

02

Literature Review

2.1 Introduction

A review of the evidence base was carried out in 2012 (Cassidy et al 2012) to support the development of the NCPSH MOC. The 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 chapter reviews the literature since 2012. The review focuses on key documents and articles in relation to the assessment and support of self-harm and suicide-related ideation. It is informed by the work of the NCPSH Implementation Advisory Group and the NCPSH Research and Audit Group, by discussions with clinicians who are implementing the programme and clinicians who work with people presenting with self-harm and suicide-related ideation. The findings from this literature review and from discussion with clinicians have provided the evidence for the changes recommended in this update. Further focused literature evidence is provided in later chapters on specific areas of care.

Since 2012, recommendations for assessing and managing patients presenting to the Emergency Department (ED) following self-harm have further supported the use of dedicated staff to provide assessment and interventions as outlined in the MOC. Kapur (2015) has demonstrated the value of a comprehensive psychosocial assessment for those who present to the ED following self-harm. In November 2016 NICE published comprehensive evidence-based guidance on urgent and emergency mental health care (NICE 2016). This guidance recommends that, within four hours of arriving in an ED or being referred from a ward, a person should have received a full biopsychosocial assessment and have an emergency and urgent care plan in place, at a minimum be on route to their next location if geographically different, or have been accepted and scheduled for follow-up care by a responding service, or have been discharged because the crisis has been resolved, or have started a mental health assessment. This builds on the recommendations in the Five-Year Forward View for Mental Health: expanding both Crisis Resolution and Home Care Treatment Teams, and providing core liaison service teams for all acute hospitals (NHS 2016a).

Suicide is a major public health problem. In Ireland in 2016, there were 437 deaths by suicide, a rate of 9.2 per 100,000. Figure 2.1 shows that the rate has been reducing since 2012 (CSO Statistics).

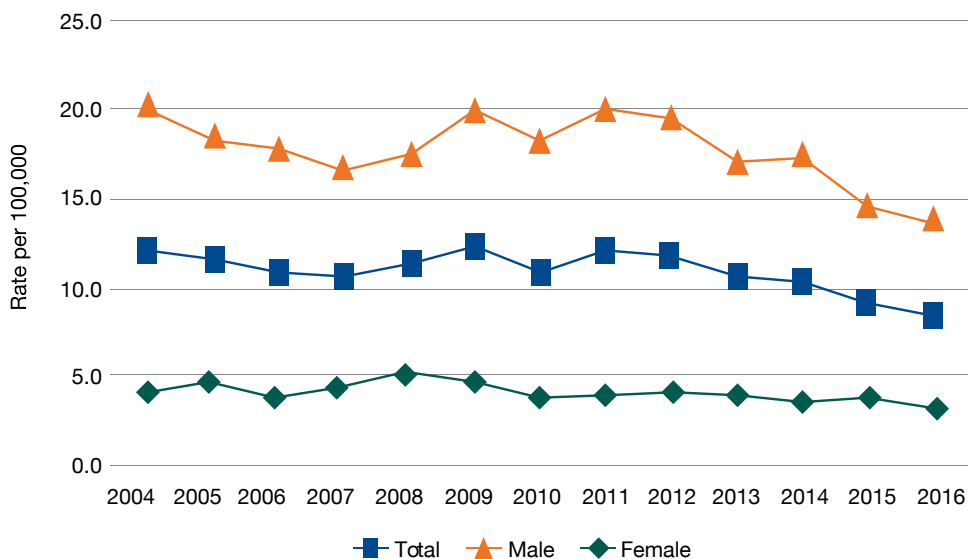
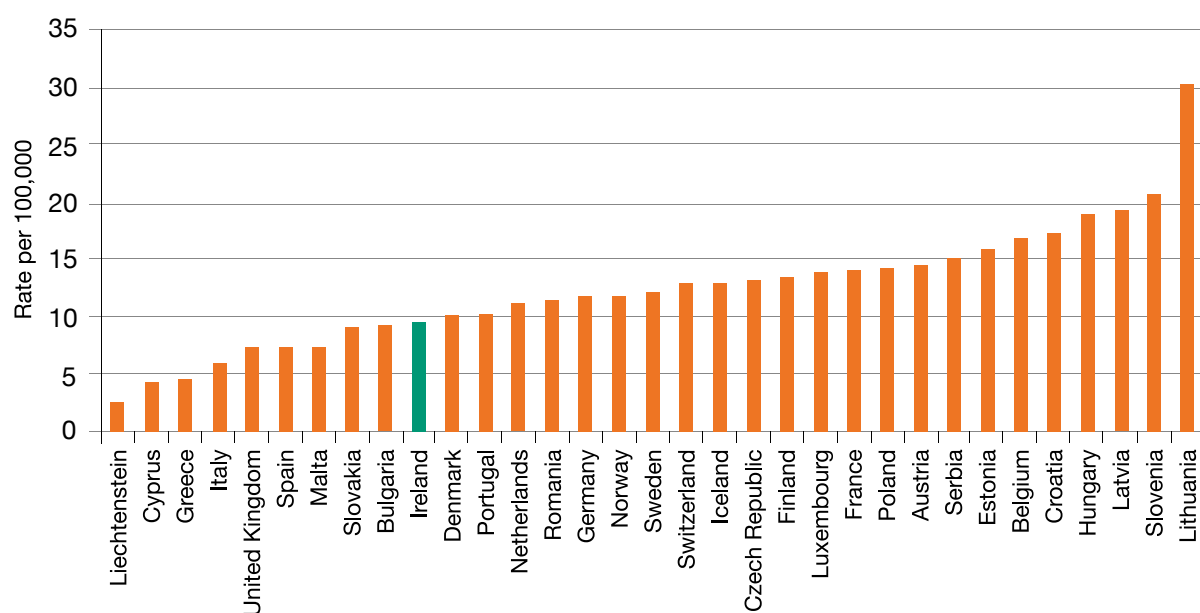


FIG. 2.1 SUICIDES IN IRELAND FOR MALE AND FEMALE PER 100,000 POPULATIONS 2004–2016 (NSRF 2019)

Suicide is the most common cause of death among young Irish men (aged 15–24) and middle-aged men (aged 45–54). Alcohol consumption is implicated in 44% of cases of suicide (Larkin et al 2017) and in 37% of cases of self-harm (Griffin et al 2015).

Suicide Rate per 100,000 for males & females, 2015*



*Death rate of a population adjusted to a standard age distribution. The standardised death rates used here are calculated on the basis of a standard European population (defined by WHO).

FIG. 2.2 RATE OF SUICIDE AMONG 15–19-YEAR-OLDS IN EUROPE IN 2015 PER 100,000 OF POPULATION

Leading causes of death, ages 15-19 years

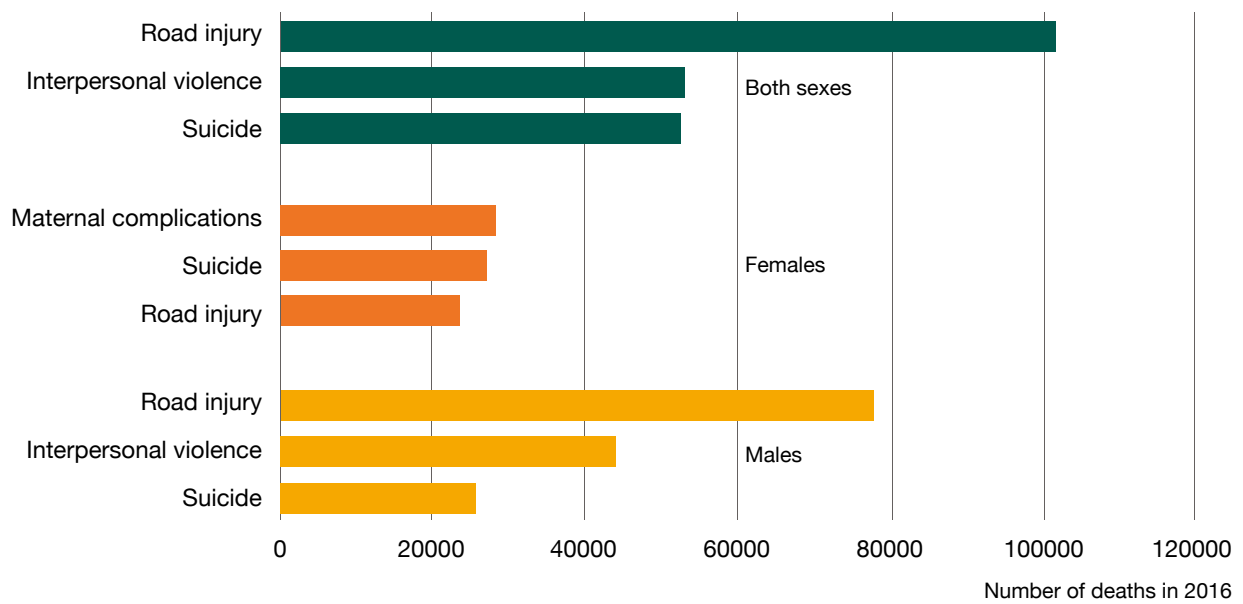


FIG. 2.3 LEADING CAUSES OF DEATH, AGES 15-19, 2016

Suicide rates by age and gender (2007-2018)

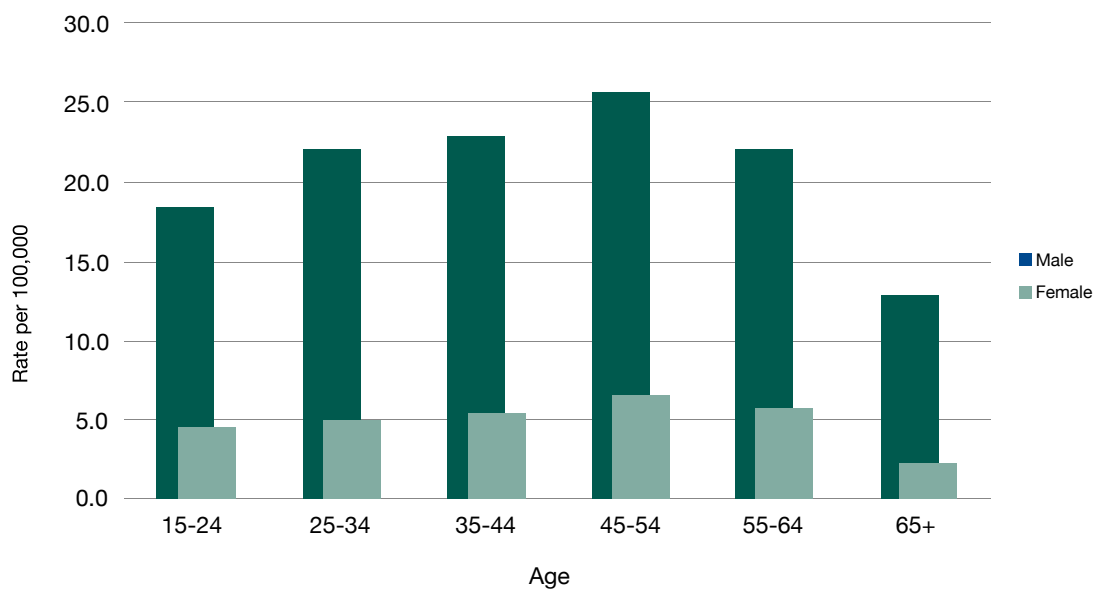


FIG. 2.4 SUICIDE RATES BY AGE AND GENDER, IRELAND, (2007-2018)

In 2021, suicide is the second leading cause of death in young people aged 15-19 years.

Over the last 12 years the suicide rate in Ireland has continued to fall (CSO 2020). Much of this can be attributed to improved economic conditions. However, there is a risk that this improvement will not be sustained, with the impact of Covid-19 (Gunnell et al 2020). Preliminary results indicate there was an increase in self-harm presentations to the ED following the third wave of Covid, and an increase in severity of mental health presentations has been predicted (O'Connor et al 2020). It is essential to ensure that clinicians are adequately trained and supported to address this increase in need.

2.2 Self-harm

Self-harm is defined as intentional self-poisoning or injury of oneself, irrespective of motivation or intent to die (Hawton et al 2012). It is estimated that approximately half of all people who die by suicide have previously self-harmed (Foster et al 1999). Of people presenting to the ED following self-harm, a meta-analysis in 2014 estimated that fatal repeat self-harm occurred in 1.6% of people within one year after their index attempt; incidence was almost double in males compared with females. It was estimated that one in 25 patients who self-harm and present to the ED will go on to die by suicide in the 10 years after their index case (Carroll et al 2014). Among patients who have been discharged from ED following self-harm, the risks of repeated acts of self-harm and suicide among all ages is highest immediately following discharge (Geulayov et al 2018).

People who self-harm are the group with the highest risk of completing suicide. Connecting for Life, Ireland's suicide prevention strategy 2015–2025, targets priority groups such as those who self-harm. It also identifies the need to enhance accessibility, consistency and care pathways, and ensure safe and high-quality services for people vulnerable to suicide (HSE NOSP 2015, 2020).

Ireland has a national registry of self-harm since 2007 (Perry et al 2013). It identifies all those who present to the ED, the nature of the self-harming behaviour, the interventions and the follow-up offered. In 2017 there were 11,600 presentations to ED following self-harm. It is estimated that, for every presentation to the ED, there are five times as many self-harm episodes in the community (Arensman et al 2018).

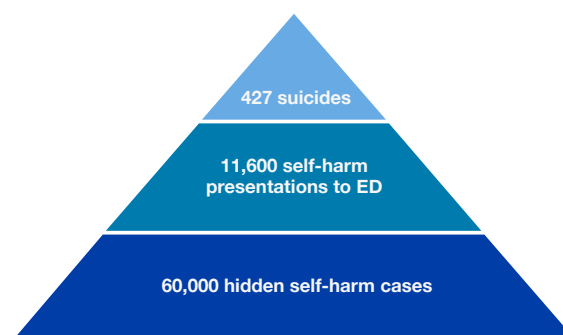


FIG. 2.5 THE ICEBERG MODEL OF SELF-HARM (ADAPTED, ARENSMAN ET AL 2018)

In 2014 67% of people presenting to the ED following self-harm received a mental health assessment (NSRF 2014.) In 2019 this number rose to 72% (NSRF 2019). Assessment was most common following attempted hanging and attempted drowning. Those with alcohol taken or who were self-cutting were less likely to receive an assessment. Of those presenting, 17% in 2014 and 14.5% in 2017 made at least one more presentation to hospital during the calendar year (Griffin et al 2014, 2017).

In recent years psychiatric practice has changed. Referral patterns from GPs have altered (Douglas and Feeney 2016); most people with suicide-related ideation are now being referred directly to community mental health teams rather than for inpatient treatment. Those who are referred for inpatient care are likely to be those that GPs or family members consider most at risk, but, as stated above, this assumption is not always reliable. Ireland has the lowest number of psychiatric beds per 100,000 population in the EU, with just under 34 beds per 100,000 population, while the EU average is 72 beds (Eurostat 2018).

A Vision for Change (DoHC 2006) recommended the development of Community Mental Health Teams and specialist health teams, but recruitment difficulties and lack of investment has resulted in deficits in both inpatient and community facilities (Kelly 2019). Very few services in Ireland have home-based treatment teams that provide intensive home treatment to people who might otherwise be admitted to hospital (O'Keeffe and Russell 2019).

2.3 Risk assessment and safety planning

The aim of the Clinical Programme is to improve engagement with people who self-harm or present with suicide-related ideation and thereby reduce recurrence of self-harm and reduce suicide. Before the introduction of the Clinical Programme, the focus of the initial contact was often on assessing immediate risk and only intervening with those who were considered to be at high risk (Griffin et al 2013). While there is evidence that the introduction of the Clinical Programme has improved the ED experience for many using the service, there is also evidence that mental health services continue to put emphasis on the use of risk assessment tools and checklists at the expense of developing effective therapeutic alliances that instil hope and improve future engagement (Doyle et al 2020, Cully et al 2020).

It has long been recognised that it is not possible to predict suicide (Pogorny 1983). Suicide risk is not binary, and the categories of high, medium and low-risk that are often used in clinical practice are arbitrary. We also know that suicide risk is dynamic, with risk changing from one assessment to the next. Standalone risk assessment tools have been found to be ineffective in assessing individuals with suicide-related behaviour (NICE 2011). They should not be used to predict future suicide or repetition of self-harm, or to determine who should or should not be offered treatment (NICE 2011). It has been clearly demonstrated by meta-analyses of their use that about half of people who die by suicide have been identified as being of low risk (Large et al 2011) and that none of the scales provides sufficient evidence to support their use (Chan et al 2016). In addition, the use of these scales, or over-reliance on identifying risk factors in clinical practice, may provide false reassurances to clinicians, and are therefore potentially dangerous (Chan 2016). Also, almost all the risk assessment tools used in the UK, many of which are also used in Ireland, have not been tested or validated and have simply been devised by the services themselves (Quinliven et al 2014). Further studies confirmed that even validated scales are not useful in predicting repeat self-harm or suicide (Quinliven 2017).

A national review of the assessment of clinical risk in UK mental health services (NCISH 2018) made a number of observations, including that risk assessment tools

should not be seen as a way of predicting future suicide-related behaviour. It advised that risk is not a number and risk assessment is not a checklist. It noted the growing consensus that risk tools and scales have little place on their own in preventing suicide, and stressed that, instead, the emphasis should be on building relationships and gathering good-quality information, and that staff should be comfortable in asking about suicide-related thoughts. The authors suggested that clinicians should be trained in how to assess, formulate and manage risk; that families and carers should have as much involvement as possible in the risk process, and that management of risk should be personalised and individualised.

Qualitative data also illustrates the fact that clinicians and service users do not find risk assessment scales helpful. A tick box or checklist approach to assessment may be experienced as alienating and hamper therapeutic engagement (Stewart 2018; Doyle et al 2020). Cully et al (2020) explored patients' experiences of engagement with healthcare services following self-harm presentation to a hospital emergency department. Positive experiences of care included 'supportive and compassionate relationships' and 'timely and comprehensive follow-up care'. This resulted in establishing trust and encouraged help-seeking behaviour and adherence to psychotropic intervention. Conversely, 'superficial and unsupportive relationships' and 'care lacking continuity and comprehensiveness' left some participants feeling isolated, contributing to inhibited help-seeking and resistance to psychotropic treatment. Furthermore, those who described unsupportive relationships more frequently reported repeated self-harm, alcohol misuse and hopelessness at follow-up (Cully et al 2020).

Cully et al (2020) further supports the significance of therapeutic engagement in developing hope, decreasing helplessness and reducing the likelihood of future self-harm and suicide-related behaviour. It is therefore necessary that clinicians working with people who experience self-harm and suicide-related behaviour use interventions that instil hope and allow those who experience self-harm to have a greater sense of agency in their recovery.

People who experience self-harm and suicide-related ideation often describe feelings of sadness, depression,

despair, helplessness, worthlessness, loneliness, guilt, despair and hopelessness (Radcliffe 2015; Pariente et al 2013; Subu 2006). It is the feelings of helplessness, hopelessness and despair that can lead to self-harm and suicide-related behaviour. It is imperative that clinicians involved in assessing people presenting with self-harm and suicide-related ideation, along with completing a full biopsychosocial assessment, instil hope and facilitate a sense of agency so that people believe there is something they can do to help such individuals to move forward, thereby directly addressing hopelessness and helplessness.

There is adequate evidence and training available for mental health practitioners to use safety planning interventions (Stanley and Brown 2018; STORM 2015). An eight-step safety plan has been in use in a number of Irish services, and is described in detail in the Review of the Operation of the Clinical Programme (HSE 2017).

As outlined in Stanley and Brown (2018), safety-planning intervention as part of a CBT intervention aimed at reducing suicide risk has been shown to be effective. It involves helping patients to identify what triggered the crisis, use skills to tolerate distress or regulate emotions, and, should the crisis not be resolved, how to access emergency care. The therapeutic interventions would look to ensure the safety of the patient by removing access to lethal means; initiate self-monitoring of the suicide-related thoughts, feelings and behaviours; target symptoms that are most likely to interrupt day-to-day functioning, as well as hopelessness and sense of isolation; reinforce the commitment to treatment and solidify the therapeutic relationship. Certain modifications have been found helpful for people seen in the Irish services.

Staff and service users have reported finding that focus on protective factors is more useful than focusing on reasons for living. A strengths perspective and solution-focused safety planning concentrates on identifying coping strategies and problem-solving as well as harnessing family and social supports. The therapeutic aim is to empower and target where possible the sense of hopelessness. The collaborative nature of developing a safety plan also ensures a sense of agency and self-efficacy, thereby addressing the sense of helplessness that people who experience self-harm and suicide-related ideation often describe.

The safety plan would show what coping strategies, external supports and triggers the service user has identified. Evidence recommends that the clinician and service user generate the plan together, and that the service user's own words are used in the written document. The collaborative nature of this intervention is essential to developing an effective safety plan (Stanley and Brown 2012, Shaffer and Pfeffer 2001).

The clinical alliance is the essential vehicle for delivering a potentially life-saving series of clinical interventions (Jobes 2009). To nurture this alliance, the practitioner takes the stance of working with the suicidal person to help resolve the problems and pain that drive the suicidal wish, rather than working against the person's plans for suicide. The practitioner validates that the person's emotions, behaviours, wishes and fears are understandable in the context of their experience. The validation is evidence of empathy. Through the safety planning, the person becomes the co-author of the safety plan that instils hope and agency.

Higgins et al (2015) state that risk assessment is only effective if it is followed by a safety plan. There is often a disconnect between the risk assessment process and the development of a safety plan. Gilbert et al (2011) and Woods (2013) found that, despite risk assessments being completed by nurses, the safety planning step was omitted or the strategies identified to support the person's safety did not correspond to the risk identified.

The co-production of a safety plan, following the identification of risk, is a critical step in meeting the objective of supporting the person and the clinician to maintain safety, while promoting the potential and priorities of the service user. It is the responsibility of the clinician to address the hopelessness, helplessness and despair that an individual presents with, following self-harm or with suicide-related ideation. Crisis theory also identifies this as an opportune time to bring about effective change.

It is timely that the NCP advises a shift in emphasis from using risk assessment tools to using collaborative safety planning. This is in keeping with the recovery ethos and supported by empirical evidence. The NCP recommends that all training curricula and clinical

practice focus on assessment of need, and includes safety planning to address that need. Standalone and locally developed risk assessment tools should not be used. Clinical risk assessment processes should be improved, with emphasis placed on building relationships and on gathering good-quality information on the current situation, on past history and on the current social circumstances to inform a collaborative approach to management using safety planning.

2.4 Trauma-informed approach

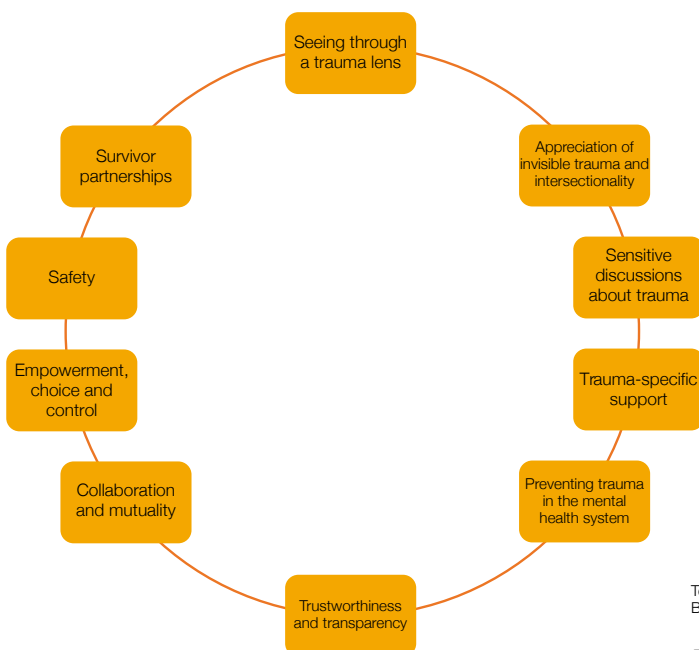
Research has consistently found that people using mental health services have experienced high rates of trauma in childhood or adulthood, and that these rates are higher than in the general population (e.g. Mauritz 2013). Furthermore, having a trauma history is associated with poorer outcomes for survivors, including a greater likelihood of attempting suicide, self-harming, longer and more frequent hospital admissions and higher levels of prescribed medication (e.g. Read 2007; Mauritz 2013). Sweeney et al (2018), in a comprehensive review of the subject, recommended that all

mental health services adopt a trauma-informed approach. Many of the principles outlined by Sweeney et al, as outlined in Figure 2.6, overlap with the principles and values used in the NCP.

Trauma-informed approaches are based on a recognition and comprehensive understanding of the widespread prevalence and effects of trauma. This leads to a fundamental paradigm shift from thinking ‘What is wrong with you?’ to considering ‘What happened to you?’

Rather than being a specific service or set of rules, trauma-informed approaches are a process of organisational change aiming to create environments and relationships that promote recovery and prevent re-traumatisation. The skilled and supervised clinician should undertake an expert biopsychosocial assessment while using a trauma-informed approach.

The NCP should be delivered using a trauma-informed approach. Practitioners should ensure that they are informed on trauma-informed approaches.



Ten key principles of trauma-informed approaches (adapted from Elliot 2005; Bloom 2006; Substance Abuse and Mental Health Services Administration 2014).

FIG. 2.6 TEN KEY PRINCIPLES OF TRAUMA-INFORMED APPROACHES
Adapted from Elliot 2005; Bloom 2006, and Substance Abuse and Mental Health Services Administration (2014) by Sweeney et al (2018).

2.5 Staff Supervision

2.5.1 Personal supervision

The role of the CNS, NCHD, Consultant and other mental health professionals working within the ED can be stressful. It is important they have access to both clinical and personal support. This minimises the risk of burnout or of developing compassion fatigue, both of which have been associated with poorer clinical outcomes (Hunsaker et al 2015).

Supervision of staff leads to improved management and care planning. Trauma-informed supervision involves a facilitated reflective group that recognises the impact of secondary traumatic stress (Applegate and Shapiro 2005). Sommer (2008) suggests that the specially trained supervisor should be alert to changes in workers' behaviour with and reactions to clients, intrusions of client stories in workers' lives, signs of burnout and feelings of being overwhelmed, signs of withdrawal in either relationships with clients or in the supervisory relationship, and signs of stress and an inability to engage in self-care. Sommer and Cox (2005) reported that trauma-sensitive supervision should include time for talking about the effects of the work and related personal feelings; directly address vicarious traumatisation, and use a collaborative, strengths-based approach.

Cultivating the practice of reflecting on one's own emotional responses to a client is an integral aspect to trauma-informed supervision. Negative reactions to suicidal individuals in counter-transference are well documented (Maltsberger and Buie 1996). The reactions of clinicians towards patients may result in feelings of incompetence, hopelessness, demoralization, hostility and/or withdrawal from emotional involvement with the client (Hunter 2015).

Balint groups are named after the psychoanalyst Michael Balint. In the late 1950s Balint and his wife began holding psychological training seminars for GPs in London. The group met on a weekly basis, encouraged doctors to discuss cases, and in a safe and supportive environment others were invited to respond to what they had heard.

Since publication on this work (Balint 1957), the Balint approach has flourished and has encouraged the development of reflective practice among GPs and psychiatrists.

Another approach to improving practice, which is used in psychotherapy, is the process of Self-Practice/Self-Reflection (SP/SR). It is a form of personal practice for cognitive behaviour therapy (CBT) that continues a long tradition of experiential group work for psychotherapists (Freeston et al 2019). SP/SR, originally proposed by James Bennett-Levy (2001), involves trainee cognitive behaviour therapists applying the CBT model to themselves and then reflecting on what they have learned by doing this, including reflections on the content, on the process and on how the theory relates to their experience. The rationale for this approach is that it is experiential and, therefore, provides insights that are unlikely to be gained from other training methods. SP/SR outcome studies indicate that the benefits to therapists include greater empathy (Davis et al 2015), enhanced conceptual skills (Haarhoff et al 2011) and improved confidence (Spendelov and Butler 2016). This approach could also be used for clinicians delivering the NCP in self-harm, giving them not only technical knowledge and expertise but also a direct lived experience of, for example, developing their own safety plan so they can develop further understanding and empathy when working with service users who experience self-harm.

- » To ensure continued working in a genuine, empathic and compassionate manner, all services should ensure that practitioners have access to reflective practice and regular supervision, at a minimum every month, and increased at times of greater stress.

2.5.2 Clinical supervision

Every CNS, NCHD or health and mental health professional will work under the clinical leadership of a Consultant Psychiatrist. Each case must be discussed with a Consultant Psychiatrist. The timing of that discussion depends on the training and experience of the mental health professional.

One of the core clinical focus competencies of a CNS is to perform a nursing assessment and initiate care and treatment modalities within agreed interdisciplinary protocols to achieve patient-centred outcomes (NCNM 2008). In the NCP SH, the recommended protocol must include discussion of all patients with a senior decision-maker such as a Consultant Psychiatrist, Higher Specialist Psychiatric Trainee or Advanced Nurse Practitioner.

Non-consultant hospital doctors (NCHDs) provide assessments and interventions out of hours or within Community Mental Health work under the clinical supervision of a named Consultant Psychiatrist (CPsych 2020). It is essential that NCHDs in psychiatry have exposure to a range of emergency assessments and are properly supervised to deliver the Clinical Programme (HSE 2017). NCHDs carrying out such emergency assessments should be in training with the College of Psychiatrists of Ireland (CPsychI 2020), while those in non-training NCHD posts should receive CPD-accredited training in delivering the NCPSH and evidence-based care (Irish Medical Council 2016). This is further addressed in Chapters 9 and 10.

It is recommended that all practitioners in their first six months in practice discuss a case with a consultant before they discharge the patient. Every mental health professional will also receive clinical and professional supervision from a clinician experienced in the area of self-harm.

2.6 Brief contact interventions

Evidence has shown that offering a therapeutic assessment is associated with reduction in repeated self-harm and improved engagement with services (Kapur 2013). Interventions associated with improved outcomes include a written safety plan (Stanley and Brown 2018), input by next-of-kin or a supportive friend (Shea 2011), and follow-up and linkage to next care (WHO 2014, Ribnet 2019). Brief contact interventions such as post-discharge telephone calls have been shown to offer social support, improve suicide prevention literacy and assist in learning alternative behaviours (Milner et al 2016).

In 2016 a Cochrane review (Hawton et al 2016) found evidence that cognitive behavioural therapy (CBT) and dialectical behaviour therapy (DBT) led to a reduction in suicide rates in those who had previously self-harmed. This review noted the paucity of well-conducted randomised controlled trials.

NICE guidelines on the short-term treatment and management of self-harm are under revision (NICE 2004, 2011, 2020). These guidelines emphasise the importance of treating people who self-harm with the same care,

respect and privacy as any patient. Healthcare professionals should take full account of the likely distress associated with self-harm. The latest update emphasises that people who repeatedly self-harm may have different reasons for self-harming on each occasion and therefore each episode needs to be treated in its own right. This is in keeping with recommendations from people with lived experience, with the aim of ensuring that reasons for self-harming are adequately explored (Palombini et al 2020).

Doyle et al (2020) published a qualitative review of service users' experiences in the ED following self-harm. It covered a period from 2013 to 2018 and thus included many EDs in which the National Clinical Programme was not implemented. Positive experiences related to a perception that the individual assessing was relaxed and unhurried and had a good understanding of the patient's needs. A number reported that their physical needs were dealt with but their emotional needs were ignored.

Similar experiences have been described in other jurisdictions. MacDonald et al (2020), in a systematic review of patients' experience, found three overarching themes in the literature: the construction and negotiation of the patient identity; the nature and quality of treatment perceived, and the perceived impact of treatment experiences on future self-harm disclosure and help-seeking. They found that across the treatment pathway, and irrespective of the level of suicidal intent, participants felt that their authenticity and legitimacy were questioned. This experience added to the sense of being a burden and reinforced the sense of worthlessness. Many patients referred to discrimination and in some cases hostility. They noted a focus on managing physical symptoms rather than addressing emotional needs. Where patients were offered individualised treatment that focused on the emotional experience of the self-harm, this legitimised their experience and made them more hopeful for the future. Finally, the review showed that those patients who had negative experiences in the ED were less likely to engage with mental health services in the future; in contrast, when emotional needs were met patients were ready to accept referrals to appropriate services. A significant theme throughout the review was the notion of feeling processed, in accordance with the regime within EDs, and a checklist approach to symptoms.

In other jurisdictions, including the UK, most self-harm assessments are commonly carried out 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). Psychosocial assessment following self-harm is not necessarily profession-specific, and a service led by experienced nurses can be cost-effective for a health service (Russell and Owens 2010). The value in training multidisciplinary professionals to develop skills for working in suicide prevention has also been demonstrated (de Beurs et al 2015). Multidisciplinary approaches have the advantage of developing services from the perspective of multiple stakeholders, which is likely to be of benefit in relation to the complex needs of individuals presenting with self-harm (Carter et al 2016).

From both a clinical and financial perspective, Consultation-Liaison Psychiatry services are recognised nationally and internationally as being most effective for providing care to patients with mental health needs in acute hospital settings (Parsonage et al 2012). A central aspect of the work of Liaison Psychiatry services includes the assessment and management of patients who present to the ED with self-harm, and the training and support of ED staff in providing care to this group. The contribution of Liaison Psychiatry in achieving considerable savings of £4 per £1 spent and improving quality of care has recently been recognised (Tadros et al 2013).

In the UK, the Liaison Psychiatry services are mostly provided by mental health trusts but serve acute hospitals. Some are provided by acute hospitals. In Ireland, there is a similar mixed picture, with some services funding a liaison team through the acute hospital, while in others funding is provided by the mental health service. Staffing arrangement has been described for optimum provision of care, with staffing levels and skills mix tailored to local factors, including size and complexity of the hospital, case mix and other local mental health services (RCPsych 2013). Reviews of services in the UK have identified the need for effective communication between primary care and liaison services and between liaison services and community mental health teams (Parsonage 2012, Aitken et al 2018).

A Liaison Psychiatry service provides assessment and management within the ED during the day; out-of-hours services are guided by the on-call Consultant Psychiatrist. Kapur et al (2016) noted the importance of the quality of the assessment in improving engagement with next appropriate services. Follow-up and bridging to next care has not been a component of traditional mental health services in the ED. Services would often signpost to next appropriate care without offering interim support. Stanley et al (2018) have shown that uptake of next-care appointments almost doubled when individuals were offered a written safety plan and a follow-up phone call (Stanley et al 2018).

In recent years there is increasing evidence supporting the use of safety planning in reducing repeat self-harming and suicide (Stanley and Brown 2012, 2018). Specific training in the use of safety planning is now incorporated into training on management of suicidality (Gask et al 2006, Arensman et al 2020).

Repeated studies have shown that people who have self-harmed or who present with suicide-related ideation want to share in the decision-making about their future care, with reasonable attention paid to their personal preferences (Claasen et al 2014). This can be achieved by providing each patient with a co-produced care plan.

A meta-analysis of randomised controlled trials on strategies to prevent death by suicide found three trials where WHO Brief Intervention and Contact was shown to result in a significant reduction in the numbers who died by suicide (Riblet et al 2019). A French study analysing the impact of telephone follow-up calls concluded that phone follow-up of outpatients after a suicide attempt is a protective factor against repeated suicide attempts (Exbrayer et al 2017).

People who present to health services following self-harm or suicide-related ideation should receive brief interventions in the form of empathic, validating, compassionate and trauma-informed response; a timely expert biopsychosocial assessment and intervention, including a written emergency safety plan, and follow-up and linkage to next appropriate care.

2.7 Response to suicide-related and self-harm ideation

While it has been known for some time that people who self-harm have an increased risk of future death by suicide, recent evidence also points to increased risk for those who present with suicide-related ideation (Griffin et al 2019a). This evidence points to the need to standardise and improve responses for people who present with suicide-related ideation. People with suicide or self-harm ideation present to the ED although good practice would recommend they be assessed in the community. Many can be adequately supported by primary mental health services and will not require a referral to a specialist mental health service. This has been shown in Ireland with the Self-Harm Intervention Project (Gardner et al 2015). If they do require specialist mental health input, this can be from a mental health nurse, a CMHT or a central crisis assessment team (Deweke et al 2018). In the UK, individual services provide a suite of responses for people in a crisis, including a 24-hour helpline, staffed by mental health professionals and open to patients and GPs, and a helpline for use 9–5 Monday to Friday, for people already known to services. GPs can receive a same-day crisis assessment for new patients and, in the rare cases where none of these services is available, the person is advised to attend the ED (NHS 2016a).

McGarry (2019) describes the development of specific self-harm and unscheduled care teams in Belfast, emphasising the need for separate services. He suggests that home-based treatments and 24/7 services are for people known to the service, and that they prevent the admission to hospital of people suffering from severe mental illnesses such as schizophrenia, bipolar disorder and severe depression. Others have also suggested that there is a need for a separate service for those with anxiety disorders and substance misuse, and those who have self-harmed in the absence of severe mental illness or are in crisis due to relationship difficulties (Onyett et al 2006).

In Ireland, information on access to such non-ED unscheduled care is sparse. A recent review of Suicide Crisis Assessment Nurses (SCANs) found that they were present in only eight of the country's 16 mental health services, and within these a SCAN service was only present in some sectors (Griffin et al 2019).

In the South East, the Self-Harm Intervention Project (SHIP) has been in place since 2004. Trained psychotherapists offer specialised non-crisis counselling to people who have self-harmed and to people with suicide-related ideation (Gardner et al 2015). The SHIP programme is provided within the context of a range of services, including SCAN, Community Mental Health Teams (CMHT), community counselling and other community supports. Services have been encouraged to develop 24/7 services for people known to the mental health services (HSE 2018a) and some services are using home-based teams to manage these crises (O'Keeffe and Russell 2019). Some services are providing crisis assessment teams (Feeney and Rossiter 2020), while a number of CMHTs provide same-day assessments, as described in Walsh et al (2013). *A Vision for Change* recommended establishing consultation liaison services with GPs, as described by Wright and Russell (2007).

Talking therapies such as a Counselling in Primary Care (HSE 2018) have been developed. These have no formal liaison with CMHTs but tend to refer people with suicide-related ideation to them. Collins et al (2020) describe a primary care psychology service in a rural Irish county that accepts walk-ins, self-referrals and health and social care referrals. It operates a stepped-care model of service provision whereby the least intensive form of intervention to meet the service user's needs is offered. This leads to a high volume of low-intensity interventions being provided and a smaller volume of high-intensity interventions. The various steps include brief assessment/consultation/signposting, guided self-help and brief (up to six sessions) CBT-informed psychological intervention. Assistant and trainee psychology students, supervised by a psychologist, provide the service. Input can be stepped up to provide senior psychologist input, or referral to secondary care mental health services (Collins et al 2020). Along with describing the service, this study also found that most of the individuals using the service wished to have a timely, positive interpersonal experience that addressed their individual concern. These factors were considered more important than the specific type of intervention offered.

Doyle et al (2020), in their qualitative review of 50 people who had presented to the ED following self-harm or with suicide-related ideation, found that a number of people presenting with suicide-related ideation experienced the ED environment as being unsuitable. They found it noisy and stressful, and

the long delay between registering and being assessed was particularly difficult. Individuals reported feeling they were in the wrong place and yet they were not aware of anywhere else to present when they had suicide-related thoughts.

Douglas and Feeney (2016) reported on the change in referrals to mental health services in the 30 years up to 2013. There has been a reduction in the proportion of referrals concerning psychosis and an increase in the proportion deemed urgent and that were concerned with suicidal risk. Suicidal ideation was mentioned in 14% of referrals in 1983 and in 50% of referrals in 2013.

Since the establishment of the Clinical Programme in 2015, over 40% of patients assessed have presented to the ED with suicide-related ideation only, while 60% presented following self-harm (HSE 2020). As resources in CMHTs are reduced, access to non-scheduled care from CMHTs has reduced, and, in the absence of other services, GPs are forced to refer individuals to the ED (Carey et al 2021). A small number of services in the country offer assessments in the approved centre, obviating the need for such patients to spend often long hours waiting in ED. Most services request that all patients attend ED first, where they are assessed by a mental health professional. Over 40% of these assessments are made out of hours by a non-consultant hospital doctor in psychiatry (HSE 2017).

While it is often quoted that over 90% of patients with mental health problems are managed in Primary Care, studies in Ireland, France and the UK have found that GPs refer between 60% and 80% of patients who have self-harmed to hospital (Fitzsimons 1997, Le Point 2004, Saini et al 2016). The complex and busy environment of ED is not the optimal environment for patients with mental illness or undergoing a psychosocial crisis. The ED is a place for undifferentiated presentations for all health conditions.

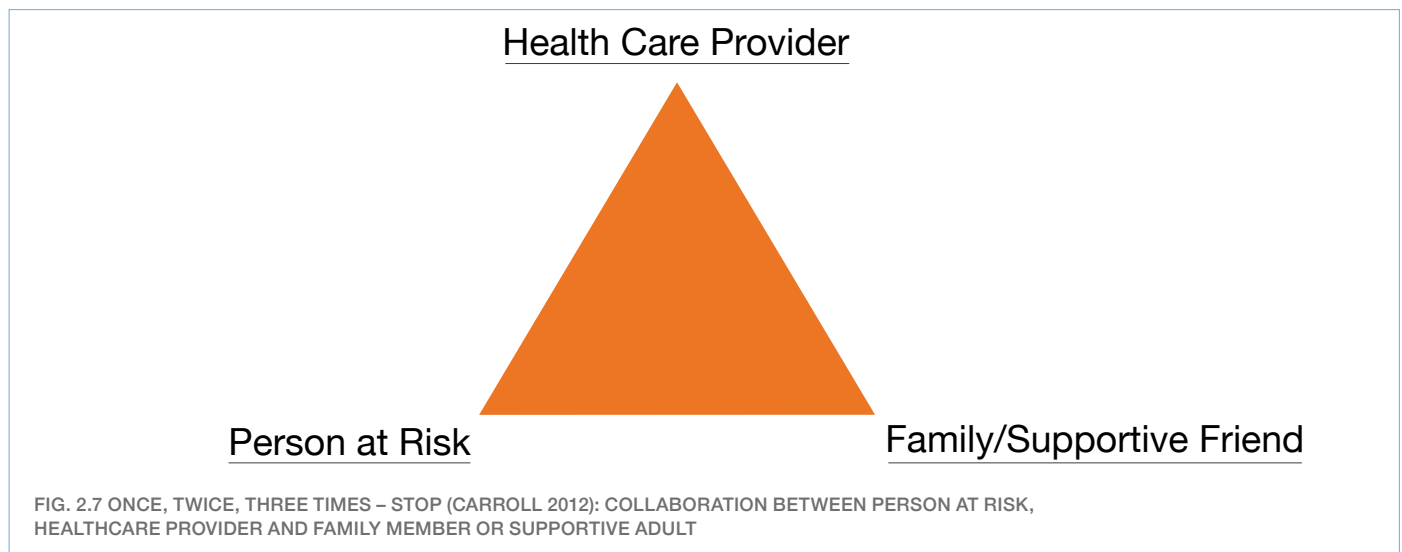
A Vision for Change (DoHC 2006) recommends that in-patient admission be coordinated and customised for each service user by the CMHT. The Mental Health Commission in its Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre (MHC 2009) stipulates that a) every approved centre have a protocol in place for dealing with urgent referrals from EDs and from primary care and b) every approved centre have in place a protocol

for dealing with individuals who self-present or who present in the company of a relative, parent or guardian. The code recommends that admission should be planned, with individuals first assessed by primary care and then referred to a CMHT and that a person who presents as urgent or is a self-referral should be assessed as soon as practicable.

Non-ED crisis assessment services should be developed by all mental health services in Ireland.

2.8 Family/supporter interventions for people who self-harm or who have suicide-related thoughts

In the NCP SH Model of Care (HSE 2016) the need for family involvement has been clearly described. Once, Twice, Three times – STOP (O’Carroll 2012) – is used to emphasise the need to ensure response to suicide-related ideation or behaviour should be swift and follow national guidelines, two parties should be involved, the suicidal person and a nominated family member and a triangle of care and support for the person should include the health care providers, the person at risk and the family or supportive friend.



Since 2012 further evidence has accumulated on the need to involve family members at both assessment and discharge planning. Family members are often the first to be contacted following a suicide attempt or an act of self-harm, whether they interrupt a deliberate act of self-harm or accompany the person to hospital and are involved in subsequent hospital care (Frey and Fulginiti 2017). According to Fulginiti et al (2016), the person with suicide-related thoughts generally confides in a family member, placing them in the position of reacting to and learning about the suicide-related behaviour. Hence, family members can be a valuable resource for healthcare professionals in providing collateral information to assist with risk assessment and care planning (Cerel et al 2008, Sellin et al 2017). It is noted that often people who are suicidal may not have family support; in that case, they may

nominate a supportive friend to take the place of a family member. Anything that applies to a family member can also apply to a supportive friend. It is recognised that suicidal people do not always share their true intentions. Even in the context of the deepest clinical engagement, the actual intent to die may not be revealed (Shea 2011).

From a broad perspective of mental health, the positive effect that family support has on the person with mental illness is well documented (Fadden and Heelis 2011, Taylor et al 2015). Frey and Fulginiti (2017) found that family reaction to suicide-related behaviour is interpreted by the suicidal person as an indication that they are either a burden on the family or are supported by and belong within their family. The positive or negative reaction of the family member has a direct effect

on the person's recovery and whether they feel they can reveal their suicide-related thoughts and behaviour to a family member (Frey et al 2016). Similarly, Chiang et al (2015) found that positive reactions from family members towards the suicidal relative have positive outcomes in terms of enhanced relationships between them, thus enabling the family member to identify suicide-related behaviour and get help.

Although family intervention has been proven to be effective from the broader mental health aspect, specific research into its effect on self-harm and suicide prevention is limited (Frey and Cerel 2015, Prabhu et al 2010). Dialectical behaviour therapy, a treatment for people with emotional dysregulation and self-harming behaviour or suicide-related thoughts, includes family intervention from the perspective that the family can provide support and comfort to reduce inner tension in times of crisis (Fruzzetti et al 2006). This programme, known as Family Connections, has been developed in Ireland by DBT Ireland (Flynn et al 2017) and there are plans to develop it further. Families receiving very basic advice on keeping environments safe and validating an individual's distress has also been shown to provide support (Grant et al 2015).

Families have expressed their own need for emotional support, feeling burdened by the person's at-risk behaviour. Feelings of confusion, feeling lost and being excluded from the person's professional healthcare have been described by family members (Stewart et al 2018, Sellin et al 2017). This in turn causes isolation and a feeling of being powerless; they struggle to share everyday life with the suicidal person (McLaughlin et al 2016). In a study that surveyed 465 patients and 254 family members/friends who accompanied the suicidal person to an ED, 220 patients reported that a family member was with them in the ED (Cerel et al 2006). In response to a question about what was particularly helpful or hurtful, family members reported that receiving information about the care of their loved one was highly valued and that better communication of discharge plans and information on supports for families was needed. Lakeman (2010) cautions that, if the carer's needs are not addressed, their capacity to care for someone can be reduced. McLaughlin et al (2014) also identify the risk of burnout for these family members.

Prominent in the literature is the issue of confidentiality: the patient's right to instruct healthcare staff to withhold information from family, and the challenge of providing the family with sufficient information to enable them to provide the best support (McLaughlin et al 2016). Family members can experience a feeling of exclusion when confidentiality is viewed as a barrier to gathering important information from the family (Tillman et al 2017).

In an Irish study Wilson et al (2015) found that 56.3% of carers responding to an evaluative questionnaire stated that they have specifically encountered difficulties accessing information from the treating mental health team. The main reasons given were lack of patient consent (46.2%) and the unavailability of staff speak with relatives (46.2%).

In another Irish qualitative study of family members of patients who presented to the ED following self-harm, Dennehy (2020) found that relatives' paramount concern was their relative's safety. They wished to be involved at all stages of their relative's care. Many arrived at the hospital in shock and believed that hospital admission was needed to keep their relative safe. They all requested support and information if they were taking their relative home (Dennehy 2020).

Professor Patricia Casey has explored the issue of confidentiality in detail (Casey 2016). Recognising the importance of both providing information to carers and gathering information in order to make a full assessment of a newly referred patient or one who is acutely ill, she outlines the ethical dilemma that can arise when a patient refuses to agree to the gathering of information or the sharing of relevant information with carers. The quandary is between beneficence (doing good by respecting the patient's wishes) and non-maleficence (doing no harm by failing to collect or disclose vital information.) Part of the solution is the recognition that confidentiality is not absolute. This is recognised in the Professional Conduct and Ethics for Registered Medical Practitioners (Irish Medical Council 2019). Confidentiality can be broken against the wishes of the patient so as to protect the person, another person or the public, or when instructed by the courts. Failure to interview family members for collateral history could, Casey argues, in certain circumstances be construed as negligent. She points to the fact that those who are intent on suicide may

deliberately conceal this from the doctor and others may exaggerate symptoms for gain; in these cases, collateral information is mandatory to confirm the veracity of the history. The confidentiality rule does not extend to refusing to take telephone calls or neglecting to respond to communication from carers expressing concern. Listening is not precluded by confidentiality, even when a patient with capacity refuses consent to share information. In these circumstances, not only must the doctor listen to carers' concerns; if they are grave enough, the doctor should act on those concerns.

Casey concludes that managing confidentially should not be cast as a competition between patients and carers. Experience within the NCPSH has found that, when patients who self-harm or have suicide-related ideation are given time and an understanding of the importance of involving family members or a supportive adult in care, almost all patients will agree to this (HSE 2017).

The European Federation of Families of People with Mental Illness (EUFAMI) in a 2019 position statement in suicide prevention described the need to ensure that families are involved in the treatment and recovery process following a suicidal attempt by a family member. They make a number of recommendations on training and support for families (EUFAMI 2019).

The National Office of Suicide Prevention (NOSP) has produced a booklet for families or supportive friends to use in this situation, *Would you know what to do if someone told you they were thinking of suicide?* (HSE NOSP 2016).

While family support is important, there is also a need to be aware of the possibility of abuse within the family. Intimate-partner violence – defined as 'behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours' (WHO 2013) – has been shown to be associated with a number of mental and physical health problems (Dillon et al 2012). A number of studies have reported an association between the lifetime experience of intimate-partner abuse and increased self-harm, suicide-related ideation and suicidal attempts among women (Himelfarb et al 2006, Roche et al 2007, Sato-Dilorenzo and Sharpe 2007).

Intimate-partner violence and coercive control has also been shown to be associated with a range of mental health problems, including depression, post-traumatic stress disorder (PTSD), suicide-related ideation, substance misuse, functional symptoms, and the exacerbation of psychotic symptoms (Howard et al 2010a). Indeed, research has shown that there is a strong association between domestic abuse and mental disorder, with evidence of bidirectional causality (Trevillion 2014).

Mental health service users are at increased risk of domestic abuse, but their experiences are often undetected by mental health professionals (Howard et al 2013). Alongside the identified barriers to disclosure for victims of domestic abuse, Rose et al (2011) found that a major barrier to disclosure is that healthcare professionals do not ask service users about such matters. There are a myriad of reasons for this, including lack of confidence among staff, the focus on symptoms, and domestic abuse not being a priority in assessing and treating mental health difficulties (Howard et al 2010b).

There is evidence that women are more likely to disclose domestic abuse to a healthcare professional than to the police; women are assaulted an average of 35 times before they report domestic violence to the police (Yearnshire 1997). However, qualitative research in primary and secondary care has found that women may not disclose unless they are asked (Feder 2009, Rose 2011). Research shows that around 15% of women and 6% of men in Ireland have experienced severe domestic violence. Emerging evidence suggests that, globally and in Ireland, domestic violence has risen since the outbreak of Covid-19 (Doyle J 2020).

Domestic abuse is under-detected in services internationally, with only 10–30% of recent violence asked about and disclosed in clinical practice (Howard 2010b). Similar findings have been reported for primary care (Feder 2009). Findings from a recent Irish study, 'The Prevalence of Domestic Abuse amongst Service Users Attending an Adult Mental Health Service', found that 73% of participants had never been asked by a professional if they had experienced domestic abuse (O'Connor et al 2021).

Disclosure of domestic violence is facilitated by a good service user-professional relationship and is likely to be facilitated further by domestic violence training of professionals. Routine enquiry increases detection but needs to be introduced in the context of comprehensive training, and only where referral and care pathways have been developed (Waalén et al 2000). It is necessary to develop and evaluate clear care pathways, involving professions with specialism in this area such as social workers and domestic abuse agencies, to address this under-detected but potentially life-threatening issue. All clinicians should be aware of this and the need to provide each patient with personal time and space to be interviewed alone.

Gathering information from family members and supportive adults and providing family members and supportive adults with support is central to the NCP SH. Every effort should be made to provide the patient with a clear understanding of the value and importance of both gathering information from and sharing information with family members or a supportive friend. Confidentiality is paramount but there are situations where it can be breached. Even in situations where it is not appropriate to breach confidentiality, listening to family members/carers is important and is not precluded by confidentiality. Providing support for family members/carers is also important.

All clinicians should ensure that all patients are given the time and space to be interviewed alone. Before requesting family or supportive friend input, clinicians need to understand the relationship the patient has with their family member, being aware of the possibility of intimate partner or family abuse.

2.9 Summary and recommendations

- » People who present following self-harm or with suicide-related ideation are at increased risk of dying by suicide in the future. Evidence supports the use of interventions in improving engagement with mental health services and reducing repeat self-harming.
- » It is timely that the NCP advises a shift in emphasis from using risk assessment tools to using collaborative emergency safety planning. This is in keeping with the recovery ethos and is supported by empirical evidence. The NCP recommends that all training curricula and clinical practice focus on assessment of need, and include safety planning to address that need. Standalone and locally developed risk assessment tools should not be used. Clinical risk assessment processes should be improved with emphasis placed on building relationships and on gathering good-quality information on the current situation, on past history and on the current social circumstances to inform a collaborative approach to management, using safety planning.
- » The NCP should be delivered using a trauma-informed approach. Practitioners should receive training on trauma-informed approaches.
- » People who present to health services following self-harm or suicide-related ideation should receive brief interventions in the form of empathic, validating, compassionate and trauma-informed response; a timely expert biopsychosocial assessment and intervention, including a written emergency safety plan, and follow-up and linkage to next appropriate care.
- » Non-ED crisis assessment services should be developed by all mental health services in Ireland. These include Crisis Assessment Teams and the use of Suicide Crisis Assessment Nurses (SCANs) to work with GPs.
- » To ensure continued working in a genuine, empathic and compassionate manner, all services should ensure that practitioners have access to reflective practice and regular supervision, at a minimum every month, and increased at times of greater stress.
- » All presentations should be discussed with a Consultant Psychiatrist. The timing of that discussion depends on the skill and experience of the mental health practitioner. It is recommended that all practitioners in their first six months in practice discuss a case with a consultant before they discharge the patient. Every mental health professional will also receive clinical and professional supervision from an experienced clinician in the area of self-harm.
- » Gathering information from family members and supportive adults and providing family members/supportive adults with support is central to the NCP SH. Every effort should be made to provide the patient with a clear understanding of the value and importance

of both gathering information from and sharing information with family members or a supportive friend. Confidentiality is paramount but there are situations where it can be breached. Even in situations where it is not appropriate to breach confidentiality, listening to family members/carers is important and is not precluded by confidentiality. Providing support for family members/carers is also important.

- » All clinicians should ensure that all patients are given the time and space to be interviewed alone. Before requesting family or supportive friend input, clinicians need to understand the relationship the patient has with their family member, being aware of the possibility of intimate partner violence or family abuse.