01

Rationale, Vision and Objectives

1.1 Rationale

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

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

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

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

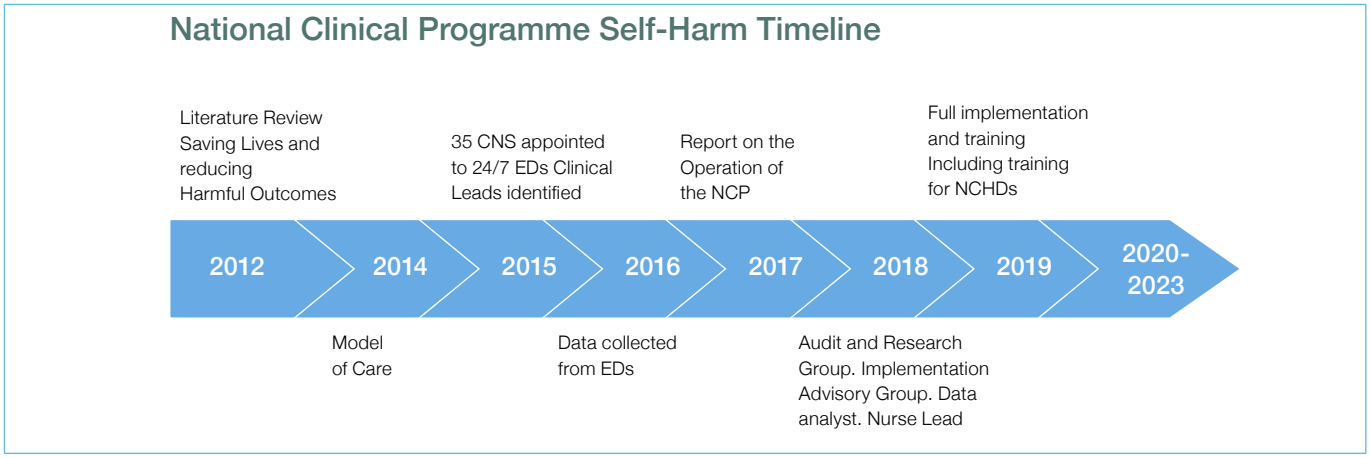

FIG. 1.1 DEVELOPMENTS IN THE CLINICAL PROGRAMME 2012–2021

1.2 Overview

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

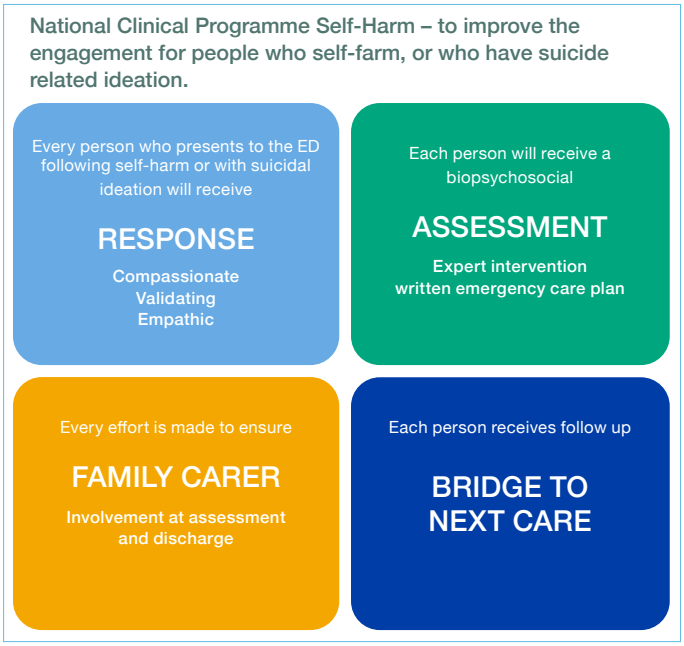

FIG. 1.2 CLINICAL COMPONENTS OF THE NCPSH

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

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

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

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

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

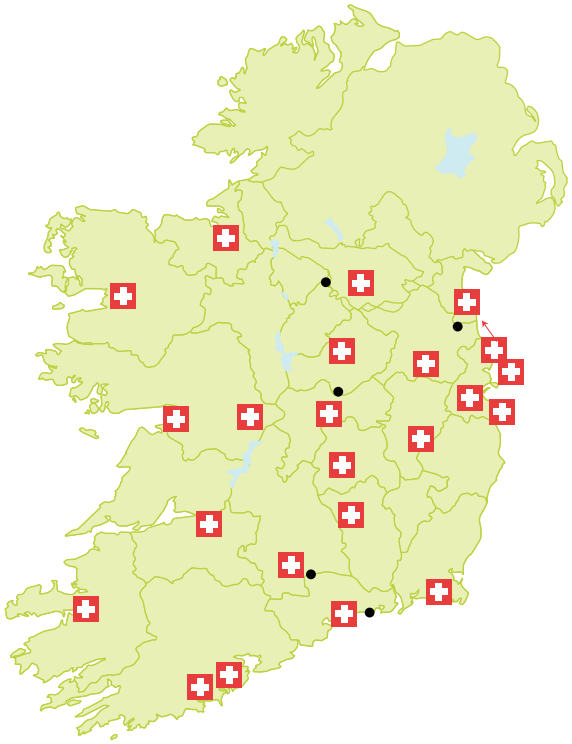

FIG. 1.3 DISTRIBUTION OF EDS THAT HAVE IMPLEMENTED THE NCPSH

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.3 Mission, Vision, Core Values and Principles

1.3.1 Vision of the Clinical Programme

The vision of the NCPSH is:

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

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

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

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

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

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

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

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

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

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

1.3.3 Sláintecare

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

1.3.4 Sharing the Vision

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

1.3.5 Programme objectives

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

1.3.6 Programme remit

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

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

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