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NATIONAL SUICIDE RESEARCH
FOUNDATION IRELAND

Nursing and Midwifery
Planning and Development Unit –
South East, HSE South

Accident & Emergency Nursing Assessment of Deliberate Self Harm

Exploring the impact of introducing a suicide education programme and a suicide intent scale into A&E/MAU nursing practice: a pilot study

**Stephen Lamb – Project Nurse, NMPDU South East, HSE South
and**

**Dr. Ella Arensman and Bernie Mullally,
National Suicide Research Foundation**



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The project was undertaken in partnership with and supported by:

- The National Council for the Professional Development of Nursing and Midwifery
- Health Research Board (HRB)
- The National Suicide Research Foundation (NSRF)



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FOREWORD

The fact that there are in excess of 11,000 presentations of deliberate self harm (DSH) to our acute general hospitals each year (National Suicide Research Foundation, 2005) is a challenge and an opportunity. It is a challenge insofar as it represents the complexity of emotional, psychological and social factors that culminate in a deliberate act of self harm. It is also a concern when one considers that a number of people who harm themselves are treated elsewhere and are additional to the above 11,000 who present to our acute services. Our opportunity lies in the provision of effective evidence-based and standardised care in terms of assessment, treatment and referral. A significant number of self harm presentations are due to repeat acts and unfortunately some will be fatal. Effective assessment of suicide intent has the potential to prevent future suicidal behaviour as well as instigating appropriate treatment and referral pathways.

A proposal to pilot nursing assessment of self harm in Accident and Emergency Departments (A&E) was developed by key stakeholders in nurse education and suicide prevention in the South East and submitted to the National Council for the Professional Development of Nursing and Midwifery in April 2002. The proposal included the introduction of a suicide intent scale. Following an initial training programme, a suicide intent scale was utilised by nursing staff in A&E and the Medical Assessment Unit (MAU), Wexford General Hospital and evaluated over a period of nine months. Four months into the study the National Suicide Research Foundation (NSRF) was invited to collaboratively prepare a successful submission to the Health Research Board (HRB) as part of 'Building Partnerships for a Healthier Future Research Awards 2004'. The NSRF undertook independent scientific evaluation of the outcomes of the suicide awareness programme. The study is in line with priorities determined by Reach Out, the National Strategy for Action on Suicide Prevention 2005-2014 (HSE, 2005) and the HSE-South East Suicide Prevention Programme through raising nursing staff awareness of the public health issue of suicide/deliberate self harm and by improving the efficiency and quality of nursing services offered to persons who present to acute hospitals with deliberate self harm.

The study findings indicate evidence to positively support nursing assessment of DSH using a suicide intent scale in terms of assessing behavioural characteristics of individual clients and their suicide risk. Enhanced confidence levels of nursing personnel in caring for suicidal clients was demonstrated by staff who participated in an education programme related to risk assessment and specifically the use of a suicide intent scale.

The support of our funding agencies is greatly acknowledged; The National Council for the Professional Development of Nursing and Midwifery and the HRB. I would also like to thank key stakeholders for their input and commitment to the study, the Project Steering Group, Project Support Group, Nursing Staff in the Pilot and Comparison sites, colleagues in the Nursing and Midwifery Planning and Development Unit and the Regional Suicide Resource Office. Particular thanks are extended to Dr. Ella Arensman and Bernie Mullally of the NSRF for expert advice and scientific evaluation. Last but by no means least thank you to Mr. Steve Lamb, Project Officer for his enthusiasm and professional commitment to the project.

Ms Joan Phelan
Director, NMPDU South East, HSE South
Chair of the Project Steering Group
1st June 2006



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The HSE - South East Area commissioned the National Suicide Research Foundation to conduct the quantitative and qualitative study with the aim to evaluate a suicide education programme and the use of a suicide intent scale by A&E and MAU nurses

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EXECUTIVE SUMMARY

This study was commissioned by the former South Eastern Health Board (SEHB) - Nursing and Midwifery Planning and Development Unit and the Regional Suicide Resource Office, in response to the significant public health issues that suicide and deliberate self harm presented both locally and across Ireland. The issues of the increasing numbers of self harming patients attending A&E and the quality of care they might be receiving are the focus of this study.

Inadequate assessment of deliberate self harm patients will result in failure to diagnose treatable underlying conditions such as depression and alcohol dependence. This will lead to inadequate treatment plans, poor compliance with treatment and increased risk of repeated suicidal behaviour, both fatal and non-fatal.

The overall aim of this quantitative and qualitative study is to evaluate the impact of a suicide awareness and skills education programme upon a cohort of A&E and MAU nurses as well as the use of a suicide intent scale in assessing DSH patients. Nursing staff within the pilot site attended a series of suicide/deliberate self harm education sessions and were instructed on assessing the suicide intent of patients attending the A&E/MAU using the Suicide Intent Scale (SIS, Beck et al., 1974). Over a nine month prospective period (September 2004 - June 2005), 193 deliberate self harm patients presented to the general hospital A&E/MAU department in Wexford. Using a pre-post design, staffs' confidence, knowledge and attitudes concerning suicidal behaviour were assessed. With regard to baseline levels of confidence, knowledge and attitudes in relation to suicidal behaviour, a comparison was made between A&E/MAU nurses in the pilot site: Wexford General Hospital and comparison site: St Luke's General Hospital Kilkenny. The study was granted ethical approval from the Regional Ethics Committee South East – HSE South.

Findings are favourable and of interest. Among the key recommendations the authors noted that:

- Providing training to A&E and MAU nurses on mental health issues and suicidal behaviour is associated with a significant increase in nursing staffs' levels of confidence in dealing with DSH patients and positive changes in their attitudes towards suicidal behaviour and its prevention. The findings support further implementation of similar training programmes for all A&E and MAU nurses.
- The nurses' increased levels of confidence in dealing with DSH patients may be influenced not only by attending training courses, but through positive reinforcement of combining training with the use of a suicide intent scale. It is therefore recommended to provide awareness and skills training on suicidal behaviour in combination with assessment instruments that may be relevant in the daily practice of A&E and MAU nurses.
- The findings indicate that DSH patients showing high levels of suicide intent are more often referred to a psychiatric service compared to those with low suicide intent. These findings support the potential value of a suicide intent scale guiding treatment referral of DSH patients following presentation at A&E/MAU.

The study is in line with priorities determined by **Reach Out**, the National Strategy for Action on Suicide Prevention, 2005-2014 (HSE, 2005) and the HSE-South East Suicide Prevention Programme.





INTRODUCTION

The Accident and Emergency (A&E) department is an important gateway for treatment of deliberate self harm (DSH) patients. The National Registry of Deliberate Self Harm (National Parasuicide Registry) has established the extent of the problem of deliberate self harm presentations to A&E departments in Ireland (National Suicide Research Foundation, 2004; 2005). The need for all deliberate self harm patients attending A&E departments to be given a comprehensive assessment by a suitably trained health professional followed by appropriate referral and follow-up has been recognised both nationally (e.g. HSE, 2005) and internationally (e.g. UK National Institute for Clinical Excellence, 2004).

A study in England found that almost half (45%) of deliberate self harm patients left the A&E department without such an assessment (Bennewith et al., 2004). The management of patients presenting with self harm in Ireland is not well documented. Preliminary findings from the National Registry of Deliberate Self Harm indicate that there is widespread variation in the care recommended following treatment in the A&E department for deliberate self harm (National Suicide Research Foundation, 2004). The percentage admitted to a general ward ranged from 25% to 76%, psychiatric admission direct from A&E ranged from 5% to 15%, while the total percentage of patients that either refused to allow themselves to be admitted, left against medical advice or were discharged from the A&E department was 38% nationally and ranged from 16% to 60% by health board. It is likely that the vast majority of this group of self harm patients were not adequately assessed. While those who used highly lethal methods, such as hanging and drowning were more often referred for inpatient psychiatric treatment, a relatively high percentage of those who tried to hang (31%) or drown themselves (25%) were not admitted at all.

These findings highlight the lack of standardised procedures for the assessment and aftercare of patients presenting with deliberate self harm nationwide. Inadequate assessment of self harm patients will result in failure to diagnose treatable underlying conditions such as alcohol dependence and depression. This will lead to inadequate treatment plans, poor compliance with treatment and increased risk of repeated suicidal behaviour, both fatal and non-fatal (Hickey et al., 2001; Kapur et al., 2002). Thus, work towards the development and implementation of standardised assessment and aftercare procedures for patients presenting to A&E departments with deliberate self harm represents a major research priority.

The available evidence with regard to the effectiveness of awareness and skills training programmes for nursing staff and attitude change towards DSH patients is limited. However, several studies have indicated the need for specialist training to facilitate the everyday practice in relation to DSH patients (Herron et al., 2001; Long & Reid, 1996; Reid & Long, 1993).

The overall aim of this quantitative and qualitative study is to evaluate the impact of a suicide awareness and skills training programme upon a cohort of A&E and MAU nurses and the use of a suicide intent scale in assessing DSH patients, which started in September 2004, thus improving the efficiency and quality of nursing service offered to persons who present with DSH. The Suicide Intent Scale (SIS) was developed by Beck et al. (1974) and is the most frequently used assessment instrument to determine the level of suicidal intent in clinical and research settings. Evidence is available to support the predictive value of the SIS in selecting DSH patients with high risk of suicide (Beck & Steer, 1989; Harris et al., 2005).

OBJECTIVES

The pilot study consists of two parts:

Part I: Deliberate self harm patients presenting to A&E - MAU: Behavioural characteristics and suicide intent.

Objectives:

- To examine behavioural characteristics of DSH patients attending A&E / MAU
- To examine the level of suicide intent among DSH patients, including differences between those with high and low suicide intent

This part of the pilot study was carried out by conducting a quantitative research project

Part II: Confidence of A&E and MAU nurses in dealing with suicidal patients, knowledge and attitudes in relation to suicidal behaviour and its prevention.

Objectives:

- To examine changes pre-post training-intervention among A&E and MAU nurses with regard to confidence in dealing with suicidal patients
- To examine changes pre-post training-intervention among A&E and MAU nurses with regard to knowledge and attitudes towards suicidal behaviour and its prevention

This part of the pilot study was carried out by conducting both a quantitative and qualitative research project.

Part I: Deliberate self harm patients presenting to A&E – MAU: Behavioural characteristics and suicide intent.

Methodology

Sample

Over a nine month prospective period (September 2004 - June 2005), 193 self-harming patients presented to the district general hospital A&E/MAU department in Wexford. All patients were given a study information leaflet and were invited to participate in the assessment process using the Suicide Intent Scale (SIS) (Beck et al., 1974). The process was quantitative in nature and involved analysis of returned Suicide Intent Scales (SIS) (Appendix 1). Information was obtained on the following aspects: age, gender, details concerning the index deliberate self harm episode, method of self-harm, triage code, SIS score and aftercare following treatment at A&E.

Definition of Deliberate Self Harm

Deliberate self harm was defined according to the definition developed by the WHO/Euro Multicentre Study Working Group and which is also used in the National Registry of Deliberate Self Harm: *'an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising that the person desires via the actual or expected physical consequences'* (Platt et al., 1992).

Suicide Intent Scale

Suicide intent was assessed using the Suicide Intent Scale (SIS, Beck et al., 1974). The SIS is an interview-administered measure to assess the level of suicide intent among those who have recently engaged in DSH. The SIS consists of 15 items, which are scored 0, 1 or 2, with a minimum score of 0 and a maximum score of 30. The first 8 items address the objective circumstances related to the DSH act including preparation and prior cues given by the patient that could aid or hamper discovery, while the remaining 7 items address the person's beliefs of the lethality of the DSH act, expectations upon rescue or intervention, the purpose of the act and the degree of premeditation. The internal consistency of the SIS can be considered satisfactory (Spirito et al., 1996). Due to the relatively small sample size, only total scores and low versus high suicide intent comparisons are included in the current report.

Triage

In A&E departments, where there are often high levels of demand and overcrowding, a system of triage is used as an effective means of prioritising patients' needs. In both the pilot site and comparison site the 'Manchester Emergency Triage System' was utilised by A&E nursing staff (Emergency Triage, 2001). The Manchester system utilises colour coded categories and a name system as a means of defining individual patients target time to first contact with the treating A&E clinician (Table 1). Within the study patients



attending the A&E department were categorised and prioritised in line with the Manchester triage system. However, the Manchester system is limited in that it predominantly focuses upon patients' physical needs and categorises in respect of life-threatening status. It is criticised for having little regard for patients' mental anguish or distress (NICE, 2004).

Table 1 Manchester Emergency Triage System

NUMBER	NAME	COLOUR	TARGET TIME (minutes)
1	Immediate	RED	0
2	Very Urgent	ORANGE	10
3	Urgent	YELLOW	60
4	Standard	GREEN	120
5	Non-urgent	BLUE	240

Data management and analysis

All data were collected on optically scannable forms and entered using high resolution optical character recognition software, based on an integrated survey design and data capture system (Formic-Scan 15 TM). Data generated were analysed using SPSS. The internal structure of the responses to the SIS was examined using Factor Analysis. T-tests were used to examine gender and repeater status differences with regard to the scores on the SIS.

Results

Response

During the pilot-study, 193 SIS forms were returned. Of these, 17 appeared to be underage (<18 years) and were therefore excluded from the final analyses. Of the total 176 SIS forms, 104 (59%) were fully completed in that a total SIS score could be calculated.

Age and gender

Thirty five percent (n=36) of the DSH patients examined were male and 64% (n=67) were females with a mean age of 33 yrs (SD 12.7, range 18-84). There was no significant age difference between male and female patients. For one patient, gender was missing.

Incomplete surveys

There were a total of 72 incomplete SIS forms (40.9% of entire sample). During phase 1 (first 3 months of using SIS) non-completed SIS forms accounted for 60% (n=29) of all SIS forms returned (20 SIS forms completed - 40.8%). A significant increase in the completion rate was evident in phase 2 (rest of pilot period) with 84 completed SIS forms (66%) and 43 non-completed SIS forms (34%) (p<.003).



Of the total 176 adult patients admitted to A&E or MAU, a minority (n=12, 7%) declined to complete the SIS form and 1 patient could not speak English. For the remaining 7 patients the reasons were not specified. Of the 72 incomplete SIS form 17% had a red and 51% had an orange triage code. Reasons for incompleteness were identified for 94% of cases. In the majority of cases (38%) the A&E and MAU DSH patients were unconscious, semi-conscious or drowsy. Twelve patients (16%) appeared to be uncooperative or aggressive, in 6 cases (8.3%) the A&E/MAU was noted as being too busy. Only in 2 cases (2.7%), were the staff dealing with the DSH patient unaware of the SIS form. If there were up to 3 missing values in the individual items on the SIS form, a predicted value was determined, resulting in eight cases with predicted SIS scores. For reasons of consistency all statistical analyses were carried out on the sample with completed SIS (n=104).

Characteristics of DSH patients

Methods of deliberate self harm and medical treatment

As expected, the most common method of DSH was drug overdose (84.4%, n=81), which was similar for both males and females. Self-cutting accounted for 7.4% (n=7) and multiple DSH methods for 6% (n=6) of the methods used. Due to relatively small numbers among those who used self-cutting and multiple methods, it was not possible to examine gender differences. More than half of all DSH patients had taken either alcohol (50%; n= 50) or illicit drugs (6%; n=5) before their DSH act.

The majority of DSH patients were identified as having an orange triage code (67%; n=61), followed by 30% (n=27) having a yellow, 2% (n=2) having a red and 1% (n=1) having a green triage code. Thirteen patients were not given a triage code; half of these were examined in the MAU department (n=7) where a triage code is not in operation. All patients presenting with a red triage code were admitted, 93% of those with an orange and 89% of those with a yellow triage code were admitted, with the overall majority undergoing general admission. For two patients data on admission was not available.

Previous deliberate self harm

The majority of the patients (n=55, 53%) reported at least one previous DSH episode, 36% (n=38) reported no previous self harm and for 11% (n=11) of the patients it was unknown whether they had previously harmed themselves or not. There was no significant difference between males and females in previously presenting with deliberate self-harm. However, those with a history of repeated self harm were significantly older (M=35.3, SD=12.8) compared to those for whom the deliberate self harm act was the first episode ever (M=30.9, SD=12.5) ($p<.05$).

Suicide Intent Scale

Factor structure of the SIS and internal consistency

The internal consistency of the total SIS scale was satisfactory (Cronbach's $\alpha = .88$). A Factor Analysis was performed to identify relevant subscales. Two factors were obtained: 1) a factor representing SIS-items relating to **Intent** (8 items), and 2) a factor representing SIS-items relating to **Planning** (7 items). The **Intent** subscale accounted for 43.3% of the variance with an eigenvalue of 3.2, while the **Planning** subscale explained 11.4% of the variance (eigenvalue: 1.03). The internal consistency of the two subscales was found to be satisfactory



for both subscales, with a Cronbach's α of .89 for the **Intent** subscale and .75 for the **Planning** subscale.

Suicide intent and gender

The median total SIS score was 9 (range 0-29) and the mean total score was 9.60 (SD 6.5) (n=104). The mean total score for male DSH patients was higher (M=9.93, SD 5.40) compared to females (M=9.56, SD 7.01), however, this was not significantly different. As expected, male DSH patients had a higher **Intent** (M=6.84, SD 3.63, range 0-16) and **Planning** score (M=3.11, SD 2.81, range 0-13) compared to female patients (**Intent**: M=6.48, SD 4.90, **Planning**: M=3.09, SD 2.91), again this was not significant.

Low versus high suicide intent

In line with the above mentioned results, no significant gender differences were found comparing DSH patients with low and high suicide intent (Table 2).

Table 2 Low versus high suicide intent by gender

	Males N (%)	Females N (%)	Total N (%)
Low suicide intent	17 (47)	35 (52)	52 (51)
High suicide intent	19 (53)	32 (48)	51 (49)
Total	36 (100)	67 (100)	103 ^a (100)

^a 1 gender missing

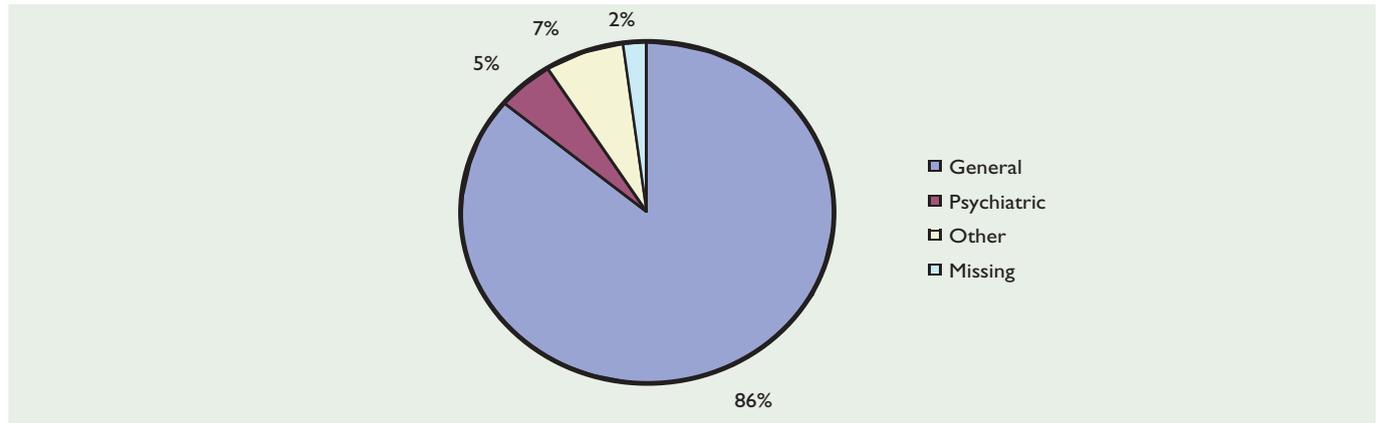
Suicide intent and previous deliberate self harm

Comparing those with and without a history of deliberate self harm, those reporting a history of previous deliberate self harm (repeaters) had a slightly higher total SIS score: M=9.5 (SD 6.6) compared to those without a self harm history (first ever): M=9.0 (SD 6.1), however, this was not significant. Looking at the two different subscales of the SIS, repeaters had a slightly higher **Planning** score (M=3.3, SD 2.8) compared to first ever (M=2.4, SD 2.3), but this was not significant. With regard to **Intent**, a different pattern was found in that first ever showed a slightly higher **Intent** score (M=6.6, SD 4.3) compared to those who were repeaters (M=6.2, SD 4.7), again this was not significant.

Referral following treatment at A&E

Following treatment at A&E, DSH patients were generally admitted and subsequently referred to a ward. The majority of patients (86%) were admitted into a general ward. Seven percent were transferred to 'other services', 5% were transferred to psychiatric services and for the remaining 2% of the patients this information was missing (Figure 1). There were no significant differences between DSH patients with and without completed SIS in terms of referral pattern following treatment at A&E.

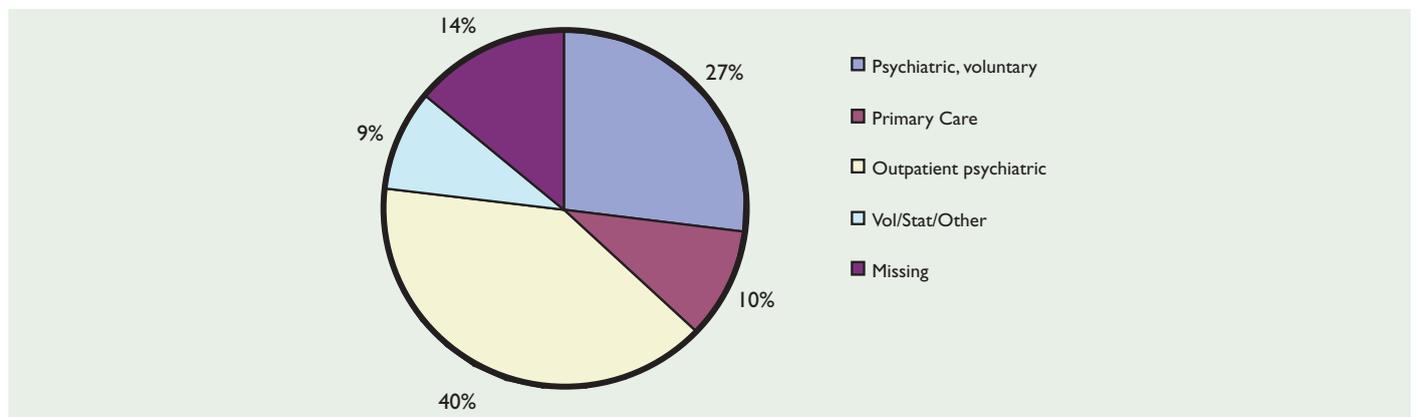
Figure 1 Referral following treatment at A&E (n=104)



Next care

Once patients are admitted next care is recorded. Forty percent of the patients were referred to an outpatient psychiatric service, 27% underwent psychiatric admission voluntarily and no patient was involuntarily admitted to psychiatric services. Ten percent of the patients were referred to primary care, 9% were referred to voluntary, statutory and other services. For the remaining 14% information on referral was not available (Figure 2). Comparing patients with and without completed SIS, those with completed SIS were significantly more often referred to an outpatient psychiatric service (40% vs. 28%, $p < .05$).

Figure 2 Next care (n=104)



Other services

Among patients who received “other” services (n=52), 81% were referred to the Wexford Self Harm Intervention Project (W-SHIP), 11% were offered a domiciliary visit in combination with the W-SHIP programme, 6% were referred to alcohol counselling and 1 patient was offered domiciliary visits alone. It is important to note that in addition to the initial referrals, 40% of the total sample (n=104) were also referred to the W-SHIP programme.

Level of suicide intent and next care

Patients with low suicide intent were more often referred to primary care compared to patients with high intent (19% vs. 4%). However, due to the relatively small numbers it was difficult to determine whether this was significant. Among those referred to psychiatric services (voluntarily) (n=28), the majority (68%) showed a high suicide intent and the remaining 32% had a low suicide intent.



Summary

- Two thirds of the deliberate self harm patients were women under the age of 34. This is slightly higher compared to the findings at national level based on the National Registry of Deliberate Self Harm (Previously known as; National Parasuicide Registry, National Suicide Research Foundation, 2004; 2005).
- Compared to the findings of the Registry (National Suicide Research Foundation, 2004; 2005), in the current study sample the use of drug overdose was overrepresented (84% vs. 71%) and the proportion of DSH patients who engaged in self-cutting was lower (7.4% vs. 19%).
- At the time of inclusion in the study, more than half (53%) of the DSH patients had a history of previous DSH episodes. This is consistent with other studies including DSH patients presenting to A&E departments.
- The factor structure and internal consistency of the Suicide Intent Scale (SIS) in the current study were consistent with findings in previous research including similar patient groups.
- A trend was found towards higher levels of suicide intent among male DSH patients compared to female patients, which is consistent with previous research.
- A trend was found towards higher levels of suicide intent among DSH patients with a history of previous DSH episodes compared to those without a self harm history. Previous studies show a lack of consistency with regard to the association between levels of suicide intent and repeater status.
- The majority of DSH patients showing high levels of suicide intent (68%), were referred to a psychiatric service, reflecting an association between level of suicide intent and type of treatment referral.

Recommendations

1. **Potential value of SIS guiding treatment referral.**

The findings indicate that DSH patients showing high levels of suicide intent are more often referred to a psychiatric service compared to those with low suicide intent. These findings support the potential value of the SIS guiding treatment referral following treatment at A&E.

2. **Review whether the A&E/MAU department is a suitable setting to conduct the SIS.**

The SIS is a useful instrument to facilitate the contact between A&E/MAU nurses and DSH patients and to enable them to assess the level of suicidal intent of the patients. However, it is recommended to review whether the A&E/MAU department is a suitable setting to conduct the SIS. We recommend exploring how the outcomes of SIS assessments can be incorporated into the Acute Hospital setting and the Specialist Liaison Psychiatric Services and perhaps into the wider community, following the structure of an interdisciplinary model. The feasibility of establishing a "Link Nurse" between A&E/MAU and Liaison Mental Health Service, in line with a pilot programme in Dublin, should be considered.

3. **Conducting the SIS requires flexibility with regard to the time of completion.**

Mostly clinical reasons were identified for non-completion of SIS forms. This underlines the need for flexibility as to the time when the SIS will be conducted in order to avoid the influence of alcohol, drugs and medication on the outcome of the assessments.

4. **A "learning period" should be considered in implementing the Suicide Intent Scale (SIS).**

During the pilot study the proportion of completed forms of the Suicide Intent Scale (SIS) increased over time, indicating that a "learning period" of at least 3-4 months should be taken into account when implementing the use of the SIS in the daily practice of A&E and MAU nurses.

5. **Assessment of suicide intent among children and adolescents who engage in deliberate self harm.**

It is recommended to examine the feasibility and effectiveness of implementing assessment instruments for children and adolescents who are presenting to A&E following DSH.



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Part II: Confidence in dealing with suicidal patients, and knowledge and attitudes in relation to suicidal behaviour and its prevention

Part II of the pilot study comprised both a quantitative (A) and qualitative part (B) of which the methodology is outlined here.

Methodology

A. Quantitative study

Pilot and comparison site

The study comprised a pilot and comparison site, selected by the Project Steering Group (Table 3). The pilot site was Wexford General Hospital (WGH). The hospital offers an array of acute hospital in-patient and out-patient services across Wexford town and county, including a catchment area population of 116,596 inhabitants. The acute mental health services are situated 'off site'. Liaison DSH/psychiatric services are provided by a specialist self-harm nurse and a NCHD psychiatrist. The hospital operates a twenty-four hour/seven days a week A&E department and a 12 hour/7 days a week Medical Assessment Unit (MAU). Both the A&E and MAU are direct points of access for patients who have engaged in DSH.

The comparison site was St. Luke's General Hospital, Kilkenny. The hospital offers in-patient and out-patient services and has a similar urban/rural demographic area to the pilot site. The Carlow - Kilkenny area covers a catchment area population of 126,353 inhabitants. The acute mental health services are situated 'on-site', with liaison services being provided via on-call NCHD. As with the pilot site, St. Luke's operates a 24 hour/seven days a week A&E department and a 12 hour/7 days a week Medical Assessment Unit (MAU). Both the A&E and MAU are direct points of access for patients following an episode of DSH. The pilot and comparison site have similar annual incidence of DSH presentations (291 and 331 respectively) (National Suicide Research Foundation, 2004).



Table 3 Characteristics of pilot – and comparison site

	Pilot Site	Comparison Site	Pilot Site	Comparison Site
	A&E Department	A&E Department	MAU Department	MAU Department
Nursing Staff levels in A&E	14.0 WTE	13.3 WTE	9.0 WTE	6.25 WTE
Facilities	4 cubicles including 1 resuscitation area	4 cubicles including 1 resuscitation area	10 beds	6 beds
Manchester Triage System	YES	YES	NO	NO
Liaison Self-Harm Nurse	YES	NO	YES	NO
Days/Hours of operation	24 hours / 7 days per week	24 hours / 7 days per week	9.00am – 8pm/ 7 days per week. [Last admission accepted at 8pm]	8.30am – 9pm/ 7 days per week. [Last admission accepted at 8pm]
Self-Harm Presentations 2004	291	331		

Sample

All A&E and MAU nurses in the pilot (n=39) and comparison site (n=33) were invited to participate in the study. Participation in the study involved completion of a structured self report questionnaire (pilot and comparison site) and attendance of the suicide education programme (pilot site). (Appendix 2)

Design

In order to determine pre-post training/intervention changes among nurses in the pilot site, the questionnaire conducted at baseline, prior to the training/intervention, was conducted again at 9 months follow-up (Appendix 3). At baseline, additional information was obtained on relevant training that nurses may have received prior to their participation in the current study. All pilot and comparison site nurses received a personal letter explaining the study plan and processes. Pre-training/intervention questionnaires were targeted at both pilot site and comparison site A&E/MAU nursing staff. Post-training/intervention questionnaires were targeted at the pilot site nursing group only.



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Educational components of the pilot study

Early on in the planning and design of the tutorials and training programme the project nurse sought the views and opinions of A&E/MAU clinicians with regard to their training needs in the area of suicidal behaviour. All tutorials were designed to support the implementation of the Suicide Intent Scale (SIS) into A&E/MAU nursing practice and to meet the training needs of the A&E/MAU nurses cohort. A series of 6 tutorials was developed (Appendix 2). Tutorials covered a broad spectrum of suicide and issues related to suicidal behaviour, including:

- Suicide Awareness
- Attitudes Towards Suicide Workshop
- Deliberate Self harm & Alcohol Misuse
- Depression & Deliberate Self Harm.

In addition to the tutorial sessions the project nurse also commissioned two ASIST Workshops (Applied Suicide Intervention Skill Training - Living Works, 1999) and a Master Class on The Law, Mental Health and A&E. A representative cohort of nurses from the pilot site attended these events. As part of the delivery of the tutorials, the project nurse sought to involve disciplines from other health and social care groups (e.g. mental health nurses, social workers and medical doctors) fostering interdisciplinary discussions, collaborative working and improving intra-professional networking within the pilot site locality.

In practical terms it should be noted that the logistics of delivering these tutorial events 'on site' proved to be difficult and challenging. This was primarily related to the workload demands within the clinical areas frustrating the release of staff to the scheduled 'on site' tutorials. In seeking resolution to this problem an interdisciplinary meeting was held. The outcome of this meeting was to develop one day events, comprising of Self-Harm/Suicide tutorials iii-to-vi (Appendix 2). Subsequently, three one day 'off-site' events were scheduled and undertaken each achieving high attendance rates from the A&E/MAU nurses.

Baseline and outcome measures

Aspects included in the questionnaires were staff demographics, confidence in dealing with suicidal people (Morriss et al., 1999), staff knowledge in relation to suicidal behaviour, and attitudes towards suicide and its prevention (Renberg & Jacobsson, 2003), see also (Appendix 3).

Data management and analysis

All data were collected on optically scannable forms and entered using high resolution optical character recognition software, based on an integrated survey design and data capture system (Formic-Scan 15 TM). All analyses were performed with SPSS. Assessments of the level of confidence in dealing with suicidal patients pre-post training/intervention and baseline differences between the two sites were analysed using t-tests, mean differences and 95% confidence intervals. Assessments of knowledge and attitudes in relation to suicidal behaviour pre-post training/intervention and differences between the two sites were analysed using chi-square tests. Due to the relatively low number of nurses, both in the pilot and comparison site, it was often not possible to determine the level of significance.



B. Qualitative study

In addition to the quantitative study, a qualitative study was carried out among A&E and MAU nurses in the pilot site. Thirteen (33%) out of the thirty nine nurses who were involved in the suicide training programme agreed to participate in the study. Other than their availability on the two days in June 2005, which were planned for conducting the interviews, no selection criteria were applied to invite nurses to participate in the study.

A semi-structured interview questionnaire was developed by the NSRF and approved by the project nurse (Appendix 4). Thirteen nurses agreed to participate and completed the interview. One nurse had not attended any of the training courses. Therefore, the findings reported are sometimes based on a total of 12 nurses. A consent form was given and completed by each participant. Each nurse was given a letter informing them about the aim of the study and the independent nature of the study. All participants were assured of confidentiality and given assurances that the information obtained would be used only for the purpose of this study. Contact details were given if they had any further questions or concerns. Confidentiality of personal details was assured and each participant was given a unique identification number. All participants underwent a recorded interview in their own workplace (private room on hospital grounds) by a trained interviewer (BM). All tapes were transcribed separately by two independent researchers (BM, LO). Recurrent themes and sub-themes were agreed upon between the two researchers. The findings of the qualitative study have been reported previously¹. A summary of the main findings will be included in this report. The qualitative findings will also be presented to further clarify some of the quantitative findings.

¹ Evaluation of a Suicide Education Programme and Suicide Intent Scale. A Qualitative Study: HSE South East Area Nursing Project. A Commissioned Report. Prepared by The National Suicide Research Foundation in collaboration with Mr Steve Lamb, Project Nurse NMPDU, HSE-South East Area, July 2005.

Results

Response

A total of fifty-five nurses completed the baseline questionnaires (n=29 pilot site and n=26 comparison site). Nearly similar baseline response rates were found for both the pilot site (74%, 29/39) and comparison site (78%, 26/33). In the pilot site, the majority (58%) were A&E nurses and 42% were MAU nurses. With regard to nurses in the pilot site who completed both pre- and post training/intervention questionnaires, a relatively high follow-up response rate of 79% (23/29) was found.

Socio-demographic characteristics

The mean average age of the nurses (A&E and MAU) in the pilot site was 36 years (SD 8.2), with a range of 23-50 years. Except one man, all participants were women, and gender was missing for 2 participants. The average number of years post registration experience was 13. In the comparison site, the mean age of the nurses in the comparison site was 38.6 years (SD 9.27), with a range of 26-60 years. Except for one nurse for whom gender was unknown, all 25 nurses were female. The average number of years post registration experience was 14.

Previous training

In the pilot site, more than one third of the nurses (39%) had received training around the topic of deliberate self-harm, prior to the baseline assessment. Twenty six percent had received training in communication skills and 10% had received training in counselling skills, with 4 nurses having received more than one of the above training. Twelve nurses (39%) had not been involved in any previous training programme. In the comparison site 8 nurses (31%) had received training on DSH, fifteen percent (4 nurses) had received communications skills training and 11% (3 nurses) had received counselling tuition. Two of this nurse cohort had undertaken training in all 3 disciplines.

Baseline findings: pilot versus comparison site

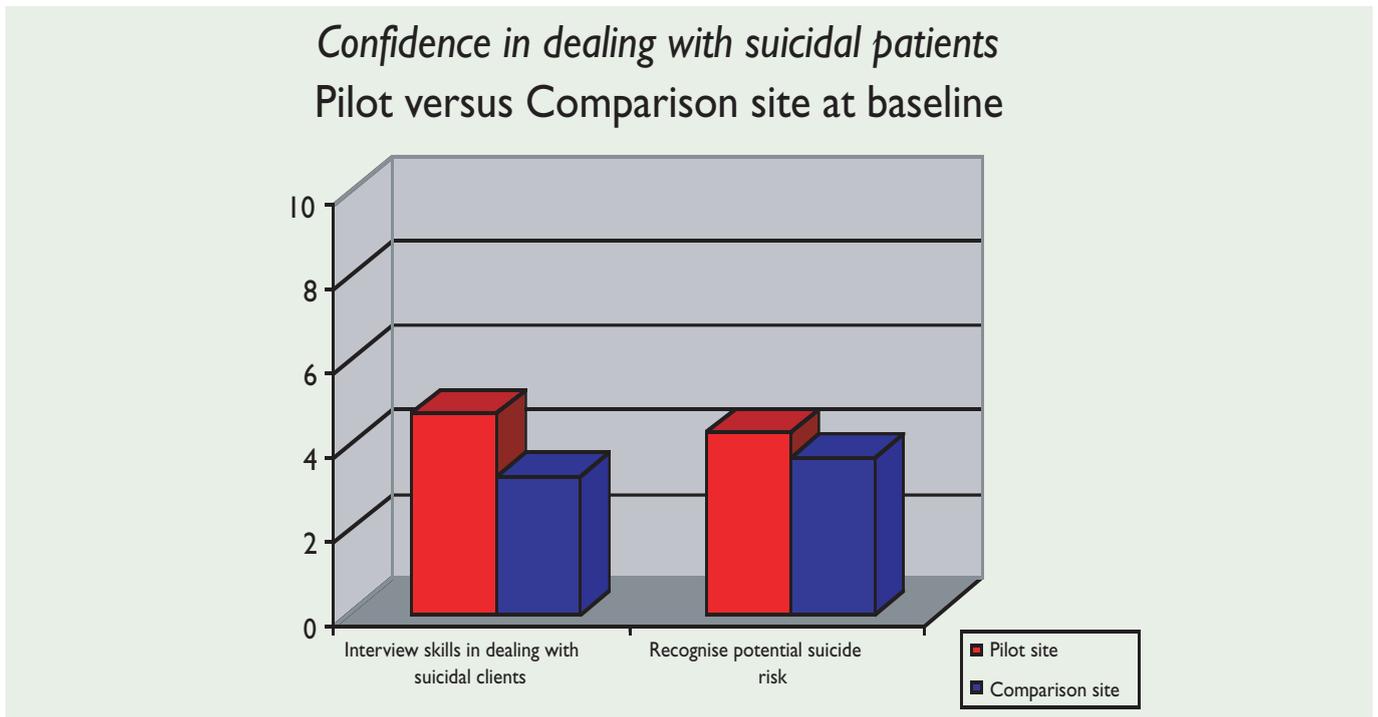
A comparison was undertaken between A&E/MAU nurses in the pilot site (n=29) and comparison site (n=26) on all baseline measures.

Baseline findings in relation to confidence in dealing with suicidal patients

Pilot versus comparison site

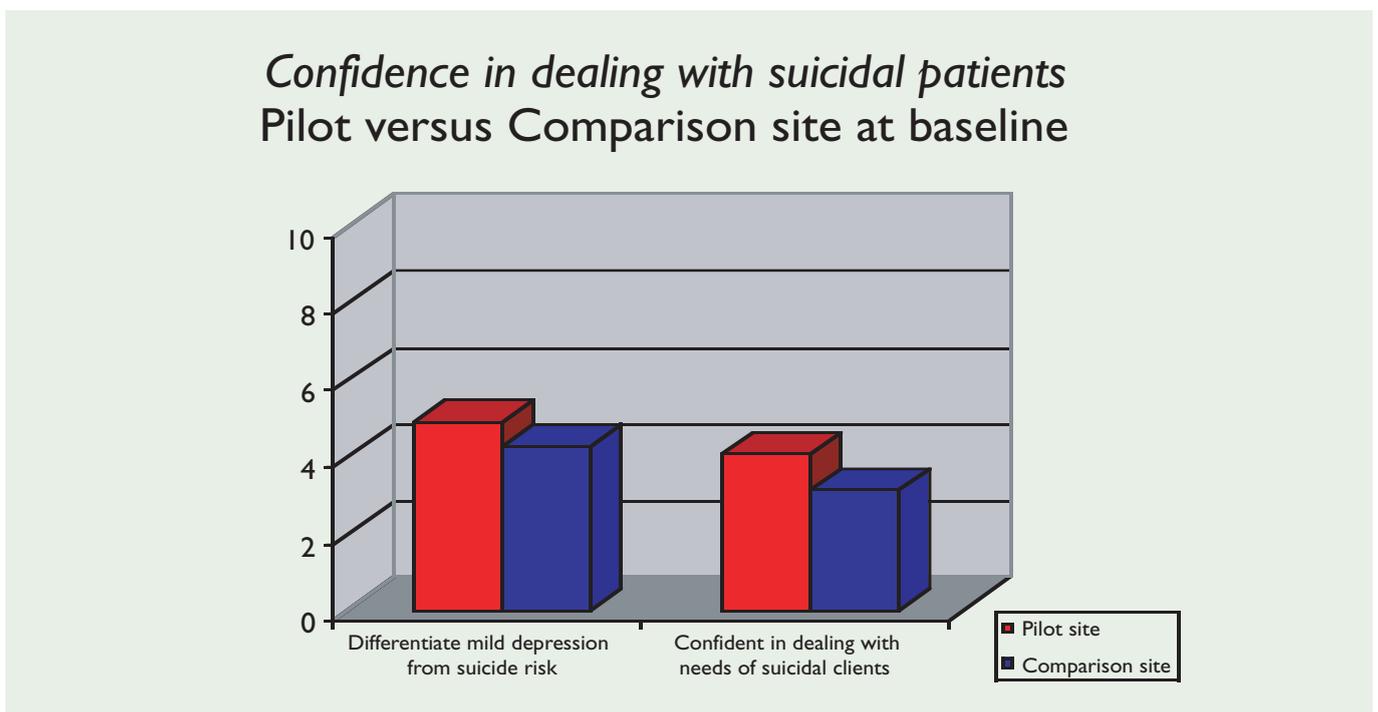
Although at baseline overall the level of confidence of nurses in dealing with suicidal clients appeared to be relatively low in both the pilot and comparison site, a number of significant differences were found between the 2 sites (Figure 3). With regard to the statement: ***“I am confident that I have the interview skills to use my time well with suicidal clients”***, the comparison site nurses showed a significantly lower level of confidence (M=3.2, SD 1.93) than the nurses in the pilot site (M=4.7, SD 2.07) ($p < .01$). Similarly, with regard to ***feeling confident in recognising potential suicide risk after having seen a client***, the comparison site nurses felt significantly less confident (M=3.71, SD 2.07) compared to those in the pilot site (M=4.32, SD 1.57) ($p < .05$).

Figure 3 Baseline findings in relation to confidence in dealing with suicidal patients, pilot versus comparison site.



Comparison site nurses appeared to be less confident in differentiating a mild depression from suicide risk (M=4.32, SD 2.24) compared to those in the pilot site (M= 4.68, SD 1.98) (Figure 4). However, this was not significant. With regard to the statement: *“I feel confident in dealing with the needs of suicidal clients”*, there was again a significant difference, with a mean score of 3.13 (SD 1.92) among the comparison site nurse versus 3.78 (SD 2.54) among the pilot site nurses ($p < .05$).

Figure 4 Baseline findings in relation to confidence in dealing with suicidal patients, pilot versus comparison site.

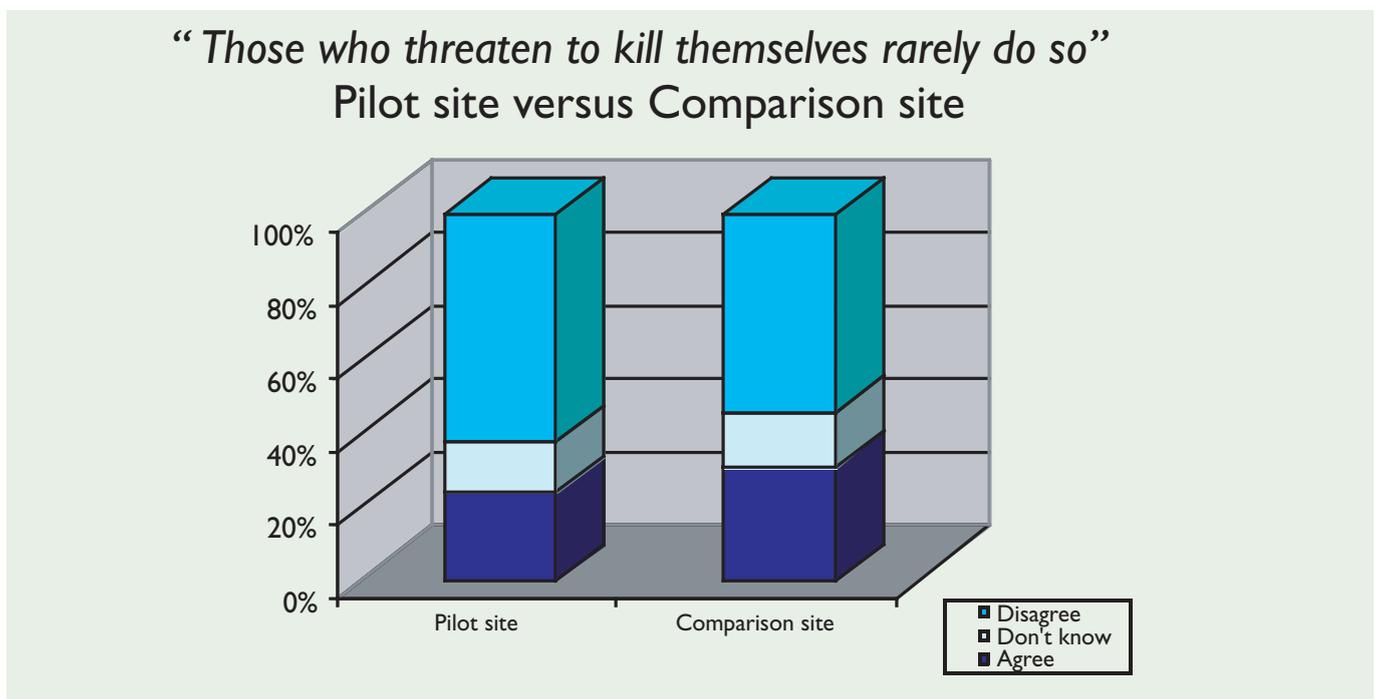


Baseline findings in relation to knowledge in relation to suicidal behaviour

Pilot versus comparison site

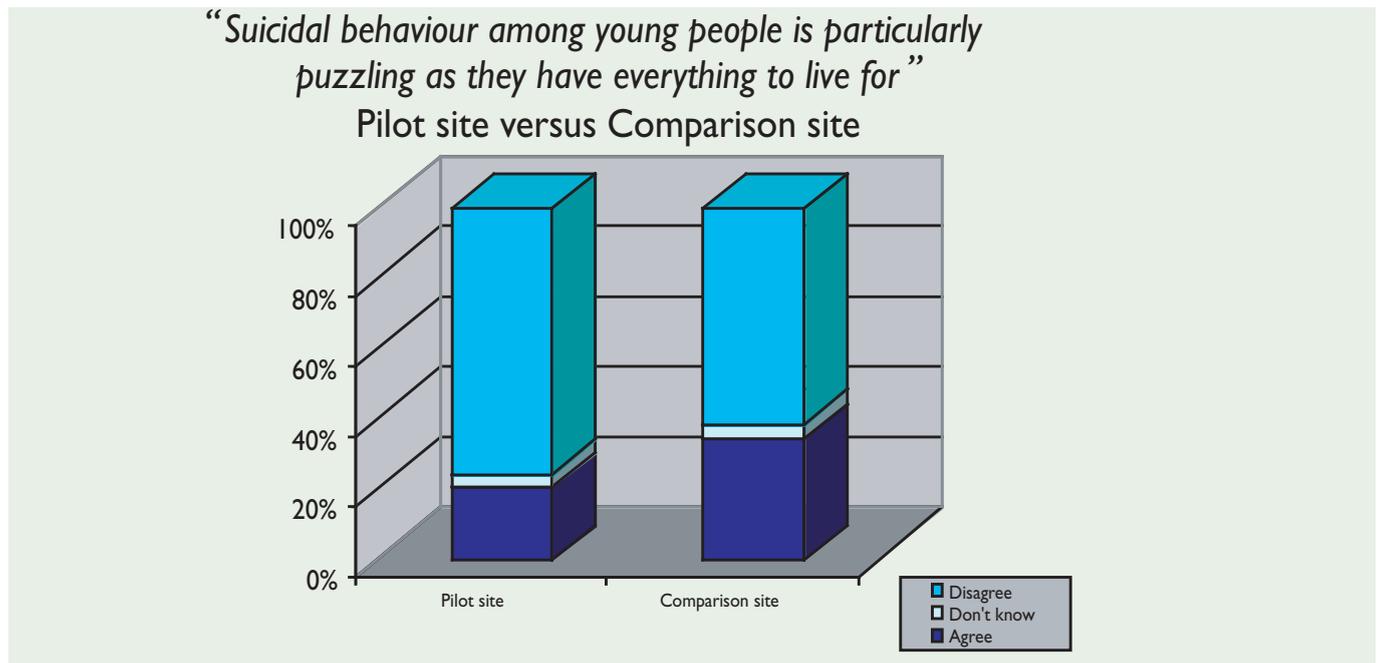
Comparing the pilot and comparison site, a number of differences were found with regard to the nurses' knowledge in relation to suicidal behaviour. In response to the statement: ***“Those who threaten to kill themselves rarely do so”*** a slightly higher percentage of nurses in the comparison site agreed with this statement (31% vs 24%). However, this was not significant (Figure 5). The percentage of those who did not know what to answer was similar in the two sites.

Figure 5 Baseline findings: knowledge in relation to suicidal behaviour, pilot versus comparison site.



With regard to the statement: ***“Suicidal behaviour among young people is particularly puzzling as they have everything to live for”***, a higher percentage of nurses (35%) in the comparison site agreed with this statement compared to 21% of the nurses in the pilot site (Figure 6). In both sites, 4% indicated that they didn't know.

Figure 6 Baseline findings: knowledge in relation to suicidal behaviour, pilot versus comparison site.

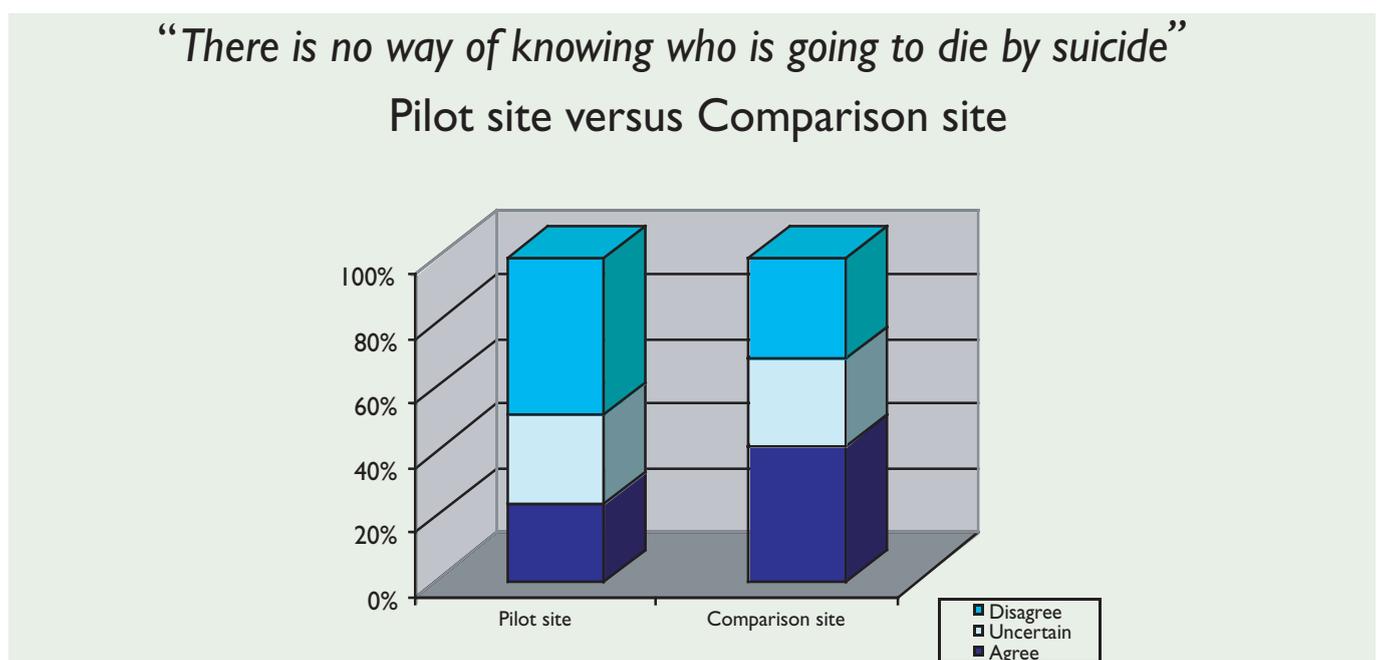


Baseline findings in relation to attitudes towards suicidal behaviour

Pilot versus comparison site

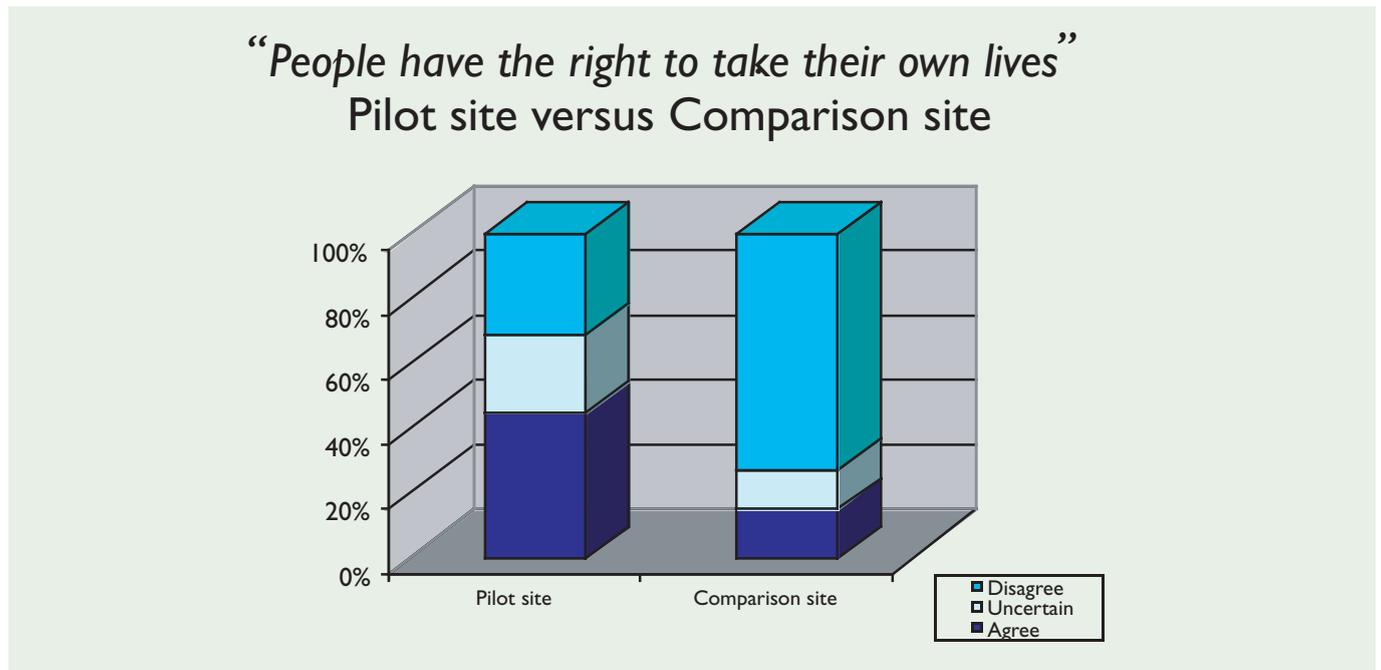
Compared to nurses in the pilot site, those in the comparison site were more likely to agree with the statement: **“There is no way of knowing who is going to die by suicide”** (42% vs. 24%) (Figure 7). Nearly half of the nurses (48%) in the pilot site disagreed with this statement compared to 31% in the comparison site. The proportion of those who indicated to be uncertain was similar in both sites.

Figure 7 Baseline findings: attitudes towards suicidal behaviour, pilot versus comparison site.



Comparing nurses in the pilot and comparison site, those in the comparison site were more likely to disagree with the statement: **“People have the right to take their own lives”** (73% vs. 31%) (Figure 8). In the pilot site, a higher percentage of nurses (24%) agreed with this statement compared to 15% in the comparison site. In the pilot site a slightly higher percentage of nurses (24%) indicated to be uncertain as to which answer to choose compared to 12% in the comparison site.

Figure 8 Baseline findings: attitudes towards suicidal behaviour, pilot versus comparison site.



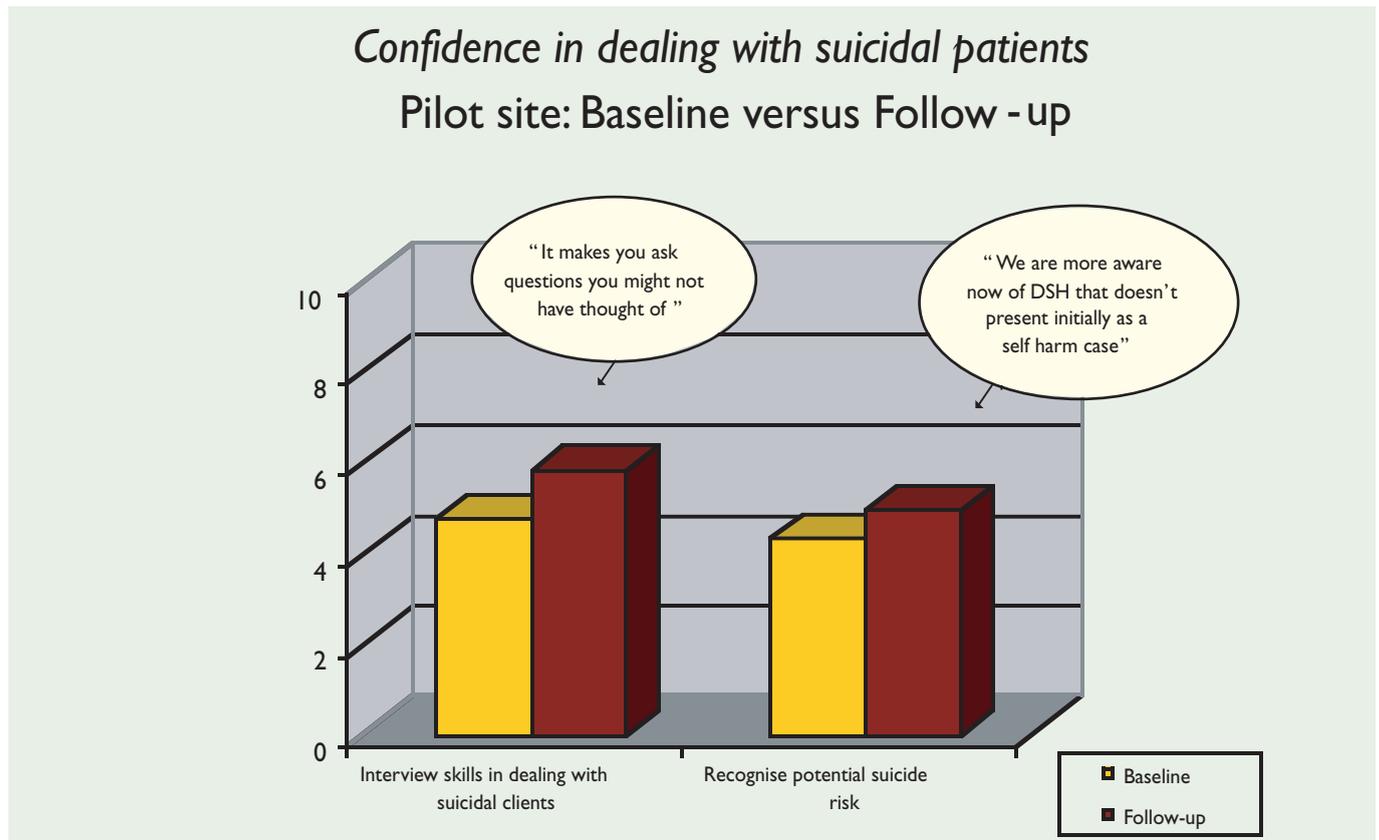
Baseline versus follow-up: pilot site

For the pilot site a comparison was made between nurses who completed both baseline and follow-up questionnaires (n=23).

Level of confidence, pre-post training and introduction of the SIS

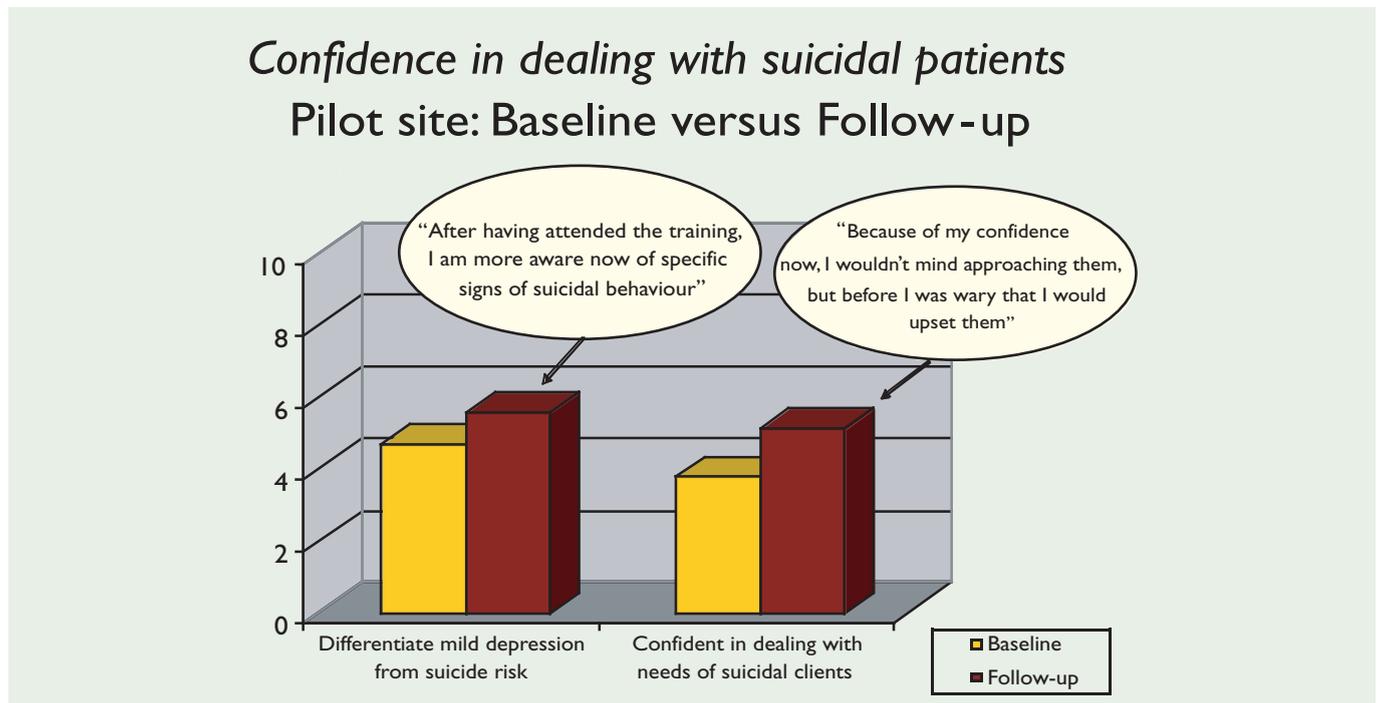
On all four items of the confidence scale, a change in the positive direction was observed comparing baseline and follow-up assessments, with three items showing a significant change. With regard to the statement: **“I am confident that I have the interview skills to use my time well with suicidal clients”**, a significant increase in the mean score was observed from 4.76 (SD 2.07) at baseline to 5.82 (SD 1.90) at follow-up (p<.01) (Figure 9). A positive change was observed in the nurses in relation to the statement: **“After seeing a client once, I would be confident that I could recognise potential suicide risk”** from M=4.32 (SD 1.57) to 4.93 (SD 2.07). However, this difference was not significant. Statements obtained from A&E/MAU nurses in the qualitative study were consistent with the quantitative findings (Figure 9).

Figure 9 Level of confidence in relation to dealing with suicidal patients, baseline versus follow-up



At follow-up the nurses felt more confident in differentiating a mild depression from a suicide risk compared to baseline (M=5.56, SD 2.49 vs. M=4.68, SD 1.98, $p < .05$) (Figure 10). With regard to the statement: *"I am confident in dealing with the needs of suicidal clients"*, a significant increase in confidence was observed comparing baseline to follow-up (M=3.78, SD 2.54 vs. M=5.12, SD 2.56, $p < .001$).

Figure 10 Level of confidence in relation to dealing with suicidal patients, baseline versus follow-up

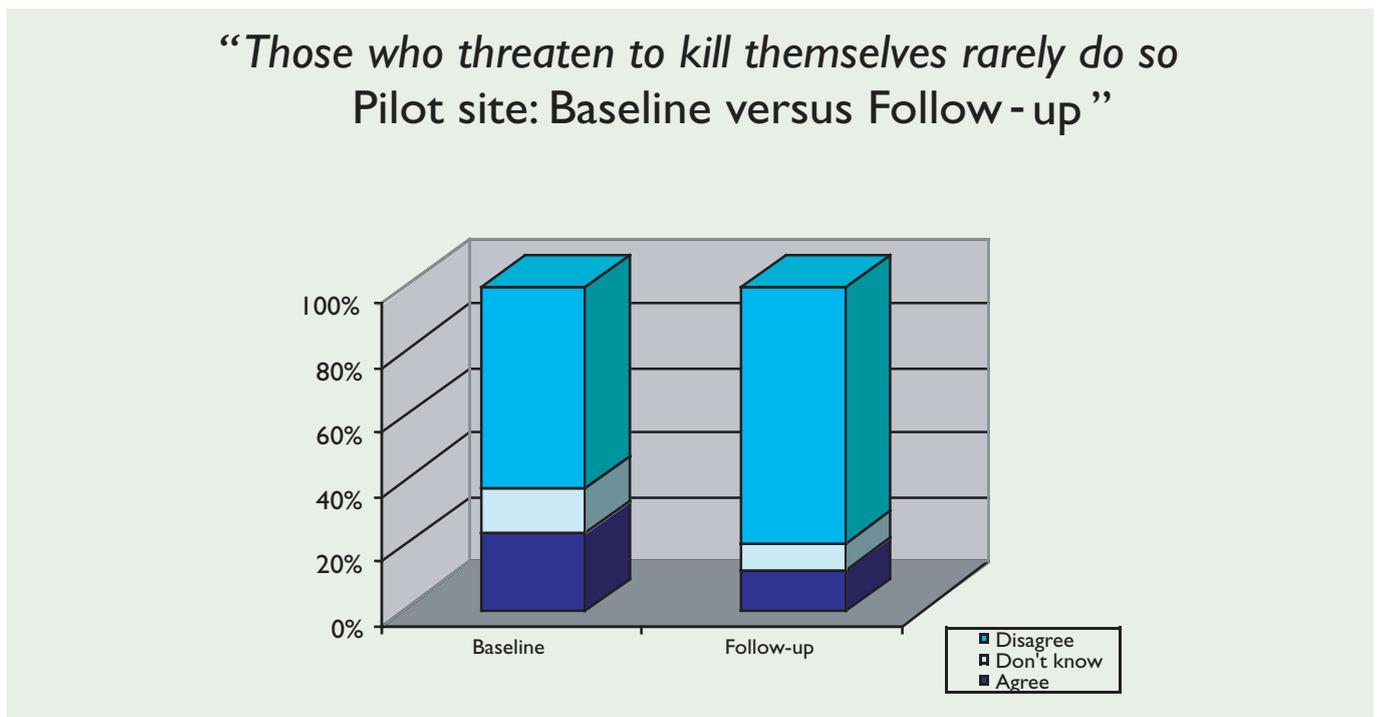


Knowledge in relation to suicidal behaviour, pre-post training and introduction of the SIS

With regard to the findings at baseline, it appeared that the majority of the nurses in the pilot site had responded correctly for most questions. In contrast with the items on the confidence scale, it was more difficult to detect significant changes on the items that are part of the knowledge and attitudes questionnaire, due to the different level measurement (ordinal vs. categorical) and the relatively low number of participants (baseline and follow-up: n=23).

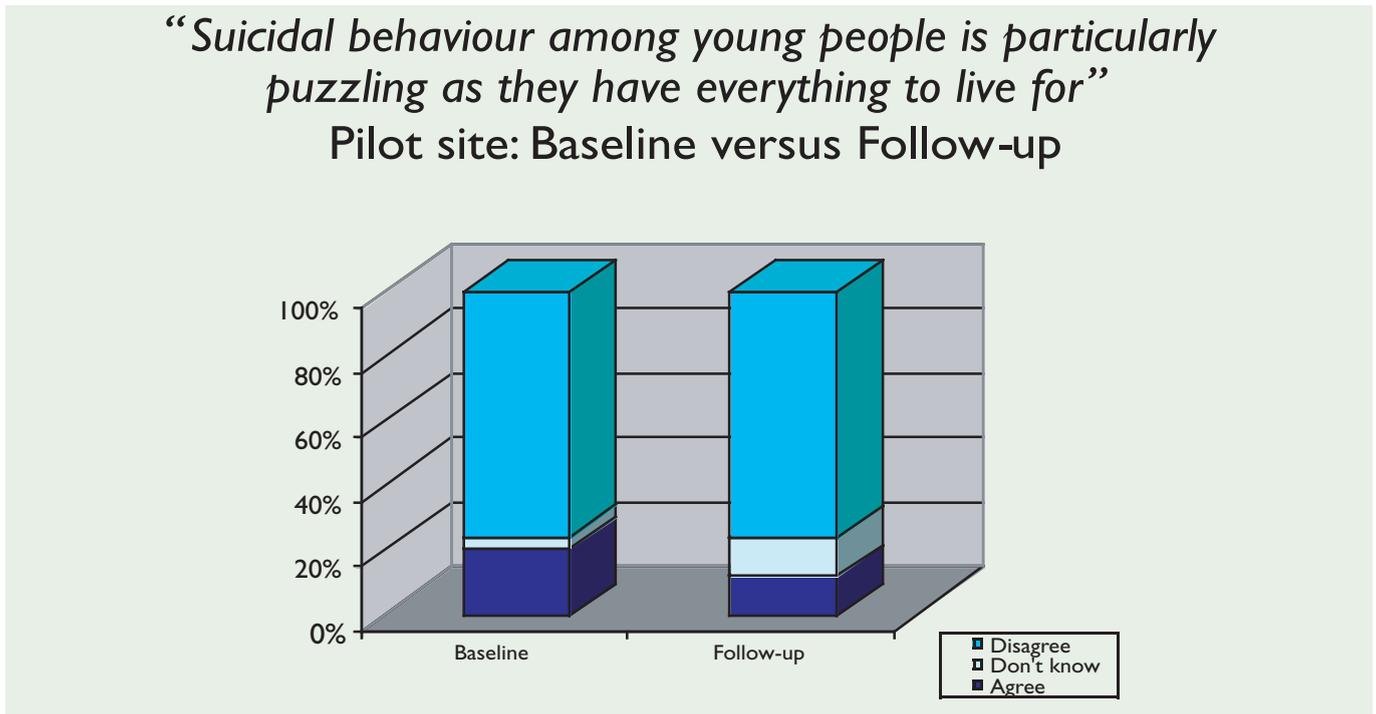
With regard to the statement: *‘Those who threaten to kill themselves rarely do so’*, it appeared that at baseline, the majority of the nurses (62%) correctly disagreed with this statement, with an increase observed after the training programme (79%) (Figure 11).

Figure 11 Knowledge in relation to suicidal behaviour, baseline versus follow-up



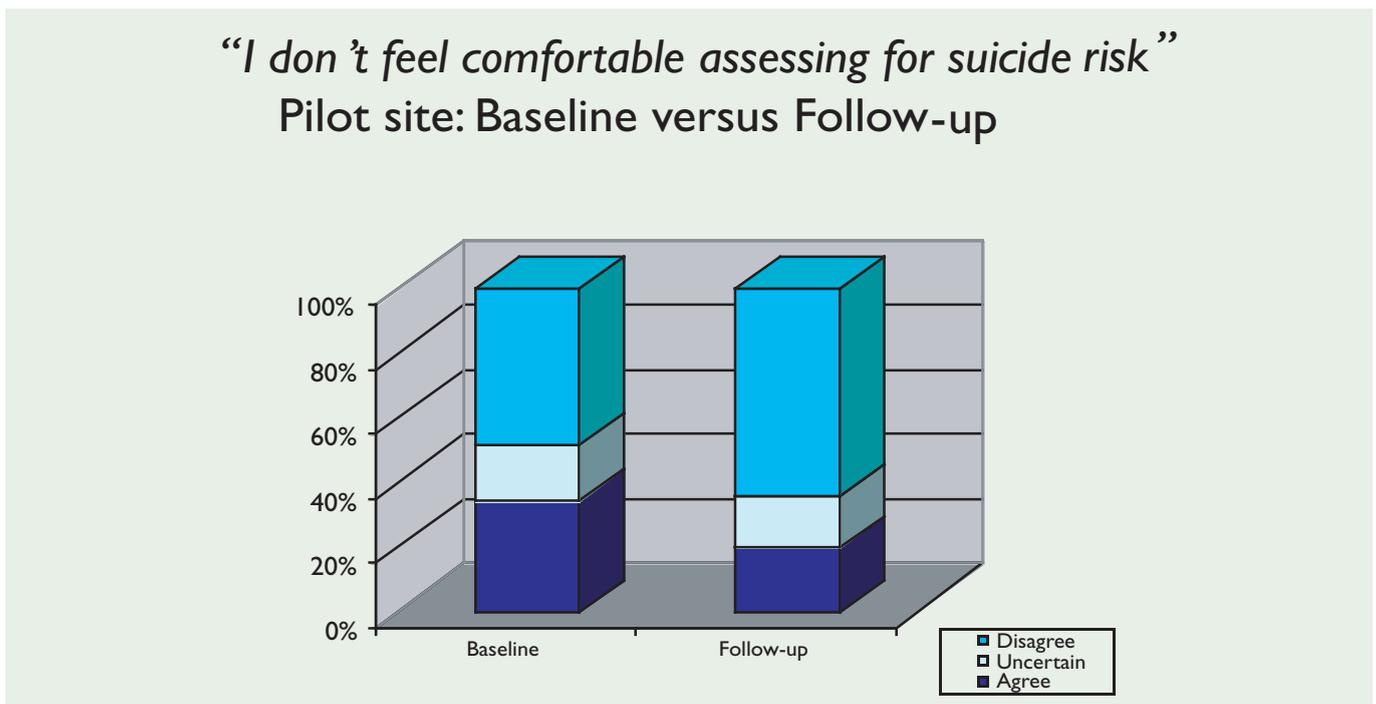
At baseline, the majority (76%) of the nurses correctly disagreed with the statement: *“Suicidal behaviour among young people is particularly puzzling as they have everything to live for”* (Figure 12). This percentage remained unchanged at follow-up. However, there was a slight increase among those who didn't know (3% vs. 12%).

Figure 12 Knowledge in relation to suicidal behaviour, baseline versus follow-up



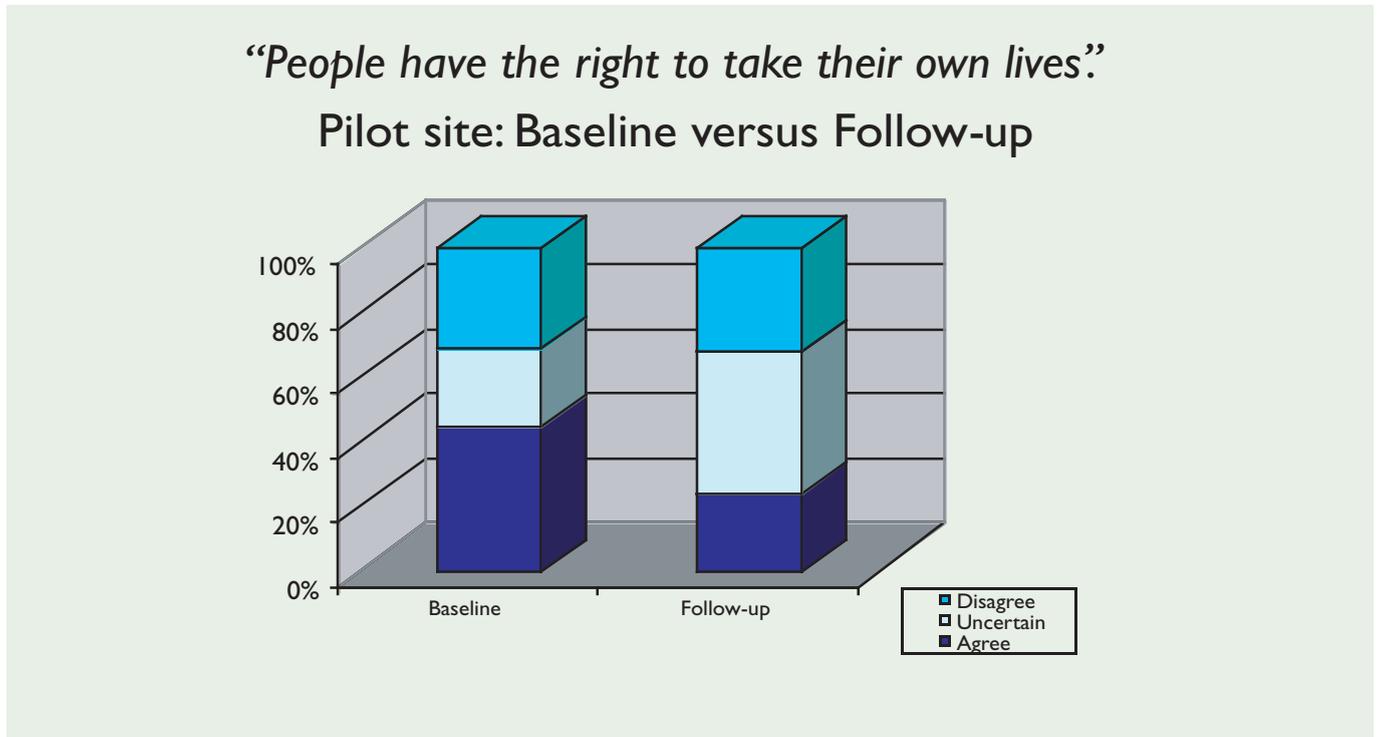
In line with the findings on the confidence scale, an increase was found from 48.3% (baseline) to 64% (follow-up) with regard to the percentage of nurses who disagreed with the statement: *“I don't feel comfortable assessing for suicide risk”* (Figure 13).

Figure 13 Attitudes towards suicidal behaviour and its prevention, baseline versus follow-up



Comparing baseline to follow-up, a decrease was found in the percentage of nurses who agreed with the statement: **“People have the right to take their own lives”** (44.8% to 24%). An increase was found among those who were uncertain (24.1% to 44%). (Figure 14).

Figure 14 Attitudes towards suicidal behaviour and its prevention, baseline versus follow-up



Findings from the qualitative study

Overall, the findings from the qualitative study were consistent with the results from the quantitative study. Below is a summary of the findings based on interviews with 13 nurses, including examples of reflective statements.

Evaluation of the different elements of the training programme

As part of the evaluation of the training programme the nurses were asked to rank the top 3 training courses of the training programmes that were offered to the A&E and MAU nurses the training course **Self-Harm and Alcohol Misuse** was ranked as the most relevant part of the programme, followed by the **Suicide Awareness** training and the **ASIST** training.

Relevance of courses as part of the training programme according to the nurses	
Training courses	
1.	Training Self-Harm and Alcohol Misuse
2.	Suicide Awareness training
3.	ASIST training
4.	Attitude workshop
5.	Practice sessions
6.	SIS Instruction sessions

Integration of knowledge and skills into daily work

The majority of the nurses indicated that they were more aware of signs and risk factors of suicidal behaviour and/or reported that they were using the acquired knowledge and skills in their everyday practice. This was reflected by statements such as:

“Before I would not have had any sympathy for repeaters, but now I would think the system is failing them” and

“Because of my confidence now, I wouldn’t mind approaching them but before I was wary that I would upset them”

Use of the Suicide Intent Scale (SIS) in assessing deliberate self harm patients

The majority of the nurses rated the SIS as a “good” instrument in assessing DSH patients, which is reflected by the following statements:



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“It makes you ask questions you might not have thought of”,

“It provides structure” and

“It helps increasing your confidence”

A number of limitations were reported in relation to use of the SIS by A&E and MAU nurses. The majority of the nurses reported that often there were time constraints in conducting the SIS. Five out of thirteen nurses stated that the lack of privacy in the A&E department was a major limitation in conducting the SIS, which is reflected by the following statement:

“Some don’t want to talk about it at that particular time, especially if they think someone is listening next door”.

In terms of wider implementation, the nurses recommended a review to determine whether the A&E Department would be a suitable place to conduct the SIS, and to incorporate the outcomes of the SIS into the Acute Hospital setting and the Specialist Liaison Psychiatric services.

Differences in staff attitudes towards deliberate self harm patients pre-post training / implementation of the SIS

One third of the nurses indicated that they had observed changes in the attitudes of A&E staff towards deliberate self harm patients following the training programme and implementation of the SIS, such as increased awareness of signs and risk factors of suicidal behaviour; increased awareness of “hidden” cases of DSH and more openness towards patients. This is illustrated by the following statement:

“Overall, it has made a difference to the staff and the patient, we are more aware now of DSH that doesn’t present initially as a self harm case”

Maintenance of acquired knowledge and skills

The nurses were asked whether they would find it useful to receive re-fresher courses or any other support to maintain their level of knowledge. Nearly all nurses stated that it would be relevant to attend re-fresher courses in the future in order to maintain and update the knowledge and skills in relation to their work with DSH patients. In terms of the frequency of re-fresher courses, half of the nurses stated that one day a year would be sufficient. They also indicated the need for standard training in working with DSH patients for new staff. With regard to future training courses, two nurses suggested to include more information on depression in addition to suicidal behaviour.



Summary

- In both the pilot and comparison site relatively low levels of confidence in dealing with suicidal patients were found among A&E and MAU nurses at baseline, with significantly lower levels of confidence among nurses in the comparison site.
- In terms of knowledge and attitudes in relation to suicidal behaviour, overall the nurses in the pilot site were more aware of signs and risk factors of suicidal behaviour at baseline than nurses in the comparison site.
- Despite the relatively high level of awareness of signs and risk factors of suicidal behaviour among nurses in the pilot site at baseline, they showed an improvement on nearly all outcome measures following attendance of the training programme and implementation of the SIS.
- The outcomes of the quantitative study (i.e. positive changes pre-post training programme – implementation of SIS) are further supported by the findings from the qualitative study.
- Due to psychometric differences of the instruments involved and limitations of the sample size, the level of significance of differences (pilot vs. comparison site, baseline vs. follow-up) could be determined for the outcomes of the confidence scale, but not for the outcomes on the questionnaires with regard to knowledge and attitudes in relation to suicidal behaviour and its prevention.



Recommendations

1. Awareness and skills training of A&E/MAU nurses in relation to mental health issues in general and suicidal behaviour in particular should be implemented at national level.

Providing training to A&E and MAU nurses on mental health issues and suicidal behaviour is associated with a significant increase in nursing staffs' levels of confidence in dealing with DSH patients and positive changes in their attitudes towards suicidal behaviour and its prevention. The findings support further implementation of similar training programmes for all A&E and MAU nurses.

2. Positive effects of awareness and skills training among A&E/MAU nurses may be reinforced by combining training with the use of assessment instruments.

The nurses' increased levels of confidence in dealing with DSH patients may be influenced not only by attending training courses, but through positive reinforcement of combining training with the use of a suicide intent scale. It is recommended to provide awareness and skills training on suicidal behaviour in combination with assessment instruments that may be relevant in the daily practice of A&E and MAU nurses.

3. Further follow-up assessments are required to verify whether the positive changes in relation to the nurses' confidence, knowledge and attitudes in relation to suicidal patients will be maintained.

In order to verify whether the positive changes with regard to the nurses' confidence, knowledge and attitudes towards suicidal behaviour will be maintained, a second follow-up assessment among the same nurses is recommended 12 months following the first follow-up assessment.

4. Refresher courses are required in order to maintain the positive changes with regard to the nurses' confidence, knowledge and attitudes.

In order to maintain the positive changes with regard to the nurses' confidence, knowledge and attitudes in relation to suicidal behaviour, it is recommended to offer refresher courses at least once a year and to ensure ongoing support of A&E and MAU nurses working with DSH patients.

5. Awareness and skills training in relation to suicidal behaviour should be offered to the nurses in the comparison site.

Considering the relatively low levels of confidence in dealing with suicidal patients among nurses in the comparison site, they may benefit from receiving a similar training programme as offered to the nurses in the pilot site.



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Notes



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Appendix I SIS Scale

DEPARTMENT: MAU
A&E

Day Month Year

TIME OF PRESENTATION

TIME OF ASSESSMENT

AGE GENDER M F

PREVIOUS SELF-HARM Y N Unknown

ALCOHOL TAKEN Y N

ILLICIT DRUG USE Y N

METHOD OF DSH: DRUG OVERDOSE OTHER POISONING

SELF-CUTTING MULTIPLE METHODS

OTHER SELF-INJURY

TRIAGE CODE:

SIS Completed: Y N

If NO state reason

SUICIDE INTENT SCALE (MARK X FOR 0, 1, or 2)

1. ISOLATION

Was anybody near you when you tried to harm yourself? e.g. in the same room, telephone conversation

- 0. Somebody present
- 1. Somebody near by or in contact (e.g. telephone)
- 2. No one near by or in contact

2. TIMING

At what moment did you do it? Were you expecting someone? Could someone soon arrive? Did you know that you had some time before anyone could arrive?

- 0. Timed so that intervention is probable
- 1. Timed so that intervention is not likely
- 2. Timed so that intervention is highly unlikely

3. PRECAUTIONS AGAINST DISCOVERY

Did you do anything to prevent someone from finding you? e.g. disconnect the telephone, put a note on the door, etc.

- 0. No precautions at all
- 1. Passive precautions such as avoiding others but doing nothing to prevent their intervention (e.g. being alone in room with unlocked door)
- 2. Active precautions (e.g. being alone in room with door locked)

4. ACTION TO GAIN HELP AFTER THE ATTEMPT

After you harmed yourself did you call someone to tell what you just did?

- 0. Notified potential helper regarding attempt
- 1. contacted but did not specifically notify potential helper regarding attempt
- 2. Did not contact or notify helper

5. FINAL ACT IN ANTICIPATION OF DEATH

Did you do anything such as paying bills, say goodbye, write a testament?

- 0. None
- 1. Patient thought about making or made some arrangements in anticipation of death
- 2. Definite plans made (making up or changing of will, giving gifts, taking out insurance)

6. DEGREE OF PLANNING

Had you planned it for some time? Did you make any preparations such as saving pills, etc?

- 0. No preparation (no plan)
- 1. Minimal or moderate preparation
- 2. Extensive preparation (detailed plan)

7. SUICIDE NOTE (FAREWELL LETTER)

Did you write one or more farewell letters? If yes, to whom? If no, did you think about writing one?

- 0. Neither written a note, nor thought about writing one.
- 1. Thought about writing one but had not done so
- 2. Presence of note written but torn up

8. COMMUNICATION OF INTENT BEFORE

During the past year did you tell neighbours, friends and/or family members implicitly or explicitly that you had the intention to harm yourself?

- 0. None
- 1. Equivocal communication (ambiguous or implied)
- 2. Unequivocal communication (explicit)

9. PURPOSE OF ACT

Can you tell me what you hoped to accomplish by harming yourself?

- 0. Mainly to manipulate others
- 1. Temporary rest
- 2. Death

10. EXPECTATIONS REGARDING FATALITY OF ACT

What did you think were the chances that you would die as a result of your act?

- 0. Patient thought death was unlikely or didn't think about it
- 1. Patient thought death was possible but not probable
- 2. Patient thought death was probable or certain

11. CONCEPTIONS OF METHOD OF LETHALITY

If overdose: Did you think that the amount of pills you took were more or less than the dose that would kill you?

Else: Did you think about other methods that would be more or less dangerous than what you did?

- 0. Patient did less to him/herself than he/she thought would be lethal or patient did not think about it (Did you have more pills)
- 1. Patient was not sure or thought what he/she did might be lethal
- 2. Act exceeded or equalled what patient thought was lethal

12. SERIOUSNESS OF ATTEMPT

Did you consider your act to be an attempt to take your life?

- 0. Patient did not consider act to be a serious attempt to take his/her life
- 1. Patient was uncertain whether act was a serious attempt to end his/her life
- 2. Patient considered act to be a serious attempt to end his/her life

13. AMBIGUITY TOWARDS LIVING

What were your feelings towards life and death? Did you want to live more strongly than you wanted to die? Or didn't you care whether to live or die?

- 0. Patient did not want to die
- 1. Patient did not care whether he/she lived or died
- 2. Patient wanted to die

14. CONCEPTION OF REVERSIBILITY

What did you think were the chances to survive if you would receive medical treatment afterwards?

- 0. Patient thought that death would be unlikely if he/she received medical treatment afterwards
- 1. Patient was uncertain if death could be averted by medical attention
- 2. Patient was certain of death even if he/she received medical treatment

15. DEGREE OF PREMEDITATION

How long before your act had you decided to do it? Had you thought about it for some time or did you do it impulsively?

- 0. None, impulsive
- 1. Act contemplated for three hours or less prior to attempt
- 2. Act contemplated for more than three hours before attempt

Scoring Total:

- 0-6 = Low Intent
- 7-12 = Medium Intent
- 13-20 = High Intent
- 21+ = Very High Intent

RESEARCHER / LIAISON NURSE USE ONLY

TRANSFER FROM A&E:

- General Admission
 - Psychiatric Admission, Voluntary
 - Psychiatric Admission, Involuntary
 - Psychiatric O.P.D.
 - Other
- Please state

If admitted as in-patient (psychiatric / general), what is next care?

- Psychiatric admission, voluntary
 - Psychiatric admission, involuntary
 - Primary care
 - Outpatient psychiatric
 - Voluntary services
 - Statutory services
 - Other
- Please state



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Appendix 2 Training programme -Tutorials

The 6 key tutorial areas:

i. Instruction Sessions.

Aim: To instruct A&E/MAU nursing staff toward improved knowledge and understanding of the limitations and value of the Suicide Intent Scale [SIS] and study protocol.

ii. Practice Sessions.

Aim: To give participants the opportunity to reflect upon & discuss aspects of assessing self-harmers using the SIS scale.

iii. Suicide Awareness.

Aim: To enhance participant's awareness of the incidence of suicide and the bio-psycho-social aspects of suicide.

iv. Attitude Workshop.

Aim: To afford participants the opportunity to explore their attitudes about suicide/ deliberate self-harm.

v. Self-Harm and Alcohol Misuse.

Aim: To improve participants awareness of alcohol misuse in respect of suicide and deliberate self-harm.

vi. Depression and Deliberate Self-Harm.

Aim: To improve participants knowledge and awareness in respect of depression (and other mood disorders) as they relate to suicide and deliberate self-harm.

Note: In addition to the above programmes the Project Nurse also commissioned two ASIST Workshops (Applied Suicide Intervention Skill Training) and a master class; 'The Law, Mental Health and A&E'. Each of these events was multidisciplinary in nature and included a representative cohort of Pilot and comparison site nursing staff.



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Appendix 3 Nursing Staff Questionnaires

PROJECT: SELF-HARM

PROJECT NURSE: Mr. Steve Lamb, R.P.N., BSc (Hons)

Please [x] where applicable

E-Mail: lambs@sehb.ie Telephone: 051 848 000 ext. 2827

AGE

GENDER MALE

FEMALE

Years of Clinical Post-Registration Experience

Professional Nursing Registration

R.G.N.

R.P.N.

R.S.C.N.

R.M.

R.N.M.H.

Current Post & Grade

Staff Nurse

Permanent

Full Time

C.N.M. 1

Temporary

Part Time

C.N.M. 2

Bank Nursing

C.N.M. 3

C.N.S.

Other, please state:

Previous Relevant Training:

Please indicate if you have any recent (within past 3 years) training or instruction relating to:

Self-harm and/or suicide

Counselling skills

Communication skills

Any comments you may wish to add in relation to self-harming behaviour or suicide management:

**PLEASE KEEP THIS FORM ATTACHED TO THE 3 ACCOMPANYING QUESTIONNAIRES
YOUR TIME, COMMENTS AND RESPONSES ARE GREATLY VALUED**

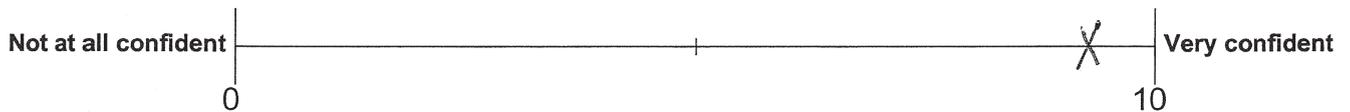


Confidence Questionnaire

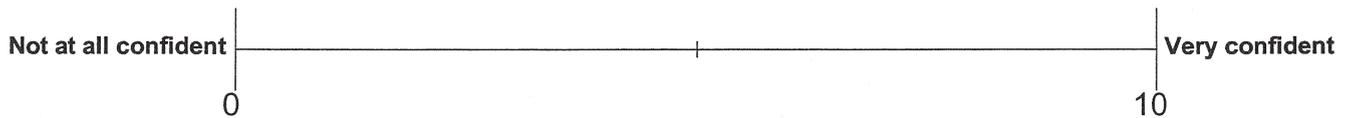
This questionnaire contains some questions about confidence in dealing with suicidal clients.

Please indicate a point on each line [X] as shown in the example which best reflects your opinion:

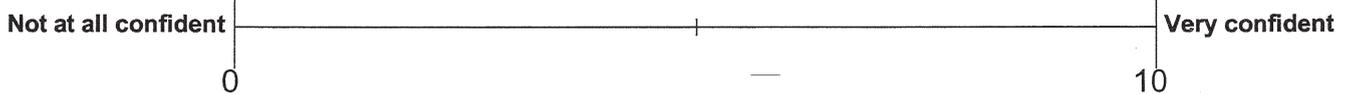
Example



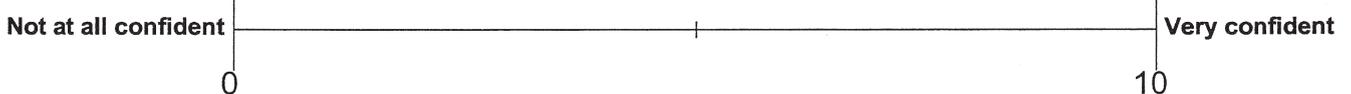
1. I am confident that I have the interview skills to use my time well with suicidal clients



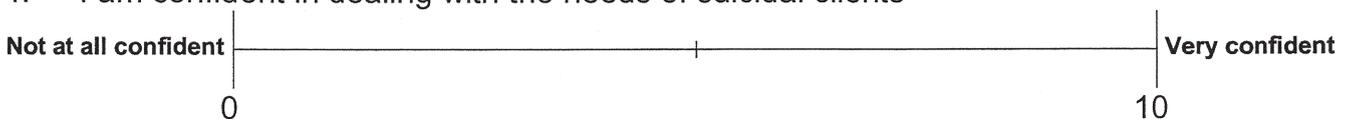
2. After seeing a client once I would be confident that I could recognise potential suicide risk



3. I feel confident that I could differentiate a mild depression from a suicide risk



4. I am confident in dealing with the needs of suicidal clients





The Attitudes to Suicide Prevention Scale (ASPS) (Please tick)

	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
1. I resent being asked to do more about suicide	<input type="checkbox"/>				
2. Suicide prevention is not my responsibility	<input type="checkbox"/>				
3. Making more funds available to the appropriate health services would make no difference to the suicide rate	<input type="checkbox"/>				
4. Working with suicidal patients is rewarding	<input type="checkbox"/>				
5. If people are serious about committing suicide they don't tell anyone	<input type="checkbox"/>				
6. I feel defensive when people offer advice about suicide prevention	<input type="checkbox"/>				
7. It is easy for people not involved in clinical practice to make judgements about suicide prevention	<input type="checkbox"/>				
8. If a person survives a suicide attempt, then this was a ploy for attention	<input type="checkbox"/>				
9. People have the right to take their own lives	<input type="checkbox"/>				
10. Since unemployment and poverty are the main causes of suicide there is little that an individual can do to prevent it	<input type="checkbox"/>				
11. I don't feel comfortable assessing for suicide risk	<input type="checkbox"/>				
12. Suicide prevention measures are a drain on resources which would be more useful elsewhere	<input type="checkbox"/>				
13. There is no way of knowing who is going to commit suicide	<input type="checkbox"/>				



KNOWLEDGE QUESTIONNAIRE

The following questions concern your opinion about suicide. There are no right or wrong answers. Please mark with a cross the alternative that you find is in best accordance with your opinion.

	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
Most people who try to kill themselves don't want to die	<input type="checkbox"/>				
People who attempt suicide are trying to get sympathy from others	<input type="checkbox"/>				
Those who attempt suicide using public places (such as a bridge or tall building) are more interested in getting attention	<input type="checkbox"/>				
Those who threaten to kill themselves rarely do so	<input type="checkbox"/>				
Once a person survives a suicide attempt, the probability of his/her trying again is minimal	<input type="checkbox"/>				
Suicidal behaviour among younger people is particularly puzzling as they have everything to live for	<input type="checkbox"/>				
Families who have experienced a suicide are at a greater risk for suicide themselves	<input type="checkbox"/>				
Patients who survive a suicide attempt cannot be serious about killing themselves, otherwise they would have used more lethal means	<input type="checkbox"/>				



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Appendix 4 Qualitative Study Semi-structured Interview

Evaluation of the Suicide Education Programme and Suicide Intent Scale

1. You received training prior to using the SIS instrument:

- a.** What do you think were the most valuable aspects of the training course: (Rank 1-3. Give reasons for No.1)
ASIST,
A Master Class The Law, Mental Health and A&E,
Instruction sessions,
Practice sessions,
Suicide Awareness,
Attitude Workshop,
Self-Harm and Alcohol Misuse
- b.** To what extent have you been able to apply what you have learnt in the training programme? Have you found it useful in your **everyday** work practices? To what extent have you applied the knowledge and skills in your work to date?
- c.** Would it be useful for you to receive re-fresher courses or any other support to maintain your level of knowledge? Can you suggest specific recommendations?

2. How useful do you find the SIS form in assessing DSH patients?
Very Good / Good / Poor / Very Poor. Can you clarify this?

- a.** Clarify the difference between how you approached DSH patients before and after the training programme.

3. Would you recommend implementing the SIS as an assessment tool for use by all A&E and MAU nurses in Ireland? Yes / No

- a.** What in your opinion are the **benefits** and **limitations** of implementing the SIS for all A&E and MAU nurses?

4. Would you consider that there was sufficient support available for you in using the SIS as a tool for the assessment of DSH? Yes / No / neither yes or no.

If Yes: What did you find supportive? Which aspects of this support were important to you?

If No: What support aspects were missing?

5. Do you think that the training course and the introduction of the SIS form into your department has contributed to changes in the way staff **approach** and **treat** DSH patients? Specify which specific changes there are.





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FOUNDATION IRELAND

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