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

March 2016

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

College of Psychiatrists of Ireland

HSE Mental Health Services

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

Contents

Foreword

Suicide is well recognised as a serious public health issue with 11,126 self-harm presentations to Emergency Departments (ED) in Ireland and 459 deaths in 2014. It requires a diversity of responses: social, educational, occupational and health related.

This Clinical Programme is a part of an overall strategy and specifically addresses the care and treatment required by people who present to the Emergency Departments (ED) of acute hospitals following an episode of self-harm or with prominent suicidal ideation. It aims to provide a standardised specialist response to all such people and, by so doing, reduce the numbers leaving Emergency Departments without an assessment, link people into appropriate care, involve families and friends as appropriate with an overall aim of reducing repetition which is known to be associated with an increased risk of completed suicide. 35.5 clinical nurse specialist nurses have been allocated to emergency departments across the country to deliver the programme in addition to the teams and staff already in place.

In tandem with the programme a training plan has been developed to ensure that staff are skilled and have on-going opportunities to develop competencies and have access to supervision in this clinical area. Training will also be provided to emergency health care staff in working with self-harm or suicidal patients to foster improved knowledge of self-harm, more positive attitudes and increased confidence in assessing and managing people in the ED.

Multidisciplinary community mental health teams for all age groups have developed and expanded in recent years and so are able to respond to acute mental health problems on the same day. However, there will always be people who directly access Emergency Departments either by choice or necessity and hence it is essential to ensure that staff with the requisite skills are available to meet their needs in a timely fashion. The importance of doing this is best illustrated by the words of a family member.

“My husband was suffering from the symptoms of suicide and he died from it.

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.

I understand that suicide is really difficult to manage, that even with intervention the person might still die, however, all I am asking is that we give sufferers and their families the best possible chance”

Once, Twice, Three times 2012: Ms. Siobhan O’ Carroll

Margo Wrigley
National Clinical Advisor and Clinical Programmes Group Lead - Mental Health

Acknowledgments

The National Clinical Advisor and Group Lead for Mental Health would like to acknowledge the following contributions:

Dr Siobhan MacHale (Chair, College of Psychiatrists of Ireland), Dr Eugene Cassidy (College of Psychiatrists of Ireland) and all the members of the subgroup representing medicine, service users, carers, National Office for Suicide Prevention, National Suicide Research Foundation, voluntary groups, nursing, occupational therapy, social work and clinical psychology (full listing in Appendix B) for their time, input and commitment to developing this programme during 2012-13.

Dr Una Geary, National Clinical Lead for Emergency Medicine and the National Clinical Programme for Emergency Medicine Working Group, and Dr Brid Hollywood, Mental Health Lead for the Irish College of General Practitioners, for reviewing and collaborating with us in the development of this clinical programme (2011-2012).

Dr. Ian Daly Clinical Lead for the National Clinical Programme for Mental Health (2011-2013) for his championing of this area of important clinical need.

We also wish to acknowledge all the organisations and individuals who gave welcome and valuable feedback throughout the development of this document, with particular thanks to Ms Siobhan O'Carroll and the National Suicide Research Foundation.

Published in March 2016 by: The National Clinical Programme for Mental Health Clinical Programme, HSE Clinical Strategy and Programmes Division.

Review date: November 2018 (Unless there are any changes in legislation or in clinical practice)

Contact information: Rhona Jennings, Programme Manager for the National Clinical Programmes for Mental Health rhona.jennings@hse.ie

This document is available online at: http://www.hse.ie/mentalhealthprogramme

List of Tables and Figures

Executive Summary

In 2014, more than 11,000 people came to Irish general hospital Emergency Departments following self-harm. From the National Self-Harm Registry Ireland, we know that up to 15% of patients who present following self-harm will leave the Emergency Department (ED) without a bio-psycho-social (BPS) assessment of risk and need, and that 17% of patients will repeat their self-harm act within 3 months (Griffin et al, 2015).

Self-harm is the single biggest risk factor for completed suicide, increasing the risk of suicide 40-fold, as compared to the general population (Owen et al, 2002; Carroll et al, 2014). Suicide is now the commonest cause of death for young men (aged 15-24 years) and middle aged men (45-54 years). Alcohol consumption is implicated in more than 37% of cases of self-harm (Griffin et al, 2015) and half of those who die by suicide have had a history of alcohol abuse in the final year of their lives (Arensman et al, 2013).

Diversity with regard to assessment procedures and management in health settings, as well as feedback from families bereaved by suicide, have led to repeated calls for the development and resourcing of an effective response for people who present to health services having engaged in self-harm.

The aim of this National Clinical Care Programme (NCP) for the *Assessment and Management of Patients Presenting to Emergency Departments Following Self-harm* is to develop a standardised and effective process for the assessment and management of individuals of all age ranges, including children, adolescents, adults and older adults, who present with self-harm to ED.

It refers to the ***mental health/bio-psycho-social assessment and initial management*** *of* both risk and need following self-harm, in the acute hospital Emergency Department, from time of presentation to discharge.

This NCP requires that all patients presenting to ED with self-harm (including suicidal ideation and intent) will receive standardised triage, bio-psycho-social assessment and assertive follow up by skilled clinicians.

Family/carers will be included in the assessment and follow up process. The quality of the programme will be monitored through a set of key metrics.

Training offered by this programme will ensure that patients and their families have access to clinicians with sufficient expertise to provide high-quality, evidence-based care and treatment. Critical to the success of this clinical programme will be the consolidation and further development of (and, in some areas, formation of) close working relationships between the ED clinical team, mental health liaison staff and community mental health teams (CMHTs) and General Practitioner (GP) services.

The objectives of this programme are to:

- Improve the assessment and management of all individuals who present to ED with self-harm
- Reduce rates of repeated self-harm
- Improve access to appropriate interventions at times of personal crisis
- Ensure rapid and timely linkage to appropriate follow-up care
- Optimise the experience of families and carers in trying to support those who present with self-harm.

Summary of Key Recommendations:

Proactive Approach:

1. The GP should be regarded as the first point of medical care for all persons with mental health disorders, including self-harm, with the exception of those requiring Emergency Department care for a physical health problem (e.g. intentional overdose).

2. GP and Emergency Department staff should be able to request an urgent mental health assessment using a single point of contact (covering the entire age span) with local Mental Health Services. Each request should be answered promptly and reliably.

3. Patients already known to Mental Health Services should have clear, written information about how to directly access their CMHT in the event of acute crisis.

4. Full implementation of the recommendations of the Steering Group Report on a National Substance Misuse Strategy is required, so as to address the key association between alcohol misuse and self-harm behaviour.

Clinical Care:

5. Emergency Department triage staff must address mental as well as physical health problems when planning care and treatment.

6. A standardised, specialist, comprehensive mental health bio-psycho-social assessment of risk and needs must be offered in a timely manner by a trained Mental Health Practitioner (Clinical Nurse Specialist or Psychiatrist), skilled in the assessment and management of this patient group. The assessment should be documented in the patient's ED notes.

7. The Mental Health Practitioner must be part of the relevant multidisciplinary mental health team.

8. On-site liaison mental health services should be provided by a Liaison Psychiatry team in each ***Model 3 and 4*** hospital, incorporating a fully staffed multidisciplinary liaison team, as recommended in *A Vision for Change*.

9. Patients should be actively supported to nominate a family member/carer to provide collateral history who can also be advised on suicide prevention care before the patient is discharged.

10. An Emergency Care Plan (ECP) should be developed by the Mental Health Practitioner with the patient and family/carer members (with consent).

11. As noted in the Emergency Medicine Programme (EMP), each large ED requires 24 hr/7day access to appropriate levels of generic Social Work cover including, but not exclusively for, child care protection issues arising out-of-hours.

Management/Governance:

12. Each Mental Health Area (MHA) must deliver the National Clinical Programme (NCP) and allocate the appropriate resources to ensure implementation on an on-going basis.

13. An agreed model of working between Mental Health Services and Emergency Medicine is essential in relation to all mental health service provision in the Emergency Department.

14. Resource decisions should be determined from a network perspective in conjunction with the Emergency Medicine Programme Emergency Care Networks.

15. A mental health area-wide bed management policy and procedure should be put in place in each acute hospital.

16. Clear national policies and procedures must be developed and disseminated through collaborative networking between the Acute Hospital and Mental Health Division, which can then be applied flexibly on a local basis to optimise patient care.
17. Services must record and report on the agreed metrics for this NCP, to enhance data collection and utilise the data to support local strategic developments.

Training and Education

1. Mental Health staff working with patients who present following self-harm must have advanced training in the management of self-harm along with access to appropriate advice, regular clinical supervision and support within the multidisciplinary team. A record of training activities must be maintained.

2. Clinical Nurse Specialists in Liaison Psychiatry and in Self-Harm will have a lead role in the delivery of training and education programmes to all ED staff on a regular basis.

3. All Emergency Department staff who have contact with people who present following self-harm must have access to basic training and education programmes on mental health.

Key Performance Indicators:

1. All mental health practitioners assessing patients who present with self-harm will have received appropriate training.

2. Ninety-five percent of all patients who present with self-harm to the Emergency Department will either be admitted to a hospital bed or discharged within 6 hours of presentation and 100% of treatment dispositions will be completed within 9 hours. Time calculated from when fit for interview by the mental health practitioner.

3. Ninety-five percent of General Practitioners with whom these patients are registered will receive a completed Emergency Care Plan within 24 hours.

4. Based on current individual ED data, a target will be set for each ED to reduce the proportion of patients leaving prior to assessment.

1. Introduction

In 2014, throughout Ireland, more than 11,000 people presented to acute hospital Emergency Departments (ED) following self-harm. From the National Self-Harm Registry Ireland (NSHRI), we know that up to 15% of these will leave ED without a completed bio-psycho-social (BPS) assessment of risk and need and that 17% will repeat a self-harm act within 3 months (Griffin et al, 2015). It is estimated that 10% will die by suicide with this figure likely to be substantially higher in certain subgroups (Carroll et al, 2014).

Suicide is now the most common cause of death among young Irish men (aged 15-24 years) and middle aged men (aged 45-54 years) and the suicide rate among young men in Ireland is among the highest in Europe. Alcohol consumption is implicated in 37% of cases of self-harm (Griffin et al, 2015) and half of those who die by suicide had a history of alcohol abuse in the final year of their lives (Arensman et al, 2013).

There is evidence that in those who have a mental health assessment in the acute hospital ED following self-harm the quality of the assessment and aftercare offered is variable. Findings of considerable diversity with regard to assessment procedures and management, as well as feedback from families bereaved by suicide, have led to repeated calls for the development and resourcing of an effective response in the health services for people who present having engaged in self-harm. National guidelines for the assessment of needs and risk by appropriately skilled staff are central to a Level B targeted approach to reducing the risk of suicide within high risk groups, as indicated in the National *Reach Out* Strategy for Action on Suicide Prevention (Health Service Executive, 2005).

The aim of this National Clinical Programme (NCP) is to develop a standardised and effective process for the assessment and management of individuals of all age ranges, including children, adolescents, adults and older adults, who present with self-harm to the Emergency Department. It refers to the *mental health biopsychosocial assessment and initial management of need and risk following self-harm* in ED from time of presentation to discharge, the need to ensure rapid and timely safe linkage to appropriate follow-up care and the need to optimise the experience of families and carers in trying to support those who present with self-harm.

2. Programme Remit

- This NCP refers to all persons who present to Emergency Departments following an act of self-harm. It addresses the biopsychosocial assessment of the patient's level of need and risk at the time of presentation until discharge from the Emergency Department and addresses linking the patient to appropriate follow-up care after discharge.

- This NCP refers only to patients who present following an episode of self-harm to Hospital Emergency Departments. It includes patients who are admitted to Clinical Decision Units under the care of Consultants in Emergency Medicine and those admitted to medical or surgical inpatient beds because of the physical severity of self-harm.

- This NCP refers to patients of all ages, including children up to 18 years, adults, and older adults aged over 65 years.

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

3. Programme Objectives

- To improve the assessment and management of all individuals who present with self-harm to the acute hospital Emergency Department.
- 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 present with self-harm.

4. Background:

Relevant health care structures and national policies

4.1 Primary Care

All individuals with acute or emergency mental health needs should ideally present to their family GP as their first point of medical care. GPs are skilled medical colleagues who can provide appropriate physical and mental health assessment of risk and needs, as well as management of a proportion of patients who engage in self-harm. They can determine whether a patient needs to be diverted to ED or can be directly linked in with mental health services, for example following superficial self-cutting. Only those patients who require medical care for their self-harm episode should be directed towards ED. All patients who have not done so should be strongly encouraged to register with a GP.

- General Practitioners should be regarded as the first point of medical care for all persons with mental health disorders, including those who engage in self-harm, with the exception of those requiring medical care arising from a self-harm episode.
- General Practitioners should be able to engage through a single point of contact with local Mental Health Services, enabling prompt and reliable response, when requesting an urgent mental health assessment, as outlined in *A Vision for Change* policy (DOHC, 2006).
- This single point of contact should be available for all age groups, including children and adults of all ages.
- Each patient attending a CMHT should be provided by their teams with clear, written information about how to directly access services in the event of an acute crisis, as part of their care plan.

A history of self-harm is associated with a four-fold increase in overall mortality rates, and a forty-fold increase in rate of suicide, as compared to the general population (Owens et al, 2002; Carroll et al, 2014). The increased risk of premature death (Bergen et al, 2012) results not only from unnatural causes, including accidents and suicide, but in two-thirds of cases occurs from natural causes. The mean age of

death for men (50yrs) and women (54yrs) who have a history of self-harm is on average 30 years earlier than expected. Deaths due to natural causes are 2 to 7.5 times more frequently seen than in the general population. These deaths are particularly due to diseases involving the circulatory and digestive systems.

Primary care, along with mental health services, has an important role in identifying longer term health needs, as well as acute medical care needs, and in managing these needs within this vulnerable group.

4.2 Mental Health Care

As noted in *A Vision for Change*, a fundamental component of mental health care is to clarify arrangements for the provision of a 24-hour crisis response capacity. The working day crisis response capacity is provided by community mental health teams. Each team must ensure it has capacity to respond to urgent referrals of new and existing patients on the same day. The on call mental health service is provided by consultant psychiatrists and their NCHDs supplemented by nursing staff in some EDs. It is recognised that a lack of adequately resourced community services causes an increase in emergency psychiatry assessments in local EDs. In addition, psychiatric services which rely more heavily on assessment in EDs, rather than on community psychiatry facilities, have higher rates of direct admissions to inpatient psychiatric units with considerable financial implications (Gibbons et al, 2012)

The complex and busy environment of ED is not the optimal environment for the management of patients with mental illness or psychosocial crisis. Its use should be minimised by ensuring a crisis response capacity within each CMHT for children, adolescents and adults including older adults.

4.3 Emergency Department Services

It is important to consider this NCP in the context of the on-going transformation of Health Care Services in Ireland, including fundamental restructuring of the Emergency Medical Services.

4.3.1 HSE Hospital Services organisation, reconfiguration and the Acute Medicine (AMP) and Emergency Medicine Programmes (EMP)

The 2010 report of the National Acute Medicine Programme Working Group identified important influences on access to Emergency Care in Ireland. The Emergency Medicine Programme (EMP) was launched in June 2012 and is the blueprint for Emergency Care in Ireland, covering all aspects of governance and management of care and supporting standardised workforce models, processes, metrics, and guidelines.

The overarching aim of the EMP is to improve the safety and quality of patient care in Emergency Departments and to reduce waiting times for patients.
Key initiatives include:

a) The definition and development of Emergency Care Networks within a National Emergency Care System;
b) Increased consultant-provided care in EDs;
c) Clinical guidelines;
d) Quality indicators and process measures;
e) Achievement of 6/9 hour ED time targets from time of presentation to admission or discharge for all patients.

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

1. Equity of access for all patients, whether presenting with predominantly physical or mental health care needs to the ED. This includes all patients requiring care following self-harm.
2. The development of a mental health decision tool at the point of ED triage.
3. The development of good working relationships between ED and mental health services.
4. Adherence to the 6 and 9 hour time targets (allowing for fitness for assessment in certain situations e.g. where alcohol involved).

4.3.2 Mental Health Services within Emergency Departments

Patients in acute hospitals, including those in Emergency Departments, have high mental health morbidity. Patients with mental ill-health and medical co-morbidity typically have complex assessment needs, experience longer hospital stays and often present unique risks in their care. These patients are entitled to the same access to emergency medical care when required as those who do not have any significant mental health problems. ED staff may not be skilled in addressing their mental health needs and risks. The presence of dedicated psychiatry staff on-site working alongside with and transferring skills to ED staff will help to ensure optimal care for this patient group.

Currently there is variation in provision of mental health services to EDs in Ireland. Funding is provided from a range of sources and budgets. Funding sources include the Mental Health Services in the main but also some Acute Hospital Services (notably voluntary hospitals). The new role of the National Clinical Advisor and Clinical Programmes Group Lead Mental Health (NCAGL) is central to achieving a coordinated national clinical programme. This is based on aligning strategy to implementation within the Mental Health Division and likewise in association with the NCAGL Acute Hospitals and the Acute Hospital Division, particularly its Emergency Care Networks, in order to optimise the impact of this NCP.

4.3.3 Liaison Psychiatry Services

In many other jurisdictions, including the UK, most self-harm assessments are commonly carried out in ED by Clinical Nurse Specialists who specialise in liaison psychiatry or self-harm. A large study of almost 4,000 ED patients confirmed that psychiatrists and mental health nurses carry out similar risk assessments on patients following an episode of self-harm (Murphy et al, 2010). Most out-of-hours on-call psychiatry services to ED in Ireland are provided by psychiatrists. It is important that psychiatry trainees are proficient in assessment of risk and need and their management as a core competency. This NCP recommends provision of this service by suitably trained Clinical Nurse Specialists. It is important that such Clinical Nurse Specialists are members of a Consultant led Liaison Psychiatry Multi-disciplinary team and receive supervision from a Consultant Liaison Psychiatrist.

Consultation-Liaison Psychiatry services are recognised nationally and internationally as most effective, from both clinical and financial perspectives, for the provision of care to patients with mental health needs in acute hospital settings (Parsonage et al, 2011). A central aspect of the work of Liaison Psychiatry services includes the assessment and management of patients who present to ED with self-harm, as well as the training and support of ED staff in providing care to this group.

A *Vision for Change* recommends that one multidisciplinary Liaison Psychiatry team in each acute admitting hospital is required to provide a day time service for the secondary care mental health needs of patients presenting to ED or admitted as inpatients. More recently recognition of the contribution of Liaison Psychiatry in achieving considerable cost savings (of £4 per £1 spent) whilst simultaneously improving quality of care, has led to considerable expansion of Liaison Psychiatry in other jurisdictions (Tadros et al, 2013).

A *Vision for Change* notes that "the main benefits of liaison mental health services are the identification and treatment of mental health problems in general medical and ED settings. This leads to reduced morbidity, reduced hospital admission, reduced inappropriate physical investigations, reduced length of stay, reduced outpatient attendances, reduced anxiety and depression and improved quality of life. Liaison mental health services also have an excellent opportunity to promote mental health through direct intervention with in-patients and through the training of hospital staff" (AVFC, 2006).

There has been a recent welcome focus on progressing *A Vision for Change* recommendations on Liaison Psychiatry. Two additional services were funded in 2014 with a further four being funded by the Mental Health Division for 2015. A Child and Adolescent Liaison Psychiatry service for Cork has also been approved and should be in place by 2015.

An agreed model of working between Mental Health Services and Emergency Medicine is essential in relation to all mental health service provision in the ED, including self-harm. This model should include clinical, educational, risk management and service issues. Clinical audit should be routinely undertaken

across the EM/Psychiatry interface, to drive continuous quality improvement in the care of patients with mental health presentations to EDs.

- On-site Liaison mental health services should be provided by one multidisciplinary Liaison Psychiatry team in each acute hospital with a 24 hour ED service.
- With the 2014/2015 developments, all hospitals with more than 500 beds will have a fully staffed multidisciplinary liaison team, as recommended in *A Vision for Change*. This includes all Model 4 hospitals and most Model 3.
- In the interim, in those acute hospitals where Liaison Psychiatry services are not available, the Area Mental Health Service must designate a Consultant Psychiatrist who will have overall responsibility for the mental health service available to patients who require psychiatric assessment in the ED. It is essential that this designated Consultant Psychiatrist is appropriately released from some of his/her duties to take on this additional workload.
- An agreed model of working between Mental Health Services and Emergency Medicine is necessary in relation to all mental health service provision in each ED.

4.4 Connecting for Life – Ireland's National Strategy to Reduce Suicide 2015-2020

The core aim of the National Office for Suicide Prevention (NOSP), based within the Mental Health Division of the HSE, is to oversee the implementation, monitoring and evaluation of Connecting Life – Ireland's National Strategy to Reduce Suicide 2015-2020.

Its key functions include:

- central coordination of the implementation of the National Strategy to reduce suicide along with
- implementation of a national training programme on suicide prevention and
- development of standards and guidelines on responding to suicidal behaviour arising within specific target groups and across different settings. These

target groups include those at high risk and most vulnerable to suicidal behaviour.

Therefore, this National Clinical Care Programme is an important contribution to the implementation of the national strategy.

5. National Self-Harm Registry Ireland

5.1 Trends

The National Suicide Research Foundation (www.nsrf.ie) has highlighted the scale of the problem of self-harm in Ireland through the National Self-Harm Registry Ireland (NSHRI) and its annual reports over the past ten years. Between 2002 and 2012 the number of self-harm presentations to Irish hospital Emergency Departments increased significantly from 10,537 to 12,010. (Table 1). 2013 saw a third consecutive decrease in the number of self-harm presentations, 8% lower than that in 2012. The number of persons treated in the ED for self-harm also decreased by 8% in that period. The number of presentations, and the number of persons involved, in 2014 were similar to that recorded in 2013.

Table 1 Number of self-harm presentations and persons who presented in the Republic of Ireland in 2002-2014

Presentations			Persons	
Year	Number	% difference	Number	% difference
2002	10,537	-	8,421	-
2003	11,204	+6%	8,805	+5%
2004	11,092	-1%	8,610	-2%
2005	10,789	-3%	8,594	-<1%
2006	10,688	-1%	8,218	-4%
2007	11,084	+4%	8,598	+5%
2008	11,700	+6%	9,218	+7%
2009	11,966	+2%	9,493	+3%
2010	12,337	+3%	9,887	+4%
2011	12,216	-1%	9,834	-<1%
2012	12,010	-2%	9,483	-<4%
2013	11,061	-8%	8,772	-8%
2014	11,126	+<1%	8,708	<1%

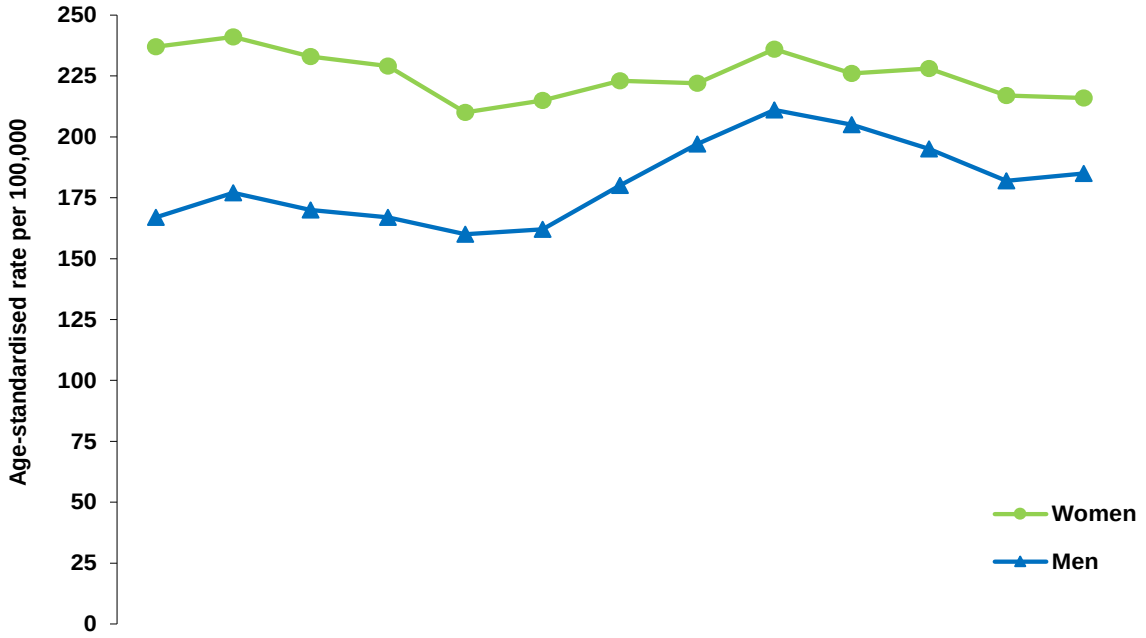
In 2014, the age-standardised rate of self-harm in Ireland was 200 per 100,000 (185 per 100,000 for men and 216 per 100,000 for women). Thus, there was virtually no change in the age-standardised rate of self-harm in 2014 from 2013 (199 per

100,000). This follows three successive decreases between 2011 and 2013. However despite this, the rate in 2012 was still 6% higher than in 2007, the year before the economic recession (Table 2; Figure 1). Rates of self-harm in Irish men have increased by 14% since 2007, with a peak age of presentation in the **20-24 year-old** age group. Rates for Irish women have increased by less than 1% over the same time period, with a peak age of presentation in the **15-19 year-old** age group (Table 2).

Table 2 Person-based European age-standardised rate (EASR) of self-harm in the Republic of Ireland in 2002-2014

	Men		Women		All	
Year	**Rate**	**% Difference**	**Rate**	**% Difference**	**Rate**	**% Difference**
2002	167	-	237	-	202	-
2003	177	+7%	241	+2%	209	+4%
2004	170	-4%	233	-4%	201	-4%
2005	167	-2%	229	-1%	198	-2%
2006	160	-4%	210	-9%	184	-7%
2007	162	+2%	215	+3%	188	+2%
2008	180	+11%	223	+4%	200	+6%
2009	197	+10%	222	-<1%	209	+5%
2010	211	+4%	236	+4%	223	+4%
2011	205	-3%	226	-4%	215	-4%
2012	195	-5%	228	+1%	211	-2%
2013	182	-7%	217	-5%	199	-6%
2014	185	+2%	216	-<1%	200	+1%

Figure 1 Self-harm trends in Ireland (2002-2014)



A slight increasing trend is observed for boys over the period 2003-2014. The number of girls presenting over this period remained relatively stable. However, in recent years, the number of girls presenting has increased, from 313 in 2011 to 458 in 2014. Given the particular challenges of meeting the mental health needs of 16- and 17-year-old patients within the current configuration of the health services and the frequency of presentations after self-harm, it is relevant to consider the data for this age group (Table 3). The numbers of self-harm presentations under the age of 16 by HSE region for the year 2014 are presented in Table 4, showing fairly similar numbers across the regions, with 16- and 17-year-olds represented in Table 5. Figure 2 shows the number of self-harm presentations among boys and girls under the age of 16, showing a significant increase in self-harm presentations in Irish girls in recent years whereas a slight decrease was observed among boys.

Table 3 Self-harm presentations to ED by 16- and 17-year-olds and by gender, 2003 - 2014

Year	Male	Female	Total
2003	151	424	575
2004	185	449	634
2005	175	414	589
2006	185	405	590
2007	214	408	622
2008	201	424	625
2009	269	418	687
2010	227	417	644
2011	242	396	638
2012	211	395	606
2013	211	375	586
2014	240	458	698

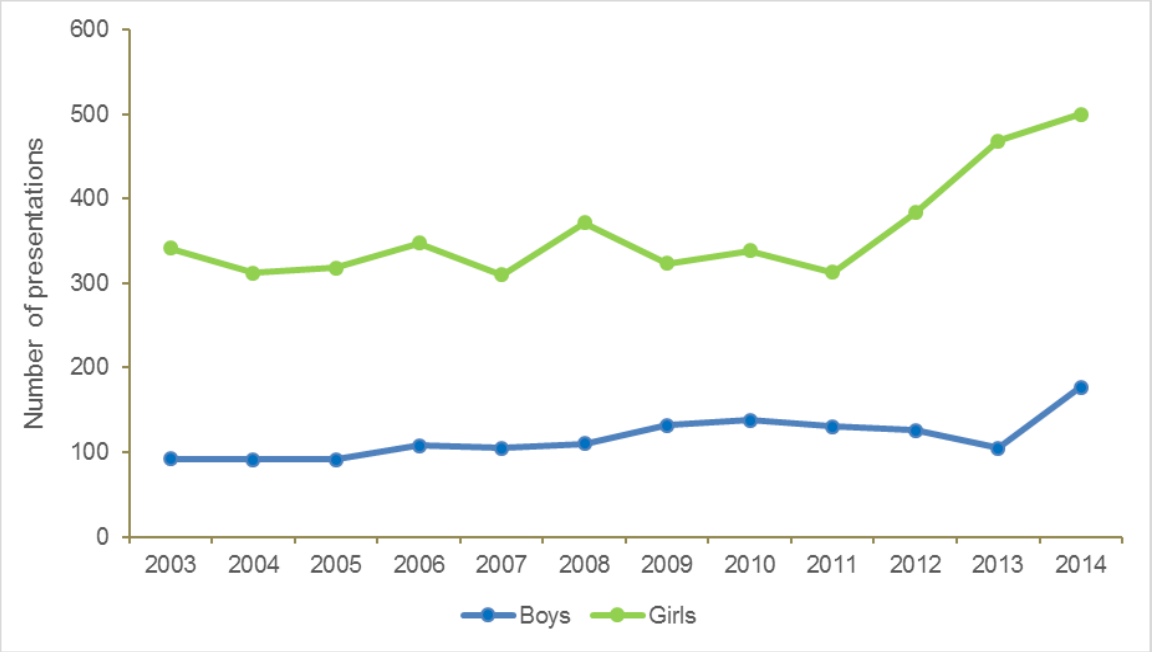
Table 4 Self-harm presentations to ED under the age of 16 by HSE region, 2014

HSE Region	N	% of SH presentations	% Pop
Dublin Mid-Leinster	215	31.8	28.3
Dublin North East	191	28.2	22.6
South	173	25.6	25.4
West	198	14.5	23.6
Total	677	100	100

Table 5 Self-harm presentations to ED by 16 and 17 year-olds by HSE region, 2014

HSE Region	N	%	% Pop
Dublin Mid-Leinster	204	29.2	27.9
Dublin North East	186	26.6	21.6
South	170	24.4	26.1
West	138	19.8	24.4
Total	698	100	100

Figure 2 Self-harm presentations in children and adolescents (under 16 years), 2003-2014



5.1.1 Patients who present with repeated self-harm to ED in Ireland

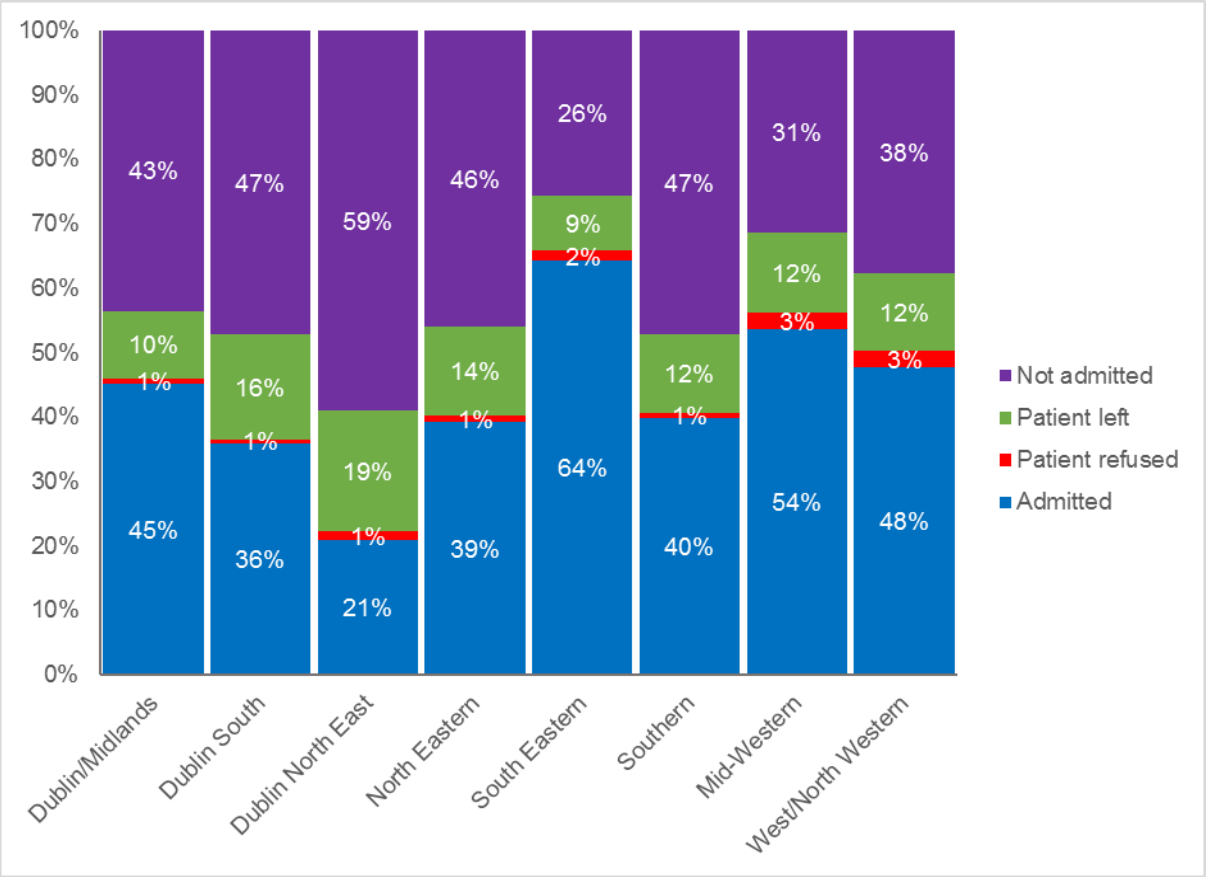
Repeat presentations to hospital due to self-harm behaviour constitute a significant problem. In 2014, 22% of all self-harm presentations were due to repeat acts, a majority occurring within the first three months after initial presentation. Those who present with self-cutting are most likely to present again with further self-harm. At least five self-harm presentations were made by 138 individuals in 2014. They accounted for just 1.6% of all self-harm patients in the year but their presentations represented 9.6% of all self-harm presentations recorded.

A specific focus is required for the subgroup which features frequent self-harm (defined as 5 or more episodes), often in a context of longstanding, maladaptive coping strategies. Improved assessment and management of self-harm is likely to reduce the risk of repeated self-harm and hence reduce the risk of suicide (Gibbons et al, 2012). In addition to being a strong predictor of completed suicide, it is known that frequent self-harm incurs high use of healthcare resources and high health service costs (Sinclair et al, 2011). Specific, proactive care planning for such patients will be an important component of their care.

5.1.2 Current management of patients presenting to ED following self-harm in Ireland

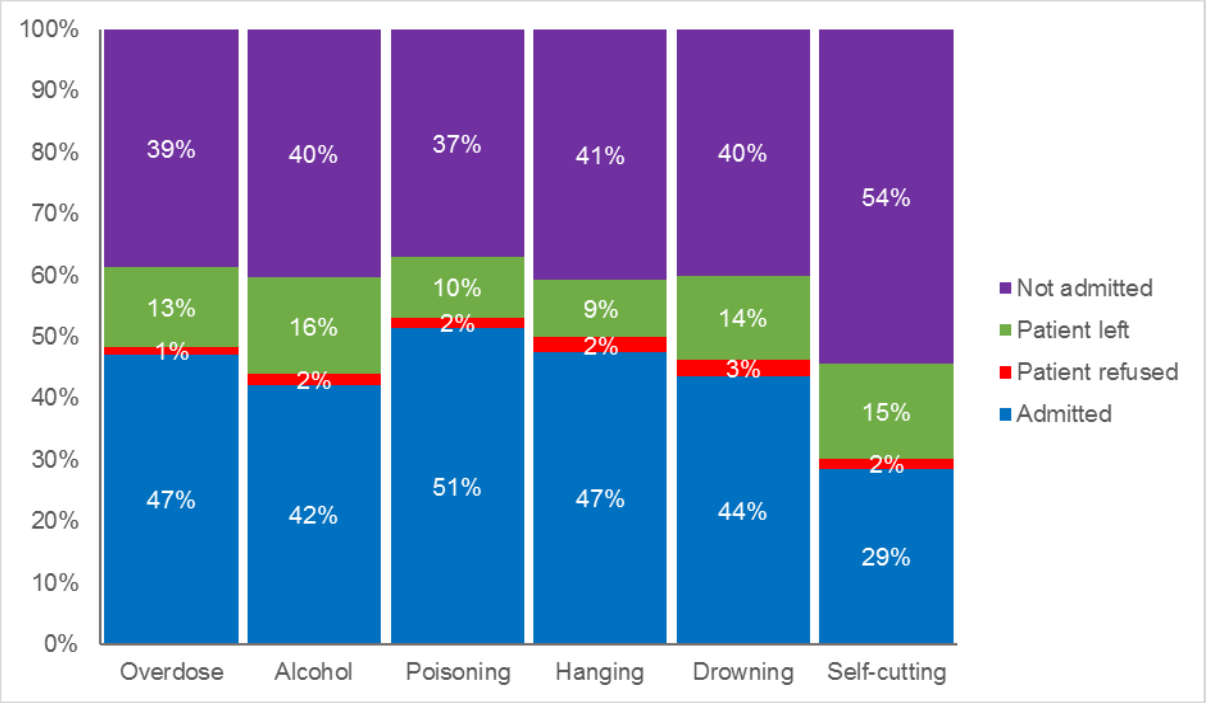
For patients who had presented to ED following self-harm, the Registry data shows that the discharge plan recommended after medical treatment at the ED varied significantly by HSE hospitals group. The rate of admission to a presenting hospital (both acute and psychiatric) following presentation to ED ranged from 21% in Dublin North East to 64% in the South Eastern Hospital Group (Figure 3). Such variation in recommended next care is likely to be due to variation in the availability of resources and services and may also indicate differing assessment and management strategies across the country. A particular concern is the relatively large proportion of patients who had presented following self-harm but left ED without a psychosocial assessment. This varied from 8% in the South East to 19% in the Dublin North East Hospitals Group.

Figure 3: Aftercare of patients presenting to ED following self-harm, by HSE Hospitals Group, average percentages 2004-2013



Comparing recommended care by method of self-harm, a diverse pattern of recommended aftercare emerged, with lower levels of admission among those where method of self-harm was self-cutting or involved alcohol as compared to those with intentional overdose or with higher-lethality methods such as self-poisoning, attempted hanging or drowning (Figure 4).

Figure 4 Aftercare of patients presenting to ED following self-harm, by self-harm method, average percentages 2004-2014



6. National Clinical Care Programme for the Assessment and Management of Patients Presenting to Emergency Departments following Self-harm

During the initial phase of this programme's development, a comprehensive review of the evidence base was carried out by Dr Eugene Cassidy et al (2012). This review included the Guidelines for Self-harm by the National Institute for Clinical Excellence (NICE, 2004 and 2011), the guidelines for assessment and management of patients presenting to ED or to psychiatry inpatient units with a suicide attempt or self-harm produced by the American Association of Suicidology and the Suicide Prevention Resource Centre (2010), and the Report of the Royal College of Psychiatrists on treatment of self-harm and suicide risk (2010). This evidence base review has informed the following recommendations:

6.1 Access

Access to Mental Health Services: Mental Health (MH) Services in the Emergency Department needs to be available and accessible:

Equity of access to quality care is essential: patients with mental health problems (including following self-harm) must have equity in accessing the same level of care as is available to other patients presenting to ED, incorporating a respectful, compassionate response from healthcare workers.

Timely access to care, a Key Performance Indicator of the Emergency Medicine Programme (EMP), must be available at all times for all patients attending ED following a self-harm episode. Adherence to this principle would be expected to reduce the number of patients who leave ED prior to completion of assessment and appropriate management. The number of all ED attendees who leave before completion of care – for all presenting problems, not only for self-harm – varies directly with the overall waiting time for full assessment and thus with ED overcrowding. The longer patients are waiting; the more likely they are to leave.

- 95% of all patients who present (including those with self-harm) should be admitted or discharged with a care plan within 6 hours of presentation, and 100% of all patients who present (including those with self-harm) within 9 hours;

- less than 5% of new patients who present to the ED (including those with self-harm) should leave before completion of treatment (see details in 9.1).

6.1.1 Single point of Contact for Mental Health Assessment

In all catchment areas there should be **a single point of contact** for ED staff to access Mental Health Services for patients which are timely, reliable and across the entire age span. The referral procedure should be a simple one.

6.1.2 Timely, skilled, accessible and responsive

Mental Health staffing resources must be adequate to provide a timely response to referrals from ED, including out-of-hours and weekends when mental health presentations (including self-harm) typically peak. Dedicated mental health staff working within a consultant-led multidisciplinary liaison psychiatry team, should provide working day cover and next day support to out-of-hours service providers (most commonly trainee psychiatrists from the two adult psychiatry specialities: General Adult and Old Age Psychiatry). Stand-alone nursing posts are unsafe and cannot be supported. Clinical Nurse Specialist in self-harm posts must be incorporated within appropriate clinical governance structures within the mental health service structures, ideally within the relevant liaison psychiatry mental health multidisciplinary team. Effective governance structures must be in place in all locations. Mental health staffing should be in accordance with need (assessed by ED activity including numbers of self-harm presentations). The strategic implementation of a nationally-networked approach will be an essential component for this NCP. Resource decisions should be determined from a network perspective in conjunction with the EMP Emergency Care Networks and in keeping with *A Vision for Change* recommendations.

6.1.3 Access to appropriate inpatient care

Each Mental Health Area should have an area-wide mental health bed management policy and procedure for each acute hospital in its Area, including reciprocity of bed sharing between different psychiatry services within the same area. This should include explicit procedures regarding timely access to inpatient care for children as well as adults. Services should have at least the minimum bed complements as

recommended in *A Vision for Change*. This will facilitate timely transfer of patients from ED to inpatient mental health care, when needed. Patients requiring transfer to inpatient mental health care should not normally need to travel across the Mental Health Area boundaries, unless returning from outwith their sector area.

6.1.4 Access to Medical Social Work

It is essential that there is 24/7 access to generic Social Work (SW) services in all Emergency Departments. Professional responsibility of SW services should include but not be restricted to a focus on child care protection issues out-of-hours.

Summary Points – Access

- ***Patients who present to ED following self-harm should be treated with respect and compassion.***
- ***Patients who present to ED following self-harm should be seen in a timely manner, in accordance with nationally approved timeframes by ED staff and by mental health practitioners (usually Clinical Nurse Specialist or psychiatrist). They should be discharged with clear Emergency Care Plans or admitted to a hospital bed within 6 hours.***
- ***Mental Health Practitioner should be skilled in the assessment and management of those presenting with self-harm, for which they should have received specific training.***
- ***A Mental Health Area-wide mental health bed management policy and procedure should be put in place to minimise the patient's waiting time for a bed, and the practitioner's time spent seeking a bed and thus away from direct service activity.***

6.2 Resources and Capacity to respond to specific groups.

Development of linkages with the Emergency Care Networks will allow equitable and appropriate allocation of resources allocated to this programme (HSE NSP 2013) in the most clinically effective and cost-efficient manner.

At a time of great pressure on mental health posts, it is essential that specialist posts are not left empty due to staff redeployment to other areas of the service. Each Mental Health Area must ensure that the NCP is delivered; in addition, priority must be given for arrangements for cover in the event of leave etc.

Further development of multidisciplinary Liaison Psychiatry teams based in acute hospitals and linked to Hospital Care Networks, is currently taking place to support the implementation of this programme.

6.2.1 Special observation/care arrangements

Special arrangements for enhanced observation and care must be immediately available to ensure patient and staff safety if patients are considered to be a risk to themselves or others during triage or at any stage of ED assessment and care. Enhanced observation may involve ‘one to one’ constant observation (‘special’ observation) or close supervision which need not be one to one observation. Enhanced observation may be delivered by suitably qualified staff and may include an enhanced security presence. The level of observation required will be decided as part of the mental health assessment and management plan. Staff who provide enhanced observation/care should have received appropriate training prior to undertaking this role. Clear written policy and procedures in relation to enhanced / special observation and care should be in place.

6.2.2 Adults

International consensus holds that mental health service delivery to acute/emergency medical patients is best provided by a specialist Liaison Psychiatry Team based on-site, where team members are trained in the assessment and management of patients who present to the acute hospital with mental health difficulties, including self-harm (NICE).

Where available, the on-site Liaison Psychiatry team – including Clinical Nurse Specialists in Self-Harm, where appointed - should provide clinical cover during weekdays as part of the service, covering agreed hours for adults (at a minimum 8-4 or 9-5, Mon-Fri). The EMP requires that all patients who present with self-harm should be assessed in Model 4 or 3 hospitals. In less accessible areas of the country, local arrangements between emergency medical and CMHT services may identify specific clinical pathways and governance structures. This NCP supports the development of such local flexibility provided essential national standards and training models are incorporated. Such less accessible areas should be well-linked with the Emergency Networks and associated clinical and managerial structures. Ongoing audit of the ability of these variations to maintain the same standards of care should be conducted.

In all 24/7 EDs, out-of-hours cover should be provided by mental health staff who are appropriately trained in the assessment of patients who present following self-harm and who are available to attend to patients as soon as possible, ideally within a maximum time period of 2 hours (where the person is fit for interview). They must be supported by an easily accessible, named consultant- on-call.

All cases must be discussed with the supervising consultant, with the timing and details of the discussion proportionate to the skills and knowledge of the person carrying out the mental health assessment.

6.2.3 Children up to 18 years

Timely access to Mental Health Services must be available at all times for children attending the ED with a mental health crisis. Each major ED should have defined access to assessment by Child and Adolescent Mental Health Services (CAMHS) through a simple referral procedure. This should be a dedicated Liaison CAMHS supported by the on-call CAMHS. This service should be accessible 24/7 via a single point of contact. The service responsible for assessment of children up to the age of 18 in the ED should be explicit. Consent should be obtained for mental health assessment from the parent or guardian.

Children aged 16 and 17 years who have engaged in self-harm are assessed in an adult ED setting. Those under 16 are assessed in Paediatric Hospital EDs in Dublin.

Of note, the requirement for 24/7 access to emergency generic social work cover is of highest relevance to this age group. It is essential that there should be 24/7 access to Social Work services in all Emergency Departments, including out-of-hours and weekend cover.

6.2.4 Older Persons

Staff with expertise in the assessment and management of older adults with mental health needs should be available as required given that, despite the relatively small number of elderly patients presenting, this age group is known to have the highest associated suicide risk. As older people are at higher risk of completed suicide it is therefore, important to elicit simple, epidemiologically-based risk factors, for example: older men, living alone, single, divorced, widowed or separated, chronic pain, substance misuse, chronic ill-health, any prior history of anxiety /depression, all of which lead to increased risk. Any episode of deliberate self-harm in an older person needs to be taken particularly seriously, with a low threshold for referral to Psychiatry of Old Age CMHTS or admission units, depending on the level of intervention required. Perceived lethality of overdose is an important issue for older people - sometimes just taking one or two extra tablets can constitute a serious suicide attempt if the individual believes that such an amount could kill them. The issue is further complicated by physical comorbidity and drug interactions as older people are frequently prescribed many medications. The elderly, confused person may have taken an unintentional overdose, so good collateral information is very important. Specialist Psychiatry of Old Age (POA) services play an important role in managing these complex cases. There should be clear guidelines in each area regarding access to these services following assessment in ED. During the on call period, POA consultants and NCHDs are an integral part of the on call response which is for adults of all ages.

6.2.5 Homeless patients

Homeless people are particularly vulnerable to physical and mental health problems and are high users of ED services. They have increased rates of alcohol and other substance abuse, higher rates of mental health difficulties and elevated rates of self-harm and suicide. Paradoxically, they are least likely to have access to appropriate mental health services.

In addition to the right to equitable access to mainstream mental health services, homeless persons with mental disorders have a need for Specialist Mental Health Services in urban areas with a higher prevalence of homelessness. In these areas of high prevalence, Specialist Mental Health Services for homeless people are effective in delivering services to an otherwise hard-to-reach population. The development of such services needs to be accelerated. Within Dublin, the Specialist Mental Health Services for homeless people have been aligned as outlined in *A Vision for Change.* This incorporates two collaborative, consultant psychiatrist-led multi-disciplinary teams with assertive outreach and inter-agency capacity. These multi-disciplinary teams should have an appropriate mix and complement of staff, reflective of teams working in this assertive outreach modality following allocation of additional funded posts in 2014. Inpatient care provision, if indicated, is provided by the Approved Centre based in the acute hospital where the homeless person presents. There is a similar service in Cork with an allocation of new funding and posts for staff to be recruited in 2015. Outside Dublin and Cork, a more variable specialist mental health service for homeless people response may be required, with either individual mental health professionals or multi-disciplinary teams necessary, as locally determined (College of Psychiatrists of Ireland, 2011). Again, there should be a clear policy in each area regarding access to this service. All mental health service clinicians working with homeless persons should have appropriate training and consultant psychiatrist supervision including for self-harm. ED clinicians' training in awareness and management of self-harm should include attention to this vulnerable group.

6.2.6 Substance Misuse

At least 50% of self-harm episodes are carried out under the influence of alcohol or illicit substances. Acute intoxication is associated with more violent methods of self-harm and suicide for both men and women, particularly among younger and middle

age groups. In addition, elevated self-harm and suicide rates are found in patients who are dependent on alcohol or other substances (Kaplan, 2013).

ED clinical staff should be trained in the recognition and treatment of substance abuse and in the provision of brief advice and feedback. A flexible approach should be taken in the care of patients with psychiatric co-morbidity who require detoxification. Clinicians in Emergency Medicine, Psychiatry and Acute Medicine should work collaboratively to address relevant needs. The role of harmful drinking patterns contributing to self-harm behaviour should be recognised. There should be a corresponding focus on brief intervention and a low threshold for referral to local alcohol services.

- The bio-psycho-social assessment of all patients who present to ED following self-harm must include a comprehensive assessment of potential misuse of alcohol and other substances.

- All staff carrying out a mental health assessment should have skills in carrying out opportunistic screening and interventions for those at risk. Each ED should have clear policies and pathways for accessing onward referral to relevant local Addiction Services.

The Steering Group Report on a National Substance Misuse Strategy published in Feb 2012 outlines the importance of addressing alcohol-related harm and of the risks associated with perceived national ambivalence toward alcohol. There is an urgent need for progress with the implementation of the recommendations of the group, given the central association between alcohol, self-harm and completed suicide in Ireland.

6.2.7 Acute Behavioural Disturbance/Violence Co-morbid with Self-harm

ED staff, including medical, nursing, security, ambulance and mental health staff, should be trained in the management of acute behavioural disturbance/violence. A national clinical guideline on the management of acute behavioural disturbance is to be developed as part of the Emergency Medicine Programme and available in each ED.

6.2.8 Treatment Refusal

All ED medical and nursing staff must be familiar with the assessment of mental capacity and its application. All patients with mental health needs (including those who present following self-harm) who refuse treatment and/or threaten to leave the ED should have an assessment of capacity by a suitably-experienced doctor. ED staff should be familiar with the principles of treatment under the 'Common Law' as well as the use of the Mental Health Act (2001). When a patient leaves the hospital prior to necessary mental health assessment or medical treatment, a clear procedure should be followed by ED staff in response. Standardised guidance is to be developed as part of the Emergency Medicine Programme, and available in each ED.

6.2.9 Patients who present frequently with Self-harm

A considerable number of patients attend the ED following repeated self-harm. Such patients are vulnerable and may be well known to their local CMHT. They consume considerable ED resources, often while continuing to demonstrate maladaptive coping strategies that cause significant distress to themselves and others. A mechanism to identify such patients who frequently attend should be in place in the ED and patient-specific care plans developed based on assessment of need for each individual. Psychiatry/ED/social work staff should work together to identify and manage these patients and to create agreed care plans which should be available to the CMHT and GPs as well as within the ED.

Summary Points – Resources and Capacity to respond to specific groups.

- ***Each Mental Health Area (MHA) must deliver the NCP and allocate the appropriate resources to ensure implementation on an on-going basis.***
- ***Patients who engage in self-harm should have access to specialist mental health professionals appropriate to their age and needs***
- ***Facilities should provide a level of safety, dignity and comfort for patients and staff***
- ***Clear arrangements for enhanced observation/care, which include all aspects of the patient journey while in ED, must be in place to ensure patient and staff safety.***
- ***Clear guidance must be in place on what to do when a patient leaves before full assessment or care.***
- ***Mental Health Professionals working with patients who present following self-harm must have skills in both assessment and brief interventions for patients with substance misuse problems.***
- ***Patients who are homeless and who present following self-harm are particularly vulnerable and specific protocols are required to ensure that they receive continuity of care.***
- ***Patients who present frequently with self-harm require enhanced coordination and care planning between ED staff and mental health services, including CMHTs.***

6.3 Clinical Pathway from triage to next care appointment (Figure 5)

***This is illustrated in Figure 5 on Page 44**

6.3.1 Triage: Triage on arrival in the ED should include Mental Health Triage:

Mental health triage scales reduce waiting times and reduce the proportion of patients who leave the hospital before being seen (Cooper J et al, 2006). The EMP has developed a Mental Health Decision Tool, based on The Manchester Triage System and the Cork mental health triage system, adapted for patients with mental health needs in the ED. All ED triage systems should incorporate a Mental Health Triage tool.

6.3.2 Mental Health Assessment

All patients who present with self-harm should have a bio-psycho-social assessment by a suitably trained Specialist Nurse or Psychiatrist as early as possible following their presentation. The use of a semi-structured assessment *pro forma* by mental health staff to guide the assessment can be useful.

A **collateral history** is an important part of a mental health assessment and should be obtained as far as is practicable. Information should be sought proactively from the patient's family/ carer / friends wherever possible (see Appendix A). Collateral information is central to accurate diagnosis, assessment of risk and optimal management and discharge planning. Information should be obtained from the patient's GP, CMHT or other appropriate services and all records should be made available and should be accessible to the assessing clinician. Mental health clinicians carrying out ED assessments need to understand all aspects of consent or withholding thereof in the context of speaking to a significant other when an individual has presented with self-harm. Guidance and supervision from the consultant psychiatrist must be available as required including the consultant on call as appropriate.

Standalone risk assessment tools may be incorporated within the assessment process but are **not a substitute** for a comprehensive bio-psycho-social assessment.

Language translation services of suitable quality should be available, where needed, for those who are not fluent in the English language.

An **Emergency Care Plan (ECP)** that addresses short-term and medium-term needs and risks should be formulated and documented. The patient, and wherever possible their carer/next-of-kin, should be involved in the determination of this.

All patients who present to ED following self-harm should have a skilled, semi-structured bio-psycho-social assessment of needs and risk by a suitably trained mental health professional prior to discharge from ED. It is recommended that this assessment is provided by an on-site nurse specialist or psychiatrist with immediately accessible consultant psychiatrist advice available as required. The mental health professionals are members of the consultant led Liaison Mental Health Team.

The bio-psycho-social assessment and initial management plan should include:

- Assessment of needs and risk, including collateral information.
- An ECP with clear, written information on how to access services, including specific contact details and telephone numbers of next step care e.g. clinic, day service and named mental health team clinician, in particular for out-of-hours presentations. The family member/carer/ significant other should be involved in this. The patient and the significant other should be advised on what to do should a further crisis occur.
- Referral to the relevant services
- On-going involvement to bridge/link patient with the relevant service as necessary

6.3.3 Involvement of family/ significant other in the patient's care pathway:

Family members/carers accompanying the patient should be included in the development of a care plan. A collateral history is an important contributor to care plan formulation. Their experience, particularly in providing follow-up support, can be crucial in trying to support those who present to ED following self-harm. Those who present following serious or repeated self-harm, or who present with other risk factors such as suicidal intent, should be actively supported to nominate a family member/carer who will be advised on suicide prevention care before the patient is discharged (Appendix A).

In rare but particularly high-risk situations it is important to balance the primacy of the patient's right to confidentiality with the rare but occasional need to over-ride this confidentiality and involve the significant other in discussions in the care plan. Such decisions should be discussed with the supervising consultant. Training in relation to the balance between duty of confidentiality and duty of care must be incorporated within the training programme. Careful documentation which adheres to quality standards is essential.

6.3.4 Clinical Decision-Making /Discharge Planning/Assertive Follow-up

Patients and carers, wherever possible, should be given a copy of their Emergency Care Plan along with other relevant written information, including contact numbers for telephone support and crisis services. Solution-focused interventions should be used at the outset to identify and prioritise needs. Patients should be referred to the relevant service for the management of specific identified needs (e.g, financial stress: Monetary Advice and Budgeting Service (MABS), drug and alcohol services; relationship counselling service, individual counselling).

It should be a matter of routine that all cases seen 'out of hours' by both the specialist nurse and on-call psychiatrist in training should be discussed with the nominated/relevant consultant psychiatrist according to local policy.

- Where clinically appropriate, patients discharged from ED following a presentation with self-harm, including those seen out of hours should be offered a telephone call within 24 hours from a Specialist Nurse (Registered Psychiatric Nurse) to offer support and discuss their care plan further.

- If indicated, they will be offered a brief follow-up support, usually to a maximum of **3 contacts**, with the aim of facilitating engagement with relevant services to address their needs.

- Where appropriate, patients should be offered referral to local mental health services with a decision taken at the time of assessment whether the referral is to inpatient psychiatric care, or to an urgent (within 1 day), early (within 1 week) or routine outpatient, day service or domiciliary appointment.

- Assertive follow-up care should be offered to encourage recommended attendance at the follow-up care facility in a timely fashion. In most cases simple techniques such as follow-up telephone calls are sufficient to achieve this purpose.

- The Specialist Nurse (CNS) will liaise with GP and /or CMHT to ensure adequate follow up is in place prior to closing the case.

- Handover: Patients assessed by NCHD out of hours should be recorded and a handover of patients for follow up, including a phone call within 24 hours provided to the CNS. A clear local policy and procedure should be developed for this handover.

Written information such as crisis cards and information leaflets should be offered to all patients and /or carers. This information should be tailored to the individual circumstances and locally available services e.g. information on financial and bereavement supports as well as how to access emergency mental health care in the event of deterioration in mental state. Details of how to contact carer groups/ Samaritans should be provided routinely. Appropriate cards and leaflets should be available in paper and electronic format to ensure rapid accessibility.

6.3.5 Voluntary Counselling Agencies

Clear and appropriate accreditation processes for voluntary agencies are required to allow the mental health practitioner to refer safely to relevant services, including those that specialise in providing services for patients experiencing suicidal crisis

and / or self-harm. There are currently an estimated 300 voluntary agencies in Ireland working in the area of self-harm.

Rationalisation and appropriate regulation in this area by NOSP, HSE or other suitable agencies will be an important step in ensuring rapid access to proper quality care from those voluntary agencies providing this easily-accessible essential service. Any such accreditation process would need to support rapid access to mental health care services for those patients who become acutely unwell whilst attending the voluntary service.

6.3.6 Communication and Information Sharing

Mental Health Services will participate in care planning in relation to patients in ED following self-harm. With the patient's agreement, this will usually involve telephone or direct contact with the follow-up agency and with the family/carer. If on occasion a person who has engaged in self-harm is judged to be at continuing serious risk and is reluctant to allow contact with family or other carers, then the responsible consultant psychiatrist e.g. the on-call consultant out-of-hours and by day the liaison consultant (where none the locally-agreed responsible consultant) will be contacted to determine a treatment plan that will assess and manage risk, bearing in mind the patient's best interest.

A semi-structured Mental Health Discharge Summary will be completed before discharge or transfer. This summary, including the Emergency Care Plan, will be sent by an agreed mechanism within 24 hours to the patient's GP and to other HSE follow-up services. A copy of the discharge summary will be retained in the healthcare record.

Where it is agreed and relevant (likely in most cases), the patient and family/carer(s) will be given a copy of the Emergency Care Plan along with relevant written information e.g. on alcohol, bereavement, management of suicide risk strategies and incorporating crisis contact details.

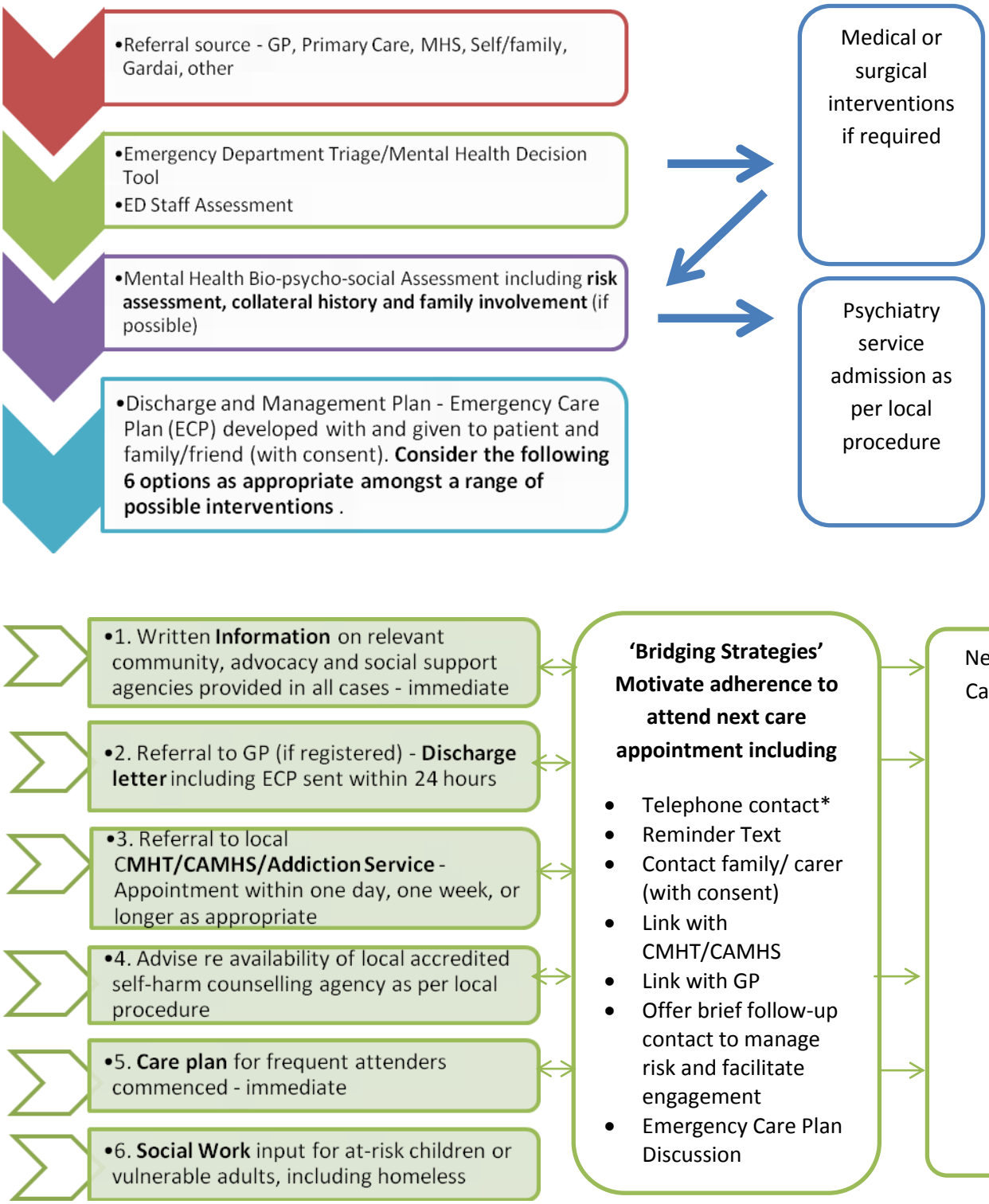
Rapid sharing of clinical information is integral to patient care in emergency settings. Communications need to be directed to all relevant professional agencies involved in that patient's care. Information and Communication Technology (ICT) systems that support effective two-way communication with Primary Care and MH services are

essential for emergency mental health assessment in ED and for timely follow-up following discharge. Sharing of appropriate data across community, CMHT and hospital interfaces should be considered with due consideration of data protection issues. IT developments in Mental Health and ED settings are a priority, given the level of risk associated with current deficits in ICT structures and systems.

Where full electronic patient records are developed, the documentation of psychiatry presentations should be considered in the patient record and designed to allow for narrative aspects of psychiatry assessment.

Future ED discharge diagnostic coding will include coding for diagnoses in mental health and should support clinical audit of self-harm presentations. Additional information including length of stay in ED, already being gathered as part of the EMP, will allow additional data collection. Potential barriers to equity of care pathways for patients with mental health difficulties in the ED compared to those with no mental health problems may be investigated as one example. The care pathway for patients who present to ED following self-harm is outlined in Figure 5 below.

Figure 5: Emergency Department Care Pathway for Management of Patients who Present following Self-Harm:



Summary Points – Care Pathway

- ***ED triage staff responsible for triage must consider mental as well as physical health issues when planning treatment.***
- ***All patients who present to ED following self-harm should have a skilled semi-structured biopsychosocial assessment of the need and risk by a suitably trained Mental Health Practitioner prior to discharge from Emergency Department.***
- ***A named consultant psychiatrist should be identified for all stages of the patient's care until discharge from secondary care service.***
- ***An Emergency Care Plan should be developed with the patient and family/carer members (with consent).***
- ***Patients should be actively supported to nominate a family member/carer who can be advised on suicide prevention care before the patient is discharged.***
- ***Information (various media) should be available for patients and family/carers appropriate to age and needs.***
- ***A discharge summary sheet including the assessment should be sent to the GP and other relevant agencies within 24 hours. A copy must be retained with patient's medical notes.***
- ***Policies and procedures to manage vulnerable groups should be developed.***
- ***Language translator services should be available where needed for those who are not fluent in the English language.***
- ***A system for accrediting any voluntary counselling agency which provides services for patients experiencing suicidal crisis and / or self-harm should be established nationally.***

7. Service Planning and Organisation

7.1 Patient Location and Mental Health Assessment:

The patients' pathway through the emergency medical services should ensure that referral to and assessment by mental health staff is prompt for all self-harm presentations independent of location; and that, at all stages, proper quality standards are met for documentation and for governance as per agreed policy. It is imperative that whatever site patients are seen is an appropriate and safe environment.

In an acute hospital ED, patients who present with self-harm will usually be medically assessed and managed in the ED. Patients who may require assessment in other clinical areas include those requiring transfer from ED Resuscitation area to ICU; patients requiring surgical intervention (typically general, cardiothoracic, plastics); patients requiring specialist medical care (e.g. liver function tests following paracetamol poisoning). These patients must be assessed for the self-harm episode when medically fit.

Facilities must be available in ED for the safe and therapeutic assessment of patients as per College of Psychiatrists of Ireland required standards (Appendix B).

Where there is no ED on-site, self-harm should only be managed in an Acute Medical Unit (AMU/MAU/AMAU) if admission criteria are met and there is on-site psychiatry available. If there is no psychiatry service available on-site, patients with self-harm should be transferred to the appropriate acute hospital where this service can be provided. In some areas, for example remote areas (Bantry Hospital) or areas with low numbers of patients presenting following self-harm, locally-agreed management plans may centre on GP and CMHT services to optimise resource management and speedy access to appropriate care. The same standards of assessment and documentation by appropriately trained personnel should apply in these arrangements together with a clear governance system. They should be linked to specialist guidance via the Emergency Care Networks.

A significant challenge to the optimal care of patients with mental health needs in ED is the lack of co-terminosity between Mental Health Areas and acute hospital services as outline in the AMP and the EMP Emergency Care Networks. Ideally

these should be the same but the clear pathway described in this CP should overcome this difficulty.

Ambulance personnel and Hospital Navigation Hub Case Managers should know acute hospitals with on-site Psychiatry services, by day and out-of-hours, to facilitate appropriate streaming of patients with emergency mental health needs.

7.2 Policies and Procedures:

A range of Policies and Procedures should be developed and brought into operation in ED to support clinical operations. These will be individualised to the Model of Hospital / ED and the level of availability of mental health services. Guidelines on the following, supported by appropriate training for emergency staff, should be in place in ED:

- mental health triage/brief risk and needs assessment
- management of acute behavioural disturbance,
- management of self-harm
- management of frequent attendees
- brief intervention for alcohol problems
- assessment of capacity and competence
- the use of the Common Law and the Mental Health Act

Policies and Procedures on the following should be in place in the ED:

- Referral to Psychiatry
- Enhanced / Special Observation/Care
- Management of Challenging Behaviour
- Assessment of patients transferred to ICU/hospital wards
- Transfer of Patients to an Acute Mental Health Unit
- Handover of Care between daytime and on-call Psychiatry
- Patients who leave prior to being assessed/before completion of treatment

- Care planning
- Involvement of families/carers
- Provision of Information
- Referral to external agencies
- Support and clinical supervision for staff.

The Liaison Psychiatry service should be mandated by the Mental Health Area Management Team within the acute hospital to take a lead role in the development of these guidelines, policies and training in collaboration with the Emergency Department team with a sharing of relevant policies for local application via the networks. These guidelines, policies and procedures should take into account the specific needs of patients following self-harm including the needs of children and older adults. All such policies, guidelines and procedures must be formally approved by both the Mental Health Area and Acute Hospitals Management Teams.

7.3 Governance and Clinical Nurse Specialists

Professional Reporting Relationship

The professional reporting relationship is to the HSE Area Director of Mental Health Nursing via the Assistant Director of Nursing (ADON).

Clinical Reporting Relationship

There are three variants of governance arrangements as outlined below all of which are based on the principle of the nurse reporting on clinical matters to a named consultant psychiatrist.

- ***HSE Hospital with Liaison Service***. The Self-Harm nurse is a member of the Liaison Psychiatric Team and reports on clinical matters to the consultant psychiatrist in that team.
- ***Non HSE Hospital where the liaison consultant is employed by that hospital.*** The nurse is a part of the Liaison Psychiatry Team and reports on all clinical matters to the liaison consultant in that team. In this situation there must be close working relationships between the Area DON Mental Health

and the DON of the acute hospital to ensure a smooth professional working relationship for that nurse.

- ***Acute Hospital with no Liaison Service.*** There must be a named HSE consultant in the Mental Health Area to whom the nurse reports and provides supportive supervision on clinical matters. The nurse is a member of that consultant's MDT.

The variant in any particular hospital must be stated in the Local Operational Policies & Guidelines for each nurse.

Summary Points –Service planning and organisation

- ***Facilities should be available in ED for the safe and therapeutic assessment of patients.***
- ***Joint and approved protocols should be agreed across hospital sites that treat people who present to ED following self-harm***
- ***Staff from ED, medicine and psychiatry should work together to implement this NCP***
- ***Services should establish an agreed model of working between the mental health services and ED for the provision of services to treat people who engage in self-harm. The planning of services should include all parties, including service users and carers.***

8. Training and Education

The UK National Institute of Health and Clinical Excellence (NICE, 2004) has recommended that 'clinical and non-clinical staff who have contact with people who self-harm should be provided with appropriate training to equip them to understand and care for people who self-harm'. In Ireland, *Reach Out* (the National strategy for Action on Suicide Prevention 2005-2014, Health Service Executive, 2005) recommends the planning and delivery of basic awareness training for all levels of hospital staff on suicidal behaviour and the need to 'develop and deliver specialist intervention, skills-based training for the appropriate staff as part of a national training programme'.

There is a need for two broadly defined training programmes:

1. **Mental Health Staff:**

   Training is mandatory for all **Clinical Nurse Specialists and Psychiatrists** who are carrying out bio-psycho-social assessments of risk and needs and are generating emergency care plans for patients who present to the ED following self-harm. The techniques and skills that are used during a comprehensive suicide risk and needs assessment are both time consuming and exacting hence the requirement for specialised training.

   This training programme will:

   - Define a nationally recognised set of minimum essential skills and core competencies necessary for suicide risk assessment and management.
   - Find the best means for most efficiently and effectively teaching and disseminating the nationally recognised set of minimum essential skills and competencies.
   - Develop a nationally recognised system to certify that health professionals have mastered the minimum essential skills and competencies.
   - Incorporate explicit guidance about procedures relevant to specific situations e.g. patients that deny intent or risk.

- Include as an essential component joint teaching between psychiatry and nursing. Should in the future any health and social care professionals be involved in front-line, emergency, bio-psych-social assessment of patients who attend at ED after self-harm such joint teaching will also apply.

- Include on-going clinical supervision by the Consultant Liaison Psychiatrist in order to enhance training and provide continual professional development.

The training described in this NCP relates equally to Clinical Nurse Specialists in Self-harm and Liaison Psychiatry and to psychiatry NCHDs, and joint training is recommended. While there is an emphasis on the specialist nurse providing the linkage service for individual patients, for example continuity of ED support and training, planning care of frequent attendees etc, these staff will also become an important source of education and support to the NCHD through all stages of their training. This NCP will also enhance the skills and knowledge of NCHDs thereby ensuring the provision of skilled comprehensive risk and needs assessment of all patients who present to ED with self-harm.

The training required by this NCP should complement the individual and College-based training schemes that include risk assessment and management of self-harm as core skills of psychiatry practice.

All staff who are responsible for carrying out a bio-psycho-social assessment of patients who have presented to ED following self-harm must receive relevant training before having unsupervised clinical responsibility for the patient's management plan.

2. ED Staff:

A second training programme is required for ED staff who have contact with patients in the ED (i.e. medical and nursing staff, including Triage Nurses) such staff should be provided with basic training on dealing with patients with mental health needs. Ambulance staff and security staff should also receive mental health awareness training tailored to their needs.

Specific areas of training should include:

- mental health triage/brief risk & needs assessment
- management of acute behavioural disturbance
- management of self-harm
- management of frequent attenders
- brief intervention for alcohol problems
- the use of Common Law and the Mental Health Act

The Clinical Nurse Specialist in liaison psychiatry and in self-harm will have a lead role in providing this training with the support of the Liaison Psychiatry MDT. (Arensman et al, 2014).

8.1 Clinical Supervision

Clinical supervision is a formal process of professional support to enhance learning, development and reflection. It will provide professional support to the clinician, allow reflection on the management of referrals/presentations and develop knowledge and competence to assume responsibility for clinical practice. This support will contribute to achieving personal, professional and organisational objectives. It is an essential component of ensuring not only good patient care but also personal self-care and team support in order to maintain optimal function and team working in a challenging clinical area.

Summary Points – Training and Education

- ***All ED staff who have contact with people present following self-harm must have access to a basic training and education programme on a regular basis.***
- ***Mental Health staff working with patients who present following self-harm must have advanced training in the management of self-harm.***
- ***All staff should have access to appropriate advice, regular clinical supervision and support***

9. Monitoring and Evaluation

On-going audit will be pivotal in monitoring the implementation of the NCP. The CNS in self-harm will have a lead role in coordinating data collection by which the programme outcomes will be monitored and evaluated using a range of indices including those outlined below.

9.1 National metrics

The Mental Health Division now collects monthly data on referral/discharge activity in each Community Mental Health Team. For each National Clinical Programme in Mental Health, specific data will be collected on a monthly basis by this process.

The following metrics will be collected in Year 1 and developed over time. The metrics will be collected locally and collated nationally. In addition KPIs will be collated and cross referenced with the Emergency Medicine Programme.

National Metric – ED Mental Health Staff	**Frequency of collection by ED MH staff**	**Frequency of collation by National Programme**
95% of all patients who present with self-harm to wait < 6 hours before discharge or admission (duration measured from time fit for mental state assessment).	Daily	Monthly
100% of all patients who present with self-harm to wait <9 hours before discharge or admission (duration measured from time fit for mental state assessment).	Daily	Monthly
Where 10% or greater leave ED before assessment, reduce to >10%. Where >10% leave, reduce to >5%.	Daily	Monthly

100% of new mental health staff assessing patients who present with self-harm to have received accredited training	Quarterly	Quarterly
95 % of GPs with whom a patient is registered will receive a discharge letter within 24 hours	Quarterly	Twice yearly

9.2 National Self-Harm Registry Ireland

As previously noted, the NSRF has been collecting national data on every episode of self-harm presenting to Irish Emergency Departments for more than a decade. Along with national implementation of the guidelines for assessment and management of self-harm patients presenting to ED, changes in levels of repeated self-harm can be monitored using the data from the National Self-Harm Registry Ireland as well as through the Mental Health Divisions data system. Development of links between the NCP and the Registry in each ED would allow each to optimise data collection and utilise the data to support local strategic developments.

9.3 Service user evaluation and outcomes

Implementing this Programme aims to improve the level of satisfaction with health service experiences among people who seek assistance in ED following a self-harm incident. In addition, it is expected to increase the level of satisfaction with services as reported by significant family/carers. This will be achieved through improved access to clinicians specifically trained to provide evidence-based treatment in a recovery-orientated fashion, actively including family members within the process. Furthermore, there is an expectation of a reduction in delays to assessment and the introduction of a bridging/link to next care appointment which will require analysis.

Summary Points – Monitoring and Evaluation

- ***Services must record and report on the agreed metrics for this NCP. This will be done through the Mental Health Division data collection system.***
- ***Local links must be developed within ED to optimise data collection.***
- ***Each Mental Health Area/Liaison Psychiatry Service should have a written plan to measure the experience of service by patients and family members***

Appendix A: Family/Carer Involvement

Actively support patient in nominating a family member/friend for ED staff to liaise with.

The experience of families and carers can be crucial in trying to support those who present with self-harm. Patients, following serious or repeated self-harm or with other risk factors such as suicidal intent, should be supported to nominate a family member/carer who will be involved in the development of the Emergency Care Plan and advised on suicide prevention care before the patient is discharged.

Consider the option of speaking to the nominated family/carer separately and/or together with the patient as appropriate. Provide them with information regarding suicide and strategies to reduce risk. Most families are unfamiliar with the risks of repeated self-harm, suicidal ideation and immediate risks of suicide in the aftermath of self-harm

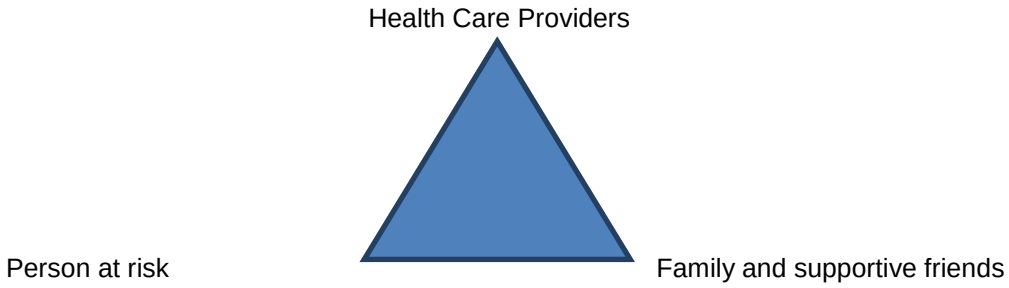
Ensure that they are provided with emergency contact numbers before leaving ED.

Three important steps have been described regarding carer involvement in ***Once, Twice, Three times (Ms. Siobhan O'Carroll 2012):***

Once a person presents with suicidal thoughts, suicidal ideation or suicidal tendencies the response must be swift and follow nationally agreed policies and procedures.

Twice – two parties should be involved (if possible): the suicidal person and a nominated family member or supportive friend.

Three times – a triangle of care and support for the person, the "triangle of dependency" includes,



ONCE, TWICE, THREE TIMES – STOP

Appendix B: Assessment Room

One of the difficulties liaison teams face when working in acute hospitals is having a dedicated high risk assessment room in which to assess patients.

The standard set out in Psychiatric Liaison Accreditation Network (PLAN) is ‘Can the liaison team access facilities and equipment for conducting high risk assessments’? PLAN requires the following. The assessment room must be:

a. located within the main Emergency Department
b. Have at least one door which opens outwards and is not lockable from the inside
c. Have an observation panel or window which allows staff from outside the room to check on the patient or staff member. A common and effective approach is to use windows with built in adjustable blinds, which allow partial viewing of the room and the option for staff to view the room fully if a situation requires it, whilst offering a degree of patient privacy. Another approach is to use obscured glass to provide privacy, in which case a small section of this must be clear so that staff can still look in if needed.
d. Have a panic button or alarm system (unless staff carry alarms at all times)
e. Only include furniture, fittings and equipment which are unlikely to be used to cause harm or injury to the patient or staff member. For example, sinks, sharp-edged furniture, lightweight chairs, tables, cables, televisions or anything else that could be used to cause harm or as a missile are not permitted.
f. Not have any ligature points.

Note: Whilst not mandatory for accreditation, PLAN highly recommends that assessment facilities should have with two doors to provide additional security.

All new assessment rooms must be designed with two doors.

Appendix C: Members of Sub Group

Dr Siobhan Mac Hale (Chair)	College of Psychiatrists of Ireland
Dr. Ella Arensman	National Suicide and Research Foundation
Ms. Mary Begley	Mental Health Nurse Managers of Ireland
Dr. Justin Brophy	Executive Clinical Directors Group
Dr. Eugene Cassidy	College of Psychiatrists of Ireland
Dr. Eleanor Corcoran	College of Psychiatrists of Ireland
Dr. Helen Keeley	College of Psychiatrists of Ireland
Dr. Mairi Keenleyside	Heads of Psychology of Ireland
Ms. Susan Kenny *	National Office for Suicide Prevention
Mr. Steve Lamb	Mental Health Nurse Managers of Ireland
Ms. Miriam Noonan	Association of Occupational Therapy of Ireland
Ms. Siobhan O'Carroll	Carer
Ms. Cindy O'Connor **	Pieta House
Ms. Elizabeth O'Donovan	National Service Users Executive
Ms. Kathleen Quinlan	Irish Association of Social Workers
Dr. Julie Anne Reidy,	College of Psychiatrists of Ireland

*replaced Ms. Catherine Brogan

** replaced Ms. Joan Freeman

Reviewed by ICGP Mental Health Co - Lead: Dr. Brid Hollywood

Reviewed by: Dr. Una Geary, Emergency Medicine Clinical Lead.

References

Alcohol Beverage Federation of Ireland. (2012) The National Substance Misuse Strategy. Minority report by the Alcohol Beverage Federation of Ireland. Alcohol Beverage Federation of Ireland, Dublin.

Arensman E, Wall A, McAuliffe C, Corcoran P, Williamson E, McCarthy J, Duggan A, Perry IJ (2013). *Second Report of the Suicide Support and Information System.* National Suicide Research Foundation, Cork, Ireland.

Bergen, H, Hawton, K, Waters, K, Ness, J, Cooper, J, Steeg, S, Kapur, N (2012). Premature death after self-harm: a multicentre cohort study. *The Lancet,* 380(9583), 1568-1574.

Bergen H, Hawton K, Waters K, Cooper J, Kapur N. Pscyhosocial assessment and repetition of self-harm: the significance of single and multiple repeat episode analyses. J Affect Disord. 2010 Dec; 127(1-3): 257-265. Epub 2010 Jun1.

Broadbent M, Creaton A, Moxham L, Dwyer T. Review of triage reform: the case for national consensus on a single triage scale for clients with a mental illness in Australian emergency departments. J Clin Nurs. 2010 Mar; 19 (5-6): 712-5.

Carroll, R, Metcalfe, C, Gunnell, D (2014). Hospital Presenting Self-Harm and Risk of Fatal and Non-Fatal Repetition: Systematic Review and Meta-Analysis. *PLOSOne,* 9(2), e89944.

Cassidy E, Arensman E, S Keeley H, Reidy J. Saving lives and reducing harmful outcomes: care systems for self-harm and suicidal behaviour, March 2012.

Cooper J, Kapur N, Dunning J, Guthrie E, Appleby L, Mackway-Jones K. A clinical tool for assessing risk after self-harm. Ann Emerg Med. 2006 Oct; 48(4):459-466.

Department of Health and Children: A Vision for Change, Report of the Expert Group on Mental Health Policy, 2006.

Gibbons P, Lee A, Parkes, J, Meaney, E. Value for Money: A Comparison of Cost and Quality in Two Models of Adult Mental Health Service Provision. Health Service Executive, Feb 2012.

Griffin E, Arensman E, Corcoran P, Dillon, CB, Williamson E, Perry IJ. (2015). 2014 Annual Report of the National Self-Harm Registry Ireland. National Suicide Research Foundation, Cork, Ireland.

Department of Health and Children. Connecting for Life. Ireland's National Strategy to Reduce Suicide 2015-2020.

Health Service Executive. Report of the National Acute Medicine Programme. 2010.

Health Service Executive National Service Plan 2013. Health Service Executive, Dublin 8.

Kaplan M, McFarland B, Huguet N, Conner K, Caetano R, Giesbrecht N, Nolte K. Acute alcohol intoxication and suicide: a gender-stratified analysis of the National Violent Death Reporting System *Inj Prev* 2013;19:38-43.

Knesper DJ. American Association of Suicidology, & Suicide Prevention Resource Center. Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit. Newton, MA: Education Development Center, Inc; 2010.

Lamb S, Arensman E. 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. Health Service Executive, National Suicide Research Foundation. Cork, Ireland; 2006.

Larkin C, DiBlasi Z, Arensman E (2014). Risk factors for repetition of self-harm: A systematic review of hospital-based studies, *PLOSOne,* 9(1), e84282.

Murphy E, Kapur N, Webb R, Cooper J. (2010). Risk assessment following self-harm: comparison of mental health nurses and psychiatrists. *Journal of Advanced Nursing* **67**(1), 127–139.

National Institute for Clinical Excellence. The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. Clinical Guideline 16. London: NICE; 2004.

O'Carroll, Ms Siobhan. Once, twice, three times: 2012. Unpublished.

Owens D, Horrocks J, House A. Fatal and non-fatal repetition of self-harm. Systematic review. British Journal of Psychiatry. 2002; 181, 193-199.

Parsonage, Michael, and Matt Fossey. *Economic evaluation of a liaison psychiatry service*. London: Centre for Mental Health, 2011

Royal College of Psychiatrists. Self-harm, Suicide and Risk: Helping People who Self-harm (Council Report 158). London: Royal College of Psychiatrists; 2010.

Royal College of Psychiatrists. Psychiatric Liaison Accreditation Network, PLAN Standards, 4th Edition 2014

Sinclair JM, Gray A, Rivero-Arias O, Saunders KE, Hawton K. Healthcare and social services resource use and costs of self-harm patients. Soc Psychiatry Epidemiol. 2011 Apr; 46(4): 263-271. Epub 2010 Feb21.

Tadros G, Salama RA, Kingston P, et al. Impact of an integrated rapid response psychiatric liaison team on quality improvement and cost savings: the Birmingham RAID model. Psychiatrist. 2013;37:4–10

The College of Psychiatrists of Ireland, Specialist Mental Health Services for Homeless People, Position Paper EAP02/2011.

2011 Annual Report of the National Registry of Deliberate Self-harm. National Suicide Research Foundation. Cork, Ireland; 2012.


Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive