can work autonomously, with support from a consultant (NMPDU, HSE). It is within their scope of practice to assess, manage and discharge a patient, following discussion with a senior registrar or consultant. All CNSs have received training through the national office, and have at least three cases directly observed and supervised by the clinical lead. The CNS should be a member of a consultant-led clinical team, either in liaison psychiatry or in general adult psychiatry. CNSs should receive managerial support from a Director of Nursing (DoN) or Assistant Director of Nursing (ADoN), and receive critical incident stress management when required.

ED work is seen as the remit of the Psychiatric Liaison services. Where such services are in place, the consultant in liaison psychiatry (CLP) is the clinical lead for the NCP. In 10 services, the CNS had clinical support and supervision from the CLP. Ten services provided clinical support and supervision by a general adult psychiatrist. Four services did not provide adequate consultant supervision and support. In one service, there is a part-time liaison team in the service; the clinical lead for the programme is a general adult psychiatrist, who has a research interest in self-harm.

In almost all services, all assessments by CNSs were discussed by phone with a consultant or senior registrar immediately following assessment. This consultant might be the clinical lead, the consultant on call, or the consultant covering the patient's catchment area. CNSs all reported receiving excellent support from consultants. Many found it more useful to discuss clinical cases with a catchment-area consultant than with the clinical lead, and only used the clinical lead to discuss patients from outside the catchment area. This was more likely to happen in smaller services which did not have a full liaison team.

In most services management was agreed with the consultant and delivered by the CNS. In some cases, the consultant would advise review by an NCHD, or would review the patient themselves. All CNSs spoke of the value of consultant discussion on each case, and the provision, although rarely required, of a joint assessment with a consultant when needed.

In some services, every case was seen by an NCHD, and in one site many cases were also seen by an SR or consultant. In one service, all assessments were by an NCHD and CNS jointly. In some services, decisions on who assessed each patient followed custom and practice rather than clinical need. As all the nurses are at CNS level, there is no clinical advantage for the patient to also receive an NCHD assessment. NCHD input will be required if medication, which has been discussed with the consultant, is needed. If there is a clinical problem requiring more senior clinical assessment, that assessment should be by a senior registrar or consultant. Recent discussion on how to best manage risk places emphasis on developing a strong therapeutic bond with the patient, and this is best supported if the individual is assessed by one clinician (Hawgood and De Leo, 2016).

Good Practice Point: To ensure optimum engagement with patients, the CNS completes the assessment, discusses with a senior decision-maker, such as a consultant or senior registrar, and agrees on the management plan. Patients should not routinely be seen by more than one mental health professional, and only if it is clinically indicated.

Supervision ranged from daily meetings to discuss all patients assessed in the previous 24 hours, to monthly meetings to review the operation of the clinical programme. All CNSs reported valuing consistent and regular support from the clinical lead. Weekly face-to-face supervision was necessary when the NCP was initially being introduced. Where there are weekly multi-disciplinary team (MDT) meetings, monthly supervision to review the operation of the clinical programme is recommended. The services that were working best ensured a lot of supervision, planning and discussion when the programme began; this level of supervision reduced, but all continued discussing all cases with a consultant or senior registrar as soon as patients were seen. Providing regular clinical support to the CNS is time-consuming for the clinical lead, who needs to be supported by the ECD in having time to develop the NCP. In busy services, use of a senior Registrar has been beneficial in ensuring that the NCP is adequately supported by senior decision-makers.

Good Practice Point: CNSs highly value regular face-to-face meetings between the CNS and the clinical lead, to discuss the implementation of the NCP, any difficult clinical cases or difficult operational issues. These meetings would be weekly when the programme is initiated, and monthly once the programme is working well. These meetings complement weekly MDT meetings.

A number of Assistant Directors of Nursing (ADoN) and Directors of Nursing (DoN) were very supportive of the NCP and provided regular support to the CNS. In a number of services, the ADoN meets with the CNS on a daily basis. In some services, the ADoN rarely meets the CNS. Many CNSs reported a need for regular discussion on how they were coping; they also wished to discuss career progression and personal support.

Good Practice Point: Regular face-to-face meetings between the CNS and the ADoN provide a space for discussion on delivery of the NCP, career progression and any personal concerns the CNS has. These meeting are best held every two months at a minimum, and more often at times of increased stress.

Personal or clinical supervision was identified as important to all interviewed. One group commented that, once they had daily clinical meetings, the need for personal supervision reduced. Others spoke of the value of clinical supervision in reducing the risk of burnout. All recognised the need for extra support following a critical incident. Some were receiving supervision as part of courses they were undertaking. Where there is more than one nurse on site, there is peer supervision. One group have set up their own regional peer supervision. Some of that group are also delivering Dialectical Behaviour Therapy (DBT), and receive Skype DBT supervision on a weekly basis. All valued the national training days for training, support and networking. Each CNS found discussion with the clinical lead and the ADoN the best way to identify their supervision needs.

Good Practice Point: The ADoN and CNS identify the level of supervision the CNS requires and review this every six months. The clinical lead can also provide input into this decision.

Recommendation: It is the remit of the Executive Clinical Director and the Director of Nursing to ensure that appropriate resources are in place to facilitate regular supervision.

Training for CNSs

Before starting in the role, it is recommended that each CNS is observed by a senior psychiatrist in completing at least three assessments. Clinical leads have taken responsibility for this training. In a number of services, CNSs gained experience in biopsychosocial assessments by completing initial assessments within a community mental health team. The NCP office arranged twice-yearly training days ensuring that CNSs received training on self-harm, suicide prevention, family involvement and data-collection. All CNSs reported ongoing learning through attendance at multidisciplinary meetings, clinical discussions with consultants and supervision with clinical leads and ADoNs.

CNSs identified a number of training needs. These are listed in Table 4. The NCP office will continue to facilitate twice-yearly training days over the next year.

Table 4: Training requirements for Clinical Nurse Specialists delivering NCP

Training	Training Body	Contact
Mandatory		
Twice-yearly national training day for CNS working with people with suicidal behaviour to include: Audit; research; working with minorities; working with families; best-practice guidelines; data-collection	HSE – NCP office	Rhona.jennings@hse.ie
Increasing awareness of suicide and self-harm among emergency healthcare staff; train-the-trainers programmes	With NSRF and UCC	Rhona.jennings@hse.ie
Biopsychosocial Assessment	Clinical lead within service	
Useful		
Modified STORM and ASSIST	National Office for Suicide Prevention (NOSP)	www.hse.ie/eng/services/list/4/mental_Health_Services/NOSP
Brief Solution Focused Therapy	Approved training body	Local Mental Health Service
Mindfulness	Approved training body	Local Mental Health Service
Cognitive Behaviour Therapy	Approved training body	Local Mental Health Service
Dialectical Behaviour Therapy (brief introduction)	Approved training body	Local Mental Health Service
Knowledge Understanding Framework	KU Framework UK	KUFEnquiries@nottshc.nhs.uk

NCHDs in Psychiatry working within the clinical programme

Assessing and managing risk is a core competency for all psychiatrists. When the CNS is not available mental health assessments of patients in the ED are provided by the NCHD in psychiatry. In some services the NCHD also worked alongside the CNSs in assessing patients who self-harm.

Figure 2 identifies the time patients were assessed, and Figure 3 identifies who carried out the first assessment.

Figure 2:
Times patients were assessed in the Emergency Department

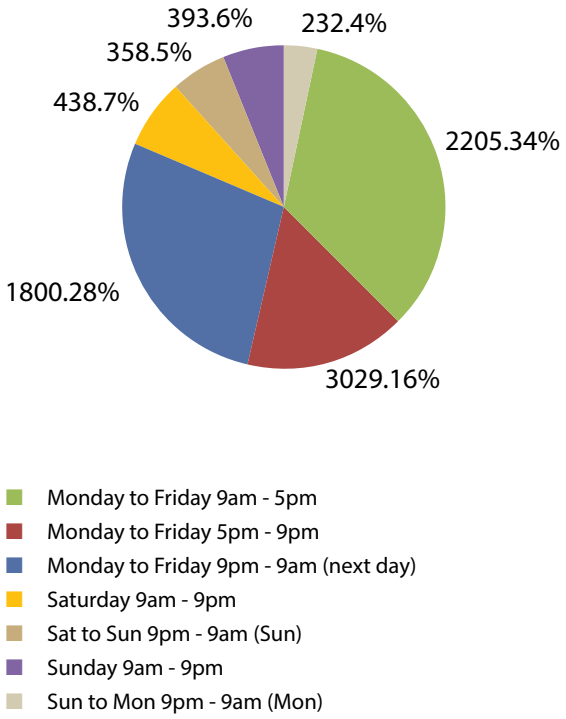
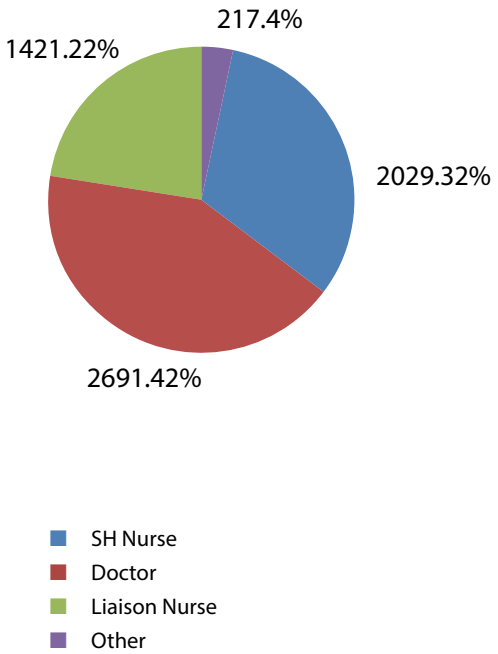


Figure 3:
Clinician who first assessed the patient



The data shows that over 42% of patients were assessed outside the hours that CNS or liaison nurses are working. These patients were assessed by the NCHDs. The data may be incomplete in that not all CNSs were recording information on all patients assessed by NCHDs.

In all services visited, it was stated by the clinical leads and others that all NCHDs received intensive training and ongoing supervision in assessing and managing self-harm. In some services, the clinical lead and CNS for the NCP provided training to the NCHDs in psychiatry every six months. In some services, clear instructions were given that it was their responsibility to comply with the NCP. In a number of centres, the NCHD completed assessments, included next of kin, discussed with the consultant on call, completed the GP letter and the Emergency Care Plan, and handed over follow-up to the CNS the next morning. The CNS then followed up with a phone call, and provided linkage to next care. In other centres this was not happening: NCHDs were not linking with the CNS and no data was available on how patients were being assessed out of hours. Some CNSs were contacting NCHDs themselves, identifying all patients assessed and ensuring that these patients received bridging to next care.

A number of NCHDs have reported finding out-of-hours assessments challenging, particularly when these assessments are completed within the ED. Some report that they receive no support from mental health nurses or from ED nurses and they may

not be encouraged to discuss cases with the consultant on call. There is evidence from an internal audit on at least one site that the proportion of patients admitted out of hours is twice the proportion admitted within working hours. This audit identifies the need for senior decision-making out of hours. In other services, a number of out of hour's admissions were deemed to be inappropriate; patients were restricted unnecessarily and they or family members received conflicting messages on the value of hospital admission.

To improve the patient journey, and also to ensure that NCHD training is appropriate, all patients presenting out of hours should receive support from a nurse and an NCHD. This nurse could be a nurse from the ED or a staff nurse from the mental health inpatient unit. The aim is to ensure that all patients and their family receive support regardless of the time of day they present. There is also a requirement that NCHD have access by telephone to a senior decision-maker, such as a consultant or senior registrar. The patient and their family should receive support and information on suicide prevention. They should also be informed that they will receive a follow-up phone call from a nurse specialist the following day. The nurse specialist can then review the emergency care plan and offer support to the patient.

Recommendation: All patients presenting out of hours will benefit from a team approach. The patient will be supported by a nurse and NCHD. The NCHD will have access by telephone to a senior decision-maker such as a consultant or senior registrar.

Good Practice Point: Adequate nursing support and senior clinician support ensures that the NCHD can provide an appropriate assessment and follow-up. This improves the patient journey and ensures appropriate management.

In the interviews conducted during the services visits, staff reported their efforts to adopt a warm, compassionate and respectful approach. CNSs reported offering cups of tea, creating a relaxed and supportive environment, and giving the patient and family member time to tell their story. While many NCHD will also take this approach, some assessments can be limited in that the focus is on identifying a diagnosis, identifying risk and offering a binary solution of admission to hospital or discharge. This can result in either needlessly restricting some individuals' freedom and giving unrealistic expectations of hospital admission, or discharging without adequate support in the community. There is evidence from around the country that this is less likely to happen when the NCHD can immediately discuss with a consultant or senior registrar.

The NCP identifies a collaborative and respectful assessment, family advice on suicide prevention, an Emergency Care Plan and a follow-up phone call within 24 hours of discharge as an effective means of avoiding these negative outcomes.

The hours of work of NCHDs make follow-up difficult. The most effective approach used is where the NCHD completes the immediate interventions, including giving an Emergency Care Plan (ECP) and a GP letter, but the follow-up phone call and bridging to next care is completed by the CNS. CNSs reported that, once the NCHD has informed the patient that they could expect a phone call from the CNS the following day, the patient welcomed this call. CNSs used the call as a means of reviewing the ECP, and some also spoke with the next of kin. Some CNSs expressed reluctance to phone patients they had not met, but where this was happening no difficulties were reported and CNSs reported that the call was valuable.

Good Practice Point: A team approach – where the NCHD provides a respectful, compassionate assessment, involves family members in the assessment and suicide prevention, provides an Emergency Care Plan and letter to the GP; where the consultant on call provides clinical advice and support in implementing the NCP, and where the NCHD hands over to the CNS for follow-up and bridging to next care – will ensure the delivery of the clinical programme for all patients presenting to the ED following self-harm or with suicidal ideation.

Role of the clinical lead

Where the clinical lead is a consultant liaison psychiatrist (CLP), the CNS will be part of the liaison team. The consultant will provide clinical cover and supervision for the CNS appointed to the programme. The clinical lead and CNS will ensure that the programme is implemented; provide education and training for NCHDs and ED staff, and record and collate data as required by the NCP office. The clinical lead will support the CNS in ensuring they receive support and training to implement the programme, and will provide support to the area management team in developing local policies and procedures for the programme.

Where there is no CLP, the clinical lead will be a named consultant psychiatrist in general adult psychiatry. 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 for at least one-hour face-to-face supervision once a week. This supervision time will be used to support the CNS in implementing the programme, to review the week's work, to problem-solve and to ensure that training needs are met. The CNS and clinical lead will record and collate data as requested by the NCP 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.

The clinical lead is also responsible for 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 is good communication between the CNS and the NCHDs. The local clinical tutor should also support this training.

The programme should be delivered in the ED. The clinical lead and CNS 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.

The clinical lead can work with the Executive Clinical Director (ECD) 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 NCP. 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.

The CNS and clinical lead are invited to the national training days organised by the NCP office.

Good Practice Point: The role of the NCP clinical lead involves training and support of the CNS and NCHDs who are delivering the programme, and liaison and collaboration with ED staff and community mental health teams. This role requires support by the ECD.

The commitment and dedication of the clinical leads to this programme was evident throughout the country. There was good evidence from the ED staff and reports from GPs on the value of the NCP, and the clinical leads were central to this. CNSs all valued the clinical advice and support provided by the clinical lead. In services where the clinical lead was the sole consultant liaison psychiatrist for the general hospital, it was challenging for them to ensure that all aspects of the NCP were delivered and at the same time provide a comprehensive liaison service to the general hospital. High numbers of patients presenting to the ED with mental health needs and no physical health needs, and also difficulties in identifying pathways to crisis mental healthcare in the community, led to the liaison psychiatrist spending excessive time on crisis mental healthcare at the expense of liaison care. One possible solution for this would be for the CNS to use sector consultants or the consultant on call for immediate consultant

advice, while the consultant liaison psychiatrist would continue to provide weekly supervision, to troubleshoot and to liaise with ED staff. Services may opt to use this approach for one or two days a week, thereby ensuring that the liaison psychiatrist is free to provide scheduled liaison care.

Good Practice Point: Having one or two days a week where consultant cover for the ED is provided by sector consultants or the consultant on call will ensure that the consultant liaison psychiatrist can develop all aspects of their service. It will also ensure all the sector consultants are familiar with the NCP and improve the patient journey.

Recommendation: The ECD will develop a forum with general adult psychiatrists, the clinical lead and the CNS to ensure that the NCP is delivered, and that all staff, including the clinical lead, are appropriately supported, so that the patient journey is improved.

Governance structure

The NCP has been most effective where the clinical lead and the CNS are well supported by their Executive Clinical Director (ECD) and Director of Nursing (DoN). This has resulted in services taking the framework of the NCP and ensuring that all aspects are delivered and at the same time the NCP is well integrated with the mental health services in place. This NCP requires true interdisciplinary working. The professional reporting relationship involves the CNS reporting to the DoN, while the clinical reporting relationship involves reporting to the clinical lead.

In planning posts and in recruiting CNSs to deliver the NCP good collaboration between the DoN and the clinical lead is essential. It is the responsibility of the DoN to work with the Office of Nursing & Midwifery Service Director (ONMSD) and National Recruitment Service (NRS) in recruiting CNSs. The ONMSD and NRS will take the job specification from the local service, and it is important that the DoN ensure that the clinical lead and other CNSs working in the NCP are consulted on both advertising and interviewing for these posts.

Good Practice Point: True interdisciplinary working is most effective when all disciplines are involved at the earliest stage in staff recruitment.

Recommendation: All members of the local NCP team will have input into the recruitment of CNSs within the scheme. The DoN will ensure that the opinion of the clinical lead and other CNSs working in the local NCP is obtained before advertising and interviewing for these posts.

Involvement of the patient's next of kin

Patient Journey

The MHCNS/NCHD gathers information from the GP, Mental Health services and patient's next of kin (NoK). ED staff and NoK are given support by the MHCNS/NCHD. When the patient is fit for full assessment MHCNS/NCHD carries this out, in a safe and private environment. All sources of information are included in completing the assessment of needs and risks.

The MHCNS/NCHD provides information for the patient and next of kin on suicide prevention, identifies the most appropriate next care, includes this in an Emergency Care Plan (ECP), and informs the patient they will receive a follow-up phone call from the MHCNS the next day.

All patients will be actively encouraged to nominate a family member who can provide information and will be advised on suicide prevention before the patient is discharged.

It is recognised that suicidal patients 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). Convergent information from other family members is therefore recommended to enable more confident and systematic suicide risk formulation.

The data for 2016 showed that a family member or a carer was involved at assessment in 67% of presentations. CNSs reported that they contacted next of kin by telephone if they were not present in the ED. All reported that in most cases the patient was happy for family to be contacted, and family members were happy to be contacted. In 61% of cases, family members were offered advice on suicide prevention. (Note that data may not have been complete in this section, in that it was not always recorded if NCHDs had contacted family members.) In a number of services, the CNS provided an Emergency Care Plan that identified emergency contact numbers, and, with the patient's permission, gave a copy of the care plan to the family member or carer. In some services, family members were supported while waiting for the patient to be medically fit for assessment. Some CNSs reported that patients did not want family involved. In those services where the programme was fully implemented, CNSs reported that all patients were agreeable for family to be involved, once the value of this involvement had been clearly explained.

One family member, who has been bereaved through suicide, and who was a member of the original NCP working group, has spoken at a number of training days and welcomed the emphasis on actively encouraging family involvement. She urged staff to increase the degree of family involvement.

"My husband died from suicide. Leading up to my husband's death we had tried three different routes to get help; he could have been three different people because of the lack of any co-ordination or links between these routes..."

"I did not realise my husband was at risk of suicide. The fact that professionals said nothing about risk allowed me to believe there was no risk."

"You do not believe you are lucky at the time, but if you are lucky enough for your loved one to give you an indication of how they are feeling, the system should and must be there to give the best possible chance of survival and recovery for those suffering and their families who suffer with them. The reality of suicide and its prevention has to be an integral part of GP provision, A&E provision and broader healthcare provision."

This family member has worked closely with the National Office of Suicide Prevention in developing an information booklet for families of people who are at risk of suicide (NOSP, 2016 – available on NOSP website).

Good Practice Point: Ensuring that patients are given clear information on the value of involving family members will increase the numbers of family members involved. Family members value verbal and written information on suicide prevention.

Recommendation: All practitioners will strive to raise family or supporter involvement to 100%. All family members spoken to will be given time to discuss their concerns and be given verbal and written information on suicide prevention.

The Emergency Care Plan

The Patient Journey

Once assessment is complete, the MHCNS gives a copy of the ECP to the patient, and sends a letter and copy of the ECP to the patient's GP.

All patients will be given a written Emergency Care Plan before discharge.

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 (Spittal et al, 2014; Claasen et al, 2014). The Emergency Care Plan (ECP) can achieve this.

Data was not collected on how many patients received an ECP. This has been described in the NCP as a care plan that addresses short-term and medium-term needs and risks. The patient, and whenever possible their next of kin, should be involved in the determination of this plan.

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, 2008).

My 8-Step Safety Plan

(Stanley and Brown 2008)

All ECPs contained numbers for next-care appointments along with emergency numbers and what to do in a crisis. In most services, CNSs believed that very few NCHDs were completing the ECP, but in at least one site it was used by the NCHDs and CNSs found it invaluable when providing the follow-up phone call to the patient.

In one service, where the NCP was not being fully implemented, the CNS was conducting an audit of NCHD use of the ECP. The audit in itself had increased the NCHD's use of the ECP and improved the quality of the ECP. A copy of the ECP was given to patients, their next of kin if they wished, and to the GP. A copy was also left in the ED file and was used during follow-up contacts.

From July 2017, all services are recording data on the use of the ECP.

Good Practice Point: An audit of the use and components of an Emergency Care Plan has been shown to increase its use, particularly its use by NCHDs out of hours.

Recommendation: All patients will receive an Emergency Care Plan or Safety Plan, which includes names and numbers for people to contact in a crisis along with names and numbers for next-care appointments. A copy of this plan will be sent to the patient's GP, and a copy kept in the ED file.

Communication with the GP

The patients' GP will be informed of the presentation and care plan within 24 hours of discharge.

Rapid sharing of clinical information is integral to patient care in emergency settings. Most services reported regular telephone contact with GPs. They were contacted for information on their patients, and all reported excellent cooperation and collaboration with GPs.

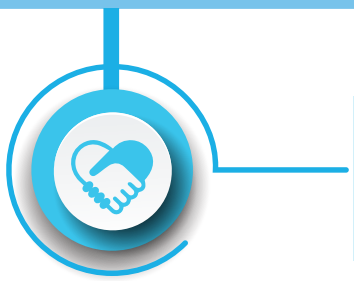
For the 6,239 patients assessed in 2016, in 61% of cases a short pro-forma letter was sent to the GP within 24 hours. In some services, this was a copy of the front page of the assessment form, including reason for presentation and follow-up plans. An ECP was included, either as a separate document or as part of the short discharge summary. In some services CNSs reported a lack of secretarial support, which often resulted in communication delays.

Most CNSs reported that they were sending the GP letter out within 24 hours. They believed that the 39% who were not receiving a letter included those seen by the NCHD.

Good Practice Point: A pro-forma page that includes reason for assessment, assessment findings and the Emergency Care Plan can be copied and sent immediately to the patient's GP.

Recommendation: For all patients, including those seen out of hours, a short note will be sent to the GP immediately after assessment. This will state the reason for referral, the outcome of the assessment, and the follow-up. This note should be accompanied by a copy of the Emergency Care Plan or Safety Plan.

Follow-up and bridging to next care



The Patient Journey

The MHCNS: phones the patient the next day to provide support and review the ECP, ensures that the patient has dates for next appointments, contacts the patient prior to next appointment to encourage attendance,

All patients will receive assertive follow-up regarding their next-care appointment.

Evidence-based practice is the gold standard for clinical practice, particularly when practitioners are asked to change their regular practice. Ensuring that patients receive assertive follow-up and bridging regarding next care was identified as key to reducing repeat self-harm and preventing suicides. Among patients who have been discharged from the ED and inpatient wards, the risk of (repeated) acts of self-harm and suicide among all age groups is highest immediately after discharge and over the next 12 months to four years (Skeem et al, 2006; Gairin et al, 2003; Stewart et al, 2001; King et al, 2001; Holley et al, 1998). A recent 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, 2017). A recent French study analysing the impact of telephone follow-up calls concluded that phone follow-up of outpatients after suicide attempt is a protective factor against repeated suicide attempts (Exbrayer et al, 2017).

The NCP has recommended that every person, where it is clinically appropriate, including those seen out of hours, be offered a phone call from a CNS to offer support and discuss their care plan. A total of 47% of those assessed were reported as receiving this phone call. Some CNSs reported phoning every patient, including those assessed out of hours. In other services, the CNS only phoned people they had assessed themselves. Where the CNS regularly phoned patients, they reported receiving a positive response. Patients valued the support and were happy to discuss their safety plan. Many CNSs reported the value of the phone call in helping reduce any rejection patients might experience if they had presented to hospital believing that an admission would help. No-one reported any difficulty related to these phone calls. In services where the CNS did not regularly phone patients, some anxiety was expressed, as well as beliefs that patients would not appreciate a phone call or that difficulties would arise if the person could not be contacted.

The experience in services where patients were routinely phoned within 24 hours of discharge from ED indicates that this is a valued service and the evidence supports its efficacy.

Two recent reports in the UK have emphasised the importance of follow-up within three days of discharge from hospital, including from the ED (Appleby, 2016; UK Parliamentary Comm., 2017).

In some services, the follow-up phone call was left to the Community Mental Health Team (CMHT), particularly if the person was known to that team. This is not fully compliant with the NCP. The recommendation remains that all patients receive a follow-up phone call from the CNS.

Good Practice Point: Once patients are given the expectation that they will receive a follow-up call within 24 hours, they welcome and value this call. The call can be used to review the Emergency Care Plan and confirm future appointments.

Recommendation: All patients, including those who are assessed out of hours, will receive a follow-up phone call from a nurse specialist within 24 hours, to offer support and to review the Emergency Care Plan.

People who self-harm describe wanting the same level of clinical care that might be expected by anyone else in the ED, delivered with the same level of openness, warmth and respect – although accompanied by acknowledgement of their fragile emotional state. They speak of the need for care delivery to be sufficiently compassionate. They know there will be some routine questioning and a necessary assessment process before they can go home, and they expect that they will be informed at all stages of what arrangements for help can be put in place (Hunter et al, 2013).

"I'm hugely grateful that I got the help, it's made a whole world of difference … people are phoning me, keeping me informed … I know that within the next couple of weeks I will have the support I need."

The NCP addressed this matter by recommending the use of bridging strategies. Suggestions for bridging included telephone contact, text reminders, linking with the Community Mental Health Team (CMHT), and offering brief follow-up contact to manage risk and facilitate engagement. The type of bridging used depended on the nature of the next-care appointment.

A total of 1,144 or 18% of patients assessed were admitted to an approved centre. It was not possible to link time of assessment with admission; many clinicians reported the belief that patients were more likely to be admitted if assessed out of hours. One service reported completing an audit showing that admission rates of people assessed on Monday to Friday 9am to 5pm were half the rates of those assessed outside those hours, the rates being 13% and 26% respectively.

A total of 60% were referred to Mental Health Teams, 16% to addictions services, 17% to GP only and 7% to voluntary counselling services. Data was incomplete and most CNSs reported they believed a greater proportion was referred to Mental Health Teams. A number of people were referred to more than one service; as the data did not use a unique identifier, it was not possible to identify how many this included. A new interactive data sheet due for introduction in late 2017 will permit collection of this information.

While all CNSs reported excellent support from consultant psychiatrists in offering urgent assessments and accepting admissions, there were some areas where work was duplicated; greater coordination between services would have resulted in better clinical practice. In some services, where the CNS identified a need for hospital admission, accepting consultants would always insist on a further full assessment by a member of their own service before admitting the patient. Also, where the CNS identified the need for an appointment at a CMHT, some consultants would treat this referral as a new patient, when in fact a comprehensive assessment had been completed and this person would more appropriately have been seen in a follow-up clinic.

Good Practice Point: When an individual is referred from the ED to a CMHT, the expert and comprehensive assessment completed by the CNS should be used by the CMHT. The patient will not require a repeat first assessment and can be seen at a follow-up clinic.

There were examples of excellent coordination between CNSs in ED and the rest of the mental health services. One service held a one-hour MDT meeting each week, attended by consultants and NCHDs from all sectors, along with the liaison team and CNS in self-harm. All patients assessed in ED in the previous week were mentioned, follow-up identified and confirmation on how bridging to next care would be completed. In another service, the CNS attended each sector's weekly inpatient MDT for

10 or 15 minutes and discussed all patients assessed during the week and their follow-up. Staff reported that these meetings were educational for all, and ensured that all consultants and NCHDs understood the NCP, and that patients received the most appropriate care.

Good Practice Point: The weekly multidisciplinary in-patient meeting is an ideal forum for the CNS to briefly mention patients from the sector who have presented to the ED. This improves continuity of care.

To ensure that the patient has clarity on the level of support they can expect, the NCP advises that dates of next-care appointments be given to the patient and that they receive a reminder contact before this appointment. Some services reported difficulty in securing a date for a non-urgent appointment. In those services where the NCP is fully implemented, the CNS ensured that they obtained this date and phoned the patient about it. This bridging has been shown to increase uptake of appointments and improve future help-seeking (Hunter et al, 2014).

In some services, the CNS and clinical lead voiced concern at the high numbers of patients presenting to the ED without physical health needs and who would be more appropriately seen by a community mental health team (CMHT). In some services, CMHTs were advising people to present to ED, even within working hours. This is not good practice. A mechanism needs to be in place to ensure that the community teams can offer crisis assessments in the community. Inappropriate referring was less likely to happen in the services where all components are well integrated and all teams meet together regularly. It is up to the ECD in the service to ensure that all efforts are made to minimise the numbers of patients presenting to the ED who do not have a physical health problem. In addressing this issue, Parsonage et al (2012) stated that the way ahead for the long-term development of liaison psychiatry was likely to lie primarily in expanded provision of community-facing services. This can be achieved in Irish services through greater collaboration between liaison and community teams.

Good Practice Point: Effective collaboration between liaison psychiatry teams and community mental health teams can minimise the numbers of patients presenting to the ED who do not have physical health needs.

Recommendation: ECDs will address delays in accessing crisis care in the CMHTs resulting in both inappropriate presentations to the ED of patients who do not have physical health needs, and in difficulties in the referral pathway from ED to CMHTs.

Some ED services cover a number of different catchment areas, with different referrals systems. The ECD has a role in standardising the services and ensuring that all CMHTs have a good understanding of the training, expertise and supervision that the CNS receives. This will ensure that patients do not receive unnecessary repeat assessments or conflicting messages.

In one inner-city service, follow-up appointments are offered by the CNS for patients who are unlikely to engage with other services. This includes people who are homeless, have addiction problems, or may require extra support before they will link with mainstream mental health services. This small group of patients are at high risk for repeat self-harm and suicide. The service reports excellent uptake of follow-up appointments and in-time, successful linking to other appropriate services.

Good Practice Point: For people at risk of self-harm, clarity on future plans and support while waiting for next-care appointment increase uptake of next-care appointments and improve future help-seeking.

Recommendation: Bridging strategies will be employed for every individual assessed. For some, who are seen immediately by next care, this involves one phone call. For others, it may involve a phone call at weekly intervals until they are seen at next care. For a tiny percentage, bridging may involve face-to-face appointments.

Follow-up of patients who do not remain for biopsychosocial assessment

NSRF data for 2015 reported that 13% of patients presenting to the ED following self-harm left before receiving a biopsychosocial assessment. This proportion differed in services, ranging from 5.2% to 27%. A key performance indicator for the NCP is to reduce this number below 10%.

Our data shows that, in 2016:

- 689 patients presenting left the ED before receiving a biopsychosocial assessment
- 231 were admitted to medical or surgical wards; although data was not collected on this group, CNSs believed that almost all received an assessment once medically fit
- 16 patients died following presentation
- 452 or 7.2% of people presenting left the ED before receiving a biopsychosocial assessment

The above total may underestimate the numbers leaving, as it is possible that data was missed for some who presented and left before assessment. This figure is also lower than the NSRF figure, in that our data includes people who present to the ED with suicidal ideation, and are thus already highly motivated to remain for a biopsychosocial assessment.

All services had a policy for following patients who left before receiving an assessment. In some services, everyone received a phone call from the CNS in mental health. Following discussion, they were advised to return or contact their GP. The GP was also contacted. In other services, the ED staff contacted the patient and their GP. If the patient had been referred to the Mental Health team, and left before assessment, the CNS always followed up with a phone call. A total of 397 of the 452 received a follow-up phone call. It is noticeable that those services that use a particularly assertive approach in following up on those who leave have the lowest numbers leaving, with the proportion below 4%.

A survey of hospital services for self-harm in 32 hospitals in England in 2013 showed the median figure for the proportion of people receiving an assessment from a mental health professional following self-harm was only 58%, and was as low as 22% at worst (Cooper et al, 2013). Our figures of 90%, even allowing for an underestimation of those leaving, are impressive and reflect the impact that mental health staff in the EDs are having.

Good Practice Point: Assertive follow-up of patients who present following self-harm but leave before receiving a biopsychosocial assessment reduces the numbers leaving. .

Recommendation: A joint policy between ED staff and Mental Health staff will be developed to ensure that all patients who have self-harmed but who leave before receiving a biopsychosocial assessment receive assertive follow-up.

Data-collection

Each CNS will collect data on patients assessed through the NCP and submit this data to the NCP office each month.

'What gets measured gets done' and 'what is measured gets improved' are maxims that emphasise the value of quantifying what we do. Since CNSs were first put in place, a detailed data sheet has been completed for each patient who has presented to the ED. For 2016, there is complete data from 16 services, and by the end of 2017 there will be data from 24 adult EDs. All the CNSs are to be congratulated on their persistence and dedication in completing the data.

The data was incomplete, in that all information on patients assessed out of hours was not always available. Different approaches have been used to overcome this problem. In some services the CNS developed a checklist for all staff to complete. The information from this checklist was used in returning the data.

The original data sheet has been refined and reviewed based on feedback from the services. The latest data sheet has improved the flow of data and includes more information on source of referral and follow-up strategies. Up to now the data has been collected on an Excel sheet. The HSE Information Technology department is currently developing an interactive data sheet. This will allow input of data within minutes and also allow the national office to develop further reports from the data. It will also permit data input by all practitioners, thereby minimising missing data and reducing the time spent by the CNS on inputting data.

The data will also be of use in identifying any gaps in the service. The full data from 2016, combined with the qualitative reviews has supported decisions on resource allocation.

Documentation

Biopsychosocial assessment tools

The NCP and Standard Operating Procedure referred to the need to avoid over-reliance on structured pro-forma or templates in completing assessments. In a number of centres, no templates were used for assessments; clinicians instead relied on obtaining a narrative account of the patient's suicidal behaviour and intent, along with completing a full biopsychosocial assessment. In many services a semi-structured pro-forma was used, but all CNS spoke of initially building up rapport and engaging the patient before completing the template. Many reported finding the template useful to summarise the patient's account.

Good Practice Point: The biopsychosocial assessment is a valuable intervention in suicide prevention. Building rapport and establishing engagement is crucial.

Risk-assessment tools

The NCP data shows that risk-assessment tools were in use in most services, but all reported that they found them of little use in predicting risk. This has been addressed earlier in this report when discussing the biopsychosocial assessment, however, in view of its importance the issues will be repeated here. The difficulties with predicting suicide have long been recognised (Pokorny, 1983), Despite increased use of suicide risk-assessment tools, it has been clearly demonstrated by meta-analyses of their use that about half of people identified as low-risk go on to kill themselves (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 the identification of risk factors in clinical practice, may provide false reassurances, and are therefore potentially dangerous (Chan, 2016). However, there is concern about abandoning risk assessment altogether (Draper, 2012). Draper argues that risk assessments might have limited value in the immediate discharge period, although not much beyond that. This is difficult to measure in a meta-analysis. Over the past 10-15 years, the conceptualisation of suicide risk assessment has graduated significantly in the clinical domain to a more sophisticated and systematic process for learning about the person. Draper suggests that risk assessment is more effective when it focuses on the individual's circumstances (including a range of social, environmental, situational, family and other areas) and involves a series of convergent data-gathering tools (e.g. interviewing family members, significant others, etc.).

Technical competence and an empathic attitude make the patient-clinician relation a trustworthy one. Hawgood and De Leo (2016) suggest that, in this light, risk assessment should be focused on mitigating risk and informing the effective and personalised care of the individual, with the ongoing aim of supporting growth and recovery, and ultimately of enhancing the person's self-stated reasons and desires for living. They developed a data-gathering tool, STARS, as a guidance framework to aid clinicians in this process. This mirrors the work carried out by CNSs and NCHDs in Ireland. All CNSs assess suicide intent; identify what supports the individual has, and how these can be used to mitigate any risk factors. They all emphasise the value of forming a therapeutic alliance with the patient and a family member in supporting risk management.

Good Practice Point: Developing a collaborative, therapeutic relationship with the patient, obtaining information from the person's family, developing a care plan with the patient and family, and bridging to next care is the most effective means of managing risk of suicide.

Emergency Care Plans

Almost all services reported developing Emergency Care Plans. 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 paper on Safety Plans (2008) (summarised in panel above).

All Emergency Care Plans contained numbers for next-care appointments along with emergency numbers and what to do in a crisis. In most services, CNSs believed that very few NCHDs were completing the ECP, but on at least one site it was used by the NCHDs, and CNSs found it invaluable when providing the follow-up phone call to the patient.

Patient satisfaction questionnaire

In one service, the CNSs have developed a short questionnaire to assess the patients' satisfaction with the service. This questionnaire is administered over the telephone; as the service has two CNSs, each one phoned the patients of the other CNS. The results of the survey were positive, but the CNSs reported that the patients who took part in the survey were likely to be those who remained in contact with the service and therefore had a high level of satisfaction. There were some constructive criticisms of the service, and the CNSs have changed practice following this survey. There is scope for all services to further develop patient satisfaction surveys.

Good Practice Point: A Patient Satisfaction Questionnaire will identify areas for service improvement.

Resource pack within ED

The NCP recommended that the CNS develop a resource file of agencies, community supports, counselling agencies and others that provide support and information for people in crisis. Almost all services have developed such a file; in most cases, this is paper-based, while in others it consists of a computer file. In one service, a list of local supports and web links has been developed, and staff refer to these with the patient following assessment.

Many services work closely with the suicide prevention officer in the area. Many have also visited other services and community facilities. A number of CNSs have been involved in developing the local Connecting for Life Suicide Prevention Strategy.

A number of services have developed their own information leaflet, explaining about self-harm and suicide prevention, as well as providing contact numbers in the case of an emergency. Some services use resources from the National Office of Suicide Prevention Office (NOSP), including a booklet for families on suicide prevention.

Good Practice Point: The National Office of Suicide Prevention regional officers are an excellent resource for NCP staff in developing a local resource pack.

Checklist

Checklists are a useful means of ensuring that all aspects of the NCP are completed. In one service, the CNS has developed a brief checklist, which is also used in data-collection. In other services, staff report using diaries and notes as an informal checklist. When the interactive datasheet (referred to above) is introduced, staff will be prompted to complete all parts of the NCP before they can submit the data.

Audit & research

The planned interactive data-collection will enable the generation of national reports. The NCP national office plans to work closely with the National Suicide Research Foundation (NSRF) in identifying how the data from the NCP can be used along with the data collected by the NSRF.

Audit & research are core concepts for the CNS role (NMPDU, HSE). Audit of current nursing/midwifery practice and evaluation of improvements in the quality of patient/client care are essential requirements of the CNS/CMS role. The CNS/CMS must keep up to date with relevant current research to ensure evidence-based practice us used. The CNS must also contribute to nursing/midwifery research that is relevant to their particular area of practice. Any outcomes of audit and/or research should contribute to the next service plan (National Council for the Professional Development of Nursing and Midwifery, 2008).

At present, some CNSs are engaged in audits. Topics audited include: follow-up of patients who leave the ED before assessment, the use of care plans, and patient satisfaction with the service.

An excellent reference guide, the New Zealand Guidelines (2011), is available online. It gives a detailed account of conducting audits and examples of audit tools. In the last quarter of 2017, the NCP national office will establish audit and research networks, including CNSs and clinical leads, for the development of audit and research.

Recommendation: The National Clinical Lead will establish audit and research networks by early 2018. These networks will include CNSs and clinical leads from the NCP.

Assessment of children

The NCP target groups include people of all ages, including those under 18 years, who presented to the ED following self-harm or with suicidal ideation. In practice the CNSs in post did not have the necessary expertise and assessment of children was completed by NCHDs on call, or in rare cases, staff from CAMHS teams providing in-reach to the ED. The only national data on children available is through the National Suicide Research Foundation. This only includes children who present following self-harm, and excludes many children with suicidal ideation who are presenting to the EDs (see Table 4) (Griffin et al, 2016). As can be seen from this data, the greatest proportion is presenting outside the hours of 9am-5pm, Monday to Friday. In many services, children presenting following self-harm are admitted to paediatric wards. In some services they are assessed by the on-call CAMHS NCHD, who is supported by the area Child and Adolescent Mental Health Services (CAMHS) consultant.

Table 4: Presentations of young people under age 18 (Griffin et al, 2015)

Hospital group			Presented 9am-5pm Mon-Fri	Presented outside these hours	Total
Ireland East Hospital Group	Hosp.	Midland Regional Hospital, Mullingar	8	24	32
		St Columcille's Hospital, Loughlinstown	1	0	1
		St Michael's Hospital, Dun Laoghaire	0	1	1
		Other	10	62	72
		Mater Misericordiae University Hospital	9	30	39
		Our Lady's Hospital, Navan	3	19	22
		St Luke's General Hospital, Kilkenny	8	23	31
		Wexford General Hospital	9	34	43
	Total		48	193	241
Children's Hospital Group	Hosp.	Our Lady's Children's Hospital, Crumlin	22	31	53
		Children's University Hospital, Temple Street	40	93	133
		National Children's Hospital, Tallaght	24	87	111
	Total		86	211	297
Saolta University Health Care Group	Hosp.	Letterkenny General Hospital	3	34	37
		Mayo General Hospital	8	28	36
		Portiuncula Hospital, Ballinasloe	3	12	15
		Sligo General Hospital	9	25	34
		University College Hospital, Galway	16	50	65
	Total		39	148	187
RCSI Hospital Group	Hosp.	Beaumont Hospital	14	38	52
		James Connolly Hospital, Blanchardstown	11	31	42
		Cavan General Hospital	8	26	34
		Our Lady of Lourdes Hospital, Drogheda	19	47	66
	Total		52	142	194
Dublin Midlands Hospital Group	Hosp.	Adelaide & Meath Hospital, Tallaght (adults)	9	49	58
		Midland Regional Hospital, Portlaoise	6	28	34
		Midland Regional Hospital, Tullamore	6	16	22
		Naas General Hospital	7	34	41
		St James's Hospital	16	29	45
	Total		44	156	200
University of Limerick Hospital Group	Hosp.	Mid-Western Regional Hospital, Limerick	12	61	73
	Total		12	61	73

The data submitted to the NCP showed that 516 under-18-year-olds presented for assessment in 16 centres in 2016. Of these, 325 were aged 16 and 17 years. In only one centre were all children assessed by the CNS; she had direct contact with and clinical advice from the CAMHS consultant, who attended ED if required. The number who presented to this service was less than five in the year.

In other centres, no-one under 16 years was seen by the CNS, although a number reported that they would support parents and staff while waiting for assessment. Many children were assessed by the on-call NCHD, who received clinical cover from the local CAMHS team. In some cases, children were kept until they were seen by a member of a CAMHS team, and this could be up to three days. However, there were examples of excellent practice. CAMHS teams provided an in-reach service, provided on the day of presentation. In one centre, assessment was provided on an extra-contractual basis and organised through the general hospital service manager.

In a number of centres, 16 and 17-year-olds were assessed by the CNS, with consultant cover provided by the local CAMHS consultant. CNSs assessing children have developed forms and a policy related to parental permission. They reported concerns that the pathway into next care was poorly defined, and if an admission bed was required this could take days or weeks.

Many CNSs worked closely with parents and CAMHS teams in ensuring that children could go directly from ED to a CAMHS outpatient appointment, rather than trying to access an admission bed.

In Dublin, with three paediatric hospitals, it is rare for children under 16 to present to adult EDs; in most cases, under-16s who do present to adult hospitals are sent on to one of the paediatric hospitals. In one adult hospital in Dublin, NCHDs will see 14-16-year-olds and the CNS sees 17-year-olds. Outside Dublin, where EDs see children of all ages, CNSs and liaison teams did not have the expertise to see younger children, and had concerns that, if they started seeing 16 and 17-year-olds, they would be left dealing with all children.

There is increasing concern, particularly in the large urban centres, that an increased number of children with mental health but not physical health needs are presenting to the hospital EDs. GPs report they are unable to obtain an urgent assessment through the CAMHS. CAMHS teams throughout the country report that they are under-resourced and, while they all strive to provide emergency appointments, this is not always possible.

The three Dublin paediatric hospitals currently provide high-quality services to children who present to the ED following self-harm or with suicidal ideation. This includes family involvement and full multidisciplinary assessment. All three hospitals report the need for extra staff in order to fully implement the NCP. Due to differing governance arrangements, there is a difference in the level of collaboration between each paediatric liaison team and the nearby community CAMHS teams. This collaboration will improve with extra funding from the NCP.

Outside Dublin, the numbers of children presenting are low: with less than four children presenting each month, with even lower numbers in rural areas. If CAMHS teams are fully resourced, they can provide an in-reach service, but currently staffing throughout the country is well below the levels recommended in A Vision for Change (DoHC 2006). All community CAMHS teams provide support and education for parents and family members, and good linkage with community and social supports;

Recommendation: Funding for extra CNSs is required to ensure that the NCP can be fully delivered to children. Initially, an extra CNS in each of the children's hospitals will be appointed, along with extra sessions for CAMHS teams in Galway, Cork and Limerick. The national office will work closely with the Paediatric Psychiatric Liaison teams and community CAMHS teams in implementing the NCP for children.

Recommendation: National funding is required to resource CAMHS teams, as recommended by A Vision for Change.

Recommendation: The National Clinical Programme office will continue to work with Paediatric Psychiatric Liaison teams and community CAMHS teams in implementing the NCP.

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Appendix 1: List of Good Practice Points.

- Parallel assessment of all patients who self-harm will reduce the proportion of patients who leave before receiving a biopsychosocial assessment and will also improve the attitude of ED staff to patients who self-harm.

- Patients and their families presenting with self-harm or suicidal ideation benefit from prompt support from mental health nurses. This reduces the risk of people leaving before assessment and ensures that they benefit from a team approach.

- CNSs in mental health are ideally placed to improve ED staff's awareness and understanding of mental health issues. Each clinical contact can be used as a training opportunity so as to improve patient outcomes.

- The most effective services use a team approach, providing a CNS supported by a consultant from 8am – 8pm seven days a week, and an NCHD supported by a consultant from 8pm – 8am, and ensuring that the CNS follows up on all cases, including those seen by the NCHD out of hours. Resource requirements to achieve this are one CNS per 200 patients per annum.

- Once all elements of the NCP are implemented, it is up to the local service to agree on who the CNS assesses. In services with a full liaison team, all members of the team, including the NCP CNS, complete assessments on all individuals with mental health needs, the NCP CNS takes responsibility to ensure that the programme is fully implemented, and data is returned to the NCP office.

- The CNS checks who has been assessed by the NCHD out of hours and provides the follow-up phone call within 24 hours. The NCHD informs the patient they can expect a phone call from a nurse specialist, and ensures that the CNS is informed about the patient.

- To ensure optimum engagement with patients, the CNS completes the assessment, discusses with a senior decision-maker, such as a consultant or senior registrar, and agrees on the management plan. Patients should not routinely be seen by more than one mental health professional, and only if it is clinically indicated.

- CNSs highly value regular face-to-face meetings between the CNS and the clinical lead, to discuss the implementation of the NCP, any difficult clinical cases or difficult operational issues. These meetings would be weekly when the programme is initiated, and monthly once the programme is working well. These meetings complement weekly MDT meetings.

- Regular face-to-face meetings between the CNS and the ADoN provide a space for discussion on delivery of the NCP, career progression and any personal concerns the CNS has. These meeting are best held every two months at a minimum, and more often at times of increased stress.

- he ADoN and CNS identify the level of supervision the CNS requires and review this every six months. The clinical lead can also provide input into this decision.

- Adequate nursing support and senior clinician support ensures that the NCHD can provide an appropriate assessment and follow-up. This improves the patient journey and ensures appropriate management.

- A team approach – where the NCHD provides a respectful, compassionate assessment, involves family members in the assessment and suicide prevention, provides an Emergency Care Plan and letter to the GP; where the consultant on call provides clinical advice and support in implementing the NCP, and where the NCHD hands over to the CNS for follow-up and bridging to next care – will ensure the delivery of the clinical programme for all patients presenting to the

ED following self-harm or with suicidal ideation.

- The role of the NCP clinical lead involves training and support of the CNS and NCHDs who are delivering the programme, and liaison and collaboration with ED staff and community mental health teams. This role requires support by the ECD.
- Having one or two days a week where consultant cover for the ED is provided by sector consultants or the consultant on call will ensure that the consultant liaison psychiatrist can develop all aspects of their service. It will also ensure all that sector consultants are familiar with the NCP and improve the patient journey.
- True interdisciplinary working is most effective when all disciplines are involved at the earliest stage in staff recruitment.
- Ensuring that patients are given clear information on the value of involving family members will increase the numbers of family members involved. Family members should be given verbal and written information on suicide prevention.
- An audit of the use and components of an Emergency Care Plan or as been shown to increase its use, particularly its use by NCHDs out of hours.
- A pro-forma page that includes reason for assessment, assessment findings and the Emergency Care Plan can be copied and sent immediately to the patient's GP.
- Once patients are given the expectation that they will receive a follow-up call within 24 hours, they welcome and value this call. The call can be used to review the Emergency Care Plan and confirm future appointments.
- Assertive follow-up of patients who present following self-harm but leave before receiving a biopsychosocial assessment reduces the numbers leaving.
- When an individual is referred from the ED to a CMHT, the expert and comprehensive assessment completed by the CNS should be used by the CMHT. The patient will not require a repeat first assessment and can be seen at a follow-up clinic.
- For people at risk of self-harm, clarity on future plans and support while waiting for next-care appointment increase uptake of next-care appointments and improve future help-seeking.
- The biopsychosocial assessment is a valuable intervention in suicide prevention. Building rapport and establishing engagement is crucial.
- Developing a collaborative, therapeutic relationship with the patient, obtaining information from the person's family, developing a care plan with the patient and family, and bridging to next care is the most effective means of managing risk of suicide.

Notes

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