06

Bridging and Linkage to Next Appropriate Care

6.1 Overview

Each patient should be followed up and bridged to next appropriate care. This is achieved through communicating with the patient's GP, phoning the patient within 24 hours of discharge from the ED or SCAN service, and maintaining contact with the patient until they have been in contact with the next appropriate care.

To achieve this, a clear record of all patients presenting to the ED, including those presenting out of hours, should be kept, and within the SCAN service a record of all referrals should be kept. The clinical lead holds responsibility for ensuring that the clinical programme is implemented. It is the responsibility of all Consultant Psychiatrists working in a service to ensure there is an integrated approach to care. Each Consultant Psychiatrist on call has a responsibility to provide clinical supervision for the clinical nurse specialist or the NCHD. The Consultant should ensure that all cases presenting should be discussed with the CNS the following morning. It is then the responsibility of the CNS to provide the follow-up and linkage to next care. Consultant Psychiatrists as a group should ensure that all cases have been appropriately followed up.

The assessing mental health professional, CNS, MHSW or NCHD is responsible for the collaborative development of an Emergency Safety Plan and for sending a letter to the patient's GP immediately following assessment. This should be sent by secure e-link. A copy of the Emergency Safety Plan should accompany this letter. If there is any delay in sending the letter, the GP should be informed by telephone.

The CNS or MHSW should phone the patient within 24 hours of discharge from the ED or SCAN service. If it is known that the patient will be contacted by a home-based treatment team or a community mental health team within 24 hours, and that this team will accept responsibility for providing the telephone call, this can be recorded in the data. There will be rare situations where a telephone call is not appropriate. If the CNS does not make contact with the patient on the first call, it is recommended that they make at least two further calls on at least two separate days. The GP and next appropriate service should be informed if the CNS has been unable to contact the patient.

Where required, the CNS or MHSW will continue to provide telephone support until the person has been linked with appropriate next care. This follow-up provides an opportunity to support family members also.

In some cases it will be appropriate for the CNS, MHSW, NCHD or consultant to provide brief follow-up support. This would usually involve a maximum of three contacts, providing further expert advice to the GP and supporting the patient in engaging with next appropriate care.

6.2 Next appropriate care and community supports

Following a full biopsychosocial assessment with family involvement and completion of a written Emergency Safety Plan, the individual should be followed up and linked to appropriate next care. This may include mental health services and services in the voluntary and community sector.

It is beyond the scope of this model of care to develop next appropriate care; however, it is important that there be a clear pathway to next appropriate care. Examples of appropriate next care will include specialist non-crisis time: limited counselling for self-harm and suicidal ideation, crisis cafés, social prescribing, and community counselling and psychological supports. It is recommended that the NCPSH CNS and the SCAN ensure there is a list of such local supports within the ED or GP surgery. They should liaise with the local HSE resource officers for suicide prevention in compiling such a list.

Sharing the Vision (DoH 2020) recommends putting a number of new services in place, including Crisis Resolution Teams, Crisis Houses, Assertive Outreach Teams and Home-based Supports.

All CHO areas should ensure there is access to a non-crisis self-harm and suicide specialist counselling service. Trained and supervised psychotherapists should staff this service and they should ensure there is an effective communication to and from other health agencies. The Self-Harm Intervention Service (SHIP) provides such a service in the South East (Gardner et al 2015). Some non-governmental organisations (NGOs) have developed similar services.

Crisis cafés have been identified in a number of countries as offering psychosocial crisis supports (Consumers of MH Report 2019; Harbour Café, Certitude 2020; The Living Room, Heyland et al 2013). The model in all these services provides a place for a person in crisis to receive psychosocial support following a mental health assessment. Links are formed with GPs, local mental health teams and EDs, with individuals referred to the crisis cafés from these services.

Crisis cafés, as described in these reports, do not provide an alternative to the ED; they provide an extra service along with the resourced mental health teams. A comprehensive review of crisis cafés and their feasibility in an Irish setting has been conducted by a number of NGOs, Waterford Institute of Technology and employees of the HSE (Kilkenny Crisis Café Feasibility Study 2020). This study outlines how a number of agencies can work together in supporting individuals in a crisis. They describe the development of a peer-led and non-clinical approach to crises. Crisis cafés can provide much-needed psychosocial support but they do not provide biopsychosocial assessment of risk and need, and thus do not replace a skilled assessment provided by a qualified mental health professional such as a SCAN, CMHT or the mental health professional in the ED. For this reason, we have not included crisis cafés on the list of pathways to care from GPs. They form part of the next appropriate care for some individuals.

Social prescribing is a means of enabling GPs and other healthcare professionals to refer patients to a link worker – to provide them with a face-to-face conversation during which they can learn about the possibilities and design their own personalised solution to provide social support. This service provides links to social activities and should not be confused with social work input. People with social, emotional or practical needs who often use services provided by the voluntary and community sector are empowered to find solutions that will improve their health and wellbeing. A recent evaluation (HSE 2020c) found that social prescribing is increasing in Ireland, with 18–20 funded projects and a continuing expanding All-Ireland Social Prescribing Network. The self-harm CNS and SCAN should link with any local social prescriber and identify a resource of suitable community agencies that can offer ongoing support. This should be available to all mental health professionals completing assessments, including those working out of hours.

The NCPSH recommends that the local Connecting for Life Action Plans include a list of available next appropriate care. Liaison between staff implementing the NCPSH and the resource officers for suicide prevention (NOSP 2021) will facilitate this.

6.3 Summary and recommendations

- The responsibility for ensuring that all patients receive effective follow-up and linkage to next appropriate care rests with all consultants who provide on-call clinical supervision.
- Each service should ensure there is a procedure in place to ensure handover of details of all patients who present out of hours.
- Each patient's GP should receive immediate communication by secure Healthlink on the patient's presentation and emergency safety plan. If this is not possible, a phone call should be made to the GP within 24 hours.
- All patients, including those assessed out of hours, should receive a follow-up phone call from a clinical nurse specialist, or equally qualified mental health professional employed through the NCPSH, within 24 hours of discharge from the ED or SCAN. In rare cases, this may not be clinically appropriate and this fact should be recorded in the notes.
- In some cases it will be appropriate for the CNS, MHSW, NCHD or consultant to provide brief follow-up support. This would usually be to a maximum of three contacts, providing further expert advice to the GP and supporting the patient in engaging with next appropriate care.
- Each CNS and SCAN professional should liaise with the resource officers for suicide prevention in their area and develop a list of community supports in that area.
- In developing Connecting for Life Action Plans, NOSP should ensure that there is input from the CNS, SCAN and the NCPSH office.