SAVING LIVES AND REDUCING HARMFUL OUTCOMES:

CARE SYSTEMS FOR SELF-HARM AND SUICIDAL BEHAVIOUR

National Guidelines for the Assessment and Management of Patients Presenting to Irish Emergency Departments following self-harm

Subgroup of the Suicidal Behaviour Working Group

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The national guidelines for the assessment and management of patients presenting to Irish Emergency Departments following self-harm were prepared by a subgroup of the Suicidal Behaviour Working Group, chaired by Dr Ian Daly.

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National Guidelines for the Assessment and Management of Self-harm Patients Presenting to Irish Emergency Departments

1 Introduction

1.1 In December 2010, the Suicidal Behaviour Working Group was established with the aim to develop national guidelines for the assessment and aftercare of deliberate self-harm patients presenting to Irish Emergency Departments. A subgroup was established in order address specific objectives:

1. To review existing guidelines for the assessment and management of self-harm and the evidence base;
2. To determine national guidelines for the assessment and management of self-harm presenting to Irish emergency departments.

1.2 Members of the subgroup reviewed key documents in relation to the assessment and management of self-harm, such as the Guideline for Self-harm by the National Institute for Clinical Excellence (NICE, 2004),[1] the guidelines for assessment and management of suicide attempters (DSH patients) presenting to EDs or psychiatry inpatient units produced by the American Association of Suicidology and the Suicide Prevention Resource Center,[2] and a report of the Royal College of Psychiatrists on treatment of self-harm and suicide risk.[3] In addition, a literature search was conducted in order to obtain information on the evidence base of the existing guidelines.

1.3 Existing guidelines for the assessment and management of self-harm were reviewed and examined in terms of their relevance within the context of the Irish setting and the remit of the Irish guidelines. A literature review was conducted to search for articles which critically reviewed these guidelines in order to further assist in the development of Irish guidelines. The overall recommendations of the NICE guidelines on self-harm have been described as 'uncontroversial' and 'simply components of good practice'.[4] However Pitmann and Tyrer have criticised the NICE guidelines as being based more on consensus opinion than on evidence.[5] They also highlight a lack of clarity regarding particular issues e.g. when

psychosocial assessment should be done, by whom and what it should contain.[5] These issues are important as guidelines are more likely to be adopted if the guidance is clear and there is a convincing evidence base.[6] The guidelines in this document have been developed based on evidence both internationally and in the Irish context. The evidence is referenced throughout the document.

Reach Out, the National Strategy for Action on Suicide Prevention 2005-2014 (Health Service Executive, 2005) and Vision for Change, Report of the Expert Group on Mental Health Policy acknowledge the need to 'develop and resource an effective response in the health services for people who present to services having engaged in deliberate self-harm'.[7] International guidelines recommend that: 'all patients who present to Emergency services following self-harm should be offered an assessment of needs and an assessment of risk'.[1,2]

2 Remit of the Guideline

a) This guideline refers to all age ranges of patient including children, adolescents, adults and older adults.
b) The guideline refers only to patients who present following an episode of self-harm to the following locations: Hospital Emergency Departments/Urgent Care Centres. Those who present in Primary Care only are not the subject of this guideline.
c) The guideline refers to the *mental health/psychosocial assessment of need and risk* following self-harm in the hospital Emergency Department from time at presentation to discharge.
d) The guideline does not include the assessment and management of physical needs following self-harm.

3 Background

3.1 *Emergency Department mental health morbidity is high and self-harm presentations are increasing*

Acute General Hospitals and in particular their Emergency Departments are places of especially high mental health morbidity. Patients with mental ill-health and medical co-morbidity typically have complex assessment needs, longer hospital stays and there are unique risks attached to their care. Patients with mental ill-health are entitled to the same access to emergency medical care when they are medically ill as others. Emergency Medicine staff, however, often feel ill-equipped to address their mental health needs and risks. The presence of dedicated Psychiatry staff on-site working alongside Emergency Medicine staff, can help ensure equal access to medical care for patients with mental ill health as well as addressing their mental health needs.

The National Suicide Research Foundation (www.nsrf.ie) has through their National Registry of Deliberate Self-harm (NRDSH) and annual reports over the past nine years, highlighted the scale of the problem of self-harm in Ireland.[8,9] Between 2007 and 2010 the number of deliberate self-harm presentations to Irish hospital Emergency Departments increased significantly from 11,084 to 11,966. Over the three-year period a stronger increase was observed in men (+25%) than in women (+7%) (Table 1)[8]. Based on the 2010 NRDSH date, almost half of all presentations (47%) were by people under 30 years of age and 87% were by people aged less than 50 years. In 2010, the peak DSH rate for women was in the 15-19 years age group, at approximately 639 per 100,000, whereas the peak rate among men was in 20-24 year-olds at 626 per 100,000.

Table 1 Incidence of deliberate self-harm in Ireland, 2003-2009, rates per 100,000 population by gender

Incidence of Deliberate Self Harm in Ireland (2002-2010) –
Person-based rates per 100,000 by gender

	Men		Women		All	
Year	Rate	% Difference	Rate	% Difference	Rate	% Difference
2002	167	-	237	-	202	-
2003	177	+7%	241	+2%	209	+4%
2004	170	-4%	233	-4%	201	-4%
2005	167	-2%	229	-1%	198	-2%
2006	160	-4%	210	-9%	184	-7%
2007	162	+2%	215	+3%	188	+2%
2008	180	+11%	223	+4%	200	+6%
2009	197	+10%	222	-<1%	209	+5%
2010	205	+4%	231	+4%	217	+4%

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3.2 *Self-harm presentations by children and young adolescents under the age of 16*

From a service provision perspective it is important to clarify the extent of the burden of self-harm by children and young adolescents nationally and across HSE regions. Table 2 provides an overview of the number of children and young adolescents under the age of 16 over the period 2003-2010. The age range is 7-15 years. Over the period 2003-2010 an increasing trend is observed for boys whereas for girls the numbers vary considerably without a clear trend.

Table 2 Self-harm presentations by under 16s and by gender, 2003-2010

Year	Male	Female	Total
2003	92	341	433
2004	91	312	403
2005	91	318	409
2006	108	347	455
2007	105	310	415
2008	110	371	481
2009	132	323	455
2010	134	332	466

The numbers of self-harm presentations under the age of 16 by HSE region for the year 2010 are presented in Table 3, showing fairly similar numbers across the regions.

Table 3 Self-harm presentations under the age of 16 by HSE region, 2010

HSE region	N	%
DubMidL	125	26.8
DubNE	117	25.1
South	114	24.5
West	110	23.6
Total	466	100.0

3.3 *The impact of repeated DSH patients presenting to emergency departments in Ireland*

Repeat presentations to hospital due to deliberate self-harm represent a significant problem. In 2010, 19.5% of all deliberate self-harm presentations were due to repeat acts, with the majority of patients repeating their DSH act within the first three months after having presented to the ED following an act of self-harm. The proportion of deliberate self-harm patients who made at least one repeat presentation during the calendar year was 13.7%. Seven-year analysis of the NRDSH data (2003-2010) shows that there were 545 individuals who engaged in 9758 DSH acts representing 11.2% of all DSH acts during this period (Table 4). This indicates an average of 18 self-harm episodes per person and clearly illustrates the considerable impact of repeated DSH on ED staff.

Table 4 The impact of repeated deliberate self-harm in Ireland, based on DSH acts over the period 2003-2010

The impact of repeated deliberate self harm presentations

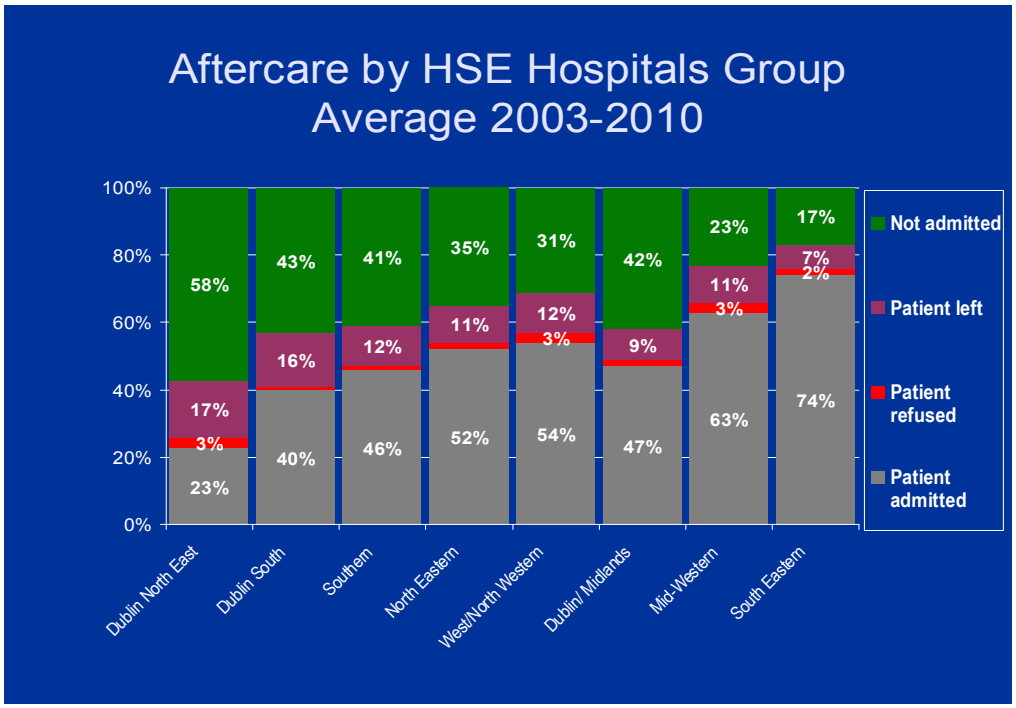
Number of DSH acts in 2003-2010	Persons		Presentations	
	Number	(%)	Number	(%)
One	42900	77.7%	42900	49.3%
Two	6870	12.4%	13740	15.8%
Three	2343	4.2%	7029	8.1%
Four	1062	1.9%	4248	4.9%
Five	575	1.0%	2875	3.3%
Six	393	0.7%	2358	2.7%
Seven	259	0.5%	1813	2.1%
Eight	165	0.3%	1320	1.5%
Nine	116	0.2%	1044	1.2%
10 or more	545	1.0%	9758	11.2%

3.4 *Assessment and aftercare of DSH patients presenting to emergency departments in Ireland*

The NRDSH shows that the next care recommended to deliberate self-harm patients after treatment at the ED varied significantly by HSE hospitals group. The rate of admission to a general hospital ward following presentation to the ED department ranged from 23% in Dublin North Eastern Hospitals to 74% in the South Eastern Hospitals (Figure 1). Such variation in next care is likely to be due to variation in the availability of resources and services but it suggests that assessment and management of deliberate self-harm patients is likely to be variable and inconsistent across the country. A particular issue of concern is the relatively large proportion of DSH patients leaving the ED without being assessed, which varied from 7% in the HSE South Eastern Hospitals to 17% in the Dublin North Eastern Hospitals. In addition, 2-3% of patients refused assessment and next care[*].

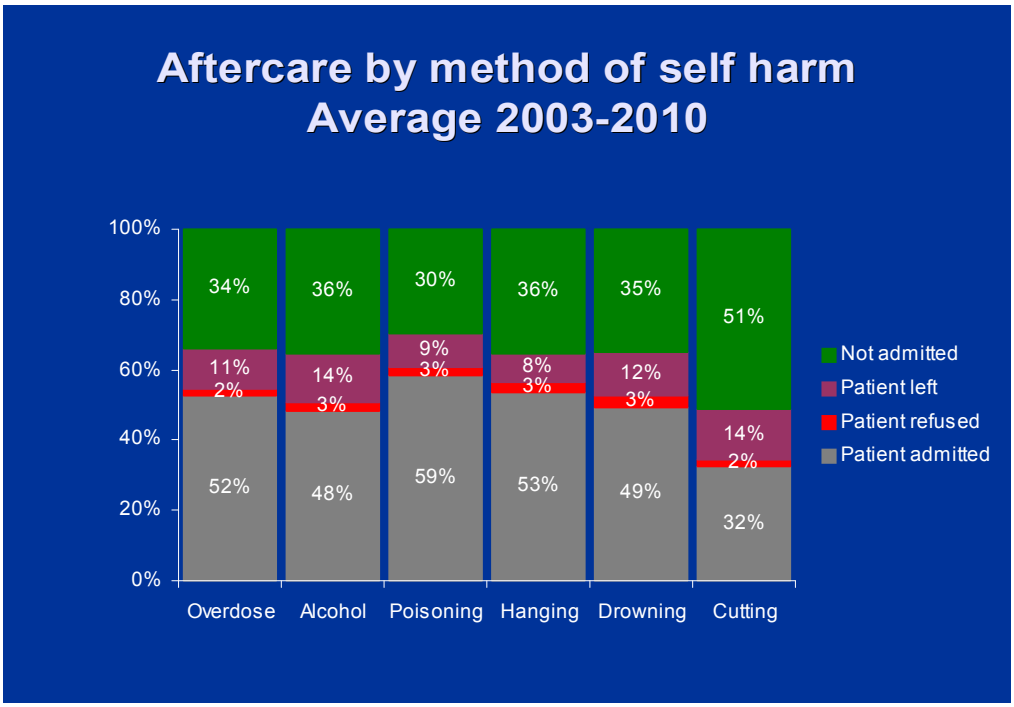
[*]The NRDSH obtains data on psychiatric admission from EDs. However, for some patients who are directly referred on to psychiatric admission, this may not be recorded in EDs.

Figure 1 Aftercare of DSH patients presenting to EDs in Ireland by HSE Hospitals Group, average percentages 2003-2010



Comparing recommended care by methods involved in DSH acts, a diverse pattern of recommended aftercare emerged, with lower levels of general admission among patients who engaged in self-cutting and those who engaged in DSH using alcohol compared to those with intentional overdose and highly lethal methods such as self-poisoning, attempted hanging and drowning (Figure 2). The proportion of patients leaving hospital without being assessed ranged from 8% among those who engaged in attempted hanging to 16% among those who used alcohol.

Figure 2 Aftercare of DSH patients presenting to EDs in Ireland by self-harm method, average percentages 2003-2010



3.5 *Assessment and management of self-harmt*

The NRDSH clearly shows that assessment of needs and risk may not be taking place in all patients who present to hospital following self-harm in Ireland. Biopsychosocial assessment of all patients who present following self-harm should be a key goal of any suicide prevention service working with this group of patients.

Deliberate self-harm is the single biggest risk factor for suicide with estimated suicide rates at long-term follow-up of 10% although this figure is likely to be substantially higher in certain subgroups.[10,11]

There is also evidence that in those who do have a mental health assessment (of needs and risk) in the emergency departments following self-harm, the quality of the assessment offered and aftercare following it is variable.[12] Minimum guidelines for assessment of needs and risk by appropriately skilled staff is clearly a key goal of any suicide prevention service in this group of patients.

3.6 *HSE Hospital services organisation, reconfiguration and the Emergency Medicine Programme*

The range of health and personal social services provided by the HSE and its funded agencies are managed within four Regions (Dublin Mid Leinster, Dublin North East, South and West). Each serves a population of approximately one million. There are currently two hospital networks in each region, eight in total. Hospital networks provide a range of medical, surgical, paediatric and maternity services. Two hospitals in each region are Cancer centres of excellence and some hospitals (mostly in Dublin) provide Supraregional/Tertiary services. For details of hospital network regions see www.hse.ie.

The HSE Reconfiguration Programme is a key part of the Health Service Executive's national change agenda, the Transformation Programme. The ongoing national transformation programme of the HSE is a programme that includes structural reform, reconfiguration of services in selected areas, and a wide range of national programmes of care being led by the Quality and Clinical Care Directorate. The HSE at national level have commenced a programme of reconfiguration of acute hospital services principally to ensure that high quality and safe services can be delivered into the future within resources available. For instance in some hospital networks, certain services have already been reconfigured (eg Emergency services in the Midwest). Recently, an ambitious Reconfiguration roadmap for the Southern Hospital Network has been published (*Reconfiguration of Acute Hospital Services, Cork and Kerry, HSE 2011*).[13] Clinical services will be delivered across multiple sites by teams of clinicians. Some Emergency Departments will be closed whereas others will have reduced hours of business or operate as Urgent Care centres.

The National Programmes of Clinical Care (in particular the Acute Medicine Programme and the Emergency Medicine Programme) are key drivers of this. The Acute Medicine Programme has published its plan (Report of the National Acute Medicine Programme Working group, 2010).[14] New Acute Medical Units (AMUs) are already operational in some hospitals with plans for 12 new AMUs in 2011. The Emergency Medicine Programme has an active working group currently preparing a plan for the National Programme. The EMP is one of the key HSE National Clinical Programmes. The overarching aim of the EMP is to improve the safety and quality of patient care in Emergency Departments (EDs) and to reduce waiting times for patients. The key solution areas are: a) Definition and development

of Emergency Care Networks within a National Emergency Care System with key collaboration between EDs and Pre-hospital care; b) Increased Consultant provided care in EDs; c) Clinical guidelines for the top 20 emergency conditions (e.g. pain management, abdominal emergencies, head injuries etc.); d) Quality indicators and process measures defined; e) Support implementation of DQCC National Programmes at 12 target sites (10 of which will have 4 or more Consultants in EM) with achievement of 6 hour Total ED Time target. The EMP Programme deliverables are: a) Standardised care in every ED; b) Guidelines for top 20 conditions; c) All critically ill patients will be seen by a Consultant in EM when on-site and Consultants will provide on-call support out-of-hours; c) Reduced numbers of patients on trolleys in EDs which is achievable through implementation of the Acute Medicine and Chronic Disease Programmes will save at least one life per week.

3.7 *Benefits of improved self-harm assessment and management*

It is envisaged that improved assessment and management of self-harm patients presenting to emergency departments is likely to reduce the risk of repeated self-harm.[15,16] It is known that major self-harm repeaters (five or more self-harm episodes) have the greatest cost impact on the health care system.[17] In Ireland, major self-harm repeaters represent 2,053 individuals who were involved in 19,168 self-harm episodes during the period 2003-2009, with an average of 9 self-harm episodes per person.[9]

Along with national implementation of the guidelines for assessment and management of self-harm patients presenting to emergency department, changes in levels of repeated self-harm will be monitored using the data from the National Registry of Deliberate Self-harm.

Investigating cost-benefits of national implementation of the guidelines also implies that costs involved in service use of people who engage in self-harm need to be determined. Detailed information on various service aspects of service use will be required, such as length of stay of self-harm patients in the hospital including those who are admitted following treatment in the emergency department, and information on the different types of treatment provided, e.g. for people who engage in intentional overdoses and those engaging in self-cutting.

O'Sullivan et al (1999) and Kennelly et al (2007) provided cost estimates for direct and indirect costs involved in hospital treated self-harm. However, considering the economic

changes and changes in health services in Ireland in recent years, this would require updating. [18, 19]

4. Review of existing evidence based guidelines

The following evidence based recommendations were selected following review of a report published by the American Association of Suicidology, Suicide Prevention Resource Center & University of Michigan in order to improve continuity of care for patients presenting to EDs following deliberate self-harm/attempted suicide[2] (4.1.1–4.1.6) and the guidelines published by the National Institute of Clinical Excellence[1] (4.2.1-4.2.6).

4.1 American Association of Suicidology Recommendations

4.1.1 Attitudes of ED and frontline staff, discrimination, frequent visits (repeat DSH patients) and suicide

There is consistent evidence that individuals with mental health problems experience various forms of discrimination. In many countries there is a high prevalence of ED clinicians with negative attitudes toward suicidal behaviour.[20-23] Clinical judgments and professional behaviours are to a large extent shaped by attitudes. This may be related to a number of factors, such as the frequency of return visits,[24] frequent misuse/abuse of alcohol and drugs, [25] and danger of physical harm.[26]

- Reduce discrimination in EDs in association with suicide risk and mental illness and address skill deficits, unrealistic fears, inadequate collaboration with mental health professionals.

4.1.2 *Education and Training for ED Clinicians*

Several studies indicate that education of physicians in recognition of depression and suicidal behaviour contributes to reduced suicide rates.[27-29] Past recommendations calling for substantially improving the education and training of health care professionals involved in the assessment and treatment self-harm patients have been largely ignored. Efforts need to be intensified to teach all health professionals working in the ED about assessment of self-harm patients, management and treatment techniques.[1,2,7] Because there are no shared

curricula or mechanisms to ensure quality, there continues to be sizeable disparities between evidence based training programmes, what is taught, and the actual services provided to self-harm patients. [23, 30]

- Define a nationally recognised set of minimum essential skills and core competencies necessary for suicide risk assessment and management.

- Find the best means for most efficiently and effectively teaching and disseminating the nationally recognised set of minimum essential skills and competencies.

- Develop a nationally recognised system to certify that health professionals have mastered the minimum essential skills and competencies.

- Provide clinicians with explicit guidance about procedures relevant to potentially lethal patients that deny suicide intent or risk (Professional associations involved with setting standards for suicide assessment and intervention need to provide clinicians with explicit guidance about procedures relevant to potentially lethal patients that deny intent or risk).

4.1.3 *Detection of concealed suicide risk in the Emergency Department*

Detection of suicide risk is complicated, because it is clinically difficult to sort at-risk patient groups. Some patients will not repeat their act of DSH. However, a considerable group will engage in many acts of non-fatal DSH,[9] and some will eventually die from suicide.[31, 32, 8] Many patients minimise risk and deny suicide intent in the immediate period prior to death.[33, 34] In order to identify DSH patients with high risk of repetition (non-fatal and fatal), a skilled and comprehensive suicide risk assessment is required when a patient presents to the ED due to self-harm.[30, 33]

- Examination of the motives and degree of suicidal intent underlying the self-harm act should be part of the assessment procedure.

- Place in EDs, increased numbers of clinical specialists trained in suicide risk assessment and management (The techniques and skills that are used during a comprehensive suicide risk assessment are both time consuming and exacting. Specialised training is required).

4.1.4 *Survival on the way to follow-up care*

Many patients who are discharged from the ED following DSH never make it to their first follow-up appointment, and among those that do, many do not remain in treatment long enough for continuing care to be successful. Among patients who have been discharged from the ED and inpatient wards, the risk of (repeated) acts of DSH and suicide among all age groups is highest immediately after discharge and over the next 12 months to 4 years.[35, 36, 37, 38, 39] Being discharged from an ED or psychiatry inpatient programme should therefore provide patients linkage to effective treatment.

- Adopt nationally recognised policies and procedures that best match patients at risk for suicide to follow-up services that begin at or near the time of discharge from an emergency department or an inpatient psychiatry unit.

4.1.5 *Patients at greatest risk for non-attendance or for untimely, discontinuous follow-up care – Guidelines and standards for discharge planning*

Discontinuity of care from a significant professional is associated with increased risk of suicide.[40-43] Disengagement is predicted by persistent and severe mental disorder, longer lengths of stay and high overall use of care.[44, 45, 46]

Organisational policies and procedures may facilitate patient engagement with follow-up plans. Efforts to improve follow-up and continuity of care and forestall readmission should target high-risk patients prone to disengagement.[47]

- Obligate health care systems to provide timely follow-up or alternative care in the event that the most appropriate continuity of care plan cannot be achieved in a timely manner (for example, if a near-term outpatient appointment is unavailable for a high-risk patient, the referring facility takes responsibility for providing interim outpatient care

until a timely appointment is secured).

- Consider setting the standard for the first follow-up contacts subsequent to high-risk patients being discharged from ED or psychiatric inpatient units at "within one week or less." (This standard needs to be linked to the identification and adoption of outreach interventions that motivate adherence to the recommended treatment plan. The rapid availability of high-quality outpatient treatment may offset the need for hospitalisation).

- Identify and adopt outreach interventions and bridging strategies that motivate adherence to the recommended treatment plan.

- Investigate the use of various types of electronic contacts (e.g., text messaging or phone call) as part of an overall follow-up plan for suicide-prone patients discharged from an emergency department or inpatient unit.

4.1.6 *Staff training and support*

Clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed.[1] Minimising staff stress and burnout in the human services area has become a major management issue. This obviously applies to accident and emergency services.

Emergency department staff are inherently exposed to critical incidents, which can be defined as events or situations 'that have sufficient emotional power to overcome the usual coping abilities of people working in environments where some degree of exposure is expected'.[48] They make intense demands on emotions and other coping skills of workers and may be single events, a protracted period of difficulty, or a series of less intense occurrences in succession. Those affected may all be directly involved in the events, or they may be affected by what has happened to one of their number, or their agency as a whole.

However, there are many situations that may evoke stress over and above that regarded as normal. These circumstances usually involve some degree of personal or professional threat

and often present situations that cannot be managed with routine practices. They are termed critical incidents and the stress evoked by them is called critical incident stress (CIS). These terms were first developed by Mitchell (1983) for programs to reduce stress in emergency workers in the USA and have now passed into general use.[49] When very serious and traumatic events occur, the staff involved is at high risk for developing post-traumatic stress disorder (PTSD). Critical incidents refer to those events that generate reactions which are likely to benefit from special support, while traumatic incidents refer to those which require more intensive clinical services. The support should provide:

- An opportunity to integrate the incident into the ongoing functioning of the agency.
- A forum for managing personal issues in order that lessons can be learned.
- The basis for identifying and meeting needs revealed by the incident.
- An opportunity to establish support structures in relation to the incident, and better understand the needs of staff in the work context.

If left unattended, the impact of critical incidents can have long-term adverse effects. Some people are able to accommodate stress, but this may be at the expense of important aspects of their life. After a period of time they may develop blunted emotions, chronic alert states, changed expectations for life (pessimism, bitterness), they may become anti-social, stop talking and interacting, narrow their scope of life, and abandon the wish for happiness: *Burnout***.**

The general framework for Critical Incident Support Management (CISM) involves personal support. This includes informal social relations, management structures, staff supervision arrangements, administrative support and the provision of specialised help. The process of coming to terms with a serious incident must be integrated into this framework. The term critical incident stress management (CISM) is used to define a set of arrangements that are initiated by an incident and draw on pre-established protocols and procedures to ensure that all aspects of the staff's needs are met. It includes:

- Considering initial notification and activation.
- Managing the incident and of the staff.
- Providing defusing as soon as possible.

• Establishing a support system.

• Providing all relevant information to staff concerning the incident.

4.2 NICE Guidelines Recommendations

The guidelines published by the National Institute for Clinical Excellence (Nice, 2004) make recommendations regarding management of self-harm within the NHS.[1] They cover management of self-harm in both primary and secondary care. Immediate medical and surgical management are included, in addition to recommendations regarding immediate and long term psychological interventions. The document contains 167 guidelines, 107 of which are based on consensus opinion.

Of the evidence based recommendations, over half deal with physical management of patients who self-harm. In addition there are evidence based recommendations regarding management of people presenting to primary care facilities and the long term management of certain subgroups (e.g. recommendations regarding Dialectical Behaviour Therapy for people with borderline personality disorder).

The following evidence based recommendations pertain to the mental health/psychosocial assessment of individuals following presentation after an episode of self-harm to the emergency department. Guidelines based on consensus are not included here.

4.2.1 *Triage*

Use of a combined physical and mental health triage scale is recommended, such as the Australian Mental Health Triage Scale. Psychosocial assessment should be offered at triage to assess mental capacity, willingness to wait for assessment, distress levels and presence of mental illness.

4.2.2 *People who wish to leave*

People who wish to leave before psychosocial assessment or treatment should be assessed for mental capacity/mental disorders and this assessment should be documented in their notes. The assessment should be communicated to the person's GP and to the relevant mental health service as soon as possible to facilitate follow-up. If the person's mental capacity is diminished or if there the person has significant mental illness, a referral should

be made for urgent mental health assessment and the person should be prevented from leaving.

4.2.3 *Psychosocial assessment of needs and risk by specialist mental health professionals*

An assessment of needs should be offered to all people who self-harm. This should include assessment of social, psychological and motivational factors regarding the act of self-harm, current intent, hopelessness, mental health and social needs.

An assessment of risk should be carried out in all people who self-harm. This should include the main clinical, demographic and psychological risk factors associated with risk of further self-harm or suicide. Standardised risk assessment scales should only be used to aid identification of those at high risk of repetition.

The assessment of needs and risk should be documented in the clinical notes.

4.2.4 *Referral, admission and discharge*

Decisions should be based on comprehensive assessment as outlined in 5.7. Referral should not be made only on the basis that the person has self-harmed. People who are at risk of repetition could be offered intensive therapeutic intervention such as admission, outreach or psychological interventions. Discharge without follow up should occur only after a combined needs/risk assessment.

4.2.5 *Children and young people*

Children and young people following an episode of self-harm should be admitted to a paediatric ward or an adolescent paediatric ward and assessed the following day. Occasionally an adolescent psychiatric ward may be needed. Following admission, consent should be obtained for mental health assessment from the parent or guardian.

During admission the child and adolescent mental health services should provide consultation for the child, their family, social services and paediatric staff. A needs and risk assessment should be carried out. Assessors should be specifically qualified to work with this age group.

4.2.6 *Training*

Both clinical and non-clinical staff who are in contact with patients who self-harm should receive training to help them understand and care for service users. Staff responsible for triage should receive training in mental health triage systems.

A Report on Self-harm, Suicide and Risk: Helping People who Self-harm published by the Royal College of Psychiatrists includes an endorsement of the NICE guidelines.[3]

5. Guidelines

5.1 *Access to Mental Health Services: Mental Health (MH) Services in the Emergency Department need to be available and accessible.*

Patients with mental ill-health (including those following self-harm) deserve the same access to Emergency medical treatment and care when they are medically ill as others. Timely access to MH services/expertise must be available at all times, for patients attending in crisis to the ED.

There should be a single point of contact for ED staff to access MH services for patients and the referral procedure should be a simple one. Services should be available in the ED that span the entire age range and are provided irrespective of the catchment area /address of the patient.

Adults: Liaison Psychiatry: During agreed hours for adults, this should be the Liaison Psychiatry team based on-site as there is consensus in Ireland and elsewhere that mental health service delivery to acute/emergency medical patients is best provided by a specialist 'Liaison' mental health team based on-site.[50, 51] Out-of-hours in all 24/7 EDs, there should be mental health staff available on-site, supported by a Consultant on-call.

Children & Adolescents: Timely access to MH services must be available at all times for children and adolescents attending the ED in crisis. All major EDs should have defined access to assessment by Child and Adolescent Mental Health services (CAMHS) via a simple referral procedure. Ideally this should be a dedicated Liaison CAMHS supported by the on-call CAMHS. This service should be accessible 24/7 via a single point of contact. In any event, the MH service responsible for assessment of 16 and 17 year-olds in the ED should be explicit. In addition to this it is essential that there should access to child protection services including out of hours and weekends.

Mental Health staffing resources should be adequate to provide a timely response to referrals from the ED including out-of-hours and weekends when mental health presentations (including self-harm) typically peak. There should be dedicated mental health staff with clinical and training competency and responsibility for co-morbid Alcohol & Drug problems in self-harm. Staff with expertise and a specific remit in the assessment and management of older adults with mental health needs including self-harm should be available. These posts should be part of a multidisciplinary Liaison mental health team and

stand-alone posts are not recommended. Staffing should be in accordance with need (assessed by ED activity including self-harm, hospital bed numbers).

Ambulance personnel and Hospital Navigation Hub Case Managers need to be appraised of Hospital locations with on-site Psychiatry by day and out-of-hours to facilitate appropriate streaming of Emergency medical patients with mental health needs.

An area-wide mental health unit inpatient bed management policy and procedure should be put in place in each Integrated Service Area. This should include explicit procedures regarding inpatient care for 16-18 year olds. This will facilitate timely transfer of patients from the Emergency Department to inpatient mental health care. Patients requiring transfer to inpatient mental health care should not normally need to travel across the Integrated Service Area boundaries.

5.2 *Staff Education and Training: There is a need for specific training for ED staff in relation to mental health and specifically in relation to self-harm.*

The UK National Institute of Clinical Excellence (NICE, 2004) has recommended that: 'clinical and non-clinical staff who have contact with people who self-harm should be provided with appropriate training to equip them to understand and care for people who self-harm'.[1] In Ireland, *Reach Out* (the National strategy for Action on Suicide Prevention 2005-2014, Health Service Executive, 2005) also recommends the planning and delivery of basic awareness training for all levels of hospital staff on suicidal behaviour and the need to 'develop and deliver specialist intervention, skills-based training for the appropriate staff as part of a national training programme'.[7]

Staff with first contact with patients in the ED (i.e. medical and nursing including Triage nursing staff) should be provided with basic training on dealing with patients with mental health needs. Ambulance staff and security staff should also receive mental health awareness training tailored to their needs. Specific areas of training include: a) mental health triage/brief risk & needs assessment, b) managing acute behavioural disturbance, c) managing self-harm, d) brief intervention for alcohol problems, e) managing of lack of treatment adherence, f) The use of the Common Law and the Mental Health Act.

Liaison Psychiatry services should take a lead role in training EM staff in relation to mental health in the Emergency medical setting and should be resourced to deliver it. Mental

health staff who provide mental health assessment and management to patients following self-harm should themselves receive appropriate training. ED staff Interdisciplinary teaching and training is recommended.

5.3 *Triage: Triage on arrival in the ED should include Mental Health Triage.*

The Manchester Triage System is currently used to categorise treatment acuity of patients following presentation to the ED. This triage system should be adapted for and used for patients with mental health needs in the ED including those following self-harm .[52] There is evidence that mental health triage scales reduce waiting times and reduce the proportion of patients who leave the hospital before being seen.[5]

5.4 *Guidelines, Policies and Procedures: There is a need for guidelines, policies and procedures in relation to mental health and emergency medical care (ie mental health referral, assessment, treatment, communication and transfer).*

These will be individualised to the Model of Hospital / ED and the level of availability of mental health services.

The following guidelines supported by appropriate Training for Emergency staff, should be in place in the ED: a) Mental Health Triage; b) Alcohol problems including brief intervention and detoxification; c) Self-harm; d) Acute behavioural disturbance; e) Management of frequent attenders. The Liaison Psychiatry service will take a lead role in the development of these.

The following Policies and Procedures should be in place in the ED: a) Referral to Psychiatry; b) Special Observation/Care; c) Management of Challenging Behaviour; d) Transfer of Patients to an Acute Mental Health Unit; e) Handover of Care between daytime and on-call Psychiatry; f) Patients who leave prior to being assessed; g) Referral to external agencies. The Liaison Psychiatry service will take a lead role in the development of these.

These guidelines, policies and procedures should take into account the specific needs of patients following self-harm including the needs of children and adolescents and older adults.

5.5 *Patient Location and Mental health assessment: The Location of a patient within the acute hospital system or their flow through it should not be a barrier to timely mental health assessment and management.*

Patient streaming through the emergency medical services should ensure that referral to and assessment by mental health staff is prompt for all self-harm presentations independent of location.

Where there is an ED on-site in a general hospital, self-harm will normally be medically assessed and managed in the ED. Exceptions are: patients requiring transfer from ED Resusc to ICU; patients requiring surgical intervention (typically general, cardiothoracic, plastics); patients requiring specialist medical care (e.g. Liver Failure following paracetamol). Where there is no ED on-site, self-harm should only be managed in an AMU/MAU/AMAU if admission criteria are met and there is on-site Psychiatry available. If there is no Psychiatry available on-site, self-harm should be diverted to the appropriate Network Hospital where it is. Patients requiring resuscitation following self-harm should only be diverted to a Network hospital ITU where there is Psychiatry on-site.

5.6 *Interview facilities*

The ED Mental Health Assessment Area should have at least one interview room. There should be an emphasis on safety of staff and patients in the design, location and proximity of security staff. Interview rooms should have two doors opening both ways and be unlockable from the inside. Doors should have shatter-proof glass panels for visibility. Furniture should be fixed or heavy enough to not be moveable. The room should contain a panic alarm. Guidelines for appropriate design are available.[53, 54]

5.7 *Mental Health Assessment*

All patients who present with self-harm should have a bio-psycho-social assessment by a suitably trained Psychiatry Doctor or Mental Health 'Crisis' Nurse as early as possible following their presentation. The use of a semi-structured assessment proforma by mental health staff to guide the assessment is recommended. Collateral history from a reliable source should routinely be part of this. Brief risk assessment tools are not recommended and are not a substitute for a comprehensive bio-psychosocial assessment.

Translators should be available where needed for those who are not fluent in English language. A management plan that addresses short and medium term needs and risks should be put in place and documented. The patient and where possible their carer/next-of-kin should be informed and involved in this. This should follow as a matter of routine from the initial engagement when taking the collateral history.

5.8 *Specific Clinical issues of relevance to self-harm*

a) Alcohol & Drugs Misuse co-morbid with self-harm

ED clinical staff should be trained in the recognition and treatment of substance abuse and in the provision of brief advice and feedback. MH services have a role and responsibility in the management of complex cases (which includes self-harm). A flexible approach should be taken in the care of patients with psychiatry co-morbidity who require detoxification and clinicians in Emergency Medicine, Psychiatry and Acute Medicine should work collaboratively to address each patient's needs.

The NRDSH shows that 45% of men and 37% of women use or misuse alcohol at the time of their self-harm act. Alcohol may be one of the factors underlying the pattern of presentation with deliberate self-harm by time of day and day of week. Presentations peaked in the hours around midnight and almost one-third of all presentations occurred on Sundays and Mondays.

b) Acute Behavioural Disturbance/Violence co-morbid with self-harm

ED staff including Medical, nursing, security, ambulance and mental health staff should be trained in the management of acute behaviour disturbance/violence. A clinical guideline on the management of acute behavioural disturbance should be available.

c) Treatment Refusal

ED medical and nursing staff should be trained in the assessment of mental capacity and its application in the ED. Patients with mental health needs (including those following self-harm) who refuse treatment and/or threaten to leave the ED should have an assessment of capacity by a doctor. ED and MH staff should be familiar with the principles of treatment under the 'Common Law' as well as the use of the Mental Health Act. When a patient leaves

the hospital prior to necessary mental health assessment or medical treatment, a clear procedure should be followed by ED staff in response.

d) Frequent Attendance

A considerable number of patients repeatedly attend the ED often following repeated self-harm. Such patients are vulnerable and consume considerable ED resources. A mechanism to identify patients who 'frequently attend' should be in place in the ED. Patient-specific care plans for frequent attenders should be in place. Psychiatry/ED/Social work staff should work together to identify and manage these patients.

5.9 *Communication/Information Sharing*

Rapid sharing of clinical information is integral to patient care in emergency settings including all relevant professional agencies involved in that patient's care.

Information and Communication Technology systems that support effective two-way communication with community (ie Primary Care and MH) services will benefit emergency mental health assessment in the ED and timely follow-up following discharge.

Mental Health services will participate in care planning in relation to patients in the ED following self-harm. With the patient's permission, this will usually involve telephone or direct contact with the follow-up agency and a process of direct engagement with the family/carer. The patient will be informed of the follow-up plan.

A semi-structured Mental Health Discharge summary will be completed before discharge or transfer. This summary will be sent by an agreed mechanism within 24 hours to the patients GP and other follow-up service and a copy will be retained in the healthcare record.

5.10 *Clinical governance*

A shared governance model between mental health services and Emergency Medicine is necessary in relation to mental health service provision in the ED including self-harm.

MH staff and activity in relation to self-harm should be part of the governance activity of the ED. This should include clinical, educational, risk management and service issues.

Clinical audit should also be undertaken across the EM/Psychiatry interface to drive continuous quality improvement of the care of patients with MH presentations to EDs.

5.11 *Special observation/care*

Special arrangements for enhanced observation/care must be immediately available to ensure patient and staff safety if patients are considered to be a risk to themselves or others during ED assessment. Special observation may involve 'one to one' care delivered by nurses or care attendants and an enhanced security presence depending on the clinical situation. Staff who provide special observation/care should have received appropriate training prior to undertaking this role. A policy and procedures in relation to Special Observation and Care should be in place.

5.12 *Follow-up care*

Patients should receive contact numbers for telephone support and crisis services. Problem-solving techniques should be used at the outset to identify and prioritise needs. Patients should be signposted to the appropriate service based on identified needs (i.e. Financial stress: Monetary Advice and Budgeting service; Addiction: Drug and Alcohol service; Relationship stress: Marriage counselling service; Individual counselling). Patients should be offered follow-up contact to facilitate engagement in relevant services to address their needs. Patients following repeated self-harm should be offered referral to local Psychological/Mental health services.

6. References

1. National Institute for Clinical Excellence. The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. Clinical Guideline 16. London: NICE; 2004.

2. Knesper DJ. American Association of Suicidology, & Suicide Prevention Resource Center. Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit. Newton, MA: Education Development Center, Inc; 2010.

3. Royal College of Psychiatrists. Self-harm, Suicide and Risk: Helping People who Self-harm (Council Report 158). London: Royal College of Psychiatrists; 2010.

4. Kapur N. Management of self-harm in adults: which way now?. Br J Psychiatry. 2005 Dec;187:497-499.

5. Pitman A, Tyrer P. Implementing clinical guidelines for self-harm – highlighting key issues arising from the NICE guideline for self-harm. Psychology and Psychotherapy: Theory Research and Practice. 2008; 81:377-397.

6. Sheldon TA, Cullum N, Dawson D, Lankshear A, Lowson K, Watt I, West P, Wright D, Wright J. What's the evidence that NICE guidance has been implemented? Results from a national evaluation using time series analysis, audit of patients'notes, and interviews. BMJ. 2004 Oct 30; 329(7473):999-1007.

7. Health Service Executive, Department of Health and Children. Reach Out: National Strategy for Action on Suicide Prevention 2005-2014. Health Service Executive; 2005.

8. 2010 Annual Report of the National Registry of Deliberate Self-harm. National Suicide Research Foundation. Cork, Ireland; 2011.

9. Perry IJ, Corcoran P, Fitzgerald AP, Keeley HS, Reulbach U, Arensman E. The Incidence and Repetition of Hospital-Treated Deliberate Self Harm: Findings from the World's First National Registry. PLoS One. 2012; 7(2):e31663. Epub 2012 Feb 20.

10. Owens D, Horrocks J, House A. Fatal and non-fatal repetition of self-harm. Systematic review. British Journal of Psychiatry. 2002; 181,193-199.

11. Runeson B, Tidemalm D, Dahlin M, Lichtenstein P, Långström N. Method of attempted suicide as predictor of subsequent successful suicide: national long term cohort study. BMJ. 2010 Jul 13; 341:c3222.

12. Arensman E, Corcoran P, Reulbach U, Fitzgerald T, Daly C, Perry I. Deliberate self harm In Ireland 2003-2008: Incidence, repetition and aftercare. National Suicide Research Foundation: Cork, Ireland; 2010.

13. Health Service Executive. Reconfiguration of acute hospital services: Cork and Kerry-A roadmap to develop an integrated university hospital network. 2010.

14. Health Service Executive. Report of the National Acute Medicine Programme. 2010.

15. Cooper J, Kapur N, Dunning J, Guthrie E, Appleby L, Mackway-Jones K. A clinical tool for assessing risk after self-harm. Ann Emerg Med. 2006 Oct; 48(4):459-466.

16. Bergen H, Hawton K, Waters K, Cooper J, Kapur N. Psychosocial assessment and repetition of self-harm: the significance of single and multiple repeat episode analyses. J Affect Disord. 2010 Dec; 127(1-3):257-265. Epub 2010 Jun 1.

17. Sinclair JM, Gray A, Rivero-Arias O, Saunders KE, Hawton K. Healthcare and social services resource use and costs of self-harm patients. Soc Psychiatry Psychiatr Epidemiol. 2011 Apr; 46(4):263-271. Epub 2010 Feb 21.

18. O'Sullivan M, Lawlor M, Corcoran P, Kelleher MJ. The cost of hospital care in the year before and after parasuicide. Crisis. 1999; 20(4):178-183.

19. Kennelly B. The economic cost of suicide in Ireland. Crisis. 2007; 28(2):89-94.

20. Anderson M. Nurses' attitudes towards suicidal behaviour-A comparative study of community mental health nurses and nurses working in an accidents and emergency department. J Adv Nurs. 1997 Jun; 25(6):1283-1291.

21. Lamb S, Arensman E. Accident & Emergency nursing assessment of deliberate self harm. Exploring the impact of introducing a suicide education programme and a suicide intent scale into A&E/MAU nursing practice: a pilot study. Health Service Executive, National Suicide Research Foundation. Cork, Ireland; 2006.

22. Suominen K, Suokas J, Lönnqvist J. Attitudes of general hospital emergency room personnel towards attempted suicide patients. Nord J Psychiatry. 2007; 61(5):387-392.

23. Scheerder G, Van Audenhove C, Arensman E, Bernik B, Giupponi G, Horel AC, Maxwell M, Sisask M, Szekely A, Värnik A, Hegerl U. Community and health professionals' attitude toward depression: a pilot study in nine EAAD countries. Int J Soc Psychiatry. 2011 Jul; 57(4):387-401. Epub 2010 Mar 11.

24. Byrne M, Murphy AW, Plunkett PK, McGee HM, Murray A, Bury G. Frequent attenders to an emergency department: A study of primary health care use, medicalprofile, and psychosocial characteristics. Ann Emerg Med. 2003 Mar; 41(3):309-318.

25. Haw C, Hawton K, Casey D. Deliberate self-harm patients of no fixed abode: a study of characteristics and subsequent deaths in patients presenting to a general hospital. Soc Psychiatry Psychiatr Epidemiol. 2006 Nov; 41(11):918-925. Epub 2006 Aug 10.

26. Cailhol L, Allen M, Moncany AH, Cicotti A, Virgillito S, Barbe RP, Lazignac C, Damsa C. Violent behavior of patients admitted in emergency following drug suicidal attempt: a specific staff educational crisis intervention. Gen Hosp Psychiatry. 2007 Jan-Feb; 29(1):42-44.

27. Mann JJ, Apter A, Bertolote J, Beautrais A, Currier D, Haas A, Hegerl U, Lonnqvist J, Malone K, Marusic A, Mehlum L, Patton G, Phillips M, Rutz W, Rihmer Z, Schmidtke A, Shaffer D, Silverman M, Takahashi Y, Varnik A, Wasserman D, Yip P, Hendin H. Suicide prevention strategies: a systematic review. JAMA. 2005 Oct 26; 294(16):2064-2074. Review.

28. Beautrais A, Fergusson D, Coggan C, Collings C, Doughty C, Ellis P, Hatcher S, Horwood J, Merry S, Mulder R, Poulton R, Surgenor L. Effective strategies for suicide prevention in New Zealand: a review of the evidence. N Z Med J. 2007 Mar 23; 120(1251):U2459. Review.

29. Hegerl U, Althaus D, Schmidtke A, Niklewski G. The alliance against depression: 2-year evaluation of a community-based intervention to reduce suicidality. Psychol Med. 2006 Sep; 36(9):1225-1233. Epub 2006 May 17.

30. Cooper J, Kapur N, Mackway-Jones K. A comparison between clinicians' assessment and the Manchester Self-Harm Rule: a cohort study. Emerg Med J. 2007 Oct; 24(10):720-721.

31. Owens D, Wood C, Greenwood DC, Hughes T, Dennis M. Mortality and suicide after non-fatal self-poisoning: 16-year outcome study. Br J Psychiatry. 2005 Nov; 187:470-475.

32. Owens D, Horrocks J, House A. Fatal and non-fatal repetition of self- harm. Systematic review. Br J Psychiatry. 2002; 181, 193-199.

33. Busch KA, Fawcett J, Jacobs DG. Clinical correlates of inpatient suicide. J Clin Psychiatry. 2003 Jan; 64(1):14-19.

34. Dieserud G, Loeb M, Ekeberg O. Suicidal behavior in the municipality of Baerum, Norway: a 12-year prospective study of parasuicide and suicide. Suicide Life Threat Behav. 2000 Spring; 30(1):61-73.

35. Skeem JL, Silver E, Aippelbaum PS, Tiemann J. Suicide-related behaviour after psychiatric hospital discharge: Implications for risk assessment and management. Behav Sci Law. 2006; 24(6):731-746.

36. Gairin I, House A, Owens D. Attendance at the accident and emergency department in the year before suicide: retrospective study. Br J Psychiatry. 2003 Jul; 183:28-33.

37. Stewart SE, Manion IG, Davidson S, Cloutier P. Suicidal children and adolescents with first emergency room presentations: predictors of six-month outcome. J Am Acad Child Adolesc Psychiatry. 2001 May; 40(5):580-587.

38. King EA, Baldwin DS, Sinclair JM, Baker NG, Campbell MJ, Thompson C. The Wessex Recent In-Patient Suicide Study, 1. Case-control study of 234 recently discharged psychiatric patient suicides. Br J Psychiatry. 2001 Jun; 178:531-536.

39. Holley HL, Fick G, Love EJ. Suicide following an inpatient hospitalization for a suicide attempt: a Canadian follow-up study. Soc Psychiatry Psychiatr Epidemiol. 1998 Nov; 33(11):543-51.

40. Tondo L, Albert MJ, Baldessarini RJ. Suicide rates in relation to health care access in the United States: an ecological study. J Clin Psychiatry. 2006 Apr; 67(4):517-523.

41. Appleby L, Shaw J, Amos T, McDonnell R, Harris C, McCann K, Kiernan K, Davies S, Bickley H, Parsons R. Suicide within 12 months of contact with mental health services: national clinical survey. BMJ. 1999 May 8; 318(7193):1235-1239.

42. Appleby L, Shaw J, Sherratt J, Amos T, Robinson J, McDonnell R, McKann K, Parsons R, Hunt IM, Burns J, Bickley H, Kiernan K, Davies S, Harris C. Safety First : Five-year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. UK Department of Health: London; 2001.

43. Appleby L, Shaw J, Kapur N, Windfuhr K, Ashton A, Swinson N, While D, Lowe R, Bickley H, Flynn S, Hunt IM, McDonnell S, Pearson A, Da Cruz D, Rodway C, Roscoe A, Saini P, Turnbull P, Burns J, Hadfield K, Stones P. Avoidable Deaths. Five-year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. UK Department of Health: London; 2006.

44. Goldberg RW, Kreyenbuhl JA, Medoff DR, Dickerson FB, Wohlheiter K, Fang LJ, Brown CH, Dixon LB. Quality of diabetes care among adults with serious mental illness. Psychiatr Serv. 2007 Apr; 58(4):536-543.

45. Rhodes AE, Bethell J, Bondy SJ. Suicidality, depression, and mental health service use in Canada. Can J Psychiatry. 2006 Jan; 51(1):35-41.

46. Boyer CA, McAlpine DD, Pottick KJ, Olfson M. Identifying risk factors and key strategies in linkage to outpatient psychiatric care. Am J Psychiatry. 2000 Oct; 157(10):1592-1598.

47. Stein G, Wilkinson G. Seminars in General Adult Psychiatry 2nd Ed. Gaskell. 2007.

48. Mitchell, JT and Bray, GP. Emergency Services Stress: Guidelines for Preserving the Health and Careers of Emergency Services Personnel. Englewood Cliffs: Prentice Hall; 1990.

49. Mitchell JT. When disaster strikes...the critical incident stress debriefing process. JEMS. 1983 Jan; 8(1):36-39.

50. Vision for Change. Report of the expert group on mental health policy, Department of Health and Children: Dublin; 2005.

51. Managing Urgent Mental Health Needs in the Acute Trust. Academy of Medical Royal Colleges: UK; 2008.

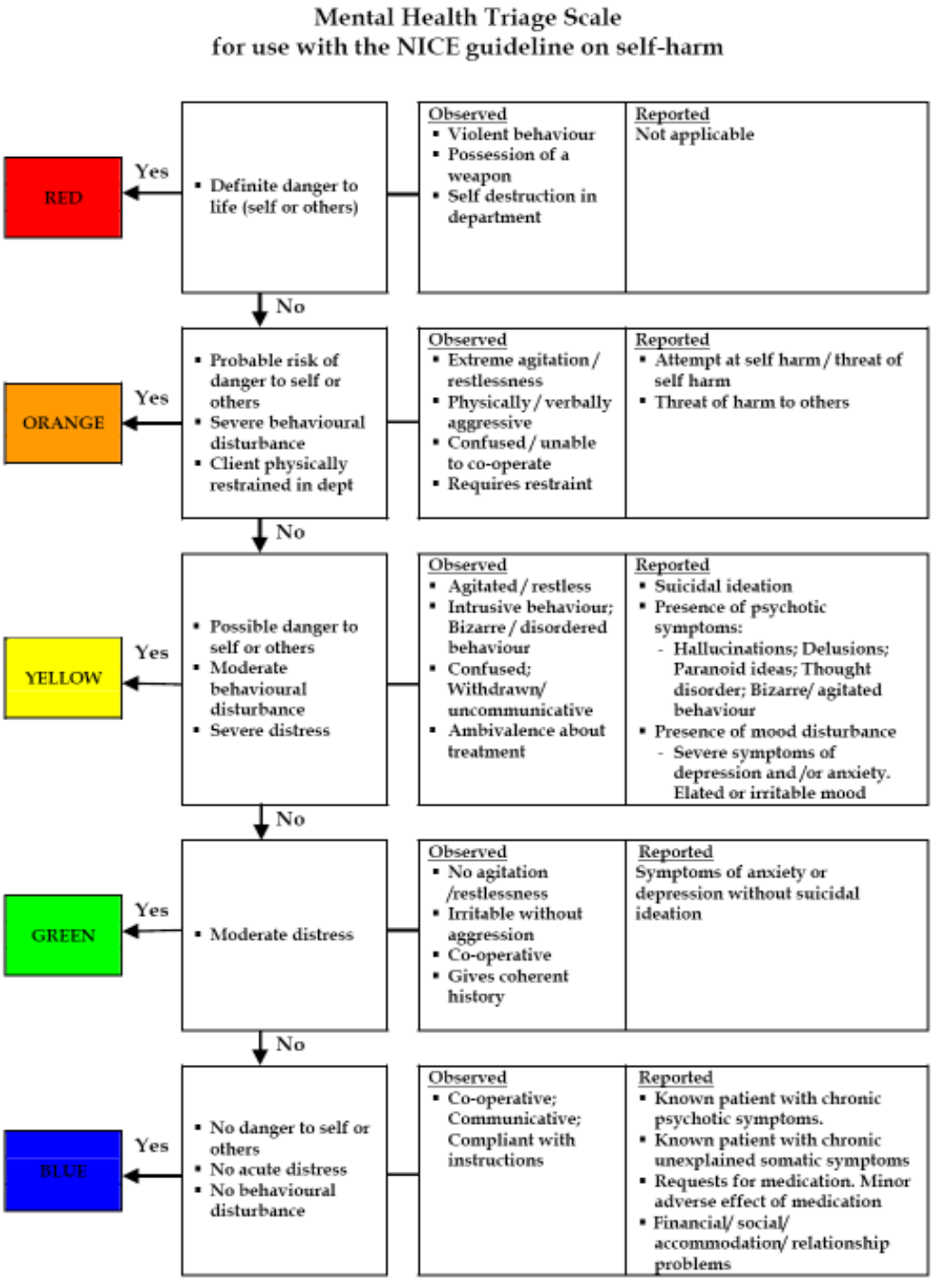
52. Bastion S. Mental Health Triage Scale. NICE Self-Harm development group. The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. National Institute of Clinical Excellence: UK; 2004.

53. Psychiatric services to accident and emergency departments. CR118. Royal College of Psychiatrists & British Association for Accident and Emergency Medicine: UK; 2004.

54. G15. Emergency Department Design. Australasian College for Emergency Medicine; 2007.

Appendix A

Mental Health Triage



Adapted from scales by Broadbent, M., Jarman, H. & Berk, M. (2002). *Improving competence in emergency mental health triage.* Accident and Emergency Nursing, 10, 155-162 and Smart, D., Pollard, C. & Walpole, B. (1999). *Mental health triage in emergency medicine.* Australian and New Zealand Journal of Psychiatry, 33 (1), 57-66

Developed by Simon Baston and the NICE self-harm guideline development group