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Accessing Care and Treatment in the Emergency Department for Self-Harm and Suicidal Ideation: A Qualitative Study of Service Users' Experiences

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ABSTRACT

Despite the availability of guidelines and protocols, service users' experiences of accessing care and treatment for self-harm and suicidal ideation at the Emergency Department (ED) are variable. There is a need to better understand what impacts service user experiences given the important role of the ED for accessing care and influencing future interactions with mental health services for people who experience self-harm and suicidal distress. This study aimed to identify the experiences of service users when presenting to the ED with self-harm and suicidal ideation. A descriptive qualitative approach was utilised encompassing in depth semi-structured interviews with 50 adult service users who attended EDs across the Republic of Ireland for self-harm and suicidal ideation. Data were analysed using reflexive thematic analysis. Findings are reported in accordance with COREQ guidelines and focus on three themes that were developed from the data: (1) Experiences of assessment, (2) Interpersonal interactions, (3) Discharge, onward referral and next steps to care. Participant experiences of care and treatment in the ED were largely negative with reports of an over-reliance on mechanistic assessments, poor interpersonal interactions and lack of support following discharge from the ED. The use of evidence-based protocols is important to ensure standardised and effective care and treatment of people attending the ED with self-harm and suicidal ideation. However, a relational approach needs to underpin their use to ensure that service users feel respected and listened to by all staff in the ED, and more positively inclined towards future help-seeking.

1 | Introduction

Self-harm and suicidal ideation remain significant public health problems that require intervention. Self-harm, whether associated with suicide intent or not, is the single biggest risk factor for completed suicide (Hawton et al. 2015) and this risk is heightened in relation to hospital-treated self-harm (Shand et al. 2018; Pellatt et al. 2025). Consequently, improving assessment and treatment after self-harm is a feature of national and international suicide prevention policies and strategies (Kapur et al. 2025; WHO 2021). The Emergency Department (ED) is often the first port of call for people who have self-harmed or are in suicidal crisis, particularly when presenting out-of-hours, and represents an important point of intervention for clinicians to engage with those in distress (Knipe et al. 2022; O'Keeffe et al. 2025). This importance is underscored by evidence that ED-treated self-harm involves more lethal methods compared to community self-harm (Geulayov et al. 2018) and is associated with a greater risk of repeated self-harm and completed suicide (Olfson et al. 2017).

Those who present to the ED with suicidal ideation or self-harm are usually seen by numerous healthcare professionals. Initial evaluation and treatment of physical injuries is conducted

by non-mental health ED staff including triage nurses and ED nurses and doctors. In many hospitals liaison psychiatry teams staffed with mental health clinicians then lead the mental health assessment and treatment response (Kapur 2020). Typically incorporated here is a suicide risk assessment which seeks to evaluate current suicidal ideation, intent, plans, previous suicide attempts, mental health history and risk and protective factors, with a view to informing clinical decision making (Betz and Boudreaux 2016). However, there is a lack of consistency in mental health service provision and variation in service models operationalised within EDs (Opmeer et al. 2017; O'Keeffe et al. 2025). In the UK, responses to those who present to EDs following self-harm are informed by National Institute for Health and Care Excellence (NICE 2022) guidance on 'Self-harm: assessment, management and preventing reoccurrence' [NG225]. Recommendations focus on the provision of care which is grounded in empathy, service user and family involvement and takes a broader psychosocial approach to assessment rather than a reliance on risk assessment tools and risk stratification. Similarly, in Ireland, care provided to people who present to the ED with self-harm or suicidal ideation is informed by the 'National Clinical Programme for Self-Harm and Suicide-Related Ideation (NCPSHI)' and the Model of Care underpinning it (HSE 2022). This National Clinical Programme was introduced in 2014 with the first Model of Care published in 2016, representing the first time that a nationally standardised approach was developed for the assessment and care of people presenting to EDs with self-harm and suicidal ideation in Ireland (Griffin et al. 2021). The central tenets of the NCPSHI focus on the provision of an empathetic, compassionate and validating response to those who present, the provision of a comprehensive biopsychosocial assessment from a mental health professional and associated emergency safety plan, the involvement of family or a supportive friend in assessment and safety planning, and linkage to appropriate follow-on care. The programme is largely delivered by Clinical Nurse Specialists (CNS), working in collaboration with ED staff, under the supervision of a Consultant Psychiatrist. People who present outside of the operating hours of the CNS are seen by Psychiatric Non-Consultant Hospital Doctors (NCHD).

However, despite the presence of guidance nationally and internationally to support clinicians in assessing and treating hospital-presenting self-harm and suicidal ideation, these standards are not always well implemented (Shand et al. 2018), with variations in implementation identified across hospital services (Griffin et al. 2020; Quinlivan et al. 2021). As the ED is often the first point of healthcare contact for many people presenting with self-harm and suicidal ideation, how people experience the ED, and their treatment within it, in this time of heightened mental distress is important to determine. Negative experiences can leave a person feeling invalidated and ultimately impact adversely on service engagement and future help-seeking intentions (MacDonald et al. 2020). Conversely, positive experiences have the potential to engage service users with critically important mental health assessment and supports (Quinlivan et al. 2021). While a body of literature exists on the experiences of service users presenting to EDs with mental health difficulties generally, a much more limited evidence base focuses specifically on the experiences in the ED of those who present with self-harm (including suicide attempt) and suicidal ideation. The literature that does exist largely highlights service users' negative experiences with substandard care, poor attitudes and poor understanding of self-harm and suicidal behaviour identified (MacDonald et al. 2020). This large qualitative study aimed to identify the experiences of service users when presenting to EDs across the Republic of Ireland with self-harm and suicidal ideation and their perceptions of the care they received.

2 | Materials and Methods

2.1 | Design

This study utilised a qualitative descriptive design in a which 'data-near' interpretation of participants' experiences is developed (Sandelowski 2010). This design recognises the subjective nature of experiences and encourages a description of these experiences that stays close to participants' own words and has been identified as a particularly useful design to provide insights into service users' experiences of healthcare (Doyle et al. 2020). The design, methods and reporting of study findings were guided by the key domains of the COREQ framework (Tong et al. 2007). Public and Patient Involvement (PPI) guidance was provided by a contributor with personal experience of presenting to the ED following self-harm. They had been involved in previous research focusing on self-harm and expressed an interest in continued PPI input, in particular advising on the recruitment advertisement and development of the interview guide. They received an honorarium as an appreciation of their time and sharing of their experiential knowledge.

2.2 | Sample and Recruitment

A volunteer purposive sample was obtained for this study. Inclusion criteria were adults (18 years or older) who presented to an ED within the Republic of Ireland for self-reported self-harm or suicidal ideation more than 3 months ago, but within the past 5 years. Self-harm was defined in accordance with national and international standards as intentional self-poisoning or injury irrespective of apparent purpose/intent to die (NICE 2022; HSE 2022). Those who presented to the ED for mental health problems in the absence of self-harm or suicidal ideation were not included in the research. Recruitment to the study was conducted using a multi-pronged approach focusing primarily on online platforms including Facebook, Twitter (now X) and Instagram together with the social media platforms of mental health organisations. Potential participants contacted the first author to receive further information about the study and if they chose to participate, a date and time for the interview was selected. A predetermined sample size was not set in advance as the aim was to obtain a wide variety of perspectives and, given the national scope of the study, to include participant experiences from as many of the 26 EDs as possible. This sampling approach was guided by 'information power', a concept developed by Malterud et al. (2016) which aligns with Braun and Clarke's (2022) reflective thematic analysis method. As this study had a broad aim focusing on 'experiences' generally in the ED, had relatively broad specificity (as it included suicidal ideation and self-harm which also incorporated suicide attempt) across a national sample, and required cross-case, rather than

individual case analysis, a large qualitative sample was justified (Malterud et al. 2016).

2.3 | Data Collection

Data were collected through individual semi-structured interviews, informed by an interview guide shaped by the objectives of the study, existing literature and input from the PPI contributor. Participants were afforded the opportunity to be interviewed face-to-face ($n = 26$) or over the telephone ($n = 24$). The length of the interviews ranged from 25 min to 1 h and 55 min, with an average of 64 min. The in-depth interviews were audio-recorded and subsequently transcribed by a professional transcription service. The majority of the interviews were conducted by the first author (LD) with the remainder conducted by other members of the research team (BK, AH and JM).

2.4 | Data Analysis

Four researchers engaged in the data analysis and write-up process (LD, BK, AH and JM), each of whom were mental health clinicians with direct experience supporting people who self-harm or experience suicidal ideation, as well as having expertise in qualitative mental health research spanning explorative descriptive, grounded theory, narrative and phenomenological approaches. The analysis was guided by Braun and Clarke's (2022) 6-phase reflexive thematic analysis process and involved the following stages:

1. Becoming familiar with the dataset through immersion achieved through detailed reading and rereading of each interview transcript initially in tandem with listening to the audio-recordings. This also enabled capturing tone or emphasis that may alter the meaning of a transcribed word. This was done for each of the 50 transcripts by the first author (LD).
2. Coding of the full dataset in a fine-grained way by one analyst (LD) resulting in the generation of 180 different codes across all interviews. A second analyst (BK) independently double coded 10 interviews (20% of total transcripts), resulting in 112 codes. There was considerable concordance between the codes of the second analyst and those of the primary analyst, and when differences in wording and merging of similar concepts were accounted for, there were 8 new codes in those of the second analyst that had not been identified by the primary analyst.
3. Generating initial themes from across the dataset resulting in the development of 11 overarching themes. These themes were developed following review and discussion of all 188 codes by the primary and secondary analysts (LD and BK).
4. Developing and further reviewing and collapsing these themes to ensure they highlighted the most important patterns across the dataset resulting in the development of 6 final themes. This was done following review and discussion with the wider analysis team (LD, BK, AH and JM).
5. Refining and naming final themes ensuring they clearly answered the research objectives and synopsising each theme was also undertaken by the wider analysis team.
6. Writing up the analytic narrative including the use of participant quotes to present a coherent story of the findings, evidenced by compelling data extracts. Each of the researchers engaged in the analysis took at least one major theme(s) for write up. The results section provides an overview of three of the six central themes developed from the data: 'Experiences of assessment', 'Interpersonal interactions' and 'Discharge, onward referral and next steps to care'. Findings from the remaining three themes focused on the ED environment, the impact of negative experiences, and improving service users' experiences in the ED will be presented in future publications.

Reflexivity is an important aspect of Braun and Clarke's (2022) thematic analysis and particular attention was paid in our group discussions to our professional experiences and the preconceptions that may be associated with these experiences. Our reflexive discussions particularly during the analysis and write-up process helped to prioritise participants' voices, and in particular helped to ensure that we did not rationalise negative participant experiences in relation to services and service providers. The PPI contributor read the draft findings but did not suggest any changes.

2.5 | Ethics

Ethical approval was granted by the Research Ethics Committee of the Faculty of Health Sciences, Trinity College Dublin (Ref: 191008). Written consent to take part and for data to be used in publications was obtained from participants in advance of the interviews. Recognising the difficult experiences being discussed and mindful of the need to be sensitive to participants, all interviews were conducted by researchers who had significant experience of conducting research interviews on sensitive topics and responding in a trauma-informed way to participant distress. A protocol was in place should participants become upset whereby the interview would be suspended temporarily or terminated, and participants provided with support in the first instance from the researcher and guided to support services. While the interviews did highlight some very difficult experiences for participants, none felt the need to suspend or terminate the interview.

3 | Results

3.1 | Participant Characteristics

A total of 50 participants took part in the study, 11 self-identified as male and 39 as female with an age range of 19–68 years, and a mean age of 35. Participants presented at 21 of the 26 Emergency Departments throughout the Republic of Ireland. Further information about the sample is provided in Table 1. Over half ($n = 28$) presented to the ED having engaged in self-harm, while the remainder presented with suicidal ideation. Almost half ($n = 22$) were referred to the ED by their general medical practitioner.

TABLE 1 | Participant characteristics.

Gender	
Male	11
Female	39
Total	50
Age range	
19–28	18
29–39	15
40–50	9
51–60	5
61+	3
Total	50
Employment status	
Paid employment	26
Unemployed	7
Student	13
Other	4
Total	50
Currently or previously attending a mental health service	
Yes	35
No	15
Total	50
Times presented to the ED	
Once	21
More than once	29
Total	50
Referral/pathway to the ED	
GP referral	22
Self-referral	14
Presentation via ambulance	11
Referral by mental health team	3
Total	50

Just over two-thirds ($n = 32$) were accompanied in the ED by a friend or family member.

3.2 | Experiences of Assessment

Most participants reported being assessed on arrival in the ED by a triage nurse followed by an ED doctor. Following this, the majority reported being then assessed by a mental health professional but there was uncertainty about who these mental health professionals were. Participants were asked to describe their experiences of assessment in the ED and for the majority their experiences were negative. Central to this was the experience of a mechanistic, 'tick-box' type of assessment where lists of pre-formulated questions were asked with little deviation from what participants believed to be a rigid set of questions:

> The doctor just stood there with his clipboard asking all these questions while I was on the trolley. He should sit down on the trolley with me and ask me the questions. I get that they probably have a list of questions they have to get through and they just need a quick answer. But I can't give that kind of quick answer to explain why I am here.
>
> (P02)

For some participants when asked questions in this reductionist way, they reported then answering in a rote, 'automatic' way:

> It was quite automatic answering really, when they asked ABC, I answered ABC, but they did not ask for much detail or really how I felt so I didn't have the opportunity to tell them more. I felt like if it wasn't on their list then they weren't interested.
>
> (P05)

Most participants understood that certain questions about their presentation had to be asked but how these questions were asked was crucial. One participant who had several presentations to the ED commented:

> There's very little variance in what they ask, but my experience of being asked these questions differs hugely. The cold way some staff ask you them, or others who ask with much more empathy and what seems to be genuine interest and care.
>
> (P04).

3.3 | Interpersonal Interactions

Across all interviews, by far the most important element of participants' ED experience centered on the interpersonal interactions they had with staff, and the impact of these interactions. Participants described a sense of othering and being made to feel 'different' from patients who were attending with physical health problems. This manifested in several ways including being placed in an observation area that was visible to other patients, visitors and staff, which left little room for privacy:

> When they brought me through, one nurse said to the other 'she's suicidal, put her where you can see her'. While I understand they needed to keep an eye on me it made me feel very observed and self-conscious because everyone could see me.
>
> (P32)

Another way this othering was evident was in the way some staff made participants feel less deserving of care compared to those presenting with physical health problems. Participants recounted instances where staff said the time they were spending with them could be spent with people presenting with 'real' problems:

> She told me that there were some very sick and elderly patients in that day who were all waiting long times to be seen and because I had done this [self-harmed] to myself, they would all have to wait longer. That just made me feel so much worse. I don't know what she hoped to gain by saying that.
>
> (P33)

Others spoke of feeling infantilised; treated and spoken to 'like a bold child' which again had a negative impact on their self-esteem at a time when they were already in significant distress:

> They spoke to me like I was a bold child for self-harming. They chastised me instead of treating it like a serious symptom of the mental difficulties and turmoil I was experiencing. I felt like I was not being taken seriously and not been treated like an adult like other patients were.
>
> (P19)

In addition to the perception that they were treated differently from other patients, participants also reported uncaring and unsupportive interactions in the ED. Negative, dismissive and judgemental attitudes were reported which exacerbated their distress:

> I could tell by her [triage nurse] body language and the look of disgust on her face when she found out that my wound was self-inflicted that she didn't have any time for me. She asked me why I had done it and who was I looking for attention from. That just made me feel so low. That had nothing to do with why I had self-harmed.
>
> (P11)

Staffs' general lack of understanding of self-harm was described by several participants who acknowledged that they did not expect ED staff to be experts in the assessment of self-harm, but they did expect them to have a level of knowledge that was above that of the general public:

> I couldn't believe some of the things they were saying, that self-harm wasn't going to solve my problems, that it was superficial and wasn't going to harm me. But they didn't understand that it wasn't superficial to me. It was me showing in a physical way the mental pain I was going through. I couldn't believe I was hearing these things from nurses and doctors who should know more than most people even if they are not mental health [staff].
>
> (P10)

Despite the negative interpersonal interactions experienced by participants, there were also positive interactions reported relating to a range of staff in the ED and particularly from specialist mental health staff. Respectful, compassionate and unhurried care was deeply valued by participants who had experienced it. A display of warmth and empathy, even in brief interactions, was important to help participants feel valued and respected:

> The specialist nurse was just fantastic. She was so kind, you know? She took her time; she really listened to me and didn't rush me. She made me feel like I was in the right place, and I did the right thing in coming in. I felt she could understand what I was going through and that wasn't something I had experienced the last time I was in.
>
> (P17)

3.4 | Discharge, Onward Referral and Next Steps to Care

Eleven participants were admitted to hospital for treatment of their self-harm, 8 to a mental health unit and 3 to a medical unit for treatment of an overdose. The remainder ($n = 39$) were discharged from the ED following treatment, with most receiving a follow-up plan including referral back to their General Practitioner or mental health team. However, 8 participants who presented with suicidal ideation without self-harm reported receiving no follow-up plan and were left with the perception that their distress needed to escalate before they would be offered treatment:

> He [psychiatry NCHD] said 'there is not much we can do for you now but come back if you are feeling any worse'. But that's why I was there in the first place... because I felt so low. It's like they wanted me to get to the very bottom before they could do anything. It shouldn't work like that.
>
> (P33)

For those who left without any further follow-on care, or who had received a referral a significant time away there was a sense of despondency, helplessness and despair that they did not know what else to do:

> I did what we are all told to do...to ask for help...but then I didn't get it. I was told I would need to wait weeks for someone to contact me. I went home feeling worse than how I felt when I went in. I had done what I needed to, but no help or care was offered. My wife couldn't believe that they sent me home as she knew how bad I was.
>
> (P15)

As alluded to above, the experience in the ED for some was traumatising and they left feeling worse than before they went in. The impact on family members was also identified:

> I could see that my mam was so worried when they sent me home with her. She was sure they would admit me and look after me. She was petrified to take me home in case I did something. It was taking a huge toll on her and then I felt bad, but I had nowhere else to go.
>
> (P11)

4 | Discussion

The assessment of a person who presents to the ED with self-harm or suicidal ideation is a critical step in understanding the factors precipitating their presentation, identifying safety concerns and signposting to appropriate intervention and supports. In Ireland, the established National Clinical Programme for Self-Harm and Suicide-related Ideation (NCPSHI) (HSE 2022) identifies the importance of a standardised approach to assessment of self-harm and suicidal ideation with a move away from formulaic risk assessments to a more holistic biopsychosocial approach encompassing collaborative safety planning. This response in the ED is provided largely by mental health Clinical Nurse Specialists and Non-Consultant Hospital Doctors however participants frequently reported uncertainty about who had conducted their assessment highlighting the importance of clearly communicating professional roles. Despite guidance promoting a more holistic and comprehensive assessment of need, participants in this study reported largely negative, reductionist experiences of the assessment process with a reliance on mechanistic, 'tick-box' exercises in which both ED and some mental health clinicians did not engage in a meaningful way. This supports the point made by Griffiths et al. (2025) that despite the established ineffectiveness of traditional suicide risk assessments, there has been, and in many cases still is, an over-reliance on structured risk assessments in ED settings (Griffiths et al. 2025). O'Keeffe et al. (2021) report that ED clinicians in their study spent twice as long documenting the assessment as the time spent with the service user. Participants in our study understood that clinicians need to ask questions about self-harm and suicidal ideation but were emphatic in the view that 'how' these questions were asked was crucial. Engaging in a discussion about risk and safety in the context of suicide and self-harm can be challenging for clinicians (Morrissey et al. 2018), particularly those without mental health training who may feel ill-equipped to engage with the person (Veresova et al. 2024; Molloy et al. 2025). Nonetheless, there is a requirement that those undertaking the assessment in the ED employ active listening strategies so that service users can feel heard and respected (Quinlivan et al. 2021). While a standardised approach to the assessment of self-harm and suicidal ideation is 'best practice', caution is required to ensure that the process does not become overly standardised, allowing little room for personal narratives resulting in the service user becoming a passive actor in the assessment (MacDonald et al. 2020). In this study, the deeply personal nature of the mental distress which led to suicidal ideation and self-harm did not lend itself to a quick question and answer process, however when enquired about in a caring, engaged and unhurried manner this contributed significantly to a person's perception of their care being positive. This speaks to the importance of a relational approach to the assessment and care of a person experiencing self-harm and suicidal ideation.

A relational approach has at its core human engagement within a therapeutic relationship that is compassionate and supportive (Morrissey et al. 2018) and grounded in values such as trust, humility and respect (Griffiths et al. 2025). This is particularly important for those who have self-harmed as previous encounters with healthcare providers may have been negative and insensitive (Morrissey et al. 2018). Participant accounts in this study identify examples of negative and unhelpful attitudes from staff within the ED, a finding which has been reported in previous studies (Lindgren et al. 2018; MacDonald et al. 2020; Byrne et al. 2021; Quinlivan et al. 2021; Knipe et al. 2022). Incidents of being infantilised, othered and made to feel as if they were less deserving of care than those presenting with a physical illness were reported by participants. Experiencing negative attitudes and unsupportive care in the ED is difficult for any patient presenting there, however this difficulty is amplified for those presenting with self-harm and suicidal ideation as it may compound already low self-esteem and feelings of worthlessness (MacDonald et al. 2020; O'Keeffe et al. 2021), internalised stigma and shame (Byrne et al. 2021; Quinlivan et al. 2021; O'Keeffe et al. 2021) and can contribute to iatrogenic harm by traumatising, or retraumatising those with a history of trauma -an experience not uncommon for people presenting with self-harm and suicidal ideation (Sweeney et al. 2018; Molloy et al. 2020; Chakraborti et al. 2021). Experiencing negative care in the ED can also contribute to a decision not to seek help in the future (Lindgren et al. 2018; MacDonald et al. 2020; Byrne et al. 2021; Quinlivan et al. 2021). Prioritising a relational approach to care should not solely be the remit of mental health clinicians in the ED but should also extend to non-mental health ED clinicians. Participants reported that they did not expect expert mental health care from non-mental health staff, however they did expect to be treated in a non-judgmental, respectful way—values which should be core to all healthcare professionals. Each interaction with the person is an opportunity for the clinician to offer support, empathy and compassion (Morrissey et al. 2018) – this is true of even brief interactions which make up the majority of interactions between clinicians and service users in the ED. Interestingly, ED clinicians in a study by O'Keeffe et al. (2021) reported that they understood the importance of the service user feeling listened to, but they did not believe that the ED was the appropriate environment for these type of interactions, and they felt limited in their ability to form a human connection with the person. Similarly, Veresova et al. (2024) reported that ED staff questioned whether discussing the 'emotional stuff' with a patient was acting outside their scope of practice. As Molloy et al. (2025) note in their meta-ethnography of how ED nurses care for people who self-harm, findings like this suggest a need for ED staff to take greater ownership of their role in providing mental health care which they argue is a core component of emergency care. This suggests the need for education of ED staff on the potential negative or positive impacts of even brief, one-off interactions in the ED. When ED staff are educated to understand more about assessing and working therapeutically with people who self-harm or experience suicidal ideation, it can lead to a change in attitudes and ultimately a change to more person-centered practices (Hasking et al. 2025) and in turn, to enhanced professional satisfaction of ED staff (Molloy et al. 2025).

The period following discharge from the ED is recognised as a high-risk period for repetition of self-harm and re-presentation to the ED (Byrne et al. 2021; Pellatt et al. 2025). Inadequate aftercare following presentation can leave the service user feeling unsupported, isolated, abandoned and at times worse than before their presentation (Byrne et al. 2021; Quinlivan et al. 2021). Participants in this study reported similar sentiments with a proportion left with no referral to next care, and many waiting lengthy periods for an appointment. The abrupt transition from the ED to home with little/no follow-on care left participants feeling unsupported and hopeless, and with the impression that their self-harm or suicidal ideation did not meet a threshold of acuity that warranted care, a sentiment also expressed by participants in a study by Byrne et al. (2021). An Irish study by Cully et al. (2022) on engagement with health services following a high-risk self-harm presentation to the ED found varying levels of satisfaction with follow-on services. While some participants reported generally good experiences with timely and comprehensive aftercare, others reported very lengthy wait times for follow-up care, or little or no aftercare from the mental health services. Similarly, Østervang et al. (2025) report how service users who presented to the ED following self-harm called for increased continuity of care having experienced highly fragmented care with poor communication between the ED and the mental health and support services.

In addition to participants themselves feeling unsupported on discharge from the ED, they also pointed to the potential impact on their accompanying family members. They reported on the difficult situations families encountered when admission or follow-up care was not provided. Participants recounted that family members were often in a state of hypervigilance and in fear of a repeated incident of self-harm. The importance of supporting family members who accompany someone to the ED is identified in clinical guidelines (HSE 2022; NICE 2022). However, gaps in support for family members have been identified in this research and in other studies (Juel et al. 2021; O'Keeffe et al. 2021) and draw attention to the need to better understand how family members can be supported to care for and assist the person who presents to the ED with self-harm or suicidal ideation.

There are some limitations to this study that should be noted. Participants self-selected into this study which may have resulted in recruitment bias, with those having more positive experiences not coming forward. Although not captured formally, it was apparent from conducting the interviews that the sample was quite homogenous in terms of ethnicity with most participants appearing to be white Irish and all participants identifying as female or male. The lack of sample diversity in terms of ethnicity and gender identity may limit the representativeness of the findings to those from marginalised identities. A strength of this study was the large sample size from across the Republic of Ireland which enabled us to capture a breadth of experiences while ensuring geographical and regional representation. The use of four researchers in the data analysis process reduced the risk of individual bias and enhanced the robustness of the study. Finally, the involvement of a PPI contributor enhanced the credibility of the study providing valuable lived-experience insights.

5 | Conclusion

EDs are challenging settings in which to deliver high quality care to people presenting with self-harm and suicidal ideation. However, in Ireland and beyond they remain the first port of call for people experiencing a suicidal crisis and people presenting to EDs represent the highest risk cohort for completed suicide, with a clear opportunity for intervention. Ensuring the implementation of evidence-based guidelines, underpinned by a relational approach, when providing care to a person presenting with self-harm or suicidal ideation is a crucial step in improving the care of people who present.

6 | Relevance for Clinical Practice

Presenting to the ED following self-harm or suicidal ideation represents a period of heightened vulnerability for a person, but also a crucial point of mental health intervention. These findings provide ED and ED-based mental health clinicians with in-depth insights on how service users experience the ED, reporting examples of care that can be fragmented, judgemental and sometimes retraumatising. By highlighting the importance of positive interpersonal interactions, even within brief interventions, these findings can inform the delivery of more compassionate, relational, and effective practices across all ED staff.

Author Contributions

Louise Doyle conducted most of the interviews and data analysis and drafted the initial manuscript. Brian Keogh, Agnes Higgins and Jean Morrissey undertook some interviews and contributed to data analysis, reviewing and editing of the manuscript. Kaity McGeehan and Róisín Reilly reviewed, provided input and edited the manuscript. All authors approved the final manuscript as submitted.

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Ethics Statement

Ethical approval was granted by the Research Ethics Committee of the Faculty of Health Sciences, Trinity College Dublin (Ref: 191008). Written consent to take part and for data to be used in publications was obtained from participants in advance of the interviews.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Research data are not shared.

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