05

Groups with Specifically Identified Needs

All people who self-harm or present with suicidal-related ideation have an elevated risk of suicide. However, a number of groups and communities have a particular vulnerability to and increased risk of suicidal behaviour, and they also have specific needs when they present to services. People may be in more than one of these groups.

5.1 Substance misuse

At least 50% of self-harm episodes are carried out under the influence of alcohol or illicit substances. Acute intoxication is associated with more violent methods of self-harm and suicide for both men and women, particularly among younger and middle-age groups. In addition, elevated self-harm and suicide rates are found in patients who are dependent on alcohol or other substances (Kaplan 2013).

Stigmatising and discriminating against people who use drugs is not limited to the general public; it can directly affect clinical care (Kelly et al 2010).

GPs should be trained in the recognition and treatment of substance misuse and in the provision of brief advice and feedback. The role of harmful drinking patterns contributing to self-harm behaviour should be recognised. There should be a corresponding focus on brief intervention and a low threshold for referral to local alcohol services.

The current strategy, ‘Reducing Harm, Supporting Recovery: A health-led approach to drug and alcohol use in Ireland 2017–2025’, identifies how the needs of this population can be met. Each local drugs task force is tasked with providing a health-focused and harm-reduction response to drug and alcohol use in Ireland. Use of SAOR (Screening, Ask and Assess, Offer Assistance and Referral), screening and brief intervention for problematic alcohol and substance use in ED settings has indicated that fewer than 10% of those screened needed onward referral to specialist addiction services (O’Shea et al 2017).

All staff carrying out a mental health assessment should have skills in carrying out opportunistic screening and interventions for those at risk, including training in SAOR. The biopsychosocial assessment of all patients who present to ED following self-harm must include a comprehensive assessment of potential misuse of alcohol and other substances. This should include a screen for alcohol and drug use, using a screening tool such as AUDIT and DUDIT (Higgins-Biddle and Bador 2018, Berman et al 2002), discussing options with the patient and referring to specialist services where appropriate. Signposting alone is not effective. Every effort should be made to provide a time and date for an appointment with a specialist service, if a referral is deemed appropriate.

A number of interventions are required to improve the response to people with alcohol and substance misuse. In the larger EDs there is a need to employ an addiction specialist/mental health professional. This is a nurse or other health and social care mental health professional who specialises in intervening with those engaged in alcohol and substance misuse. These professionals will be funded through the Primary Care Addiction Programme and will improve the engagement with mental health services. They also have a role in educating the ED staff.

There is a need to address the needs of those with co-morbid mental illness and alcohol or substance misuse. The HSE Dual Diagnosis Clinical Programme will support this.

There is a need to improve access to addictions services at a primary care level. This is relevant for next appropriate care following review in the ED, and also for GP referrals.

5.2 Homeless population

Homeless people, in particular rough sleepers, are vulnerable to physical and mental health problems and are high users of ED services. They have increased rates of alcohol and other substance misuse, higher rates of mental health difficulties and elevated rates of self-harm and suicide. However, they are least likely to have access to appropriate mental health services (CPsychI 2011).

Using data from the national Self-Harm Registry, the age-standardised incidence rate of self-harm was 30 times higher among homeless people compared with domiciled people in Ireland (Barrett et al 2018). Homeless people had significantly higher odds of being male, of self-cutting and of having a psychiatric admission. They were also found to have higher odds of repetition of self-harm within 12 months of first presentation.

Dunne et al (2012) profiled the users of the specialist mental health service for homeless people in Cork and found users of the specialist service were more likely to have a history of self-harm compared with those attending a general adult mental health service (54% vs. 21%). They also found that those using the specialist service had a higher prevalence of schizophrenia (50% vs. 34%), personality disorder (37% vs. 11%) and substance dependence (74% vs. 19%).

Glynn et al (2017), in addressing the problem of premature death and self-harm among the homeless in Ireland, recognised that we have a care system that is failing one of its most vulnerable groups. Addressing these issues will require a multifaceted approach. While a housing-led strategy is required, Glynn also identified an urgent need to adequately resource and coordinate those services which aim to address all of the other factors (social and health inequalities, mental ill-health and addiction) which lead people into and prevent them from exiting homelessness.

In September 2018, the ‘Housing First National Implementation Plan 2018–2021’ was launched by the Minister for Housing, Planning and Local Government and the Minister for Health (Dublin Regional Housing Executive 2018). This plan recognised the critical need for a joined-up approach between government departments, local authorities, the HSE, homeless service providers and voluntary housing bodies. It is a model, first developed in the US in the 1990s, that looks at housing individuals and providing wraparound support to them in a flexible, assertive, outreached modelled approach. Housing First is currently being piloted in Dublin, Cork, Waterford, Limerick and Galway.

The specialist mental health teams for the homeless work with people who have mental illness and severe and complex social needs, and are homeless. Specialist homeless teams, local CMHTs and addiction services in inner Dublin are under-resourced (CPsychI 2011). The mental health services provide for all those with severe and complex mental health and social care needs; if adequately resourced, that support could extend to provide for those with significant mental health and social care needs in the inner city. Fully resourced teams would also work more flexibly with each other. There would still be a need to develop a separate service for those who are in a suicidal crisis but have minor or no mental health needs. There are also specialist services in Galway, Cork, Waterford and Limerick; homeless people use EDs, CMHTs and the specialist services.

While homeless people have a right to mental health services along with the rest of the population, it is also important to provide additional services that acknowledge the logistical difficulties they experience. Homeless people who are suicidal, but whose mental health and social care needs are not severe and complex, are best supported by other community-based services. The Dublin Simon Community has established a specific counselling service for homeless people who are suicidal, with support staff and counsellors trained in Collaborative Assessment and Management of Suicidality (CAMS) (Dublin Simon 2018). This has been part-funded by NOSP. They have recently developed the Suicide Specific Treatment Track (SSTT), an abridged form of CAMS that is used effectively by support workers who are supervised by trained counsellors (Dublin Simon Community, personal communication 2021). The aim of this service is to provide support to individuals in the most appropriate place; for most, this is in a day centre or hostel where they are accessing other services. There is anecdotal evidence that this service is reducing the numbers referred to the ED, ensuring that people are more appropriately supported. The service has identified the need for input from a mental health professional in relation to a small group of clients.

GP services supporting people who are homeless link with support services and counselling services (Safety Net 2020). If the person does not have a severe mental illness and requires a mental health assessment, they are referred to the ED.

Patients who are homeless and present or are referred to the ED, either following self-harm or with suicidal ideation, may not always wait to be seen by a mental health professional. Following mental health assessment they require considerable support in ensuring they are linked to appropriate next care. This may require offering two or three follow-up appointments until this link is made. Collaborative working between the clinical nurse specialist in self-harm, other clinicians and groups working with homeless people is required.

Dedicated mental health staff, such as a Suicide Crisis Assessment Nurse or equally qualified mental health professional, would be well placed to provide a liaison role and support for GPs and homeless services working with people who are in a suicidal crisis but do not have a severe mental illness and therefore do not obtain input from either the specialised mental health teams for homeless people or the local CMHTs. A Suicide Crisis Assessment Nurse (SCAN) would provide a comprehensive biopsychosocial assessment and identify the most appropriate next care. In some cases it would be appropriate to provide up to three follow-up sessions. They would also provide a liaison role between primary care, homeless services and secondary care services. They would refer the most complex cases to the specialist mental health team for homeless people or to the local CMHTs. The CNS would develop links and work alongside other agencies for homeless people. (Governance is discussed further in Chapter 10).

The mental health service would employ the SCAN. They would receive professional supervision from their line manager and clinical supervision from a Consultant Psychiatrist, either from one of the specialist mental health teams for homeless people, or from a CMHT.

Chapter 7 describes the role of a SCAN professional in more detail. For the rest of the population, it is recommended that there be one SCAN professional for every 75,000 population. In relation to the homeless population in any area, the SCAN professional would work as part of the specialist team mental health team for the homeless and be available to also provide other input within the team.

The combination of the Simon Community's Suicide Specific Treatment Track and the use of SCAN should be piloted in Dublin, with a view to extending this to other parts of the country.

5.3 People who identify as LGBTQI+

Members of the lesbian, gay, bisexual, transgender, queer and/or questioning, intersex, asexual and two-spirit (LGBTQIA2S+) community have been shown by national and international research to have increased risk of suicidal behaviour (Higgins et al 2016, Russell et al 2016, King et al 2008), and have been identified as a priority group in Connecting for Life. There is a high rate of self-harm and suicidal ideation in lesbian, gay, bisexual and transgender groups. Internationally, the rate has been estimated to be between four and eight times higher among LGB and transgender young people compared with heterosexual and cisgender peers (Haas et al 2011). While, as a broad group, sexual and gender minorities have high levels of suicidal ideation and behaviour, among transgender people these rates are even greater (Richards and Barker 2013, Bauer et al 2013, Mottman et al 2010, Grant et al 2011).

Many of the risk factors for self-harm and suicide in the LGBTI+ population overlap with those of non-LGBTI populations, such as depression, alcohol and substance misuse (Hottes et al 2016). There are also unique risks factors to sexual and gender minorities. For example, the experience of abuse, discrimination or harassment due to an individual's gender identity or presentation has been shown to be linked to high levels of attempted suicide (Kelleher 2009, Taliaferro and Meuhlenkamp 2017). It has been suggested that young people may internalise the experiences of public stigma in relation to being LGTBI, and this affects self-perception and beliefs which could increase suicidal behaviour or self-harm (Puckett et al 2017).

Higgins et al in their 2016 study of Irish LGBTI found that 34% reported a lifetime history of self-harm; 60% of people who had self-harmed related their self-harming to their LGBTI identity and their struggle to be accepted by others and society. They emphasised the need to improve the knowledge and skills of professionals and service providers to ensure that practice guidelines and training programmes would be LGBTI-inclusive. Russell et al (2018) highlighted the positive effect that using chosen names and pronouns has on reducing depression and suicide rates among young people. They also emphasised the need to improve the knowledge and skills of professionals and service providers.

All staff carrying out mental health assessments in the ED and in SCAN should receive training in understanding and supporting people with different gender and sexual identities.

5.4 Students in higher education

The college age years are a time of great change and it is also a time when there is a higher risk of manifesting mental health problems; 75% of serious mental health difficulties emerge in the age range 15 to 25 (Kessler et al 2005). Within the student population, 35% of first-year students screened positive for at least one mental health disorder – depression, anxiety or substance use (WHO 2014). Suicide is a leading cause of death in young people (WHO 2014.) The My World Survey in Ireland (Dooley and Fitzgerald 2012) found that the number one health issue for students was mental health. On average, 131 young people under the age of 30 die by suicide in Ireland each year (NOSP 2016).

In both Irish and UK studies, a number of factors have been identified that may increase the risk of mental health difficulties (UUK 2018 and Dooley et al 2019). These include academic pressures, exam and assignment stress, transitions in and out of higher education, financial burdens, managing jobs and academic work, social and cultural pressures (including family, friends and intimate relationships), social media, and broader geopolitical concerns. Some groups of students are at higher risk of developing mental health difficulties; these include those who identify as LGBTQIA2S+, international students, asylum-seekers and refugees, those who experience trauma, online remote students, first-generation students, mature students, those from disadvantaged socioeconomic backgrounds and those from minority ethnic backgrounds.

In September 2020 Ireland launched the National Student Mental Health and Suicide Prevention Strategy (HEA 2020). The National Framework draws from international evidence and calls for an embedded whole-system approach. It provides an opportunity for higher education institutions (HEIs) to review and reflect on their current support for student mental health and actions for suicide prevention. In the whole-system approach, awareness training for all staff and students in recognition and referral for mental health difficulties is prioritised, as is providing students with safe, accessible and well-resourced mental health supports.

Close liaison between CNSs working on the Clinical Programme and GPs, counsellors and psychiatrists within universities is appropriate in dealing with individual cases. All staff should have an awareness of the contents of the Student Suicide Prevention Strategy.

5.5 The Traveller community

Irish Travellers are an indigenous minority group in Ireland, first officially recognised by the Irish Government in March 2017 (Joint Committee on Justice and Equality 2017). They are distinct in their culture, language and value system originating from their nomadic tradition (NiShuinear 1994). The Equal Status Acts (Government of Ireland 2016) defines Travellers as: ‘The community of people who are commonly called Travellers and who are identified (both by themselves and others) as people with a shared history, culture and traditions, including an affinity to a nomadic way of life on the island of Ireland’.

Travellers are noted to have a higher rate of suicide than the rest of the Irish population (O’Shea 2011, Pavee Point 2013, Malone et al 2017.) McKey et al (2020) have reviewed the literature on Travellers and suicide, and reported a paucity of research in the area. The largest of the studies examining the health of Travellers is the All-Ireland Traveller Health Study – Our Geels 2010 (AITHS), a community-based survey of all Traveller households on the island of Ireland in 2008 and 2009 (All-Ireland Traveller Health Study Team, 2010). The AITHS included an overall census of 7,042 Traveller families, followed by a random selection of an individual member of the family to answer either a health status or a health utilisation questionnaire. One AITHS paper focused on disparities in fatal and non-fatal injuries in the Traveller population compared with the general public. Findings showed increased intentional injury, including suicide and self-harm in the Traveller population. Men were six times and women four times more likely to have an intentional injury, of which the majority were suicide deaths (Abdalla et al 2013). Malone et al (2017) described suicide in the Traveller community in more detail. McKey and Malone both note that an increase in suicide is common in all indigenous populations, with an increased use of drugs and alcohol noted, although this does not fully explain the increase.

Due to chronic under-usage of mainstream health services (and the attendant obstacles that exist for Travellers accessing healthcare), the Traveller health response seems to focus on ED assessment and input, where the ED is seen as the only resort as well as the last resort for their health (and mental health) needs. On the other hand, the ED is configured to triage and prioritise the most ill, and may not understand the crisis-led life and death culture observed among Travellers, contributing to communication breakdown and mutual mistrust (Beach 2006, McGorrian et al 2012). McKey et al make the point that the ED is an area where cultural competence can affect outcomes, and stigma and discrimination contribute to poor outcomes. A recent study by the European Union Agency for Fundamental Rights (FRA 2020) found that 68% of Traveller men and 62% of Traveller women reported experiencing discrimination.

All staff carrying out mental health assessments in the ED and in SCAN following GP referral should receive training in Traveller cultural awareness.

5.6 Asylum-seekers and refugees

Kavalidou and Albanese (2021) have pointed to the many risk factors for suicide that are seen among asylum-seekers and refugees. They come from a number of heterogeneous groups, and their social, cultural and health needs differ, as do their current legal status and migration experiences. However, Kavalidou and Albanese (2021) propose that the experience of forced migration, pre-migration trauma and entrapment would all pose an increased risk of suicide. They highlight the paucity of studies on self-harm and suicide among asylum-seekers and refugees.

Besides common mental health issues, studies from Australia highlight that prolonged uncertainty and feelings of being trapped among asylum-seekers may lead to suicidal behaviours (Proctor et al 2018). However, there is scarce evidence of suicide and self-harm among refugees and asylum-seekers from other hosting countries (Vijayakumar 2016), although this seems to be due to a lack of studies. A recent systematic review found that unaccompanied minors have an evident risk of self-harm according to the few studies conducted mainly in the UK, Sweden and Belgium (Gargiulo, A 2020). Kavalidou and Albanese (2021) call for further research in this area.

Miller et al (2019) and Im and Swan (2020) have described pointers for ensuring trauma-informed practices in working with young and older refugees.

All staff working with asylum-seekers and refugees should receive training in trauma-informed clinical practices. The national Clinical Programme is well placed to research presentations of asylum-seekers or refuges following self-harm.

5.7 The deaf and hard-of-hearing community

People who are deaf or hard of hearing have an increased rate of mental illness compared with the hearing population (Fellinger et al 2012). They also experience difficulties in accessing mental health care. Turner et al (2007) completed a literature review of suicide in deaf populations. They did not find evidence of increased rates of suicide, but the number of studies was small, and they noted the need for more studies and improved access to specialist mental health services. Mental Health Reform (2015) produced a briefing statement on supporting people from the deaf community who have mental health difficulties. Among other recommendations it recommended that remote interpretation services should be made available in EDs across the country to ensure that people who are deaf are adequately supported should they present in a mental health crisis.

A Vision for Change clearly sets out that mental health services should respond to the mental health needs of minority groups, including the needs of deaf people. The policy recognises that this group of people may have additional needs upon accessing a mental health service; therefore mental health services need to have the necessary understanding and knowledge to meet the care needs of deaf individuals.

More specifically, *A Vision for Change* recommends that effective interpretation services be made available to ensure that deaf people can access mental health services. It recognises that good communication is of crucial importance in service provision and 'is at the heart of mental health work'. The policy states, 'Mental health work requires interpreters who are able to interpret the “idiom” of the individual’s distress as well as the actual words used. Interpreters must be able to empathise with the individual’s position and children and/or family members of the individual in question should not be used as interpreters’.

Deaf or hard-of-hearing people must have their interview facilitated by an Irish Sign Language (ISL) interpreter. Services should ensure that the phone number and video facility for an ISL interpreter is available for use.

Deaf or hard-of-hearing people who present following self-harm need support in being linked to appropriate next care. While some specialist non-crisis suicide counselling services can provide a service for deaf people, there is a need for specialist mental health services for the deaf community. In 2005 the HSE established a specialist service with a part-time Consultant Psychiatrist and a full-time clinical nurse specialist. Following a break in the service provision following retirement of the Consultant Psychiatrist, it has been restarted and is now provided by Consultant Psychiatrist Dr Aiden Collins and CNS Ms Blessing Obioha. The service is based in the Thomas Mahon Building in the Deaf Village in Cabra, Dublin. It accepts referrals from CMHTs and GPs. Assessments depend on the availability of ISL interpreters (Chime 2021).

5.8 Autistic people

Suicide, self-harm and non-suicidal self-injury are major health concerns for autistic people. Suicidality is exceptionally common, occurring in 66% of autistic individuals (Cassidy et al 2018). Suicide risk is seven times higher in autistic people, contributes substantially to premature mortality in adults on the autistic spectrum (Hirvikoski et al 2016) and is associated with a greater risk of suicide at a younger age (Chen et al 2017) and in autistic females (Kirby et al 2019) compared with non-autistic peers.

Among autistic youth, estimates of suicidality range from 10.9% to 50% (Segers et al 2014, Horowitz et al 2018, Demirkiya et al 2016). Increased rates in comparison with non-autistic children are reported (Hunche et al 2020). Autistic children and/or children with an intellectual disability are disproportionately overrepresented in emergency presentations (20%) in Ireland, and more recently are presenting with high-lethality methods of self-harm, namely ligature use, in comparison with their non-autistic peers (Maguire et al 2020).

Many risk factors associated with suicidality generally are also relevant to autistic adults and youth (Connor et al 2020). Autistic youth may have increased exposure to several risk factors, such as social isolation, peer victimisation, abuse and cyber bullying (Park et al 2020). Park found that autistic traits inherently appear to increase risk and may affect timely detection and intervention. Alexithymia (the inability to identify and describe one’s emotions), repetitive behaviours, IQ and adaptive behaviour are implicated in suicide risk in autism (South et al 2020). Theoretically, cognitive rigidity coupled with low mood may act together to reduce coping and problem-solving and increase risk of suicide in autistic people (Culpin et al 2018). This has relevance also in the general population, since autistic traits in childhood predict suicidality in adolescence (Cassidy et al 2014).

There is overwhelming evidence that mental health comorbidities are significant risk factors for suicidality in autistic adults (Rosen et al 2018). However, they are frequently underdiagnosed due to diagnostic overshadowing. The latter refers to non-identification of comorbid conditions in autistic people, which are instead attributed to autism (Rosen et al 2018); 70% of autistic youth experience one or more mental health comorbidities (Simonoff et al 2013), the commonest of which are anxiety, depression and ADHD. However, some studies suggest that mood disorders are less prevalent in suicide attempts by autistic compared with non-autistic people, although this could be related to underdiagnosis of depression (Crane et al 2019). Emotional deregulation could be an underlying factor and target for support.

Autism spectrum disorder (ASD) is often overlooked or misdiagnosed in adult patients, especially in those with other psychiatric comorbidities (Kondo 2015). Five disorders (schizophrenia, psychotic disorder, bipolar disorder, major depressive disorder, and personality disorder) were specifically highlighted as misdiagnosed psychiatric diseases or comorbidities responsible for unrecognised ASD (Kondo 2015).

Significant systemic and autism-specific barriers to accessing a range of health services generally, including mental health services, have been reported (Jager-Hymen et al 2020). Health professionals, including psychiatrists, report difficulties communicating with autistic patients and understanding their needs, which may negatively affect the quality of mental health and suicide risk assessment provided. In one survey, clinicians reported lower confidence with suicide risk assessment, and rated safety planning as significantly less acceptable for their autistic clients (Unigwe et al 2017). Further research is needed in this area.

Autism-specific social difficulties could be bidirectional in nature and people of different neurotypes may be misunderstanding each other. An increasing number of studies provide converging evidence of non-autistic people misreading social situations with autistic people. For example, non-autistic people interpret facial emotions of autistic people less accurately than do autistic individuals and are less willing to interact with autistic people, overestimate how egocentric autistic people are (Sasson el at 2017) and overestimate how helpful they are to autistic people (Heasman and Gillespie 2019). Non-autistic people are less accurate than autistic people at interpreting the mental states of autistic people (Edey et al 2016), while finding autistic people difficult to read is related to their being perceived unfavourably by non-autistic people (Alkhaldi et al 2019).

Autistic people may communicate through spoken language, augmentive and alternative communication (AAC) devices, pictures, sign language, typing, texting, writing, sounds and movements. Some autistic people are non-speaking while others can temporarily lose access to fluid speech, especially during times of distress. Staff should accept an autistic individual’s preferred method of communication.

All staff carrying out assessments on people with suicide-related ideation and self-harm should receive training in understanding autism, awareness of the presentation of co-occurring psychiatric disorders, and how to best communicate with and support autistic people who present with self-harm or suicidal ideation.

Information and resources for practitioners are available on the websites of key advocacy groups, such as:
https://asiam.ie
https://www.autism.org.uk/advice-and-guidance/topics/mental-health/suicide
https://www.autistica.org.uk/what-is-autism/signs-and-symptoms/suicide-and-autism

5.9 ADHD and suicidality

Attention deficit/hyperactivity disorder (ADHD) is associated with an increased risk of both attempted suicide and death by suicide (Impey et al 2012). A large population-based study in Sweden confirmed this association and also found an increase in suicide among close relatives of people with ADHD, suggesting that this association is partly due to shared genetic factors (Ljung et al 2014).

Diagnosis, support and treatment for adults with ADHD in Ireland are inconsistent and underfunded. The HSE recently launched a National Clinical Programme for Adults with ADHD (HSE 2021). Staff working with people who self-harm or with suicide-related ideation should understand the links between ADHD and suicide.

5.10 Older persons

The proportion of the population aged 65 and over is expected to grow from 13% in 2016 to 18% by 2030, creating extra challenges for service providers (Wren et al 2017). While the numbers of patients over 65 presenting with self-harm is more modest than in other age groups, this number is growing and those who do present need special consideration.

Among patients presenting, this age group has the highest associated suicide risk (Troya et al 2019, Morgan et al 2018). NICE (2020) recommended that all acts of self-harm in people older than 65 years of age should be regarded as evidence of suicidal intent until proven otherwise.

It is therefore important that all staff carrying out a mental health assessment on this cohort of patients should have knowledge of the special considerations which will enable them to complete a comprehensive assessment, including epidemiologically based risk factors. Wand et al (2017), in reviewing qualitative studies of self-harm and suicidal behaviour in older people, identified a number of themes which should be explored in any assessment, such as issues related to loss and regaining control; alienation; disconnectedness and invisibility; meaningless and lack of raison d'être, accumulated suffering and a painful life. Comorbid chronic pain, sensory (hearing/vision) loss and covert substance misuse are important common additional factors to consider among this group.

Among these patients, the perceived lethality of any overdose is often important to carefully explore. Even a seemingly small overdose of one or two tablets can constitute a serious suicide attempt if the individual believes that such an amount could kill them. Any episode of deliberate self-harm in an older person needs to be taken particularly seriously.

For patients presenting with acute confusion, it is important to consider that they may have taken an unintentional or intentional overdose. Collateral, and paying special attention to emerging cognitive issues in addition to the issues mentioned above, is very important to ensure complete assessment in this cohort.

Following assessment in ED or by SCAN, there should be clear guidelines in each area regarding access and referral pathways to mental health services for older people. Psychiatry of Later Life (POLL) community mental health teams are usually community-based, with close links to primary care. Establishing and building trusted, consistent lines of communication between SCAN/ self-harm programme staff and local POLL services will ensure efficient, timely care for patients who need further expert assessment and management.

5.11 People with physical illnesses including chronic pain

Research on suicide prevention indicates that people with chronic physical illnesses are at a higher risk of suicide-related outcomes (including suicidal thoughts, behaviours and deaths by suicide). Clinical focus has been given to populations with multiple health conditions, defined as multimorbid (Hawton et al, 2003, Nock et al 2010, Scott et al 2010). Heart disease, chronic obstructive airway disease (COPD), stroke, cancer and asthma have all been associated with increased risk for suicide (Juurlink et al 2004, Webb et al 2012). A large primary care-based study in the UK suggested that the rate of suicide was significantly elevated in people with a range of physical illnesses, especially in women. The presence of depression largely explained the elevated risks, although not in women with cancer or coronary heart disease (Webb et al 2012). Connecting for Life (DoH 2015) recognises people with chronic physical illness as a priority group.

Although the co-occurrence of mental health conditions, such as depression along with other Axis I disorders and alcohol abuse, have been seen as significant clinical factors for predicting future self-harm and suicide (Tuisku et al 2012), physical illness multimorbidity seems to also increase suicide risk, taking into account the mediating effect of depression (Anguiano et al 2012, Scott et al 2010).

Based on the interplay of physical and mental illness, mental and physical illness multimorbidity has more recently been described as a risk factor for suicidal thoughts. Patients with neurological disease are at particular risk from self-harm and completing suicide. Multiple sclerosis (Arciniegas & Anderson 2002) and epilepsy have been linked to increased suicide risk, accounting for 10% of all epilepsy deaths in one study (Bell et al 2009). Suicidal ideation is increased in cases of Parkinson's disease (Kummer et al 2009). Among neurodegenerative disease, suicide rates in Huntington disease remain the highest (Druss and Pincus 2000); completed suicide is reported to be as high as 13% (Cummings 1995). A report of the Neurological Alliance of Ireland in 2014 indicated that the needs of people with advanced neurological conditions were not being met by existing palliative care and neurology services (Weafer 2014). The College of Psychiatrists of Ireland have also described the deficits in neuropsychiatry services nationally and pointed to the need to increase neuropsychiatric service provision (College of Psychiatrists 2016).

Individuals with chronic pain are at least twice as likely to report suicidal behaviours or to die by suicide. Racine (2018) found evidence that chronic pain itself, regardless of type, is an important independent risk factor for suicidality. Pain-related factors such as sleep problems, poorer perceived mental health, concurrent chronic pain conditions, and more frequent episodes of intermittent pain, were all found to be predictors of suicidality. Pain characteristics (e.g. type, duration, intensity/severity) and physical status (e.g. pain interference, disability) were not related to suicide risk. Racine (2018) identified particular psychosocial factors (e.g. mental defeat, pain catastrophising, hopelessness, perceived burdensomeness, thwarted belongingness) as being associated with suicidality outcomes. A large number of these factors are amenable to change through targeted intervention, highlighting the importance of comprehensively assessing chronic-pain patients at risk for suicide, while also incorporating a suicide prevention component into chronic-pain management programmes.

All staff delivering the NCPSH should have an understanding of the impact that physical illness has on physical illness. The benefit of developing fully staffed multidisciplinary teams in liaison psychiatry has been highlighted (Buzkova et al 2019, Parsonage 2012).

5.12 People who present frequently to the ED, after self-harm or with suicide-related ideation

The national Self-Harm Registry (Griffin et al 2018) has consistently shown that between 20% and 23% of all presentations to the ED following self-harm are for repeat acts. Ness et al (2016) reviewed over 90 people who had presented to mental health services 15 times or more over a four-year period. They found that this group made up less than 1% of all presentations to the ED for self-harm, and repeated the need to educate both ED and mental health staff of this fact. Of the frequent attenders, the majority tended to present in clusters, interspersed with long periods of non-attendance. Some of these are people with untreated mental illness. Mental health assessments need to focus specifically on signs of mental illness.

It has also been shown that presentations of people who repeat self-harm change over time; therefore, a comprehensive assessment of need is required on each presentation (Witt et al 2019). People who present to the ED on more than one occasion in a short period of time need particular attention. Okore et al (2011) found that individuals who attended frequently made up 5.3% of all patients who attended ED for psychiatric care, and accounted for 19% of all admissions. They also found that people who frequently presented were younger and had higher rates of schizophrenia and psychiatric admissions. They recommended targeting these patients with effective community-based strategies such as home-based treatments, which could improve quality of life and reduce the cost of care.

The latest NICE update (2016) specifies 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 and other recent literature emphasises the need to complete assessments each time a person presents (Palombini et al 2020).

A number of people repeatedly self-harm due to emotional dysregulation, resulting in distress for themselves and others. They are at particularly high risk of dying by suicide. Staff require specific expertise in ensuring that such people receive a compassionate, empathic and trauma-informed response, while at the same time both staff and the patients themselves accept that they need support to change their behaviour. They may benefit from skilled support and acknowledgment from staff, a trauma-informed assessment and Safety Plan, with onward referral to specialist services such as dialectical behaviour therapy (Flynn et al 2017a) and mentalisation therapy.

A very small number of patients self-harm frequently.
A specific care plan should be developed between the individual, their treating community mental health team and the mental health staff providing input into the ED, specifying the input the patient requires should they present to the ED. This care plan should be available to the ED staff to optimise care on re-presentation. In rare occasions, this care plan may advise that the patient's physical needs be addressed in the ED, but, where their mental health needs and a pathway of psychiatric care for such presentations are already clearly defined, the patient does not need to stay for the purpose of a further psychiatric assessment. The patient's treating community mental health team will be informed of each of these presentations to ED. At any time, if the ED staff have a particular concern for the individual, or there is a change in the patient's mental health presentation, this plan can be overridden and the ED staff can request a mental health assessment in the ED. A decision not to offer a mental health assessment in the ED or in SCAN should be exceptional and never taken without such a collaboratively developed care plan.
A mechanism to identify patients who frequently attend should be in place in the ED and patient-specific care plans developed based on assessment of need for each individual. Psychiatry/ED/social work staff should work together to identify and support these patients and to create agreed

care plans, which should be available to the CMHT and GPs as well as within the ED. It is important that this plan be developed collaboratively with the patient. Nothing in the plan should prevent the patient from receiving a compassionate and empathic response if they present to the ED or to SCAN.

5.13 Summary and recommendations

- A number of identified groups who present to the ED or to the GP following self-harm or with suicidal ideation require enhanced input from the mental health professional to ensure they are linked to appropriate next care.
- These groups include those with substance misuse, those who are homeless, asylum-seekers, members of the Travelling community, deaf people, the LGBTQIA2s+ community, people with chronic health conditions, autistic people and older people.
- All staff carrying out a mental health assessment in the ED or in SCAN should have skills in carrying out opportunistic screening and interventions for those at risk of alcohol and substance misuse, including training in SAOR (Screening, Ask and Assess, Offer Assistance and Referral).
- Each ED and GP should have clear policies and pathways for accessing onward referral to relevant local addiction services.
- Each ED should have access to onsite addiction specialists. This needs to be developed through the Primary Care Addictions Programme and the Dual Diagnosis Clinical Programme.
- People who are homeless benefit most from mental health services that are delivered alongside other services, such as daycare or shelter. A SCAN practitioner in crisis mental health care would be ideally placed to provide clinical expertise to teams working with the homeless population.
- A SCAN or equally qualified mental health professional should be available to work with the homeless population who present with self-harm and suicidal behaviour, providing biopsychosocial assessment and intervention. In addition, the SCAN would liaise between the specialist mental health services for the homeless and the secondary care mental health service.
- All staff carrying out mental health assessments in the ED and in SCAN should receive training in understanding gender and sexual identities.
- All staff carrying out mental health assessments in the ED and in SCAN should receive cultural awareness training in addressing the mental health needs of Travellers, asylum-seekers and refugees.
- All staff carrying out mental health assessments in the ED and in SCAN should receive training to better support the varying needs of autistic people and those with ADHD. Staff must accept the different communication methods used by some autistic individuals.
- All staff will ensure that reasonable accommodation and access are provided for people with disability.
- Non-English-speakers must have their interview facilitated by appropriate interpreters/translators. Services should ensure that their phone number and video facility is available for use.
- Deaf or hard-of-hearing patients must have their interview facilitated by an Irish Sign Language interpreter. (ISL) Services should ensure that the phone number and video facility for an ISL interpreter is available for use. Information on specialist mental health services for the deaf and hard of hearing community are available at www.chime.ie.
- All staff carrying out mental health assessments in the ED and in SCAN should receive training to better support people with physical illnesses, including chronic pain.
- A mechanism should be put in place to identify people who frequently present in the ED following self-harm. These people require particular attention and collaborative care planning to include all agencies involved in their care.