Evaluation of a specialist crisis nursing service for deliberate self-harm/parasuicide
section 1
INTRODUCTION

1.1 Background to the Evaluation 2
1.2 Aims of the Evaluation 3

section 2
LITERATURE REVIEW

2.1 Deliberate Self-harm / Parasuicide 4
2.2 The Need for a Specialist Service 5
2.3 Crisis Assessments in A&E Departments 5
2.4 Liaison with Primary Care Providers 6
2.5 Guidelines on Deliberate Self-harm / Parasuicide 7
2.6 Outline of the Crisis Nursing Service 8

section 3
METHODOLOGY

3.1 Evaluation Method 9
3.2 Ethical Approval 9
3.3 Data Collection and Analysis 9

section 4
FINDINGS

4.1 Profile of Clients Attending A&E 11
4.2 Client Satisfaction Survey 15
4.2.1 Overall Satisfaction 15
4.2.2 Professional Skills 16
4.2.3 Efficacy 16
4.2.4 Types of Interventions 17
4.2.5 Information 17
4.2.6 Relative Involvement 18
4.2.7 Discussion on Client Satisfaction Survey 19
4.3 GP Satisfaction Survey 21
4.3.1 Frequency of Contact with Crisis Nursing Service 21
4.3.2 Overall Service Satisfaction 22
4.3.3 Efficacy 22
4.3.4 Professional Skills of Crisis Nurses 23
4.3.5 Types of Interventions with GPs 23
4.3.6 Benefit of a Crisis Nursing Service to Primary Care 24
4.3.7 Discussion on GP Survey 24
4.4 Focus Groups at A&E Departments 25
4.4.1 Findings from the Focus Groups 25
4.4.2 The Fast Response 26
4.4.3 Availability 24 Hours Seven Days 26
4.4.4 Offering “Time” to the Client 26
4.4.5 Assessment Review of Risk and Treatment 27
4.4.6 Support to A&E Staff 27
4.4.7 Discussion of Focus Group Findings 28
4.5 Personal stories of Suicidal Attempts 28

section 5
CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion 31
5.2 Recommendations 32

ACKNOWLEDGEMENTS 33
REFERENCES & BIBLIOGRAPHY 34
1. Aims of the Evaluation

1. Undertake an audit of clients who used the Cork Crisis Nursing Service.

2. Ascertain the level of satisfaction of clients and their experience of the Crisis Nursing Service at three Cork hospitals.

3. Establish the level of satisfaction of GPs with the Cork Crisis Nursing Service.

4. Determine the impact of the crisis nursing service at the three Cork city Accident & Emergency Departments.

The rationale for this type of evaluation has been that satisfaction with this sort of nursing suicide prevention service has rarely been described from clients’ and service provider’s perspectives in empirical published nursing research. It is hoped that this evaluation highlights the relevant outcomes of the Cork Crisis Nursing Service and makes appropriate recommendations based on the evaluation’s findings.

1.1 Background to the Evaluation

Deliberate self-harm and parasuicide is a major public health problem. The incidence of self-harm and parasuicide is higher in Ireland than in any other European country. The National Suicide Register (2003) recorded presentations to Irish hospitals at 9,839 consisting of 7,825 individuals. Over 40% of these parasuicide presentations were treated in the Eastern Regional Health Authority. The HSE - Southern Area recorded 30% of the national figures and recorded 1,134 individuals for 1,321 episodes of self-harm. 39.9% of these presentations were men and 60.1% were women. Almost half of the presentations were of people under the age of 30, and 86% were under 50 years.

The terms “attempter suicide” and “parasuicide” are synonyms, and are defined (Platt et al 1992) in a World Health Organization multi centre study on Parasuicide as:

“An act with non fatal outcome in which an individual deliberately initiates a non habitual behaviour that without intervention from others will cause self-harm or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences.”

Parasuicide and acts of self-harm result from various crises and are one of the strongest associations with suicide. Deliberate self-harm is a high risk factor for further suicide because individuals who have deliberately self-harmed at a time of crisis, have a 100 fold increased risk of suicide compared with the general population (Hawton & Fagg 1988). A classic definition of “crisis” is according to Caplan (1964 p64):

“A psychological disequilibrium in a person who confronts a hazardous circumstance that for them constitutes an important problem which they can for the time being neither escape nor solve with their customary problem-solving techniques. The essential factor influencing the occurrence of crisis is an imbalance between the difficulty and importance of the problem and the resources immediately available to deal with.”

Statistics suggest that a significant percentage of deaths from suicide could be prevented, for this reason, and because suicide can devastate families and other ‘survivors’ psychologically, spiritually, economically and constitutes a more general loss to society, the Irish Government’s Task Force on Suicide (1998) made suicide prevention one of its health priorities. The HSE – Southern Area has taken action by targeting suicidal behaviour with a number of initiatives, including the establishment of a Crisis Nursing Service at three Cork city hospital Accident & Emergency Departments. This Crisis Nursing Service was established in 2001 and offers assessment, response and follow-up to individuals who deliberately self-harm and cause parasuicide situations.

Quality and Fairness (DOH&C 2001) Action 48 of the Health Strategy, identifies the need for the measurement of client satisfaction, consistent with placing the client at the centre in the delivery of care. Feedback from clients can influence the whole quality improvement agenda and provide an opportunity for learning, improvement and development. It provides crucial information on what the client’s expectations are and how they perceive the quality of care, which may differ from the staff who are providing that care. There is clearly a need to investigate the perceptions and level of satisfaction regarding the quality of the service offered to the Crisis Nursing Service clients who present with self-harm/parasuicide at A&E Departments. The impact of this service on A&E staff and GPs also warrants investigation. This evaluation can then be utilised for future planning and contribute to the provision of easily accessible high-quality service.
2.1 Deliberate Self-Harm / Parasuicide

The impact of deliberate self-harm on the health service is considerable (Platt et al 1992). The WHO/EURO Multicentre Study of Suicide (Platt et al 1992) was set up in research centres across Europe, to monitor trends in the epidemiology of suicide and conduct follow-up investigations with a view to predicting future suicidal behaviour. Based on the data collected, the study has estimated that the average European rate of suicide for persons aged over 15 years is 140 per 100,000 for males and 193 per 100,000 females. In the past fifteen years in Ireland, an estimated 300 - 800 per 100,000 people over the age of 15 years made a non-fatal suicide attempt, this results in ten times more suicide attempts than fatal outcomes.

Deliberate self-harm/parasuicide accounted for 527 male and 793 female of A&E attendances in the Health Service Executive - Southern Area in 2003 (NSRF). Various terms are used in literature to describe self-harm, such as deliberate self-harm syndrome (Rosen & Collins 1993, Allen et al. 1997), self-mutilation (FavaZZa 1996) and parasuicide (Linehan 1993). Deliberate self-harm and parasuicide acts, range from relatively minor gestures such as superficial skin scratching, burning, to life-threatening overdoses of medication, hanging, stabbing and cutting (WHO 1992). Deliberate self-harm through cutting, burning and overdose can lead to physical injury, long-term disability, organ damage, scars and cosmetic impairment and possibly premature death (Poutie & Neville 2004). A previous history of self-harm is common in cases of suicide; it is estimated that 40% to 50% of completed suicides have a previous history of self-harm (Bird and Faulkner 2000, Diekstra 1993, Hawton et al 2004).

Deliberate self-harm behaviour is distressing for patients, their carers and families (Carrigan 1994, Farrington 1995). Lindgren et al (2004 p 286) described people who self-harm as:

“Struggling for hopefulness through met and unmet expectations to be confirmed”.

Lindgren et al (2004) describe the paradoxical nature of hopefulness and illustrate client’s experiences around positive and negative aspects of being seen or not being seen, being valued or being stigmatised, being connected or disconnected, being believed or doubted, and being understood or not being understood. People who deliberately self-harm according to Koerner & Linehan (2000) are distressed and seeking release from distressing circumstances. The intense desire for release from problems leads individuals to ‘change’ their environment and circumstances. Individuals who have been raised in an emotionally invalidating environment or those who have experienced childhood abuse or neglect often exhibited this behaviour. An extreme example is a desire for release from life itself, leading to a pre-mediated suicide attempt. Reports have described automatism and feelings of numbness immediately prior to self-injury. Orbach (1994), & Maltzberger (1995) report that suicidal acts may be related to high tolerance for pain and indifference to the body. Individuals often report that at the moment of the suicidal action (e.g. when cutting) they did not feel pain.

According to the National Suicide Research Foundation (2004) a substantial number of people are thought to harm themselves without coming to the attention of A&E Departments, opting instead to be treated by their GP or receiving no attention at all. NSRF research carried out with 4,000 young people in Ireland aged 15-17 found that only 15% engaged with services after engaging in deliberate self-harm, concurring with Dastral (1993), Hughes & Owens (1995) and Hawton et al (2004), observations that many who self-injure do not seek medical assistance, and so the health services may only see the ‘tip of the iceberg’.

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2.2 The Need for a Specialist Service

The mainstreaming of psychiatric services into the general healthcare system has increased the pressure on A&E Departments to treat patients/clients with acute psychiatric needs. People who self-harm are most likely to present at A&E Departments, although this will depend on the nature and severity of harm caused by their behaviour. Published nursing research about self-harm is sparse. There has been little research directly examining client satisfaction with the system of care delivery at A&E departments, there is a growing body of research that highlights the problems associated with the treatment of so called “psychiatric” clients within the A&E Department. A common theme throughout the literature is that A&E nurses find clients with psychosocial presentations challenging. Staff in the A&E Departments of hospitals are reported as being negative or ambivalent toward suicidal or self-harming individuals. Pompili et al (2005) suggests these individuals are subjected to stigmatisation and lack of empathy. This phenomenon they propose is linked to a decreased quality of care offered to these individuals and to missing an important opportunity to prevent further suicidal behaviour or repetition of deliberate self-harm. A&E nurses believed they do not have the skills and experience and lack the appropriate facilities to cater for individuals with psychiatric problems. Gillette & Bucknill (1996) found that A&E nurses acknowledged they do not like dealing with these clients, as demonstrated through the following quotes:

“They demand a lot of time and attention …”

“They are hard to deal with and it’s frustrating to see them coming back.”

Heslop et al (2000) reported that a majority of psychiatric presentations occurred outside business hours of nine to five. McEvoy (1998) noted that clients who self-harm are more likely to present after hours, were more psychiatrically disturbed than those who presented within normal business hours. Crowley (2000) suggested that the A&E Department environment is not conducive to the needs of psychiatric clients, the lack of privacy, high noise levels, inadequate nursing time available and an open environment that made disturbed behaviour difficult to contain were specific features that demonstrated the difficulties of this environment.

2.3 Crisis Assessment in Accident & Emergency Departments

The first initial contact that self-harm clients experience with health and social care professionals can have a significant impact on their willingness to accept help (Cook et al 2004). An effective outcome identified from Heslop et al (2000) was the recommendation that an identified expert practitioner be easily accessible in the A&E Department setting. McEvoy (1998) indicated that the A&E Department assessment of deliberate self-harm and suicide risk should be a principal area of practice for a specialist practitioner. McEvoy (1998) noted that clients who were directly referred to psychiatric nurses after triage or medical intervention, found that clients already linked with a mental health worker were more likely to present with psychosis, suicidal ideation or anxiety. Those who presented in crisis with actual self-harm or under the effect of substances were more likely not to be linked with any support agencies.

In reviewing the histories of clients who left the A&E Departments without being seen Smart et al (1998) found these clients to be more likely to re-present to the A&E department, within the following week. This outcome supports the significance of psychiatric client risk factors being recognised at A&E triage, and fast tracking the client to been seen, as soon as possible. Heslop et al. (2000) highlighted the importance of this approach in the triage of psychiatric clients, through a study undertaken at an A&E Department in Australia. The A&E staff in this study perceived an increase in presentation by clients presenting for psychiatric problems since the Psychiatric Inpatient Unit had opened. They described...
LITERATURE REVIEW cont’d.

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...direction to succeed, new relationships between mental health services and the wider health promotion and prevention, as crucial components. For this direction to succeed, new relationships between mental health services and the wider health promotion and prevention, as crucial components. For this direction to succeed, new relationships between mental health services and the wider health sector is essential, along with the building of partnerships and linkages with Mental Health Services across GPs, private practitioners, and voluntary agencies. Models of shared care that have been researched worldwide, describe ways of providing a collaborative approach to coordinating patient care between specialists and primary health care providers, assisting people with mental health problems to gain access to the right services and the right blend of services. Shared care recognises that GPs can contribute to the organised care of persons in crisis situations, including those individuals engaging in deliberate self-harming and with suicidal intent. Lang, Johnstone & Murray (1997, p167.) report:

“GPs seek additional support for patients with psychological problems, especially from community psychiatric nurses and their involvement in patient care is considered to be of central importance in improving communication between the specialist and primary care services.”

Good communication between GPs and psychiatric services is essential, as are shared care plans and the identification of key workers. Lang, Johnstone & Murray (1997) proposed a more structured and coordinated approach to patient management as a key requirement. If improvements in patient care are to be afforded. Bindman et al (1997) assessed GP satisfaction with communication and the joint working in the care of patients, GP knowledge about the psychiatric care received by each patient and GPs’ perceived role in the care of each patient. Results showed deficiencies in communication and continuity of care between psychiatric services and primary care, and GPs were unaware of aspects of care received by their patients and did not feel their role was clear.

2.4 Liaison with Primary Care Providers

The National Health Strategy (2001) set out a new direction for primary care, it promoted a team-based approach to service provision that could contribute to sustainable health and social development. Primary care is the first point of contact that people in Ireland have with the health and social services. The Primary Care Strategy (2001) identified the development of community based mental health provision integrated with good inpatient, outpatient and primary care facilities. This demands collaboration, partnerships, linkages, coordination, with health promotion and prevention, as crucial components. For this direction to succeed, new relationships between mental health services and the wider health sector is essential, along with the building of partnerships and linkages with Mental Health Services across GPs, private practitioners, and voluntary agencies.

The potential value of a specialist crisis nurse’s role was evaluated in a study by Gillette & Bucknell (1996). Crisis nurses conducted direct clinical assessments with clients, interventions included psychiatric/mental state examinations, counselling, crisis intervention and ensuring appropriate follow-up arrangements were made. As a result of this research, it was found that direct clinical assessments of clients with psycho-social problems by psychiatric nurses assisted the A&E nurses, they felt reassured that the clients was safe whilst they attended to other patient needs.

2.5 Guidelines on Deliberate Self-harm/ Parasuicide

Those who have self-harmed should receive assessment and treatment within 48 hours, according to guidelines from the U.K. based National Institute for Clinical Excellence and the National Collaborating Centre for Mental Health (NICE). The Institute for Clinical Excellence (NICE) produced a comprehensive Clinical Guideline in July 2004, on best practice in the physical and psychological management of people who self-harm in primary and secondary care. The following are the key priorities of this guideline:

People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm. 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. Ambulance and A&E Department services whose staff may be involved in the care of people who have self-harmed by poisoning should ensure that activated charcoal is immediately available to staff at all times.

All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings). Assessment should determine a person’s mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness. If a person who has self-harmed has to wait for treatment, he or she should be offered an environment that is safe, supportive and minimises any distress. For many patients, this may be a separate, quiet room with supervision and regular contact with a named member of staff to ensure safety.

The NICE guideline clearly states that a full psycho-social assessment should be undertaken by a suitably qualified specialist mental health professional, and states that all people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment. It also states that all people who have self-harmed should be assessed for risk: this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent. Following a psychosocial assessment for people who have self-harmed, the decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment, including an assessment of risk, and should not be determined solely on the basis of having self-harmed.
2.6 Outline of the Crisis Nursing Service

The HSE - Southern Area introduced this Crisis Nursing Service in September 2001 as a pilot project. It consisted of the provision of appointing specialist psychiatric nurses on a 24-hour roster system for the three Cork city hospitals. The main objective of this initiative was to improve the quality of care delivered to individuals attending the A&E Departments, following deliberate self-harm and attempted suicide. The clientele includes both males and females, over the age of 16 who have attempted to self-injure or endeavour to commit suicide or who have been interrupted in an attempt to either of the above. The specific role of the crisis nurses is to take a full psychosocial history and define problem areas with the client. The objective of a psychosocial assessment as stated by the Royal College of Psychiatrists London (1994) is to:

“… Identify those who have a psychiatric illness, those with high suicide risk, and those with coexisting problems (for example alcohol or drug problems) and those in social crisis….”

The crisis nurses, in their initial clinical assessment, carry out a suicide risk assessment, looking at levels of depression/anxiety/hopelessness. The expectation is that following the assessment any necessary psychiatric treatment or aftercare will be provided for those with mental illness, alcohol/drug problems and social and psychological help will be given. The crisis nurse’s role is to identify the client’s significant other/family members or friend to be closely involved with the client and crisis nurse during and after the initial intervention. In addition to the history of multiple attempts, a history of self-injurious behaviour also increases the risk for suicide (Linehan, 1993; Stanley et al 2001). Stanley et al (2001) found that clients with self-injurious behaviour were at risk for suicide attempts because of their high levels of depression, hopelessness and impulsivity. They also tend to misperceive and underestimate the lethality of their suicidal behaviour. The client’s level of chronic risk can be estimated by taking a careful psychosocial history of the previous suicidal behaviour and focusing on the times when the client may have demonstrated attempts with the greatest intent and medical lethality.

Following the crisis nurse’s assessment of the client, both become involved in providing an effective and efficient response to deal with the client’s crisis. They devise an overall care pathway, which suggests problem solving, and management skills, where both the client’s long term and short-term goals are incorporated. Problem solving therapy is a brief intervention that seeks to improve the client’s problem solving skills in the hope that in the future, when faced with similar problem(s) to those that prompted their current deliberate self-harm behaviour, so that they will be able to solve those problems without resorting to self-harm (House et al 1992).

Home care follow-up and support with up to six individual sessions is an important part of the service provided by the crisis nurses. This usually consists of contact with the client either by phone or by meeting as frequently as required, initially and for up to a six week period. This offers time for discussion, support, modifying of goals or setting new goals and any other issues that may come up within the period. The Crisis Nursing Service also liaises with the client’s GP, significant others, and any other service providers, which may be involved with them during this period. If the client needs referral to any other voluntary or statutory service, the nurses will organise this for them, for example: bereavement counselling, assistance with money management and budgeting, addiction services, etc.

3.1 Evaluation Methods

This evaluation has used a multi-method approach in order to achieve the evaluations aims, namely by:

1. Undertaking an audit of individuals who were assessed by the Crisis Nursing Service with deliberate self-harm/parasuicide during the period Jan 2002 - Dec 2004.

2. Ascertaining using a survey, the level of satisfaction of clients with their experience of the Crisis Nursing Service in the A&E Departments.

3. Establishing using a survey the level of satisfaction of GPs with the Crisis Nursing Service.

4. Evaluate using focus groups the impact/efficacy of the Crisis Nursing Service with A&E staff.

Evaluation of new services in mental health needs to take place over a period of several years. Consistent with this, a retrospective representative sample was gathered from the case files of individuals who were assessed and treated by the Crisis Nursing Service, over three years from the launch of the Crisis Nursing Service in January 2001 to December 2004. GP’s views and other service providers at A&E Departments including psychiatric liaison teams, are also relevant, and have been considered. A structured questionnaire was used to seek information from clients and GPs regarding what was helpful and what was not helpful, about their treatment, and feedback was sought on improvements to the service. Focus groups were used at A&E Departments with relevant staff members. The personal stories of two individual service users have also been obtained.

3.2 Ethical Approval

This research evaluation was presented and approved by the HSE - Southern Area’s Ethics Committee in the spring of 2005. The evaluation of this established crisis service ensured that the ethical standards of research, including the maintenance of confidentiality and voluntary participation, were adhered to at all times. It was envisaged that the decision of the committee was based on the concept that the evaluation fell within the scope of quality assurance.
The Statistical Package for the Social Sciences (SPSS) V.13 was used for conducting statistical analyses and manipulating the quantitative data. Both sets of survey data was presented using summary tables, charts, frequencies, percentages and measures of central tendency in an effort to describe and characterise the data by summarising them into more understandable terms without losing or distorting much of the information. Nominal and ordinal measurement scales only were utilised in the evaluation.

A qualitative hermeneutic approach was used to analyse all the qualitative statements that were returned in the survey questionnaires and the data generated from the three focus groups. The goal of understanding a phenomenon from the point of view of the A&E staff and its particular social context was felt, could have been lost if textual data was quantified. A hermeneutic approach is a philosophical approach to human understanding and provides a philosophical grounding for interpretivism. All the qualitative transcripts were transcribed into a Microsoft Word document. Units of meaning, clusters, and then categories were inductively determined from each line of data. Subjective comments made by the focus group participants are included as they are meaningful and best describe their experiences of the Crisis Nursing Service. Two personal stories were obtained to gain a further understanding through dialogue of the service user’s first hand experiences of the Crisis Nursing Service.

4.1 Profile of Clients Attending A&E

A systematic audit was carried out on self-harm presentations to the Crisis Nursing Service over the three-year period Jan 2002 to Dec 2004. Audit is considered routine practice, is generally conducted without informed consent, and is not subject to ethical approval. A specifically designed audit form was used to gather client information on the following areas: gender, age, marital status, mode of attempt, previous attempt, suicide notes left, precipitating factors, other factors, family history, and follow-up treatments.

GENDER OF CLIENTS

Of the 702 presentations recorded, 296 (approx 40%) were male and 406 (approx 60%) were female. Figure 1.

AGE PROFILE OF CLIENTS

Of the 702 clients, assessed 327 (56.5 %) were under the age of 25. 235 clients (33.4%) were under the age of 40. 129 clients were (18%) were under the age of 65. 11 clients (1.5%) were aged between 65 and 85 years. Figure 2.

The gender and age group of female to male clients varied considerably. Figure 3.
MARITAL STATUS OF CLIENTS
The marital status of clients recorded the majority of clients to be single 451 (64%), followed by married or cohabiting were 193 (27%). 51 (7%) were divorced or separated. In addition, there were 10 clients (2%) widowed. Figure 4.

MODE OF ATTEMPT
Overdose was the most frequently recorded method, used by 546 clients (77.5%), followed by self-inflicted cutting by 80 clients (12.7%), drowning by 23 clients (3.2%). Other methods were falling, poisoning, road traffic accidents, suicidal ideation, hanging and missing. Figure 5.

PREVIOUS ATTEMPTS
104 (14.8%) clients made one previous attempt. 15 (2%) clients had two previous attempts another 12 (1.7%) of clients had numerous suicidal attempts.

SUICIDE NOTES
160 (23%) of the 702 clients audited left suicides notes. 93 (58%) suicide notes were left by females and 67 (41%) were left by males. Figure 6.

PRECIPITATING FACTORS
Numerous precipitating factors were cited by the 702 clients as participating factors in their act of deliberate self-harm/parasuicide. Included are the following most cited factors. Figure 7.

<table>
<thead>
<tr>
<th>No. Clients</th>
<th>%</th>
<th>Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>267</td>
<td>38%</td>
<td>Depression</td>
</tr>
<tr>
<td>204</td>
<td>29%</td>
<td>Relationship Problems</td>
</tr>
<tr>
<td>126</td>
<td>18%</td>
<td>Impulsive Act</td>
</tr>
<tr>
<td>42</td>
<td>6%</td>
<td>Financial Problems</td>
</tr>
<tr>
<td>35</td>
<td>5%</td>
<td>Another Mental Illness</td>
</tr>
<tr>
<td>28</td>
<td>4%</td>
<td>Physical Illness</td>
</tr>
</tbody>
</table>

Other participating factors cited by clients in their act of deliberate self-harm/parasuicide include the fact that 44% of the clients admitted that they were intoxicated with alcohol and over 5% by illegal drugs at the time of their attempted suicide and over 10% had family problems. Figure 8.

FAMILY HISTORY
Only 5.4% (38) of the clients audited gave a family history of suicide/parasuicide/self-harm. The relationship of the family member included: seven clients cited fathers, three mothers, four brothers, two sons, five uncles, four cousins, the remainder included nephews, aunts and in-laws.
Client Satisfaction Survey

Client satisfaction with the Crisis Nursing Service was evaluated using an adaptation of the Verona Service Satisfaction Scale (Ruggeri & Dall’Agnola, 1993). The Verona Service Satisfaction scale (VSSS-EU) is a setting-specific, validated, multidimensional scale for measuring customer’s satisfaction with the Mental Health Services.

The adapted Verona questionnaire comprised of the following six domains:

- Overall satisfaction/respect
- Professionals skill and behaviour
- Efficacy
- Types of intervention
- Information
- Relative’s involvement and support.

A convenience sample of 227 was selected, approximately one third of the 702 clients who were assessed at the three A&E Departments, by the Crisis Nursing Service within the years 2001-2004. Two hundred and twenty seven (227) questionnaires were distributed (33 clients did not receive a questionnaire, these were returned: not at that address). Fifty four (54) questionnaires were completed and returned giving a response rate of 28%.

Discussion on Client Profile

A WHO document on Health in Ireland (1998), reported that women in this country are still more likely to attempt suicide than men. The findings of the 702 A&E presentations concurs with that findings and finds that approximately 60% of presentation with deliberate self-harm to the three Cork city A&E Departments were female while 40% were male. The age profile revealed that 62% were under the age of 30. Findings also revealed that 64% of presentations were single people, 28% married or cohabiting and 10% either divorced/separated or widowed.

Looking at factors connected with parasuicide, the WHO/EURO study (Platt et al 1992) found that, compared with the general population, people who attempted suicide were more likely to belong to social categories associated with social destabilisation and poverty. Those with increased risk of parasuicide were individuals with poor coping skills, a diagnosis of mental illness and substance misuse i.e. alcohol or drugs.

The finding of this audit of 702 presentations found that the main method of parasuicide used by clients was found to be overdose, accounting for over 76%.

Cutting was the next most commonly used method, accounting for 12.7%. Drowning was used by 3.2%. Hanging was next with 3% of males but only one female and poisoning was used by 2%. Precipitating factors cited depression by 42% clients, relationship problems by 33% while 20% stated that it was an impulsive act.

Kelleher et al (2000) found that the client’s personal psychopathy, often interacts with social pressures, including relationship difficulties and loss events, leading to a perceived absence of any choice other than suicidal behaviour. Almost half of the presentations said that they were intoxicated with alcohol 44% and over 5% by illegal drugs at the time of their attempted suicide. Interpersonal difficulties in the form of family difficulties were cited by over 10%; and life changes was cited by over 8%, with bereavement by almost 8% and child sexual abuse by 5%. Finally, a small proportion only cited bullying 3.5%; exam pressures 2.8%, work pressures 3.5%, pregnancy/rape 3.2% as the reason for their suicide attempt. It is worth noting that 23% of this sample left suicide notes and only 5% had a family history of suicide/parasuicide/self-harm.

4.2 Overall Satisfaction

Clients were asked to rate the overall effectiveness of the service in helping them to deal with their problem/crisis situation. Over 83.3% of clients were either very satisfied or satisfied, 7.4% had mixed feelings when asked to rate the overall effectiveness of the Crisis Nursing Service. 9% percent were dissatisfied. Figure 10.

Clients were asked to rate the confidentiality and respect shown to their rights. Over 85% were very satisfied or satisfied, 9% had mixed feelings and 2% were dissatisfied, 4% (2 individuals) rated this as terrible. Figure 11.
4.2.2 Professional Skills

Clients were asked to rate their satisfaction on the ability of the crisis nurse(s) to listen and understand their problem(s). 83.3% were either very satisfied or satisfied. 8% percent had mixed feelings or were dissatisfied and one client found the service terrible. Figure 12.

Clients were asked to rate their satisfaction of the professional knowledge and competence of the crisis nurse(s). Over 80% were either very satisfied or satisfied. 7% had mixed feelings or were dissatisfied and one client responded terrible. Figure 13.

4.2.3 Efficacy

Clients were asked to rate the effectiveness of the service in helping their recovery and preventing relapse. 74% were very satisfied or satisfied. 11% had mixed feelings, 11% were dissatisfied and 4% found it terrible. Figure 14.

Clients were asked to rate the effectiveness of the service in helping improve their knowledge and understanding of their problem(s). Over 85% were either very satisfied or satisfied. 13% had mixed feelings or were dissatisfied and one client responded terrible. Figure 15.

4.2.4 Types of Interventions

Clients were asked to rate their satisfaction with the amount of time and help they received from the crisis nurse(s). 77.8% were either very satisfied or satisfied. 18% had mixed feelings or were dissatisfied and two clients responded terrible. Figure 16.

Clients were asked to rate their satisfaction with the explanations of specific plans of care they received from the crisis nurse(s). 81.4% were either very satisfied or satisfied. 15% had mixed feelings or were dissatisfied and two clients responded terrible. Figure 17.

4.2.5 Information

Clients were asked to rate their satisfaction with the instructions given by the crisis nurse(s) on what to do “on their own” between visits. 57.7% were either very satisfied or satisfied. 13% had mixed feelings, 9% were either dissatisfied or responded terrible. Figure 18.

Clients were asked to rate their satisfaction with the information given by the crisis nurse(s) to relatives about their problem and “what to expect”. 66.6% were either very satisfied or satisfied. 22% had mixed feelings, and 11% were either dissatisfied or responded terrible. Figure 19.
4.2.7 Discussion on Client Satisfaction Survey

This survey investigated client satisfaction with the specialist Crisis Nursing Service. The more specific aim was to describe client satisfaction with overall satisfaction, respect, professional’s skill and behaviour, efficacy, types of intervention, information, and relative involvement. The results of the client satisfaction survey show that the vast majority of clients were satisfied with the overall treatment they received. Comments made by clients support the evidence from the satisfaction survey. Clients noted that:

"Any problems I had, I was able to talk to them (the crisis nurses) and feel comfortable especially if I couldn’t talk to anyone else."

"When I was not feeling too good the crisis nurse called to my house, so I didn’t have to meet in a public place, I really appreciated that."

83% of clients indicated that they were satisfied that the service had helped them deal with their crisis situation. One client stated:

"The thing I liked most was when I was with the crisis nurse I felt at ease; I didn’t feel like a crazy person or anything. She was a great listener and an even better advisor. I owe a lot to her."

85% were satisfied with the respect and confidentiality shown to them. 83% were satisfied with the nurse’s ability to listen and understand their problem(s). Clients remarked that:

"The nurse made me relax and listened to everything I had to say and reassured me that I was not on my own. It definitely helped me to have the crisis nurse there."

"It was good having someone who listened and didn’t judge, who coached me back to ‘normality’. Having “one to one” meetings really helped me."

80% were satisfied with the professional knowledge and competency of the crisis nurses, the following are comments clients made:

"She (the crisis nurse) didn’t judge me on my overdose and she completely understood my depression."

"I was very satisfied with the crisis nurse; she was the first person I think I ever really opened up to. It helped me to open up to a lot more people. I have made a complete recovery and will address my depression straight away if it occurs again - hope to God it won’t."

85% were satisfied that the service had helped improve their knowledge and understanding of their problem(s). Another client believes:

"It helped me reach out and to seek further treatment. It took away my guilt feelings and the shame I felt about myself. It was the start of a full recovery and I am very grateful for it."

A number of clients expressed unhappiness about the service provision at the A&E Departments. Disapproving comments on service provision include the following comments made by clients:

"The cubicles in A&E were not very private, outside everything can be heard by patients waiting to be seen, so you are frightened to talk."

"When I was in hospital I felt everyone knew my business, more privacy needed."

"The psychiatrist I dealt with didn’t care how I was feeling, she should have been more sympathetic."

"I found that other people I dealt with in A&E other than the crisis nurse, didn’t want to hear how I arrived at the situation I found myself in."

"The psychiatrist I dealt with didn’t care how I was feeling, she should have been more sympathetic."

85% were satisfied with the relative involvement of the crisis nurses, the following are comments clients made:

"Clients were asked to rate the effectiveness of the service in helping their relative(s) understand their problem(s).

57% were very satisfied or satisfied, 30% had mixed feelings and 13% responded dissatisfied or terrible. Figure 20.

Clients were asked to rate the effectiveness of the service in helping their relative(s) improve their capacity to deal with the problem(s) they had. Over 59% were very satisfied or satisfied, 26% had mixed feelings and 15% were dissatisfied or terrible. Figure 21.
4.3 GP Satisfaction Survey

The use of GP satisfaction surveys to measure various aspects of shared care is widely reported. A specifically designed anonymous survey containing questions on specific aspects of the Crisis Nursing Service from levels of satisfaction to an opportunity to express what was helpful, was thought to offer GPs an acceptable and practical way to measuring satisfaction and also to detect areas of the service that may need attention. One hundred and twenty seven (127) questionnaires were posted to GPs in the Cork area who had had contact with the Crisis Nursing Service over the previous three years. Six questionnaires were returned with no knowledge of the service and forty eight (48) questionnaires were completed and returned, giving a return response rate of 38%.

Subjective comments made by the GPs are included, as they are meaningful and best describe their experiences of the Crisis Nursing Service.

4.3.1 Frequency of Contact with Crisis Nursing Service

GPs were initially asked the number of times a year that they would have contact with the Crisis Nursing Service. Responses include 6 to 12 months was the most frequent contact with 33.3%, 1-3 months was 9.5%, 3-6 months was 16.7%, once a year was 23.8% and less often was 16.7%. Figure 22.
4.3.2 Overall Service Satisfaction

GPs were asked what their satisfaction of the service and its effectiveness in helping their patient and preventing suicide? 83% responded very satisfied to satisfied. 14% had mixed feelings and only one GP was dissatisfied with the Crisis Nursing Service. Figure 23.

GPs comments included: “I think this service is essential” and “The crisis nurse is another shoulder to lean on” and “It is effective help in time of need, a designated specialist service”.

GPs were asked what their satisfaction with the amount of “time” and “help” their patient received. Over 90% responded very satisfied to satisfied. 7% had mixed feelings and only one GP was dissatisfied with the Crisis Nursing Service. Figure 24.

GP comment: “The nurse gives TIME to the patient.”

4.3.3 Efficacy

GPs were asked to rate the effectiveness of the service in helping their patient deal with the crisis problem(s) they had? 83% were very satisfied or satisfied with the service. 14% had mixed feelings and one GP was dissatisfied with the service. Figure 25.

GP comment: “I feel the service needs greater support from psychiatrists to offer greater continuity.”

4.3.4 Professional Skills of Crisis Nurses

GP were asked to rate their satisfaction on the knowledge and competence of the crisis nurses: 93% were very satisfied or satisfied and 7% had mixed feelings. Figure 26.

4.3.5 Types of Interventions with GPs

GPs were asked to rate how helpful the contact phone calls made by the crisis nurses to them following the presentation at A&E of one of their patients?

Over 90% of GP found this service, very helpful or helpful, 7% had mixed feelings and one GP found it unhelpful. Figure 27.

GP comment: “More communication with GPs would be helpful.”

GPs were asked to rate how helpful the discharge summaries sent to them by the crisis nurses following the presentation at A&E of one of their patients.

Here again over 90% of GPs found this service very helpful or helpful, 7% had mixed feelings and one GP found it unhelpful. Figure 28.

GP comment: “They let you know that one of your patients has taken an overdose and you don’t have to hear it through the grapevine.”
4.3.6 Benefit of a Crisis Nursing Service to Primary Care

GPs were asked if they felt that the Crisis Nursing Service would be of benefit in the primary care setting. Responses included: Yes - 76.2%, Don't Know - 21.4%, No - 2.4%. Figure 29.

4.3.7 Discussion on GP Survey

The results of these 48 GPs, who participated in this survey, show that good communication and continuity of care exists with the shared care of clients who presented to the Crisis Nursing Service with acts of deliberate self-harm and suicidal intent. The vast majority of GPs who participated in this survey appreciated the essential need for and paid tribute to the Crisis Nursing Service. 90% of GPs were satisfied with the amount of time and help their patients received from the crisis nurses. 83% were satisfied with the effectiveness of the service in helping their patient and in preventing suicide. 93% were satisfied with the knowledge and competency of the Crisis Nursing Service.

A great deal of psychiatric morbidity, for example, anxiety, depression and relatively minor emotional disorders are managed by GPs who provide the first point of access to services for people with mental health difficulties. A major finding from this survey was that 90% of the GPs surveyed found the phone calls and discharge summaries they received from the crisis nurses very helpful or helpful. GPs are clearly seeking a form of share care and support for clients engaging in self-harm and with suicidal intent. This concurs with Lang, Johnstone & Murray (1997) study on the role of the GP with people with mental health problems and the involvement of psychiatric nurses in client care, which they considered to be of central importance in improving communication between the specialist and primary care services.

76% of GPs felt that the Crisis Nursing Service would be of benefit to the primary care setting and their comments point out the preventive work that could be carried out in the area of averting suicides.

The following comments made by the GPs surveyed stated:

“I would welcome an extension of the service so that it could be accessed prior to a suicide attempt.”

“The nurses can only help after an attempt at DSH. I wish to question, is this closing the stable door after the horse has bolted?”

“I think the patient has passed the immediate suicidal point by the time they meet the crisis nurse, unfortunately there is very little follow up and support through the psychiatric, counselling or psychological services.”

According the WHO/EURO (1998) study, it was found that clients managed by the person’s own GP might have a lower repetition rate than those managed by hospital services alone. With regard to reducing the rates of repetition, cognitive behavioural therapy and other psychosocial interventions, also demonstrated to be effective. There is a clear appreciation and a need for the existence of the Cork Crisis Nursing Service. There is also a perception by GPs familiar with the service, for a need to extend the service to the primary care setting. It is worth noting that a particular GP remarked, “that nobody working in the area of suicide prevention wants to close the stable door after the horse has bolted”, thus indicating the need for more preventative strategies at primary care level.

4.4 Focus Group at A&E Departments

This evaluation addressed the impact of the Crisis Nursing Service on A&E Department staff over the last three years and asked a number of key questions. Focus groups took place in which 16 staff members contributed at the South Infirmary - Victoria University Hospital, Cork University Hospital and the Mercy University Hospital. The purpose of using focus groups was to assess, using a face-to-face method, the effectiveness of the service with the Accident & Emergency Department staff, which included emergency nurses, SHOs, social workers and members of the Psychiatric Liaison team.

Pawson & Tilley’s (1997) realistic evaluation methodology was utilised to frame the following four realistic evaluative questions.

1. Whether the Crisis Nursing Service works?
2. Under what circumstances does it work?
3. How or why it works?
4. For whom does it work?

The following themes were generated from the focus groups:

1. The fast response
2. Available 24 by 7
3. Offering time to the client
4. Assessment and review of risk and treatment
5. Support to A&E staff

4.4.1 Findings from the Focus Groups

Informants at each of the three focus groups established that the Crisis Nursing Service is a 24-hour Mobile Service, managed with the use of agreed protocols. This includes seeing all clients over the age of 16 who present with deliberate self-harm, and met the original aims on the setting up of this service, that of addressing the needs of these clients presenting to A&E Departments in crisis. The informants clearly articulated how this service had worked and for whom it worked. The subjective comments made by the informants are included in this report, as they are meaningful to the overall findings. All informants noted that the Crisis Nursing Service has being outstanding, as the following comments qualify:

“They (the crisis nurses) offer an exceptional service to the clients, their families and to other health professionals within the health service provision.”

“We all know what these nurses do, they have time to sit down and talk to the client.”

“The Crisis Nursing Service is an addition to what is a very limited range of services available to this identifiable target population”

“The system was so bad, it (the Crisis Nursing Service) has made a tremendous difference, they have changed the whole concept of risk assessment, review and treatment, since they came the unification is much better”

“I have never heard anyone say God! I don’t want to see her (crisis nurse) again”.

Findings from the Focus Groups
4.4.2 The Fast Response

There was consensus by the A&E staff informants across each of the three hospitals that the Crisis Nursing Service offered a quick response to clients attending with deliberate self-harm and parasuicide. A large number of informants agreed that this resulted in the client being seen almost straight away by the crisis nurses and as a result the client moves faster through the system.

“...They see all first time deliberate self-harm presentations over the age of 16. Before this service became operational clients had to wait 6 to 8 hours and longer to be seen by a psychiatric health professional, now they are seen almost at once or within 1 to 2 hours.”

4.4.3 Availability 24 Hours a Day/Seven Days a Week

Informants at each of the A&E Departments remarked upon the availability of the Crisis Nursing Service. Each of the three hospitals concurred that the crisis nurses send a roster every Monday morning with details of who is “on call” and their mobile number, to be easily contactable. Staff remarked that:

“The quantities of overdoses in this hospital is immense maybe 3 to 4 a day, at least 20 a week, they (crisis nurses) also ring us every morning asking if there is anybody there for them to see.”

“We ring them with a GCS2 of 11 or self inflicted wounds, they will be for review but not immediately, the crisis nurse will ring back later to arrange to see the patient when they are medically fit.”

4.4.4 Offering “Time” to the Client

A recurrent theme from the informants was that the Crisis Nursing Service offered quality time to each client they met. Informant comments include:

“I have had feedback from patients, they liked talking to her (the crisis nurse).”

“They (the crisis nurses) are at the bedside it works well for the patient.”

“I recall a first presentation overdose case where the husband said: this service was great it offered my wife over a six week period down to earth practical help.”

“They have a very good working relationship with all the A&E staff, they are excellent and approachable nurses and spend time with the patient developing a bond and assisting their family at a very difficult time.”

4.4.5 Assessment, Review of Risk and Treatment

All the A&E staff nurses in particular pointed to the fact that they do not carry out psychiatric assessments, just complete a short referral form. They also stated that they were not skilled in this area and considered deliberate self-harm/parasuicide to be a specialised area of nursing care; therefore, they appreciated the expertise of the Crisis Nursing Service. Several of the nurse’s informants went on to say:

“We are general trained nurses not qualified to do this ….. they make our lives a lot easier, ………we feel reassured when they come.”

“They offer such a range of services; it’s so extensive and continues to expand with family therapy and cognitive behaviour therapy. I hope they do not overextend themselves with the amount of work they take on.”

“Their assessment is four pages long and takes over a half an hour to complete. They always document their visit in the patient case notes in clear legible writing.”

4.4.6 Support to A&E Staff

The final theme revolved around the support the Crisis Nursing Service offered to the A&E staff. Several A&E staff agreed that the service helped them in getting patients seen, they also advise on patient’s treatment options. Informant observations include:

“In our hospital the A&E senior house officers rotate every three months and the registrars work 9 to 5 Monday to Friday, with the consultants available on a sessional basis only. I find that they (the crisis nurses) defuse a lot of situations for the para-suicidal client, the families and the staff: such is their expertise.”

“I welcome the cross referring to us (Social Workers) with regards to child protection issues , the crisis nurses always offer practical solutions.”

“Reflecting back, I (Hospital Consultant) feel it is a very positive service, despite being under-staffed and experiencing which they must, some levels of stress. I feel their clinical isolation could lead to poor clinical supervision and a danger of burnout, we (A&E staff) need to support them as well as they support us.”
4.47 Discussion on Focus Group Findings

The main objective of Crisis Nursing Service in the A&E Departments of Cork city hospitals was to improve the quality of care delivered to clients attending A&E Departments who had attempted suicide. The nurses were rostered on call for the three city hospitals, seven days a week. Following assessment of clients, and in association with the on-call psychiatric team, and the GP, the Crisis Nursing Service is responsible for providing an efficient and effective response to deal with the client’s crisis situation. The impact of this Crisis Nursing Service at the three Cork city A&E Departments found that staff were of the opinion that the Crisis Nursing Service worked well and offers an exceptional service to the clients, their families and to other health professionals within the health service provision. The service has meant that clients presenting with self-harm/parasuicide are responded to quickly, usually within 1-2 hours, due to the availability of a specialist professional 24 hours a day.

It is accepted that the initial contact a client has with a health professional has a significant impact on their willingness to accept or reject help (Cook et al 2004). Staff from the A&E Departments acknowledged that the Crisis Nursing Service does offer time to: build a therapeutic relationship with each client; carry out a complete psychosocial assessment and offer the client down to earth practical help over a six week period. Nurse informants at the three A&E focus groups stated that they were not skilled in the assessments and review of risk of clients who have self-harm and depression. Even going for the antidepres- sants, I was already having thoughts of worse. We had no idea the local chemist would know me. Women can talk more openly about these things, fellows don’t. My male friends wouldn’t understand, I wouldn’t ask my male friends for help or support. I suppose what I am saying is that, I am a timid man but told to be a strong lad and take the world on the chin, don’t verbalise your doubts or fears, guys, hold on to them. That’s what I did until the dam cracked.

I saw the crisis nurse the following Monday. I talked through it all with her. It was the first time I ever told anyone how I felt. It was an impulsive act, resigning from my job made it happen, then changing my mind particularly as the line manager had validated that I was doing a good job. I was in my corner and I couldn’t see a way out of it, all I felt was despair. I did not care if I lived or died, I didn’t know the risks and wasn’t sure if it would work or not. I didn’t think logically about it.

I met the crisis nurse twice the first week then every week from March until May. Those meetings lasted an hour. We talked and I told her things I had never told anyone, stuff down through the years. I recognised that I was clinically depressed and learned to cope with my depression. I also learned to deal with my problems. Before I would have said: ‘Who would want to hire someone like me – now I realise that I have good qualifications and am very employable’. The crisis nurse during those sessions changed my mind set.

In hindsight, I now know I was depressed but somehow the stigma or me not really knowing what was going on had a lot to do with it. My parents or family do not know. I will probably never tell them, at least I don’t think I could ever tell them. It’s not the proudest moment of my life. There is stigma attached to self-harm and depression. Even going for the antidepressants, I was already having thoughts of worse. We had no idea the local chemist would know me. Women can talk more openly about these things, fellows don’t. My male friends wouldn’t understand, I wouldn’t ask my male friends for help or support. I suppose what I am saying is that, I am a timid man but told to be a strong lad and take the world on the chin, don’t verbalise your doubts or fears, guys, hold on to them. That’s what I did until the dam cracked.

I feel more motivated now. The crisis nurse turned me around, the black cloud has been lifted, she gave me more than hope - I got a different future. Now, I have a new job that I am happy in. If I ever got bad again I would seek out help. I have my GP and I have the Crisis Nursing Service’s phone number.”

4.5 Personal Stories of Suicidal Attempts

Case stories are another form of naturalistic research inquiry; they provide an opportunity of having intimate knowledge of a person’s condition, thoughts, feelings, actions (past or present), intentions and environment (Polit & Beck 2004). The following two stories give two individual experiences of self harm and how the Crisis Nursing Service uses the core philosophy of bringing the client to a better place in their heads than where they were at. The author has changed the informant’s names to protect their confidentiality but can guarantee that everything they said is transcribed verbatim.

DAVID’S STORY

David agreed to meet with me to talk about the “event” that he says has changed his life. David is a single man in his early thirties. He told me that he has always enjoyed life, does not drink nor smoke, loves the outdoor life, has travelled, worked and lived abroad for many years but is currently back in Ireland and living with his parents. I asked David what had brought him to the personal crisis that led to the serious over-dose, which happened on the 16th March 2005.

“A combination of factors I feel led to the event. Looking back over the winter months I recognised now that I was feeling sad a lot of the time, not taking pleasure in things I used to enjoy doing and losing interest in going out with my friends. I felt that over a couple of months I was not coping as well as I should in my workplace. I was being self-critical, restless and obsessive to the extent that I worried about work when I got home in the evenings and as a result, I could not sleep. On the second week on March, the company I was working for had a performance review. I got it into my head that I was not on top of my job, so the stress I was experiencing came to a head and I decided to resign. There and then, I handed in my notice. It was a Friday evening; I had the following Monday and Tuesday booked off as annual leave days.

I returned to work the following Wednesday still full of self doubt but my line manager spoke to me, he reassured and supported me and talked me out of resigning, he then spoke to the boss, but the boss had already hired someone else. That was my trigger, my head went in to a spiral; I found a quiet spot in a storeroom to find some peace. I had painkillers in my pocket that my GP had prescribed for back pain. I took out the file of tablets and took them all about 12-14. All I was could think about was how depressed, and stressed I was and how he could have replaced me so easily. It was about 11.30am. My line manager found me and brought me to Cork University Hospital A&E Department where they gave me charcoal.

A few hours later the crisis nurse saw me, asked numerous questions, and arranged to meet me the following week. I was discharged home at 6pm with a letter to my GP. The next day was St. Patrick’s Day. On Friday I went to my GP and he was fantastic, he understood, he prescribed antidepressants for me, I am still on them.
ALISON’S STORY

Alison is a married woman in her late forties and has four teenage children. Alison began by briefly describing a very dysfunctional abusive childhood, where her father physically, psychologically and sexually abused her and a number of her siblings. This Alison feels has led to her having inadequate coping skills, an abuse of alcohol and numerous bouts of depression. I asked Alison what she thought had brought her to the crisis situation that lead to her overdose which happened on Saturday 25th June 2005.

“Two years ago, I was diagnosed with breast cancer. I had a lumpectomy followed by chemotherapy. At the time, I coped well and got the physical all clear but over the last year, I was feeling low in myself. I was crying for no reason, feeling worthless like I was nobody. I don’t know if it was the chemo or what but I couldn’t eat nor sleep. I started drinking every night up to and over six cans to help me sleep. I eventually went to my GP and he prescribed sleeping tablets, but did not diagnose depression at that time. I continued to have no interest in life and there were days when I wouldn’t wash or get dressed up. Family pressures started to build, I felt my children were making a slave out of me, I had difficulty coping on a day-to-day basis.

During the last few weeks of May into June my son started stealing and drinking and was out of control and wouldn’t go to school. The night of the overdose, it was a Saturday night I had had a few drinks, at home in the kitchen. I had a row with my daughter, she was very moody at that time and I felt it was over her smoking hash. I tried to talk to her about the hash but I got into a temper with her, said a lot of hurtful things and afterwards I felt really bad. Childhood memories came flooding back, we were taught not to talk when we were growing up. I didn’t want to deal with life anymore, I wanted to die. I took the sleeping tablets and some painkillers about 12 tablets in all. I later told my husband what had happened. He called an ambulance and it took me to the Mercy Hospital. In the A&E, they took my blood pressure and asked questions. I was kept in overnight. The next day Sunday I met the crisis nurse she spent an hour or two with me and arranged to call to my house later that week. When I went to my GP he just looked at me, told me he knew. (The crisis nurse had rung him). I was glad the crisis nurse had told him it made it easier for me. I was probably embarrassed about the whole thing. He understood however and made me feel comfortable and prescribed antidepressants for me.

The crisis nurse came to see me every week for 6-8 weeks. I trusted her and I didn’t pretend but talked openly to her. She arranged for me to see a counsellor in child sexual abuse. I talked to her about life and death, it opened my eyes. I had a cancer scare and dealt with that. I was probably too good and too strong for too long, no wonder I went down hill. She taught me to sigh out - as in deep breathing and get relief, I find it works. She talked and advised me on drinking too much alcohol. I now recognise it is a depressant which counteracts with the antidepressants I am taking.

I have now stopped drinking to excess. I feel stronger and more in control of my life, more able to deal with the pressures of everyday living. Life is short and it’s for living. I am one of the lucky ones having got two chances. I am happy and grateful to be still around and I appreciate the help I received.”

I

5.1 Conclusion

This evaluation began with an audit of 702 presentations at three Cork A&E Departments. This revealed a gender mix of 60% female and 40% male and showed that 76.8% of presentations were from overdoses of medication. The main participating factor cited was depression 42% and relationship problems 33%. There was use of alcohol in 44% of presentations. Repeat self-harm presentations to A&E were made by 14.6% of clients with only 4% of presentations having had two or more previous self-harm presentations. Anecdotal evidence gathered from the A&E staff indicates that the number of repeat presentations has dropped significantly since the commencement of the Crisis Nursing Service.

With the recent rise of consumerism within health care, the views of clients are becoming increasingly important, and the views of clients attending A&E following acts of deliberate self-harm was relatively untested. The satisfaction survey that was carried out of clients who attended the Crisis Nursing Service, indicated that the vast majority of clients are satisfied with the time and help they received from the Crisis Nursing Service. Areas of dissatisfaction related to information needs of clients and their carers/ families and the actual service provision at A&E Departments. There is no doubt that if we are to meet the National target of a reduction in the suicide rates, it is crucial that there should be a marked improvement in the types of services offered to individuals who self-harm presenting at A&E Departments.

Feedback from a GP satisfaction survey revealed that the vast majority of GPs appreciated the essential need for and paid tribute to the Crisis Nursing Service. A&E Department staff, were of the opinion that the Crisis Nursing Service has worked out well and offers an exceptional service to the clients, their families and to other health professionals within the health service provision. Working with clients who deliberately self-harm can be a difficult and frustrating experience for GPs, mental health care professionals, and particularly A&E staff. The two service users (David and Alison’s) stories gave their personal account of the depression, despair and the crisis situations which preceded their overdose. Both report feeling devalued as human beings and having felt humiliated by others prior to attempting suicide, which resulted in feelings of worthlessness and loss of self-respect. Both David and Alison expressed that the relationship with the crisis nurse and the time she had given to listen and advise, has moved them to a better place in their heads than where they were at, in their crisis.

Those in contact with clients who self-harm must keep in mind that the apparently manipulative and often thought of as time wasting, deliberate self-harm behaviours may be the only way the client has to represent the profound mental anguish and suffering they are enduring. Many if not most health professionals in the general hospital setting are by their training, ill equipped to understand emotional states that lead to an act of self-harm. The traditional bio-medical illness model assumes some form of pathology, for which the cause must be identified and treated. Consistent with the bio-medical illness model, many health professionals search for the fault in the system as they have been trained to. The Crisis Nursing Service however seeks only to accept the client without attributing blame, it offers positive regard, as an interactive developmental human activity to respond to and meet the client needs.

A number of reservations may be made with regard to the interpretation of the evaluation. Firstly, a postal survey to clients and GPs appeared to be an efficient and nonintrusive way to collect satisfaction data anonymously from individuals who had contact with the Crisis Nursing Service. The response rate however was quite low at 28% for the client satisfaction survey, although somewhat higher at 38% for the GP survey. This seems to be quite typical of satisfaction studies in various psychiatric contexts (Gerber & Prince 1999). Sampling may have been biased in that motivated clients or GPs those with satisfaction of the service perhaps participated while those with discontent may have not. Clients often have difficulty
ACKNOWLEDGEMENTS

As author of this evaluation, I wish to express my gratitude to the service users, particularly David and Alison for their personal stories, and to the general practitioners and A&E staff who provided feedback and shared their experiences of the Crisis Nursing Service. I wish to acknowledge the support of Ms Brenda Crowley, Mental Health Resource Officer, HSE - Southern Area, for her invaluable input and collaboration along with the assistance of nurse Rose Lynch and her colleagues in the Cork Crisis Nursing Service. Many thanks to Theresa Ward, clerical officer for her assistance with the audit and Agnes Cahill for her secretarial support. Finally, I conclude by acknowledging the support received from the Nursing and Midwifery Planning and Development Unit, HSE - Southern Area.

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section 5 CONCLUSION AND RECOMMENDATIONS cont'd.

criticising the care they received, although the client survey was anonymous and highly confidential. Similarly GPs may not always be aware of the exact care their patient received from the Crisis Nursing Service. Focus groups at A&E Departments managed to generate a good deal of discussion on the Crisis Nursing Service, however the sample of 16 staff who chose to participate from three A&E Departments is quite small and may be unrepresentative and not the broad consensus of the entire Cork A&E staff. Bearing these limitations in mind, the affirmations given by the two personal stories, the evaluation of clients, GPs and A&E staff satisfaction of the Crisis Nursing Service validated the pivotal role of the service in the treatment and management of clients who deliberately self-harm. This evaluation also provides valuable clues for future development of this specialist crisis service and may illuminate further research areas in deliberate self-harm/parasuicide and suicide prevention.

5.2 Recommendations

Of the 9,839 individuals presenting to Irish A&E Departments in Irish hospitals in 2003 due to deliberate self-harm, 1,134 (30%) were treated in six A&E Departments in the HSE - Southern Area, (National Para-suicide Registry). This highlights an increasingly serious problem in Ireland. There is an urgent need for a Government commitment to providing quality crisis intervention services to all HSE areas, for individuals who present in crisis and distress due to psychological and/or emotional issues. This should include the provision of a 24 hour crisis nursing support service to assess, refer, and assist individuals in crisis situations and to provide crisis planning and short-term counselling at all hospital A&E Departments. Specific to the HSE - Southern Area:

- There should be adequate resources, organisational and administrative support as well as the appropriate facilitation to further develop, implement, and support this Crisis Nursing Service in order for it to continue to meet the needs of service users and their families.
- The provision of the Crisis Nursing Service should be reflected in hospitals’ mission and vision statements and awareness training on the role and function of the Crisis Nursing Service given to A&E staff and other health service providers.
- To enhance the continuum of Crisis Nursing Service, the HSE - Southern Area should continuously strive to achieve a collaborative crisis intervention practice model with interdisciplinary teams, including GPs, psychiatric multidisciplinary teams, A&E Staff and other allied health professionals.
- There should be a commitment from the HSE - Southern Area to actively advocate for the provision of quality crisis intervention services on multiple levels with individuals, families, GPs in primary care and in community settings, by offering a range of counselling and other psychosocial interventions.
- There is a clear need for the development and implementation of best practice guidelines similar to the U.K., NICE guidelines on the overall management of para-suicide/deliberate self-harm at A&E Departments.
- It is essential that the provision of the Applied Suicide Intervention Skills Training (ASIST) workshops continue to train all front-line staff, groups and agencies who are interested in promoting suicide awareness and prevention.
- Additional client information is needed and innovative methods to promote positive mental health and to increase client’s knowledge level regarding their own psychological problem(s)/ illness and opportunities to influence their own treatment should receive more attention.
REFERENCES AND BIBLIOGRAPHY


REFERENCES AND BIBLIOGRAPHY cont’d.

Acta Psychiatrica Scandinavica 85, pp97-104

Pompili, Maurizio; Girardi, Paolo; Ruberto, Amedeo; Kotzalidis, Giorgio D; Tatarelli, Roberto. (2005) 

Accident and Emergency Nursing 6, 192–196.


Curtains 16, 50–55


Ruggeri, M. & Dall’Agnola, R. (1993) The development and use of the Verona Expectations for Care Scale (VECS) and the Verona Service Satisfaction Scale (VSSS) for measuring expectations and satisfaction with community-based psychiatric services in patients, relatives and professionals. 
Psychological Medicine 23, pp 511 -523


Australian and New Zealand Journal of Psychiatry 33 pp 20-28


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August 2005