03

Update on Services for People who Present to the Emergency Department following Self-Harm or with Suicide-related Ideation

3.1 Consultant Psychiatrist clinical supervision

Clinical Nurse Specialists (CNSs), other equally qualified mental health professionals and Non-Consultant Hospital Doctors (NCHDs), all of whom receive clinical guidance and supervision from Consultant Psychiatrists, deliver this programme. During the day this supervision is provided by Consultant Liaison Psychiatrists and out of hours by the on-call Consultant Psychiatrist. Consultant General Adult, Later Life and Child and Adolescent Psychiatrists also provide clinical guidance.

FIG. 3.1 CLINICAL COMPONENTS OF THE NCPSH

3.1.1 General adult, child and adolescent and older-life psychiatry services

It is the responsibility of all Consultant Psychiatrists to ensure that the NCPSH is fully implemented. Out of hours, all patients assessed by the CNS or NCHD should be discussed with the Consultant Psychiatrist on call. The timing of this discussion will depend on the experience of the CNS or NCHD. A core competency of all psychiatrists is the assessment and management of risk and need in those who have self-harmed. As educational supervisors and tutors of psychiatrists in training, all Consultant Psychiatrists should understand the NCPSH, including the values and evidence underpinning the NCPSH (as described in Chapters 1 and 2). The National Clinical Programme clearly states that the ED is not a suitable place for people who do not have emergency physical health needs, and that urgent or emergency mental health needs should be managed

outside the ED. Mental health crises take weeks, even months to develop; if community and specialist mental health services offer sufficient early intervention, emergency presentations can often be avoided.

All Community Mental Health Teams (CMHTs) should ensure that each of their patients has a crisis management plan in place, and that there is access to crisis assessments for both patients known to their services and new patients (*A Vision for Change*, DoHC 2006). The assessment of and intervention for any associated self-harm or suicide-related ideation should be delivered in a non-ED setting, unless there is an immediate physical injury or need, while meeting the standards outlined in the NCPSH.

The GP is the first point of contact for patients who self-harm or have suicide-related ideation. Such patients who present to their GPs should only be referred to the ED where there is an immediate physical need. The pathway of care for these patients is described in detail in Chapter 7.

3.1.2 Adult Liaison Psychiatry Services

The specialist Liaison Psychiatry team, including a consultant, non-consultant hospital doctors and psychiatric liaison nurses, provides mental health assessment and intervention for patients in the acute hospital setting. The current funding streams do not include out-of-hours cover, and so the specialist Liaison Psychiatry team are the first point of psychiatric contact for patients who present to the ED following self-harm or with suicide-related ideation during working hours only.(NCCMH 2016). These services have been well developed in the UK but not in Ireland (HSE 2016). For the last four decades in Ireland, the model in place has been that all patients who self-harm and present to the ED are referred to a psychiatrist for assessment and linkage to next appropriate care.

The NCPSH recommends provision of this service by suitably trained clinical nurse specialists (CNSs) or equally trained mental health professionals, and out of hours by

non-consultant hospital psychiatrists (NCHDs). The CNS is responsible for implementing the NCPSH, including providing assessments and follow-up for all patients, including those who are assessed out of hours by NCHDs. The recommended staffing is one CNS per 200 presentations of self-harm to the ED per annum. It is important that such CNSs are members of a Consultant-led Liaison Psychiatry multidisciplinary team and receive clinical supervision from a Consultant Liaison psychiatrist during working hours and from the on-call Consultant Psychiatrist if working extended hours (e.g. 8pm to 8am).

A Vision for Change (DoHC 2006) recommends having one multidisciplinary liaison psychiatry team, which should include at a minimum a consultant psychiatrist; a non-consultant hospital doctor; 2 clinical psychologists; 5 clinical nurse specialists, including 2 specialist behaviour nurse therapists or psychotherapists and 2 secretaries/administrators per regional hospital, or roughly 1 per 300,000 population, for every acute admitting hospital in Ireland. In 2006 there were 9 liaison psychiatry teams nationally. In 2021, there are 16 adult liaison teams – 7 in Dublin, 2 in Cork, 1 in Limerick, Galway, Drogheda, Cavan, Waterford, Sligo and Mayo. Letterkenny has funding agreed since 2015, but to date has been unable to recruit a consultant liaison psychiatrist. The number for Mullingar, Portiuncula and Kerry is 0.5 consultant liaison psychiatrist per acute hospital.

This leaves seven EDs that do not have input from a consultant in liaison psychiatry. CNSs and NCHDs provide assessments and each case is discussed with a General Adult Consultant Psychiatrist – either a Sector Consultant or the on-call Consultant. A designated Consultant Psychiatrist provides clinical governance. Experience has shown that the programme is well delivered by CNSs and NCHDs, with no significant difference between services that have fulltime Consultant Liaison Psychiatrists and those that do not (HSE 2017). Ongoing managerial support from the National Clinical Office has shown anecdotal evidence of a reduction of stress in CNSs following the introduction of a Liaison Psychiatrist, and an increased burden on CNSs working without a Consultant Liaison Psychiatrist at times of particular stress, such as during the Covid-19 pandemic. The programme now recommends that all services have input from a Consultant-led Liaison Psychiatry team.

3.1.3 Liaison mental health services for children

A Vision for Change also recommends that Child and Adolescent Liaison mental health services be provided for 300,000 catchment areas. Along with the full multidisciplinary teams in each of the three national children's hospitals, these services would provide liaison services to paediatric and general services. *A Vision for Change* recognised four categories of problems that require referral to child and adolescent liaison services: children and adolescents with chronic physical illness; those with chronic and medically unexplained somatic symptoms that have perpetuating and precipitating psychogenic factors; those who overdose and engage in deliberate self-harm and present to the hospital; and those with mental health disorders and coexisting physical illness.

This programme recommends that a child and family who present in crisis to an ED receive an assessment by a mental health professional who has timely access to clinical supervision by a CAMHS consultant on the phone.

Children in the three Dublin liaison services receive an immediate assessment following referral. In Tallaght and Crumlin, a small number of children, who are first presentations and deemed not to require further input from the community CAMHS team, will be followed up by the CAMHS liaison team. In Dublin EDs 16 and 17-year-olds present to adult acute hospitals. Mental health staff who assess these children do not currently have access to CAMHS consultant supervision. This programme recommends access to timely (before the patient leaves the ED) CAMHS consultant supervision over the phone, at a minimum.

In Limerick the community CAMHS has been developed over the past 19 years. The crisis nurse in ED will assess children at night, and the community CAMHS will provide assessments within 24 hours. The team uses a transdisciplinary approach, with one team member available for urgent assessments each afternoon. This person provides assessments in the ED during the day. This process has developed in the absence of a liaison CAMHS service. When a liaison CAMHS service is introduced, the ideal would be to continue to provide a team member for emergency assessments, who can carry out joint assessments with the ED-based liaison team member. This can facilitate separate

family and child assessments and also ensure there is access to a mental health professional who can follow up the child if required, along with a mental health professional who is working in the ED.

In Galway, the CAMHS consultants provide support and advice for the NCHDs or liaison staff who assess children. There is a rota system, and they provide on-call services to a number of hospitals in the area. There can be a delay in assessment during the day, while teams are in clinics. Individuals who are assessed will be linked with CAMHS within 24 hours.

In Dublin, funding has been secured to provide a CNS, working in the CAMHS team as a crisis intervention specialist. As part of this post, there would be a commitment to provide inreach to the ED in the local area. The Children's University Hospital, Temple Street and North Dublin could be used as a pilot, with joint meetings arranged to agree job description, clinical governance, training, policies and procedures.

3.2 Emergency Medicine Programme and the NCPSH

3.2.1 Interface between the NCPSH and the Emergency Medicine Programme

It is important to consider this NCPSH in the context of the ongoing transformation of healthcare services in Ireland, including fundamental restructuring of the emergency services.

The Emergency Medicine Programme (EMP), launched in June 2012, is the blueprint for emergency care in HSE, covering all aspects of governance and management of care and supporting standardised workforce models, processes, metrics and guidelines. Since 2012 there have been further developments in managing urgent and unscheduled care (Acute Medicine Programme and EMP 2020). These developments focus on the use of ED for emergency and undifferentiated presentations. A presentation with a problem clearly defined as the remit of a particular speciality can be referred directly for a non-ED assessment, such as the acute floor. This will apply in all medical specialties including psychiatry.

The overarching aim of the EMP is to improve the safety and quality of patient care in EDs and to reduce waiting times for patients.

Key initiatives of the EMP include:

- **a.** The definition and development of Emergency Care Networks within a National Emergency Care System. The networks of EDs will be fully integrated with pre-hospital and hospital-based services, ensuring a standardised approach to the delivery of high-quality emergency care.
- **b.** Increased consultant-provided care in EDs
- **c.** Developing clinical guidelines
- **d.** Developing roles for nurses including staff nurses, clinical nurse specialists, advanced nurse practitioners, therapy professionals, medical social workers and other members of the multidisciplinary team
- **e.** Implementing new clinical governance structures and processes to ensure clear authority, accountability and responsibility across the emergency care system
- **f.** Integrating implementation of the Emergency Medicine Programme with all relevant programmes, particularly the Acute Medicine, Surgery, Critical Care, Paediatrics, Medicine for the Elderly and Diagnostic Imaging
- **g.** Achievement of 6/9-hour ED time targets, from time of presentation to admission or discharge of patients

The overarching aim of both Clinical Programmes is to improve the safety and quality of patient care in EDs and to reduce waiting times for patients. Both programmes recommend ensuring clarity of communication between the ED staff and the mental health staff who are providing psychiatric services. The aim should be to improve access to mental health when needed, and to ensure that all patients have access to medical care. Within each ED, we advise that the ED staff and the mental health staff – to include both liaison and general adult psychiatrists who provide out-of-hours mental health service – hold regular meetings (at a minimum three monthly) to promote development of collaborative work practices. They provide a forum to address issues such as developing shared protocols around referrals, behaviour causing disturbance, patient transfer, admissions and clinical responsibility.

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

1. Equity of access for all patients, whether presenting to the ED with predominantly physical or with mental healthcare needs. This includes all patients requiring care following self-harm.
2. The use of a mental health decision tool at the point of ED triage (Post-Triage Mental Health Triage Tool) (HSE 2017a). This has been introduced in some EDs. Further training and support is required to ensure it is used in all EDs.
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 assessments in certain situations – e.g. where drug or alcohol intoxication is present).
5. Mental health staff provide training for ED staff on mental health and self-harm awareness. This training should be developed and delivered in collaboration with people with lived experience.
6. The NCPSH recommends that all patients who present receive a timely expert biopsychosocial assessment of needs. In some cases those presenting may be reluctant to wait for such an assessment. It is the responsibility of the ED, working with the mental health staff, to develop a clear protocol on contacting these patients' GP and ensuring they have an opportunity to link with next appropriate care.
7. ED staff and mental health staff should work with NOSP in developing 'distress' or 'support ' cards for people in mental health distress, similar to those developed for persons presenting following a head injury. These cards would be useful to support individuals and family members in accessing next appropriate care.
8. ED and mental health staff working in the ED should obtain feedback on the experience of people who use the service. This can be facilitated through the Mental Health Engagement and Recovery Forums that are now present in each CHO.

3.2.2 Assessment rooms suitable for patients requiring a mental health assessment

The Model of Care (HSE 2016) recommends that all EDs have a suitable room for assessment of people who require a mental health assessment. This recommendation is aligned with Irish and UK best practice (DoH Design Council 2011, IAEM 2006). This room should provide a calming atmosphere and be equipped for assessments of patients whose mental illness increases their risk of harm towards themselves or others (NICE 2004).

The Psychiatric Liaison Accreditation Network (PLAN) has identified standards suitable for this assessment room. PLAN is an initiative of the UK's Royal College of Psychiatrists' Centre for Quality Improvement, in partnership with the Royal College of Physicians, Royal College of Nursing, College of Emergency Medicine and the mental health charity Mind (RCPsych 2020). Patient and carer representatives are integral to the setting of quality standards and accreditation of services. These standards developed in the UK have been recommended for adoption in Irish EDs (McCraith Report 2014, College of Psychiatrists of Ireland 2018, National Clinical Programme Model of Care 2016.) A national audit of assessment rooms found high compliance with these standards (Jeffers et al 2020).

Standards
Is located within the main emergency department
Has at least one door, which opens outwards and is not lockable from the inside
Has an observation panel or window which allows staff from outside the room to check on
the patient or staff member but which still provides a sufficient degree of privacy
Has a panic button or alarm system (unless staff carry alarms at all times)
Only includes furniture, fittings and equipment that 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
Is appropriately decorated to provide a sense of calmness
Has a ceiling which has been risk-assessed
Does not have any ligature points

TABLE 3.1 STANDARDS FOR ED ROOMS FOR ASSESSING PATIENTS PRESENTING WITH MENTAL HEALTH PROBLEMS

3.2.3 Assessment of patients with mental health needs only

The complex and busy environment of ED is not the optimal environment for assessing patients with mental illness or psychosocial crisis. 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 be planned, with individuals first assessed by primary care and then referred to a community mental health team, and that a person who presents as urgent or as a self-referral should be assessed as soon as is practicable.

People with lived experience of self-harming or suicide-related ideation do not find the ED suitable for assessment (Doyle et al 2020). GPs do not find it a suitable environment (Carey et al 2021) and there is also evidence that patients assessed in the ED, rather than in the community, are more likely to be admitted to an approved centre when compared with people assessed in a community (non-ED) mental health setting (Gibbons 2012).

The experience of the Covid-19 pandemic has required many services to develop non-ED crisis assessment units in order to protect patients and staff from contracting Covid-19. This took the form of telephone triage, stand-alone crisis assessment hubs, or assessments within the approved centre.

In keeping with *A Vision for Change* and the Code of Practice of the Mental Health Commission, all services should develop acute assessment facilities outside of the ED.
If a patient with a well-differentiated mental illness and with no physical health needs presents to the ED, there should be a policy in place to ensure that person is redirected to a more appropriate place of assessment. This is consistent with all other differentiated medical presentations to ED, and with a parity of esteem approach.

It is the responsibility of the mental health services to provide an alternative to the ED for crisis assessments. A clear written policy should be in place in each ED describing how a person can be safely transferred to such a service. Barry et al (2020) have described service initiatives introduced during the Covid-19 pandemic, many of which include non-ED crisis assessment facilities. These should be continued in the post-Covid period.

3.2.4 Assessment of patients with both physical and mental health needs

For patients with both physical and mental health needs, both NCPSH and EMP promote the use of parallel assessments, whereby a mental health professional can work alongside ED staff or medical staff in meeting patients' needs. Access to mental healthcare should follow the same principles as access to any other hospital specialty and be guided at all times by the needs of the patient.

Timings of mental health assistance should be based on both the needs of the patient and the referrers rather than rules around whether the patient is able to participate in a full psychiatric assessment, often erroneously called 'medical clearance'. Even prior to interview, liaison psychiatry staff can give advice on the basis of past records, take collateral history from family or carers, support patients, advise clinical teams and plan appropriate timing for mental health interview. Mental health practitioners, usually clinical nurse specialists or non-consultant hospital doctors, should have received specific training and appropriate supervision. Mental health practitioners should discuss all presentations with a Senior Psychiatrist (Consultant or Higher Specialist trainee) or an Advanced Nurse Practitioner. The timing of that discussion depends on the training and experience of the mental health practitioner.

Interventions aimed at discouraging help-seeking are not effective, can be counter-productive and harmful, and should not be used. There is no place for inaccurate terms such as 'medically cleared', which have been used in the past to defer mental health assessments. These should be replaced with terms such as 'fit for assessment', 'fit for review' or 'fit for discharge' that can bring about an improvement in collaborative working and will improve the quality of the service the patient receives. The psychiatry service has an important role in guiding ED staff around management of patients who may lack capacity.

For parallel assessments to work effectively, patients whose care includes input from mental health teams while in the ED must remain under joint care of both the ED team and the psychiatry team. Liaison Psychiatry services do not have access to inpatient beds. If a decision is made to admit a person to the approved centre, the mental health services must continue to provide input until they leave the ED. Joint ownership will ensure that the patients' medical needs are addressed along with collaborative interdisciplinary working between mental health and ED staff in addressing patients' healthcare needs, including the management of safety needs and risks.

Alexander et al (2020) provide a detailed description of introducing process mapping from lean management into an Irish ED to improve the flow of patients with mental health problems. They found that process mapping addressed delays in patient flow, role confusion, duplication of work and communication difficulties. The process they describe would be an asset to any ED consultation liaison service.

3.2.5 Timely, expert, biopsychosocial assessment

Each person who presents following self-harm or with suicide-related ideation should receive a timely, expert biopsychosocial assessment. This assessment should be conducted by a clinical nurse specialist, social worker or non-consultant hospital doctor.

As well as being a thorough assessment of the individual's needs, this assessment should form a therapeutic connection. Collateral information should be obtained, with a person's permission, from family members, GPs and mental healthcare records.

Following this intervention, an emergency safety plan should be co-produced by the mental health professional in collaboration with the patient, and if possible with a family member or supportive adult. The patient should be given a copy of the emergency safety plan, a copy should be sent to their GP, and a copy should be retained in their notes.

CNSs employed by the mental health service and receiving clinical guidance from a Consultant Psychiatrist complete assessments during the day. They should be incorporated into the appropriate clinical governance of the mental health service. Ideally this is as part of the Consultant-led Liaison Psychiatry service. One CNS per 200 presentations per annum is funded through the NCPSH. This allows the CNS to complete the clinical role of providing assessments and follow-up phone calls, including for those assessed out of hours, along with their role in teaching, research and audit and supervision.

Appropriately trained Mental Health Social Workers (MHSWs) employed by the mental health services and receiving clinical guidance from a Consultant Psychiatrist can complete assessments. MHSWs are registered practitioners with CORU, Ireland's multi-profession health regulator. They must also engage in continuous practice development and hold a Level 8 or above on the NQAI framework. Social work in mental health seeks to address

the social and environmental factors affecting the individual's and family's mental health, working in partnership with the person and their family/support person. MHSW inform care planning on multidisciplinary teams in mental health, ensuring a psychosocial aspect and perspective to client care. MHSWs are ideally placed to provide individual assessment and also to add to the interdisciplinary working of the liaison team.

The NCPSH should be delivered 24/7. A patient presenting out of hours should have access to the same four clinical components of the NCPSH: they should receive an empathic, compassionate, trauma-informed and validating response; they should receive a timely, expert biopsychosocial assessment and intervention, including a written emergency safety plan; every effort should be made to involve family in assessment and safety planning, and the patient should be followed up and bridged to next appropriate care. The CNS will provide the follow-up phone call within 24 hours, but it is the responsibility of each assessing clinician, including the NCHD out of hours, to provide the Emergency Safety Plan, to send a letter to the GP within 24 hours and to send information and notes, as appropriate, to the next appropriate care. The CNS on duty the following day should be informed of the assessment.

On-call and crisis psychiatry is becoming very challenging for psychiatrists in training. Over one-third of trainees surveyed reported dissatisfaction with their experience on call, reporting poor training, overwork and lack of suitable facilities to see patients (O'Donovan et al 2020). It is the responsibility of the clinical director to ensure that the NCHD is supported to carry out all aspects of the NCPSH. This includes training, consultant supervision and, in some of the busier services, ensuring there is extra staff to provide support where required. A recent report of service innovations during Covid-19 provides helpful recommendations for services, including in the post-Covid period (Barry et al 2020).

NCHDs are invited to the training offered twice yearly for CNSs and mental health professionals delivering the NCPSH. The College of Psychiatrists of Ireland in collaboration with the NCPSH office has developed an e-module on the NCPSH (CPsychI 2021). NOSP, the NCP office and CPsychI continue to collaborate on delivering training.

3.3 The role of emergency safety planning in mitigating suicide risk

The risk of suicide is raised in any person who self-harms or presents to hospital with suicide-related ideation. The aim of the Clinical Programme is to introduce practices that mitigate this risk.

Self-harm and talking about suicide leads to understandable anxiety and distress among individuals and family members. The assessing mental health clinician needs to provide compassionate support and develop a therapeutic rapport in order to complete an expert assessment. Many individuals and their families will have an expectation that hospital admission may be required. In practice, most individuals will be treated within the community. Hospital admission will only be required for a very small percentage of people – those presenting with symptoms of psychosis or extreme agitation or hopelessness caused by mental illness.

Most people will not present an immediate risk of suicide, and yet on any actuarial assessment of risk they would have a high score, simply by virtue of having made a previous suicidal attempt or presenting with suicide-related ideation. We know that risk assessment tools cannot predict suicide (Chan 2016). We also know that, in the UK, most risk assessment tools used in services have not been tested or validated (Quinliven 2014) and it is likely that the same applies in Ireland. We also know that a preoccupation with risk assessment tools is often used to manage organisational risk and is not in the patient's best interest. Patients complain of feeling processed or partaking in a tickbox exercise when their risk is being assessed. Along with the expert biopsychosocial assessment, patients also want hope and support (Doyle et al 2020).

Brief interventions, such as follow-up phone calls, safety planning, cognitive behavioural therapy and dialectical behavioural therapy, have been shown to have benefit (Milner et al 2016, Stanley and Brown 2018). Knowledge of these different interventions is required to instil hope and explain future treatment plans. These should address the helplessness, hopelessness and despair the individual experiences, and at the same time acknowledge that during this crisis the person will be most open to change.

The brief treatment and crisis intervention model most frequently used in social work practice is the Albert Roberts Seven-Stage Crisis Intervention Model, which has similarities with safety planning. This model facilitates the clinician's effective intervening by emphasising rapid assessment of the client's problem and resources, collaborating on goal selection and attainment, finding alternative coping methods, developing a working alliance, and building on the client's strengths (Roberts 2005). Stages in the model include: assessing safety and lethality, rapport-building problem identification; addressing feelings, generating alternatives, developing an action plan, and follow-up. Building rapport is essential throughout this process. Here the therapeutic core conditions, as outlined by Carl Rogers' person-centred approaches, are used: genuineness, empathy, acceptance and caring, thus instilling hope and trust.

Evidence described in Chapter 2 shows it is now timely that the NCPSH advise a shift in emphasis from using risk assessment tools to using collaborative emergency safety planning. This is in keeping with the recovery ethos and supported by empirical evidence. The NCPSH 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.

While the original Model of Care suggested that each person should have an Emergency Care Plan, now, in keeping with recovery principles, we advocate the use of Emergency Safety Planning, focusing on building a therapeutic relationship with the individual. We also emphasise the importance of including the family member or supportive adult, as shown in Figure 3.1.

The following suicide risk mitigation plan should be followed for each person presenting to the ED.

a) Ensure that the person receives an empathic, compassionate and validating response in the ED. This has been shown to improve trust and foster openness to receiving appropriate help.

b) Provide a timely, expert biopsychosocial assessment, ensuring that a family member or supportive friend is contacted to provide collateral information. If the patient does not give permission for this, every effort should be made to persuade them of the value of such input. A comprehensive biopsychosocial assessment will identify an individual's needs and strengths and point to the most appropriate next care.

c) This assessment is a therapeutic intervention in itself, providing support and validation, along with expert direction and the instillation of hope. Genuineness, empathy and acceptance are central to this.

d) Following the assessment, and where possible using family or supporter input, a collaborative emergency safety plan should be developed by the patient and the mental health clinician.

e) This emergency safety plan is aimed at co-producing, with the individual and their family member, a written plan for the following 24 hours. It should include how to provide a safe environment, who to contact in an emergency and what the next professional contact should be, while addressing what the individual needs to do, what the family member needs to do and what the service needs to do.

f) The case should be presented to the Consultant Psychiatrist on call. The clinician ensures that care is transferred to next appropriate care. The timing of this discussion with the Consultant Psychiatrist depends on the skill and experience of the clinician. The clinician ensures that the CNS in self-harm is aware of the case and the future care arrangements. It is the responsibility of the assessing clinician to ensure that the safety plan is completed, a letter is sent to the GP and, if required, notes are sent on to the next service.

g) Within the following 24 hours, the person should be contacted by phone by the CNS in self-harm to review the safety plan and confirm any further appointments.

h) In some cases, 2 or 3 follow-up appointments may be required, to facilitate engagement in next appropriate care.

Patient's Name: **Date of Birth:**
Mental Health Professional (MHP) Name:
ESP completed in collaboration by the MHP and the patient: **Yes ❑ No ❑**
Family member/supporter has been part of the care plan: **Y ❑** N ❑

	RESPONSES	**ACTIONS**
Keep safe	Individual Family member/supporter GP /SCAN	*(e.g. Remove firearms, tablets, means of self-harm. Stay with relatives/supportive friend. Identify internal/personal coping strategies.)*
Emergency numbers		*(Include numbers for Samaritans 116123; daytime numbers for CMHT and GP; and for supportive family members or friends who can be contacted in an emergency.)*
Mental Health Support		*(e.g. Name of place and phone number for next appointment; plan for what the next communication will be with the patient.)*

Patient has requested family member is not included: **Y ❑** N ❑
Family member given a copy of *Would you know what to do if someone told you they were suicidal? (NOSP)*: Y❑N❑
Copy of the ESP given to the patient: **Y ❑** N ❑
Signed (MHP)
Signed (Patient – *optional*)

FIG. 3.2 EXAMPLE OF AN EMERGENCY SAFETY PLAN

3.4 Family/supportive friend intervention

An important objective of the Clinical Programme is to enhance the experience of families in supporting their relative. This includes the mental health professional taking collateral information from family members, providing advice on suicide prevention and, with patient consent, informing family members of the care plan. If the patient is discharged home, the CNS provides brief follow-up support, up to three times, by phone or in person to the patient and the family member between ED assessment and the time they reach the next point of care – for example, the GP, mental health team or a counselling service. Underpinning this model is the triangle of care of the person at risk, the family member and the healthcare professional.

and support to family members and to take any collateral history a family may wish to give. Specific training on confidentiality is required for all staff, including ED staff.

The Emergency Safety Plan should be produced with the individual and their family member/supportive adult. This is a written plan for the following 24 hours. It should include how to provide a safe environment, whom to contact in an emergency and what the next professional contact will be. It should address what the individual, family members/ supportive friend and the service need to do.

Family members or supportive friends will require support in their own right. It is appropriate that clinicians provide time for family members or supportive adults to be interviewed alone.

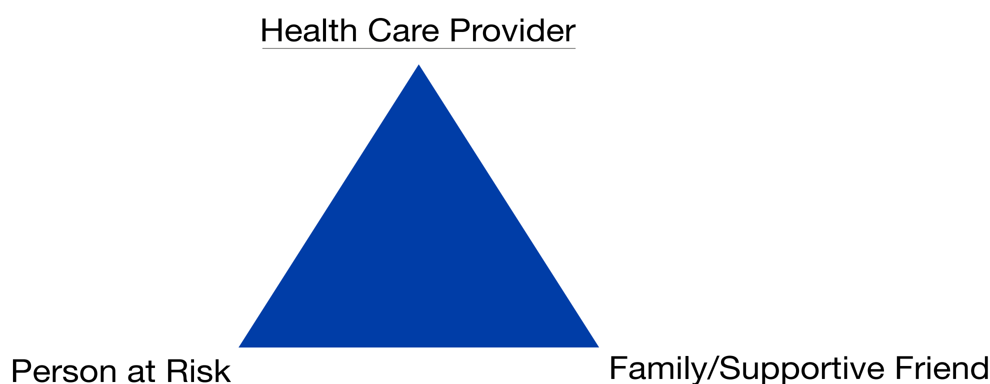

FIG. 3.3 ONCE, TWICE, THREE TIMES – STOP (CARROLL 2012). COLLABORATION BETWEEN PERSON AT RISK, HEALTHCARE PROVIDER AND FAMILY MEMBER OR SUPPORTIVE ADULT

Gathering information from family members and supportive adults and providing them with support is central to the NCPSH. 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. Listening to family members/carers can be essential and is not precluded by confidentiality. While confidentiality is paramount, there are situations where the level of risk requires that a family member or carer must be contacted for further information. Clinicians can provide support for family members/carers without breaching patient confidentiality. ED staff should be able to access a mental health professional to provide advice

However, it is also important to be aware of the risks of possible abuse by family members. 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 in women (Dillon et al 2012). All clinicians should be aware of this and the need to provide each patient with personal time and space to be interviewed alone.

3.5 Summary and recommendations

- The mental health services should ensure that the NCPSH in the ED is delivered 24 hours a day 7 days a week.
- The four clinical components – an empathic response, an expert assessment and intervention, family/ supporter involvement, and follow-up and bridging to next care – should be offered to all patients who present following self-harm or with suicide-related ideation.
- The NCPSH is led by Consultant Psychiatrists and delivered by a CNS, MHSW or NCHD.
- It is the responsibility of the Clinical Director to ensure that the NCHD is supported to carry out all aspects of the NCPSH. This includes training, consultant supervision and, in some of the busier services, ensuring extra staff to provide support where required.
- On-site liaison mental health services should be provided by one multidisciplinary Liaison Psychiatry team, as recommended in *A Vision for Change*. This includes all Model 4 and Model 3 hospitals.
- Access to liaison mental health services should be provided in all hospitals. In smaller hospitals this would include a 0.5 WTE Consultant Psychiatrist providing clinical leadership to a smaller team.
- In the interim, in those acute hospitals where Liaison Psychiatry services are not available, the area mental health service should fund appropriate Consultant Psychiatrist time to provide coordination of the mental health service available for patients presenting to the ED following self-harm or with suicide related ideation.
- Child and Adolescent Liaison mental health services should be provided by one multidisciplinary liaison psychiatry team, as recommended in *A Vision for Change*. This may be on-site services in the larger hospitals and in-reach provided by community-based CAMHS teams.
- The Area Mental Health service should fund appropriate Consultant Child and Adolescent Psychiatrist time to coordinate the mental health service available to children in the ED and general hospital who present with suicide-related ideation or self-harm.
- All Consultant Psychiatrists should ensure they have a working knowledge of the NCPSH and that all patients, including those presenting out of hours, receive all clinical components.
- The mental health team should provide regular training for ED staff on mental health and suicide awareness.
- The Post Triage Mental Health Triage tool should be introduced in each ED. Training is required for ED staff.
- Parallel assessments addressing both mental health and physical health needs should be usual practice.
- Joint responsibility between ED teams and the mental health teams for patients in the ED will provide improved outcomes.
- Regular meetings between the ED staff and the mental health staff providing consultations in the ED should occur to address issues related to assessments, admissions and clinical responsibility of patients.
- ED staff and mental health staff working in the ED should use attendance at the local HSE Mental Health Engagement forum in order to obtain feedback from people who use the service.
- Connecting for Life Local Implementation Plans should include input from mental health staff working in the ED and in SCAN service.
- In keeping with *A Vision for Change* and the Code of Practice of the Mental Health Commissions that all services develop acute assessment facilities outside of the ED.
- Each patient presenting to the Emergency Department following self-harm should be treated with respect and compassion. They should receive an empathic, compassionate, trauma-informed and validating response.
- Each ED should ensure there is high-quality, dedicated accommodation for the assessment of patients with mental problems.
- Each mental health service should ensure there is a clear pathway to transfer patients to a non-ED facility for mental health assessment, where there is no physical health problem and the need for mental health care is clearly differentiated.

» Each patient should be seen in a timely manner by ED staff and by mental health practitioners (usually CNSs or Psychiatrists).

» The interview should focus on developing a therapeutic alliance to instil hope and trust. Genuineness, empathy, acceptance and caring are central to this.

» 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.

» Each presentation should be discussed with a senior Psychiatrist (Consultant or Higher Specialist Trainee) or Advanced Nurse Practitioner. The timing of that discussion depends on the training and experience of the mental health practitioner.

» An Emergency Safety Plan should be co-produced by the patient, a family member or supportive adult and the mental health clinician.

» This Emergency Safety Plan is aimed at co-producing, with the individual and their family member, a written plan for the following 24 hours. It should include how to provide a safe environment, who to contact in an emergency and what the next professional contact should be, while addressing what the individual needs to do, what the family member needs to do and what the service needs to do.

» The Emergency Safety Plan should include a safe environment, emergency numbers and plans for next care appointment.

» Every effort should be made to involve a family member or trusted adult in assessment and in safety planning.

» Family member/supportive friend should co-produce the emergency safety plan, along with the patient and the mental health clinician.

» Family members/supportive friend should be supported in supporting their loved one, including being given a copy of Would you know what to do if someone told you they were thinking of suicide?

» Confidentiality is paramount but there are situations where it can be breached, such as risk to the individual. Even in situations where it is not appropriate to breach confidentiality, listening to family members/carers is important and is not precluded by confidentiality.

» Support for family members/carers can also be provided without breaching confidentiality.

» ED staff should be able to access a mental health professional to provide advice and support to family members and to take any collateral history a family may wish to give.

» Specific training on confidentiality is required for all staff including ED staff.

» All clinicians should be aware of the possibility of intimate partner violence and the need to provide each patient with personal time and space to be interviewed alone.

Training and governance are discussed in more detail in Chapters 9 and 10.