Trinity College Dublin
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The University of Dublin

The Experiences and Support Needs of Family/Supporting Adults who Accompany Someone who Presents to the Emergency Department with Self-Harm, Suicide-Related Ideation, and Suicide Attempt.

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‘Sometimes they run out of strength, lend them some of yours’.

‘It was not the place for someone struggling so badly’

‘The loneliest time in any parents’ life.’

‘For the first time ever concerns about his mental health were taken seriously. He was treated with compassion.’

‘Mental health issues are very much focused on the person affected; family members involved are just as important as their needs can sometimes be forgotten.’

‘You’re in the best position to help others when you are supported.’

‘We can’t do anything by ourselves to change the system, we have to come together and make change as a group’.

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Glossary and Acronyms

Emergency Department (ED): An Emergency Department is a department in a general hospital where people present with serious illness or injury. There are 26 adult Emergency Departments in public hospitals throughout the Republic of Ireland which are open 24 hours a day, 365 days a year.

CAMHS: Child and Adolescent Mental Health Services.

Self-harm: Self-harm is a broad term to describe an intentional act of harming oneself which can include both self-harm with suicide intent (e.g. suicide attempt) but also self-harm where there is little/no intent to die. Both these forms of self-harm can serve different functions for different people.

Suicide-related ideation: Having thoughts about suicide, considering or planning suicide.

National Clinical Programme for Self-Harm and Suicide-Related Ideation (NCPSHI): The NCPSHI is the National Clinical Programme Self-Harm and Suicide-Related Ideation. The aim of the programme is to develop a standardised process for the assessment and management of individuals of all age ranges who present with self-harm and suicide-related ideation to the ED. There are four clinical components of the programme which are an empathic response, an expert assessment and intervention, family involvement and follow-up, and bridging to next-care. The NCPSHI is currently running in 24 of the 26 adult EDs in the Republic of Ireland and its focus has extended beyond the ED to include primary care and non-ED settings for crisis mental health presentations.

Clinical Nurse Specialist (CNS): A Clinical Nurse Specialist is a nurse working at an advanced level of practice in a specified area with specially focused knowledge and skills. They have undertaken post-registration education in their specialist role and work at a more autonomous level than a staff nurse. Clinical Nurse Specialists in Self-Harm are attached to the NCP in Ireland. In this report, many participants referred to them as the ‘self-harm nurse’.

Psychiatric Non-Consultant Hospital Doctor (NCHD): Within this report, the Psychiatric NCHD refers to doctors who are working in mental health and are on-call to the ED and may be called to undertake an assessment when a patient presents with self-harm or suicidal ideation when the CNS is unavailable.

Suicide Crisis Assessment Nurse (SCAN): A Suicide Crisis Assessment Nurse is a nurse who provides support to GPs in the assessment of patients presenting with self-harm or suicidal ideation in the primary care setting.

Emergency Department Doctor: Within this report, the 'ED doctor' refers to non-mental health doctors who are working in the ED and may be involved in the treatment of the patient's physical self-harm injuries.

Triage: Triage refers to a system of assessment operationalised in every ED where a triage nurse undertakes a preliminary assessment of all patients who present to determine the urgency of care required.

‘We can’t do anything by ourselves to change the system, we have to come together and make change as a group’.

Section 1: Introduction and Methods

1.1 Introduction

The Emergency Department (ED) represents an important setting for intervention around self-harm and suicide prevention (Ceniti, Heinecke & McInerney, 2020), particularly as it is often the first entry point to the health system and a gateway to accessing follow-on services (Egan et al., 2012). In Ireland in 2023, there were 12,792 presentations to Emergency Departments for treatment of self-harm (Joyce et al., 2025). On discharge from the ED, family members and others who accompany the person to the ED and/or support the person at home often bear the heaviest responsibility for keeping their family member safe (Juel et al., 2021). Recognising their importance, the National Clinical Programme for Self-Harm and Suicide-Related Ideation (NCPSHI) (Health Service Executive, 2022) identifies that the experiences of families and carers can be crucial in trying to support those who present with self-harm. Despite this, these experiences have not been elicited systematically and there are few published studies in Ireland identifying the experiences and support requirements of families and supporting adults. This study therefore aims to elicit experiences of family members and other supporting adults to identify how they can be better equipped to support the person presenting to the ED with self-harm, suicide-related ideation and suicide attempt to improve outcomes for all.

This study builds on an existing collaboration between the research team at Trinity College Dublin and the suicide prevention charity 3ts. In 2020, our study ‘Accessing Help for Self-Harm and Suicidal Behaviour in the Emergency Department: The Experiences of Service Users’ was published, funded by the 3ts (Doyle et al., 2020). Findings from this study demonstrated the importance of family support of the person who presents with self-harm/suicidal ideation both in the ED, and after discharge. However, it also identified, from the perspective of the service-user, that families were often left with the ‘burden of observation’ and ‘surveillance’ following self-harm with no information about how best to help, leaving them feeling insecure and uncertain about their own ability to cope or prevent future incidents. The Irish Mental Health Policy ‘Sharing the Vision’ (Department of Health, 2020) also recognises the importance of family members as a supportive resource to those experiencing mental health difficulties. Family members or other accompanying adults who support a person presenting to the ED with self-harm or suicidal ideation can provide crucial collateral to clinicians (Collom et al., 2019) and support on discharge to the person. Their presence with the person in the ED can improve engagement with services by impacting on their decision to stay for assessment, treatment and onward referral (Doyle et al., 2020). One of five programme objectives of the revised Model of Care of the NCPSHI is to optimise the experience of families and carers in supporting those who present to the ED with self-harm and suicide-related ideation (HSE, 2022). By eliciting the experiences and importantly the information and support needs of people who accompany someone to the ED and/or who support them at home, findings from this study will provide the basis from which to improve support provided to family members and other supporting adults contributing ultimately to better outcomes for the service user and their family/supporting adult.

1.2 Aim and Objectives

The aim of this study is to capture the experiences of family members or supporting adults who accompany someone who presents to the Emergency Department with self-harm, suicide-related ideation or suicide attempt. The specific objectives are to:

- Explore family members'/supporting adults' experiences accompanying a person who presents to the ED with self-harm, suicide-related ideation or suicide attempt.
- Explore their perceptions of their inclusion in the assessment process.
- Identify supports/advice provided to them to help them support the person who presented to the ED.
- Explore their experiences of supporting a person after presentation to the ED.
- Identify what further supports are required to help them better support the person who presents to the ED with self-harm, suicide-related ideation or suicide attempt.
- Identify how the Emergency Department experience can be improved for family members/supporting adults who accompany a person who presents to the ED with self-harm, suicide-related ideation or suicide attempt.

1.3 Research Design

This study utilised an exploratory online survey method to elicit the key experiences of family members and supporting adults. Online survey research is particularly useful in capturing large samples that are easier to obtain and offers flexibility, convenience and speed in completion of the survey. Data were collected though an anonymous online survey using the Qualtrics survey software licensed to the School of Nursing and Midwifery, TCD. This survey was developed based on a review of existing international literature, consultation with two Public and Patient Involvement (PPI) advisors with personal experience of supporting a family member in the ED, and consultation with other key stakeholders. The 30-item survey comprised 15 closed questions, 7 closed questions with a free-text option to expand on the responses provided to that item, and 8 fully open-ended questions which allowed a significant amount of qualitative data to be captured.

1.4 Ethical Considerations

Ethical approval to conduct the study was granted by the Faculty of Health Sciences Research Ethics Committee, Trinity College Dublin. All involved with the study were bound by national and international codes of practice in research, and by professional standards within their disciplines. The rights and dignity of participants were respected throughout by adherence to models of good practice relating to recruitment, voluntary inclusion, informed consent, and confidentiality. It is recognised that the topic under exploration in this study is a sensitive one with the potential for participants to recount distressing experiences. Potential participants were made aware of this in advance in the Participant Information Leaflet and were advised not to take part if they believed that answering questions about these experiences would be upsetting. Following completion of the survey, participants were signposted to relevant support organisations. Although this survey was anonymous, any potentially identifying information provided in the responses was removed to protect the privacy of participants.

1.5 Sample and Recruitment

The population for this study comprised family members/supporting adults who accompanied a person who attended the ED with self-harm, suicide-related ideation or suicide attempt within the previous 5 years. A pre-determined sample size was not sought as there are no data for how many family members/supporting adults accompany a person to the ED.

1.5.1 Inclusion criteria:

- Family members/supporting adults who accompanied a person who presented to the ED following self-harm, suicide-related ideation or suicide attempt.
- Family members can include any relative of the person. Supporting adults can include informal carers, professional carers or friends who accompany a person to the ED.
- Participants must be 18 years of age or over.
- Participants must have accompanied someone to the ED in the past 5 years, but not within the previous 2 months.
- Participants must have accompanied someone to an ED in the Republic of Ireland.

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 specific social media platforms and webpages of relevant organisations. An online flyer drawing attention to the study and providing some information about it was distributed via these media – a link to the survey including the Participant Information Leaflet was contained in the flyer for those who were interested in participating. Recruitment via social media is an increasingly popular phenomenon in healthcare research and is shown to be a particularly useful tool to improve representation and maximise participant selection.

The 3ts, as our civic society partner in this IRC funded research, had a prime role in the promotion of and recruitment for this study utilising their extensive contacts in the mental health field, and in particular with other organisations involved in supporting people who experience self-harm and/or suicidal thinking. They promoted the study through targeted advertising in:

- INFORM Health Information Services via Newsletter to GPs & Hospitals and Flourish Magazine
- Online via Activelink
- Via contact network and mailing list
- Online via www.3ts.ie and across their social media platforms.

As survey responses were coming in, it became clear that the sample was predominantly female, so a concerted effort was made by the 3ts to attract male participants through targeted and boosted social media posts. While this did improve the male participation rate somewhat, as seen in section 2.2, the number of males participating remained low overall.

1.6 Data Analysis

We analysed the structured questions deductively using a form of content analysis. We analysed the broader open-ended questions using thematic analysis for qualitative surveys informed by Braun et al., (2021) and Braun and Clarke (2022). Many participants presented very detailed written reports of their experiences. Their quotes are used extensively verbatim throughout this report to evidence the findings highlighted. Identifiers include participant number, gender and their relationship to the patient. Any geographical or personal information that may identify an individual was removed from quotes. Findings are presented in this report from sections 2 to 11 inclusive.

Section 2:
Presentation to the Emergency Department

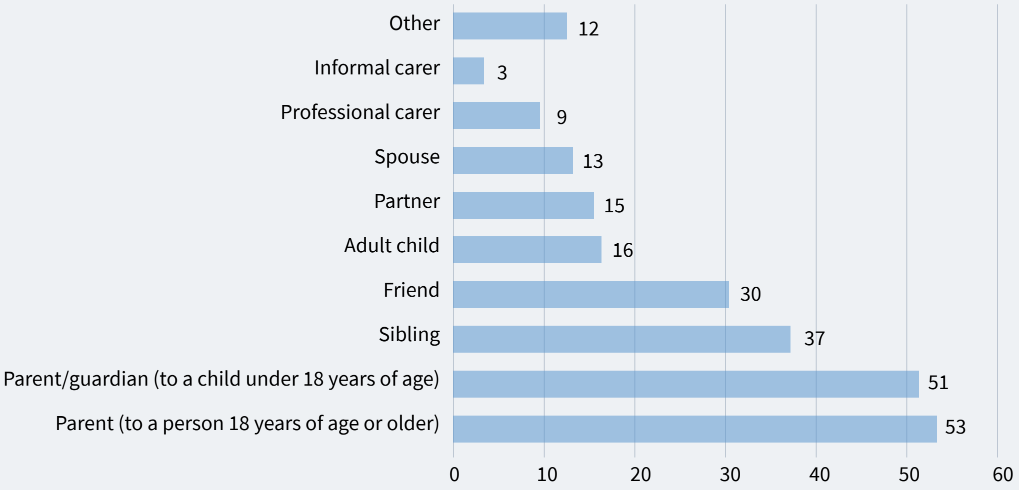
2.1 Introduction

This section sets out the demographic information of participants and details around their presentation to the Emergency Department.

2.2 Demographics and Pathway to the ED

In total, 305 people started the survey of whom 18 identified that they were not a family member or supporting adult but were instead the patient, so these responses were omitted. The number of participants dropped to 255 following completion of the demographic questions and dropped further to 239 who had completed the survey to the end. It was decided to only use the responses from those who had completed the full survey in the final analysis. The majority of participants were female (n=210, 88%), with 9% male (n=22), and 3% non-binary/prefer not to say (n=7). The age of participants ranged from 18 to 81 years with the average age of participants being 43 years old. Parents to adults (n=53, 22%) and parents/guardians to children (n=51, 21%) made up over four in ten participants cumulatively, followed by siblings (n=37, 16%). A further breakdown of participants' relationship to patients is presented in Figure 2.1.

Figure 2. 1 Relationship to the patient



Of the 12 participants whose relationship was reported as 'other' there were a range of familial (e.g. niece, grandchild) and professional (e.g. mental health key worker, search and rescue personnel) relationships identified.

Participants were asked to identify in what year they presented to the ED. Just over one-fifth (21%) presented in 2022, one-fifth in 2021 (20%), with the remainder presenting in 2018-2020. Participants were asked to identify in what region the ED was located. As is presented in Table 2.1, most participants accompanied a patient to EDs in the east of Ireland, with Dublin (n=82, 34%) and the broader Leinster region (n=56, 24%) accounting for over half of participants. Over one-quarter of participants accompanied someone to an ED in Munster (n=64, 27%).

Table 2.1 Region where ED was located

Response	**N**	**Percent**
Dublin	82	34%
Leinster (excluding Dublin)	56	24%
Munster	64	27%
Connaught	29	12%
Ulster	8	3%
Total	**239**	**100%**

It was more common for participants to accompany a patient to an ED on a weekday (n=149, 62%). As is presented in Table 2.2, just over one in five participants (n=53, 22%) accompanied someone at the weekend.

Table 2.2 Day of the week ED was attended

Response	**N**	**Percent**
Weekday	149	62%
Weekend	53	22%
Don't know	37	16%
Total	**239**	**100%**

Participants were asked to identify what time of the day they accompanied the patient to the ED, with the largest proportion presenting between 1pm to 7pm (40%), followed by 7pm to midnight (24%).

Participants were asked to identify how the patient got to the Emergency Department. Over six in ten participants (n=148, 62%) brought the patient to ED themselves (Table 2.3).

Table 2.3 How did the patient get to the Emergency Department?

Response	**N**	**Percent**
I brought them to the ED	148	62%
Arrived by ambulance	68	29%
Made their own way alone (e.g. walked, drove, taxi, public transport etc.)	17	7%
Other	6	2%
Total	**239**	**100%**

The ‘other’ responses included being brought by An Garda Síochána[1] and being brought by another family/friend. In one case, it required two people to accompany the person for safety reasons where an ambulance was not available:

> *Her husband brought her by car with another neighbour sitting beside her to stop her jumping from the car, ambulance not available.*
> (P120: female, extended family member)

For most participants, (n=147, 62%) it was not their first time accompanying the patient to ED. Of those who had presented to the ED previously, the majority (75%) attended less than 5 times. Participants were asked how long they spent in the ED with the patient. Over three-quarters of participants spent four hours or more in the ED with a significant proportion spending over 8 hours with the person in the ED (38%) (Table 2.4).

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[1] The Irish police force

Table 2.4 How long did you spend in the ED with the patient?

Response	N	Percent
Less than an hour	14	6%
Between 1 and 3 hours	39	16%
Between 4 and 8 hours	95	40%
More than 8 hours	91	38%
Total	**239**	**100%**

2.3 Reasons for Emergency Department Presentation

Participants were asked to identify if the patient presented with self-harm, attempted suicide, thoughts of suicide or another reason and were given the option to choose more than one reason. Participants reported that 56% (n=134) of patients presented with attempted suicide, 52% (n=124) presented with thoughts of suicide, and 38% (n=92) presented with self-harm. Of those who selected ‘other’, responses included psychosis and alcohol abuse.

In an open-ended survey question, participants were asked to describe what type of mental health problems the patient was experiencing. Responses were received from all participants (n=239) and ranged from one-word answers (e.g. depression, anxiety), to responses of several hundred words long providing great depth on the mental health difficulties of the patient. Some participants identified a number of different and co-occurring mental health problems as evidenced in the quotes below:

Very low mood. Anxiety, depression. Nightmares. Insomnia. Terrifying uncontrollable mood changes. Difficulty managing emotions. Desire to end it all. Diagnosed with anxiety and depression 6 years ago.
(P100: female, parent to an adult child)

Severe depression, substance abuse and later diagnosed bipolar disorder.
(P85: female, sibling)

Others provided detail on the circumstances surrounding their presentation to the ED, often including their waiting time, treatment and interactions with staff as exemplified by the example provided below:

> *The patient (under 18) had left a suicide note for peers and had gone missing from school. A school principal rang myself and the patient's parent to let us know that patient had been found. Patient had been awaiting a CAMHS appointment for approximately 6+ months when they attempted suicide. Patient was experiencing depression, anxiety, suicidal ideation, and bereavement following the death of their parent.*
> (P24: female, sibling)

Depression was the most commonly identified mental health difficulty cited by 37% (n= 89) of participants. Often, participants responded with the single word 'depression', but some provided further detail on the symptoms of depression:

> *Patient was extremely depressed and suicidal. Low mood, low motivation, suicidal ideation.*
> (P96: female, friend)

Anxiety also featured prominently in the responses (n=70). Where elaboration was provided, participants detailed the circumstances surrounding the patient's presentation.

> *Severe anxious state. Had been diagnosed with depression and anxiety 1.5 years before age 13. She was suicidal during that time but this time she made preparations to hang herself. In ED she was very anxious and had numerous panic attacks.*
> (P80: female, parent/guardian to a child under 18)

> *Had been experiencing extreme anxiety surrounding school and bullying that had been going on*.
> (P167: female, sibling)

A total of 47 participants detailed that the individuals they accompanied to the ED experienced both anxiety and depression. While most listed 'anxiety and depression' without providing further detail, some provided additional information and context surrounding the patient's presentation to the ED:

> *Depression and Anxiety. We were told that he had experienced sudden onset of suicidal thoughts following a breakup of a relationship and some debt mounting up.*
>
> (P237: female, parent to an adult child)

There were 25 references to personality disorders in the responses with most providing no further detail, however, in some cases a little further elaboration was provided:

> *Personality disorder. History of Trauma. Poor coping strategies resulting in self-harm following a sexual assault.*
>
> (P137: female, social care worker)

Fifteen participants identified accompanying someone to the ED who experienced substance abuse. In the responses, the most commonly cited substance was alcohol, while legal and prescription substances were also referenced. In some instances, participants alluded to the substance playing a role in the incident leading to their presentation to the ED:

> *He suffers with social anxiety due to bullying. Occasional bouts of severe depression and self-harm. He had consumed alcohol on the day.*
>
> (P40: female, partner)

A significant proportion of participants named self-harming and suicide thoughts as the primary reasons that precipitated the patient's presentation to the ED. While some reported these with an associated mental health diagnosis, others reported on the self-harm/suicide thoughts in isolation:

> *Long term suicidal ideation. Detailed plan. Very scared.*
>
> (P209: female, parent to an adult child)

> *Suicidal planning with a history of suicide attempts.*
>
> (P55: female, friend)

Self-harming…cutting arms and legs. Suicidal…howling on the floor in emotional anguish, shouting 'help me, help me'. Extremely distressed.
(P198: female, parent/guardian to a child under 18)

It was common for participants to detail some precipitating factors that played a role in the person they accompanied presenting to the ED. These included relationship break-ups, and living with health difficulties:

Struggling to accept a very debilitating physical condition and the difficulties it brought into everyday life.
(P154: female, parent/guardian to a child)

Tried to take multiple tablets after a breakup. Also dealing with an invisible illness and isolation.
(P67: female, friend)

Section 3:
Patient Assessment in the Emergency Department

3.1 Introduction

The provision of a comprehensive expert assessment to someone presenting with self-harm, suicide-related ideation or suicide attempt is a cornerstone of the NCPSHI programme. This section sets out findings around the assessment of the patient in the ED, including who undertook the assessment, whether the participants were included in that assessment and the privacy of the environment in which the assessment took place. It also reports on whether an emergency safety plan was conducted for and with the presenting patient.

3.2 Mental Health Assessment

Participants were asked to identify if the patient received a mental health assessment from a mental health clinician. An explanatory note was provided detailing that a mental health assessment is an interview with a mental health professional about what led to the person presenting to the ED with self-harm, suicide-related ideation or suicide attempt. As is presented in Table 3.1, almost seven in ten (n=175, 68%) participants indicated that the patient they accompanied received a mental health assessment.

Table 3.1 Did the person receive a mental health assessment from a mental health clinician?

Response	**N**	**Percent**
Yes	163	68%
No because the patient left before being assessed	14	6%
No because one was not offered	48	20%
Don’t know	13	5%
Did not respond	1	<1%
Total	**239**	**100%**

One-fifth of the sample (n=48) however reported that the patient was not offered an assessment with a further 14 participants reporting that the patient left before being assessed. These results identify that there is still a significant minority of patients leaving the ED without having received a mental health assessment. Some participants reported that due to a lack of mental health staff in the ED, they would not be able to be seen and assessed by a mental health professional with some told to return the next day:

No psychiatric doctor available until next day... sent home with advice for me to watch over them 24/7.
(P198: female, parent/guardian to a child under 18)

My daughter was interviewed and told to come back when the mental health staff were on call or go to [names another hospital].
(P152: female, parent to an adult child)

Patient left as was told more or less we have nowhere to put you, and no psychiatrist can see you until the following day.
(P102: female, friend)

Of those who received a mental health assessment they were most commonly undertaken by a Consultant Psychiatrist (n=50, 31%), followed by a Non-Consultant Hospital Doctor (NCHD) in Psychiatry (n=45, 28%). As can be seen in Table 3.2, 17% (n=28) of the sample did not know who conducted the assessment. Of the 6% who indicated 'other' as an option this included a medical doctor, a member of the Child and Adolescent Mental Health Team, a Crisis Nurse and a Clinical Nurse Specialist in Psychiatry. Although Clinical Nurse Specialists in Self-harm have a primary role in assessing people who present to the ED with self-harm and suicide-related ideation, it was surprising to see that only 5% of participants reported that the assessment of the patient was carried out by this cohort. However, this may reflect some confusion about job titles and role demarcation.

Table 3.2 Who conducted the mental health assessment?

Response	N	Percent
Consultant Psychiatrist	50	31%
Non-Consultant Hospital Doctor in Psychiatry	45	28%
Don’t know	28	17%
Mental Health Liaison Nurse	16	10%
Other	10	6%
Clinical Nurse Specialist in Self-Harm	8	5%
Mental Health Social Worker	4	2%
Did not respond	2	1%
Total	**163**	**100%**

3.2.1 Participant Inclusion in the Assessment

As identified earlier in this report, an important component of the Model of Care for people presenting to the ED with self-harm, suicide-related ideation or suicide attempt is to ensure that every effort is made to include family members or supportive adults in the assessment of the patient. Therefore, participants in this study were asked to identify if they were included in the assessment of the patient, with just over half (52%, n=85) reporting they were included.

Those who were included in the assessment were asked to identify in what way they were included. Responses were received from 84 of the 85 participants. These responses ranged from very brief statements like ‘provided history’, ‘there for support’; to much fuller responses detailing the level of inclusion. Participants mostly reported providing contextual information to the relevant staff. In some instances, participants detailed a passive experience, simply stating that they assisted by answering questions. However, others detailed how they provided in-depth accounts about the individual they accompanied to the ED, supplying information regarding the individual’s background, the incident that led to their presentation to the ED and, in some cases, medical histories. One such example is provided below, where the participant discusses the information they provided to the ‘crisis nurse’[2] and noted how the patient had told this nurse different information to what they had told them:

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[2] The term ‘crisis nurse’ is not a nursing role within the Emergency Department and it is likely the participant is referring to either a Clinical Nurse Specialist – Self-Harm or a Mental Health Liaison Nurse.

> *I was asked about situation before overdose, what tablets were taken, and where the patient would go after discharge - if he has had supports. I advised patient was homeless & person he had been staying with didn't want him to return. Patient was telling me he was still suicidal with hallucinations but told Crisis Nurse opposite.*
> (P88: female, friend).

Similarly, other participants highlighted that the information they provided presented the mental health team with a collateral history that they would not otherwise have access to, noting that the patient's behaviour had changed since they presented to the hospital:

> *Asked about his mental health issues, I expressed serious concerns and that what he presented with at the time of examination varied to a few hours beforehand in keeping with the condition of bipolar disorder.*
> (P139: female, sibling)

> *I sat in on the conversation with the doctor and was surprised at the lack of input her husband or close family got to give. She had expressed suicide plans to us and yet told doctor it was all ok and only a recent issue. Even though she is in and out of the unit over 7 years.*
> (P106: female, extended family member)

The importance of including information from a next-of-kin or supporting other was identified by this participant:

> *I was very upset that no effort was made to find out from me what his behaviour and state of mind at home had been…they relied entirely on his account, and he minimised his behaviour towards myself and our child…he was never honest with mental health professionals about his hostile, aggressive and violent behaviour at home.*
> (P147: female, spouse)

Some participants identified that the nature of the patient's mental health problem and their level of distress meant they could not adequately answer the questions put to them, so their input was required:

When in manic state like she was she doesn't remember things, struggles to coherently verbalise medical history, family history, previous episodes, behaviours, etc.
(P26: female, friend)

I was given opportunity to speak, my son was extremely embarrassed and hoarse at this point.
(P159: parent to an adult child)

In other cases, collateral information was required when the patient did not or could not participate in the assessment:

I have sat in on the assessments when the young person either refused to engage or needed assistance in giving information.
(P92: female, professional carer)

I insisted on being involved as my child was not very responsive...
(P157: parent/guardian to a child under 18)

They asked me what happened because she couldn't tell them, then the doctor made me leave.
(P43: female, friend)

Some participants described positive experiences of being included in the assessment:

I was asked to explain what was happening that brought us to the dept in cases of suicidal thoughts and when actually attempting suicide was consulted on how we were dealing with the situation. On the majority of visits (3 or 4 times weekly) doctors were good at communicating clearly and involved me in discussions on the best way to proceed.
(P207: female, parent to an adult child)

I was brought in after the initial conversations to essentially provide my view/context in a supportive way.
(P35: non-binary, informal carer)

Participants also discussed engaging with staff regarding the assessment, treatment and aftercare of the person they accompanied to the ED:

The psychiatrist then spoke to us and asked us questions. Nurse followed up with details of what our next steps should be.
(P121: female, parent/guardian to a child under 18).

Doctor asked me some questions and we discussed a plan in case it happened again.
(P23: male, partner).

After assessment I was contacted by phone and explained everything that was going to happen, I was also asked if I had any questions.
(P155: female, parent to an adult child)

A number of participants identified that they were advocating for the patient when they were included in the assessment:

I had to advocate for my son or he was out door as quick as he arrived in.
(P123: female, parent/guardian to a child under 18)

CAMHS asked for young person be admitted to the hospital. Went with letter from them, but consultant in the ED wanted to let her home. I refused and stood my ground with them.
(P78: female, parent/guardian to a child under 18)

Others identified their role in encouraging the patient to stay for assessment and treatment:

I was present at all times and elaborated on the symptoms I also tried to keep the person there as they wanted to go home due to sheer exhaustion. The delay was disgraceful and upsetting for both of us.
(P200: female, parent to an adult child)

Elsewhere, participants simply stated that they were present at the assessment to support their loved one and many did so at the request of the individual they accompanied.

For emotional support at the request of the patient.
(P137: female, social care worker)

I sat in, I offered to leave but was asked to stay by my partner as hospital settings make him anxious.
(P5: male, partner)

My child asked me to sit with him and the consultant asked me questions.
(P18: female, parent to an adult child).

Many participants reported that they were included at a point during the assessment and then asked to leave so that the patient could be interviewed on their own:

The doctor spoke to me & then I was asked to leave the room. So the doctor & u18 could continue assessment privately as u18 requested.
(P193: female, parent/guardian to a child under 18)

I was there when spouse was being spoken to about further involvement with the mental health team.
(P48: female, spouse)

Others reported that they were interviewed separately from the patient:

Spoken to separately for background information.
(P130: female, parent/guardian to a child under 18)

The psychiatric doctor on call came and asked me to go to speak to him, alone without the patient, he asked me questions and how I felt about the patient.
(P64, female, partner)

Participants were asked to identify if the patient's permission was sought for their involvement in the assessment. As can be seen in Table 3.3, for just less than half of those who participated in the assessment, the patient's permission was sought with 28% reporting that no permission was sought and 27% were not sure.

Table 3.3 Was the patient's permission sought for your involvement in the assessment?

Response	**N**	**Percent**
Yes	71	44%
No	46	28%
Don't know	44	27%
Did not respond	2	1%
Total	**163**	**100%**

One participant, when responding about their participation in the assessment, identified that not seeking permission was problematic:

I was interviewed alone in the hallway out of their earshot by a nurse (this caused more distress for partner as they didn't get to be part of the discussion). The psychiatrist launched into personal questions without asking partner if it was ok, I answered and then left to allow them some privacy.
(P56: female, partner)

For almost two-thirds of participants (65%), they were not provided with the opportunity to be interviewed on their own.

3.2.2. Privacy in the Emergency Department

It is a recommendation of the NCPSHI that designated accommodation within the ED is provided for the assessment of someone presenting with self-harm, suicide-related ideation or suicide attempt. Although the Emergency Department is recognised as a busy and often crowded environment, when asked if the environment in which the assessment took place allowed for privacy, promisingly over two-thirds of participants (67%) reported that it did.

Instances where privacy was not afforded to participants and the patient in the assessment process are outlined in responses across a number of the open-ended questions:

Overcrowded A&E, No privacy. Just an awful experience.
(P230: female, parent to an adult child)

Those presenting to triage have no privacy and can often be left waiting as a low priority. It would be great to have more comfortable and private interview rooms.
(P31: female, adult child)

There was no privacy, and it was very hard not being able to sit right beside my son.
(P121: female, parent/guardian to a child under 18)

As seen later in this report (section 9.5), the provision of a more suitable environment is a recommendation made by participants for improving the response to people who present to the ED with self-harm, suicide-related ideation or suicide attempt.

3.3 Safety Planning in the Emergency Department

Participants were asked to identify if an emergency safety plan was developed with/for the patient. A safety plan was defined for participants as a written plan for the next 24 hours with details of how to provide a safe environment, whom to contact in an emergency, and details of when/where the next professional contact would be. The provision of a written emergency safety plan is an important component of the NCPSHI. As identified in Table 3.4, Almost three-quarters (n=171, 72%) of participants indicated that an emergency plan was not developed with/for the person they accompanied.

Table 3.4 Was an Emergency Safety Plan developed?

Response	**N**	**Percent**
Yes	24	10%
No	171	72%
Don’t know	17	7
Did not respond	27	11%
Total	**239**	**100%**

Qualitative comments elaborated on the lack of provision of a safety plan:

> *We were not given any plan or support. He didn't get a prescription, and he had been on medication in the past. We didn't get any advice to go to his own GP or to come back if still suicidal. Nothing. Turfed out onto the street twice in 12 hours.*
>
> (P228: male, other)

> *There was no safety plan in place when my friend left. I honestly feel I can never tell anyone else to go to the hospital if they need help because they've never helped any of my friends.*
>
> (P19: non-binary, friend)

For those who identified that a safety plan was developed, less than half (46%) reported that they were involved in the development of this plan and half (50%) reported that they were provided with a copy of the plan. Involvement of next-of-kin or supportive adults in the development of an emergency safety plan, and the provision of a copy of the plan to them is part of the NCPSHI. The importance of emergency safety planning which provides the patient and their families with guidance on what to do in an emergency was outlined frequently by participants when asked about the type of information they should have received. It was clear that many participants felt unprepared to support the patient on their discharge from the ED and would appreciate some instruction and plan of care to follow when the patient became distressed:

> *My brother has attempted suicide at least 20 times in his life. Support for him and family is needed and aftercare interlinked with different agencies to make a safety plan around recovery and moving forward.*
>
> (P148: female, sibling)

> *It should have been dealt with more seriously and help should have been provided such as a therapist or a safety plan as she still suffers from self-harm.*
>
> (P2, female, friend)

> *Give better guidance. A plan for next 24/48 hours.*
>
> (P174: female, parent to a person over 18)

It was evident that some participants were aware of the service recommendation that a safety plan be required for the person:

> *We should have been told to come back if we felt the patient needed help. We should have been given a written care plan as is written on the service information leaflet. We should have been told to present to a GP or current treating team if needed.*
>
> (P206: female, parent to a person over 18)

Section 4:
Interventions and Experiences in the Emergency Department

4.1 Introduction

This section sets out the interventions the patient received in the Emergency Department and the experiences and perceptions of the participants who accompanied them. The interventions include medical treatment, medication, and the process of referral (or not) to mental health services. This section also encapsulates participants' frustrations at the perceived difficulties in helping the patient access timely and appropriate service provision with a particular focus on the experiences of parents/guardians of children and adolescents.

4.2 Treatment Received in the Emergency Department

4.2.1 Medical treatment in the Emergency Department

Participants were asked to provide a summary of the treatment the patient received in the Emergency Department. Responses were received from 212 participants and many detailed physical interventions to treat self-harm presentations:

Medical treatment of cuts, stitching/glueing of wounds.
(P160: female, sibling)

Kept overnight. Bloods checked as she had taken tablets. Wrists bandaged.
(P224: female, parent to an adult child)

Stomach pumped, left on trolley in a corridor.
(P88: female, friend)

A significant proportion of participants reported that the patient was prescribed some form of psychiatric medication in the ED as part of their treatment. Some reported that this was the only treatment available to them at that time, while others were prescribed it while waiting for referrals to other services:

...told he would be placed on a waiting list and given a prescription for Seroquel[3]*.*
(P237: female, parent to an adult child)

Prescribed Prozac[4] *and sent away as no bed available.*
(P94: female, spouse)

Prescribed anti-depressant and sleep medications. Referred to outpatient clinic and discharged home.
(P90: male, adult child)

4.2.2 Overall experiences and service provision in the Emergency Department

Most of the responses to the question of treatment in the ED focused on the difficulties around being seen by appropriate mental health personnel and referral to appropriate follow-on care. Participants voiced their frustration at the perceived lack of services, excessive waiting time for services and disjointed service provision:

She was seen by the nurse specialist who was lovely and very reassuring to my daughter but aside from that there was little treatment available to her. She was referred to the mental health services, but we were told this could take a good bit of time which it did, so I left with her that night with a situation that was in no way improved, and this is the big problem I have with how we do things here.
(P172: female, parent to an adult child)

[3] An antipsychotic medication

[4] An antidepressant medication

She was assessed by the emergency psychiatric doctor in A&E after many hours of waiting. This was the second visit. At her first visit she was given a preliminary diagnosis of borderline personality disorder and referred to adult psych team in [names hospital]. *She attended there, received official diagnosis and was signed out of their care despite my protests that she was very unwell, and life was at risk. 2 weeks later she had to attend A&E again for suicide attempt. This psychiatric doctor again referred back to GP and private CBT that we have to pay for.*
(P100: female, parent to an adult child)

The ED processes that required triage by an ED nurse and further assessment by an ED doctor before assessment by the mental health team led to very long waits for some. The participant below explains when this resulted in the patient leaving the hospital and coming back again the next day, the process had to start over again:

Had to wait 2 hours to go through triage nurse; then had to wait for ED Dr to first physically clear as not hurt physically which took 4 hours, then told a psychiatrist needed to come from another unit to approve for taking into approved centre[5]*; this took another 4 hours. Even though triage nurse and unit knew she needed to be admitted. She convinced her husband at this point to take her home (a 1-hour drive away); we then convinced her to go back in. So on day 2 she had to again go through ED and triage and wait again 6 hours for psychiatrist to come and admit her.*
(P106: female, extended family member)

Many of the participants referred to the long waiting time to be seen and not knowing how long they were going to be waiting for:

She was assessed and then referred to a mental health team, but they didn't know how long it was going to take to get seen by them. And this was our problem when we were in there. The uncertainty of knowing how long it would be.
(P127: female, sibling)

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[5] A service registered by the Mental Health Commission to provide in-patient mental health care.

Assessment by triage then a doctor and a long wait to be admitted approx 12 hours after first presenting to A&E.
(P154: female, parent/guardian to a child under 18)

For some, there was no further interaction with staff during that wait period:

Triage nurse asked what was the situation, said nothing and advised us to wait in the waiting area, we waited for over 7 hours without acknowledgement.
(P81: female, parent/guardian to a child under 18)

For others, the long wait time resulted in the patient leaving the ED before being seen:

Assessed by triage nurse but no one available for mental health in, so we both left after about 10 hrs. I couldn't keep them there.
(P179: female, stepdaughter)

While long waiting times were distressing for all, some participants referred to the fact that as it was difficult to get the patient there in the first place, the long waiting times compounded that difficulty. For others, it was hard to convince the person to wait for further treatment or referral:

It was very poor treatment because of the huge delays in getting a member of the psychiatric team up to A&E to assess. I felt we were continually being fobbed off even though it was hard to get the patient to agree to go in the first place. It just was a nightmare.
(P200: female, parent to an adult child)

In some instances, participants reported that the person they accompanied received no treatment due to self-discharge or being 'sent home'. None, we were sent home.
(P210: female, parent to an adult child)

Nothing. We sat and waited for a doctor. No doctor came. She insisted on leaving.
(P13: female, friend)

None. Patient left immediately after being seen by doctor. Felt doctor wasn't listening to her.
(P218: female, friend)

There was a general sense from participants that physical health issues were treated quickly, but there was slower progress, or in some cases, no progress with the patient's mental health presentation:

The main focus was on the physical health, but when she had come around and was physically better there was no mention of the fact that it was a suicide attempt. It was like they just wanted her out.
(P11: female, friend)

She was medically assessed and treated and when she was physically well enough, they sent her home the next day because they said she was" medically" fit, no psychiatric intervention, not even a medical social worker.
(P191: female, parent/guardian to a child under 18)

Some participants reported that patients were not afforded what they viewed as adequate treatment or follow-up because of the type of mental health problem they were presenting with, and this was particularly the issue when alcohol or drugs were involved in the presentation:

When a person is taking overdoses, the attitude is that if they do not fall within a certain remit of disorders, they cannot be detained. They are sent out in the full knowledge that they will attempt suicide again.
(P194: female, parent/guardian to a child under 18)

Because of alcohol issues underlying mental health issue was not addressed at all and no referral or follow up.
(P209: female, parent to an adult child)

Traces of marijuana were found in his blood and therefore they would not refer him to other services.
(P128: female, female, parent/guardian to a child under 18)

4.2.3 The experiences of parents/guardians to children/adolescents

As detailed earlier in this report, 21% of participants (n=51) identified that they were a parent/guardian to a child younger than 18. It was particularly apparent in their responses to this question of treatment in the ED that this group believed their child was not receiving the required care and many reported falling between the Adult, and the Child and Adolescent Mental Health Services. The frustration and despair felt by some parents, or in some cases adult siblings of children, is depicted in the following responses:

> *I was told that no bed was available because the patient was sixteen, they could not go to an adult unit but were "too old" for paeds. I was offered a private bed in Dublin which I declined nearly 250 miles from family support. I refused to take them home until a bed was found where I was. We spent a week in the ED. She was specialed*[6] *by security not a mental health nurse despite being at high risk of suicide in the opinion of a consultant psychiatrist. I was pressured to take her home and had to repeatedly refuse and argue with the bed manager. I am medically qualified and suspect if I had not known how to argue including asking if the bed manager would take personal responsibility for the outcome of sending her home she would have been forced home. She was admitted to a child and adolescent psych unit after a week and had a three month stay. In my opinion we are failing adolescents with mental health issues especially those between 16-18 who are neither one thing or another. I was lucky I knew the system and I knew what "buttons to push" and I still have my beloved daughter. Others I am sure are not so lucky.*
>
> (P208: female, parent/guardian to a child under 18 years)

The experience of this mother of the need to be a staunch advocate for her child and to know 'what buttons to push' to ensure appropriate action is taken is a recurring theme in the findings of this study and is reported on further in section 10.2.

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[6] Not left unaccompanied

For some, medical treatment was provided but the specialist mental health assessment never materialised:

> *Patient was medically managed (airway and seizure control) until side effects of overdose substance subsided. Was then promised a review by CAMHS but this never happened, and we were discharged from Emergency Department after 72 hours.*
> (P220: female, parent/guardian to a child under 18)

Some participants reported that staff acknowledged the inappropriateness of an adult ED for a patient under 18, but that there were no alternatives which left the family member in a position of responsibility for the person while waiting to be admitted to a more appropriate environment:

> *Patient was left in general waiting area with myself from approx 5pm until being admitted to a trolley in triage. Patient was deeply upset and distressed and staff did their best but admitted from the start that they were limited due to his age being under 18. Patient tried to leave multiple times, but staff were aware that he would be more likely to succeed in a suicide attempt if he left, so nurses did their best to try and reason with him as did I. Patient was admitted by a consultant who was transparent from the start about how the ED was not the appropriate place for a young person, but the only option available. Patient was given a cubicle for 2 nights in ED and I (sibling) slept in a sleeping bag and stayed with him at all times per the request of staff.*
> (P24: female, sibling)

Some participants identified that despite the systemic difficulties accessing assessment and treatment for their child, individual staff members in the ED did all they could to help:

> *Patient was assessed then we waited to be seen. We waited on till the next morning around 9:30am. She was then seen by ED doctor who was caring and compassionate but let us know that he wasn't trained in mental health and that there would not be anyone to see to do a mental health assessment as she is 16yrs. He proceeded to stitch the wound. He then said we could go, and I could contact CAMHS myself (parent) or we could wait in the waiting area, and he would try to make contact but that would probably take a while and not really result in anything happening that day. I said I would appreciate him making contact. We waited about an hour, and he called me back in explaining he had made contact,*

and they asked him to send a referral letter he said he suggested he do so by fax, and I would follow up. This is what he did. He really did the best he could.

(P142: female, parent/guardian to a child under 18)

In addition to barriers accessing appropriate services, parents of adolescents identified the difficulties experienced when adolescents were in adult EDs or admitted to adult wards:

Underage child sitting in A&E waiting to be seen from 7pm to 3am next morning absolutely disgraceful, should have been offered somewhere more private.

(P203: female, parent to an adult child)

Very poor, the nurses were lovely, but it is unacceptable that a teenager who had attempted suicide had to sit in an A&E for over 12 hours before a nurse could see the panic I was experiencing and allowed my son and I to sit through the locked doors.

(P140: female, parent to an adult child)

The inappropriateness of adult-orientated services for adolescents is vividly depicted in the following excerpt:

Two overnights. Horrific experience on the first night because she was in a cardiac ward with seriously ill, mostly male patients, one man with dementia / very confused and shouting all night; one man with COPD, I think - we actually thought this poor man was going to die in the cubicle next to us; one very disruptive and mischievous incontinent man - we had to hear all about his nappies - he mildly harassed us every time we walked past him; an elderly woman with an addiction problem who was constantly trying to get morphine or similar from the nurses. We were told that she had to be on this ward because she was on a heart monitor, but she was moved the next day on my insistence- it was a completely unsuitable environment for a young girl who had taken an overdose. It was suggested to me by a social worker at a later date that they deliberately put 'these girls' in wards like that to put them off trying again. I seriously hope this isn't true. This was a major Dublin teaching hospital.

(P196: female, parent to a [now] adult child).

4.3 Referral to Other Services

Participants were asked what referral, if any, the patient received to other services and were presented with a list of possible options.

Table 4.1 Referral to other services

Response	N	Percent
No referral	43	18%
New patient referral to a mental health team	39	16%
Own mental health team (if patient attended one previously)	34	14%
Admitted to a mental health unit	24	10%
GP	16	7%
None due to self-discharge	12	5%
Admitted to the general hospital	12	5%
Voluntary services (e.g. Pieta house)	8	3%
Follow-up phone call from Clinical Nurse Specialist from the National Self-Harm Programme	3	1%
Other	21	9%
Did not respond	27	12%
Total	**239**	**100%**

As can be seen in Table 4.1, 18% of participants received no referral to any service. Qualitative comments from other survey questions also make reference to receiving no referral on discharge from the ED. In some cases, this followed a lengthy interaction:

> *Was seen by doctor in emergency department who had a long conversation with the patient and decided they did not need to be referred for a mental health assessment.*
> (P114: female, parent to an adult child)

For some, no referral was received, however, they were advised to source counselling themselves:

Given charcoal to drink and left waiting in a cubicle bed for doctor to assess her. Taken to separate room to be assessed when doctor arrived and then discharged home as they didn't think she would do it again. Told her to source counselling herself and didn't give us any advice. I was sibling home alone with her while parents were abroad. She was told that because she's not hallucinating or delusional that they can't help her.
(P63: female, sibling)

Almost one-third (30%) of participants reported that the patient was referred back to their own mental health team or as a new patient to a mental health team, including the Child and Adolescent Mental Health Services. In some cases, the referral to a mental health team was because the patient was not 'unwell enough' to be admitted to an in-patient service.

Was assessed by psychiatric/mental health team and told would be referred to mental health community team. Asked me to continue to watch her when home. They said she wasn't bad enough to admit to hospital.
(P131: female, parent to an adult child)

Apparently due to the first time being an overdose the doctors said "it was a cry for help" and could not transfer him to the mental health ward after he had just woken from ICU.
(P30: female, sibling)

For some, there were significant delays in receiving follow-up from these services, and this was a period when participants felt unsupported:

…He was discharged and referred to CAMHS and we waited 3 weeks for another meeting. I phoned every day. It was shocking! They advised us that if he attempted self-harm or suicide to return to the ED!!!
(P81: female, parent/guardian to a child under 18)

They discharged my child with very little support arranged for weeks after we left.
(P101: female, parent to an adult child)

Someone spoke to him. Then a nurse came and spoke to me to tell me they were sending him home and referring him to a home care crisis intervention team. I didn't feel safe as he was very hostile. I was told to call the gardai if I felt in danger.
(P147: female, spouse)

In some cases, the follow-up did not occur at all:

They were assessed, given a diagnosis of BPD[7] *and were told they would be contacted by the community team, but it was not followed up with them.*
(P18: female, sibling)

Sent home on medication and told appointment would be sent out. It never came.
(P238: female, informal carer)

One participant describes how the patient was referred directly from the ED to a CAMHS in-patient unit, but that there was uncertainty if on arrival at the unit they would actually be admitted. They describe what had to occur, with the knowledge of staff, to ensure that they would either be admitted to CAMHS unit, or at the very least keep their place in the general ward:

We left ED to bring patient to a CAMHS inpatient unit via our own car. Via phone the CAMHS residential nurse advised me to not tell the patient where we were bringing him. I was advised to child lock the doors and to not make any stops on our 1-hour journey. The CAMHS nurse also explained that we would need to tell the General ward nurses nothing about our transfer, as they could not guarantee a CAMHS bed. As such, we were advised to try and hold the general ward bed covertly, to avoid a readmission process via ED again.
(P24: female, sibling)

7% of participants reported that patients were referred back to GPs and in many of these cases this was for onwards referral to a mental health service taking a somewhat circuitous route:

The patient was seen by a mental health consultant and then sent home and referred to GP for a referral for CAMHS.
(P27: female, professional carer)

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[7] Borderline Personality Disorder

> *I was waiting outside while they spoke with my dad, ultimately, he was sent home and told to phone GP and they would write to psych services.*
> (P57: female, adult child)

A number of participants reported how the patient was being discharged without further referral or treatment, however, they strongly advocated for the patient to be seen and in some cases admitted:

> *On the second day of attending A&E only because family member was a medic and contacted consultants and pleaded for help, was my sister admitted to acute psychiatric hospital for inpatient care.*
> (P170: female, sibling)

> *No treatment - was being discharged with nothing until I went back in and requested to speak to the consultant as a family member and telling them how my partner was really presenting.*
> (P181: female, spouse)

Of the 9% who reported that they were referred to 'other' services these mainly included day hospitals, mental health social worker, and home care team.

4.4 The ED as an 'Inappropriate' Setting

Many participants reported that the Emergency Department was not an appropriate environment for a patient presenting in mental distress. This point was made in relation to patients who presented following a self-harm episode or suicide attempt, but particularly in the case of those who presented without having hurt themselves but in mental distress. As previously identified, there was a perception that medical needs were quickly and expertly attended to, while mental health needs were not:

> *They were left for 5 days in A&E, after initially receiving treatment to offset the overdose. While the nurses and everyone were great it was not the place to be for someone struggling so badly.*
> (P89: female, sibling)

The long waiting times, noise and general busyness of the ED were identified as some of the main reasons that participants questioned the appropriateness of the ED as a treatment setting for people in significant mental distress. Some simply reported that "staff are ran into the ground." (P 180: female, friend). The fast-paced environment of the ED coupled with the long wait times was also seen as exacerbating the distress of the patient:

> *EDs for suicidal/self-harm presentations are not fit for purpose and the environments can be additionally triggering for already vulnerable people being made to wait (unattended) for hours upon hours.*
> (P26, female, friend)

> *I don't think the regular waiting room in the ED is the place to be when someone is suicidal.*
> (P121, female, parent/guardian to a child under 18)

> *Long waiting times in ED are common but a person with suicidal ideation/ tendencies can feel unimportant so making them wait so long reinforces this negative thought.*
> (P145: female, parent/guardian to a child under 18)

Others reported how the busyness of the ED and the staff within it meant that they were relied upon to look after the patient:

> *All staff were far too busy to provide much care other than appropriate medication. The knew they could trust me (the mother) to alert them if there was any change in my daughter's condition.*
> (P 220: female, parent to a child under 18)

> *I was told I was not allowed to wait with her…then upon seeing a nurse for a first eval [evaluation] around 9pm I was told I had to stay with her because they had no one to watch her until psych turned up.*
> (P26: female, friend)

One participant, who was a mental health professional, identified the difficulty involved in advising others to attend the Emergency Department in a professional capacity, when they were aware of the difficulties within it for people presenting with suicidal behaviour:

> *I am not a negative person, but honestly my experience was horrific, and the sad thing is I am a* [identifies their role as a mental health professional] *and I am telling parents of children with suicidal ideation (weekly, sometimes daily) their safety plan is to seek help from GP, go to A&E, and I know unfortunately what their experience will be. GP can refer, but once you get to A&E you are treated like everyone else, attempted suicide is not the same as a broken leg, [it] needs specific care.*
> (P170: female, sibling).

Participants' suggestions of changes/alternatives to the Emergency Department are considered in section 9.5

Section 5:
Information Provided to Accompanying Adult

5.1 Introduction

This section sets out findings related to three main areas encompassing information provided to participants on suicide prevention, information provided on how to support the patient, and what information participants believed they should have been provided with.

5.2 Information on Suicide Prevention

As identified in Table 5.1, most participants (72%, n=171) were not provided with any information about suicide prevention before they left the hospital with the patient. Only 3% of participants received written and verbal information, 3% received written information only and 11% received verbal information only.

Table 5.1 Before you left the hospital, were you provided with details around suicide prevention?

Response	N	Percent
Yes, written and verbal information	8	3%
Yes, written information only	6	3%
Yes, verbal information only	27	11%
No information was provided	171	72%
Did not respond	27	11%
Total	**239**	**100%**

Those who were provided with information were asked to elaborate on what that information was. In total, 38 of the 41 participants who received information answered this question, however, a number were unable to recall the specifics:

Can't recall. It wasn't very detailed I don't think.
(P154: female, parent/guardian to a child under 18)

Those who received written information mostly reported being provided with leaflets, although most did not elaborate on the content of these leaflets, while others identified not finding them very useful:

Leaflets on mindfulness and helplines. Not helpful at a time of crisis.
(P49: female, sibling)

For the majority of those who received verbal information this largely centred on keeping the patient safe through observation and reducing access to means of suicide:

Keep checking on him and remove "dangerous objects" from his possession.
(P72: female, parent/guardian to a child under 18)

What to be aware of, not to allow her to be alone, no knives, scissors around etc. Constant supervision.
(P219: female, parent/guardian to a child under 18)

For some, it was clear that this requirement for constant supervision was anxiety-provoking for the person and placed quite a burden on them:

It was really just to keep an eye on her, but I feel this leaves a big burden on me. And I was constantly on alert and exhausted.
(P172: female, parent to an adult child)

The potential for the patient to attempt suicide if left alone was made clear to some participants:

I was told the patient was at high risk of attempting suicide again if left at home.
(P24: female, sibling)

Others noted that they were provided with more useful information and guidance:

Doctor spent time with me to discuss how I was feeling and how I could help the patient in the future and what to look for to avoid future occurrence.
(P114: female, parent to an adult child)

5.3 Information Provided on How to Support the Person

Participants were also asked to identify if they were provided with information about how to support the person they were accompanying. As can be seen in Table 5.2 and similar to the responses to the previous question most participants (71%, n=170) received no information on how to support the patient.

Table 5.2 Before you left the hospital, were you provided with information about how to support the person you were accompanying?

Response	**N**	**Percent**
Yes, written and verbal information	7	3%
Yes, written information only	2	1%
Yes, verbal information only	33	14%
No information was provided	170	71%
Did not respond	27	11%
Total	**239**	**100%**

Of those who received information (18%, n=42), most again reported receiving general advice on not leaving the person alone, and about keeping the environment safe. Again, some found the responsibility to observe the patient and to keep them safe to be a big one:

> *Just to keep an eye out. But it is a big burden to be left on me and the family. This is not our expertise.*
> (P172: female, parent to an adult child)

In other cases, their role as a support was emphasised:

> *An explanation of why it happened, my role as a spouse (support, not responsible).*
> (P69: female, spouse)

Some participants did report receiving helpful information:

Referral was made. Also given details of numbers to call for counselling services. Small information leaflet for us. Can't remember exactly what was said as it was a very traumatic time. But I did feel comfort and that we were in the right place for help.
(P121: female, parent/guardian to a child under 18)

5.4 What Type of Information Should have been Provided?

As most participants did not receive any information to help support the patient, it is unsurprising that many took the opportunity to provide detailed responses to the question that asked what type of information they should have received. Responses to this question were received from 154 participants, ranging from one word to long paragraphs of text. The most commonly reported one-word answer was 'anything', sometimes written in all capitals hinting at a sense of frustration and suggesting that participants would appreciate any information about how best to support the patient. In some responses, it was clear that participants were frustrated and believed that the mental health needs of the patient were more important than their own information needs:

Didn't need info the patient needed help! A leaflet doesn't suffice.
(P102: female, friend)

Why would I want information on what I do? He should have been kept in.
(P226: female, sibling)

Information is not what's needed when you're in a crisis. Action is needed and parents need to be listened to as they are on the frontline 24/7.
(P200: female, parent to an adult child)

In the more detailed responses, participants described a number of different supports required in the one answer:

> *Literally anything could have helped, anything on how best to support my friend, how to take care of myself while helping my friend, what signs to look out for, what to do in case of another attempt. We had to put my friend on 24hr watch between friends and family, it was a very difficult time for everyone involved and there was zero support given by any mental health professional.*
>
> (P19: non-binary, friend)

One of the most common supports required was contact numbers to be used in emergencies if the patient became unwell:

> *Contact details for all of the support agencies including community groups. Details on the mental health family support group. Details on who to contact if she got worse – who was her key worker and how to notify that person in the mental health team of family member concerns. Details on out of hours services.*
>
> (P106: female, extended family member)

> *Some ideas on how to keep her safe, maybe an emergency phone number? Something more than 'keep an eye on her and ring CAMHS on Monday' anyway.*
>
> (P163: female, parent/guardian to a child under 18)

Also requested was a list of support services – both for the patient but also for family members, recognising the impact it can have on families. The impact on family and accompanying adults is outlined in more detail in Section 8 of this report, however, the participant accounts below portray the despair and terror experienced when they perceived themselves to be ill-equipped to support the patient:

…Support information for me…I was scared to death, had to be on red alert 24/7. No advice on what to do if things escalated again.
(P198: female, parent/guardian to a child under 18)

> *Any information would have been helpful. I was terrified he would kill himself and we were sent home.*
>
> (P94: female, spouse)

> *Any information as to how to help…after we left I spent the night standing beside the motorway trying to talk him out of stepping in to traffic.*
> (P40: female, partner)

There was also a recognition that while they may have been supplied with some practical information to help the patient e.g. helping them to manage their medication, there was little information about how to support them with their mental health needs, and this was the information that participants required. Many participants also referred to needing guidance on what to do if a mental health problem re-emerged:

> *We were told to monitor her medications and weekly blister packs are to be used. But no conversation regarding how to deal with her mood swings etc.*
> (P31: female, adult child)

> *Signs of typical potential or possible suicide behaviour. How best to approach and support that person.*
> (P218: female, friend)

As identified earlier in this report, many participants referred to the long waiting time between discharge from the ED, and referral to another service. Unsurprisingly then, many participants highlighted the need for information on how to support the patient in this crucial period:

> *I just wanted some help and advice about what to look out for. What to do to help while we were waiting for the referral to come through. It was very frightening to go home with her and not really know how to help.*
> (P127: female, sibling)

Section 6:
Emergency Department Staff Skills, Knowledge and Understanding

6.1 Introduction

This section reports findings relating to participants' experiences of staff interactions and their perceptions of staff confidence, skills and understanding of self-harm and suicidal behaviour.

6.2 Staff Confidence and Skills

Participants were asked to identify if they believed ED staff had the required confidence and skills to care for the patient. As can be seen in Table 6.1, over half (54%, n=129) of the participants did not believe that staff had the required confidence and skills, with just one-fifth (n=47) believing they had.

Table 6.1 Do you believe staff had the required confidence and skills to care for the patient?

Response	**N**	**Percent**
Yes	47	20%
No	129	54%
Don't know	36	15%
Did not respond	27	11%
Total	**239**	**100%**

Throughout the open-ended responses in this survey, participants provided more detail on their perceptions of clinical staff they engaged with. Both positive and negative interactions were identified. Negative interactions focused on two key areas, 1. Poor attitudes of healthcare staff and 2. Staff's poor understanding of mental health issues and in particular of self-harm and suicidal behaviour.

6.3 Attitudes of Healthcare Staff in the Emergency Department

It is widely reported in the literature that staff attitudes towards people who present to the ED with self-harm or in suicidal crisis are not always positive. This was also the experience of some participants in this study who reported harsh, judgemental and dismissive attitudes amongst some staff:

> *My son presented with extensive self-harm. In less than 24 hours, he had over 120 self-inflicted cuts from a Stanley blade. Some of the cuts were deep and needed attention. The initial ED doctor was rough and asked my son why he would do it. He appeared to have very poor knowledge of self-harming and was very unsympathetic to both of us. He was discharging my son, but I requested a psychiatric evaluation. We waited overnight for the psychiatrist to come. When he came he was great.*
> (P116: female, parent/guardian to a child under 18)

For some, it centred on poor interpersonal communication and a reductionist focus on the 'tick-box' exercise of assessment:

> *My sibling found the doctor very cold. He spoke to her based on ticking criteria and didn't go beyond that.*
> (P63: female, sibling)

Others reported negative attitudes particularly when patients made repeat presentations for the same difficulties:

> *[I would like…] for my client not to be told "You're back again??" in a judgemental, irritated tone.*
> (P105: male, professional carer)

> *I would have liked to receive information on the support and management of my child rather than just a roll of the eyes because my child was a "frequent flyer[8]".*
> (P220: female, parent/guardian to a child under 18)

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[8] A pejorative term use to describe people who frequently attend the ED for self-harm

Some participants reported these negative attitudes coming from senior members of the healthcare team:

Consultant was very dismissive and not very patient when she refused to show her arms. I feel a psychologist was needed here as this approach caused her more distress.
(P71: female, parent/guardian to a child under 18)

While the doctors and nurses were very sympathetic and understanding to our daughter, the senior consultant in [names hospital] was horribly dismissive and completely undermined the severity of what we were all going through.
(P100: female, parent to an adult child)

Throughout the responses, a number of participants made reference to the patient being under the influence of drugs or alcohol when they presented to the ED, and that this impacted the treatment they received in the ED:

Because he had consumed alcohol, he was automatically assumed to be causing a problem and couldn't have been treated worse. The staff were horribly mannered. Unwilling to help at a time of crisis.
(P40: female, partner)

Despite the Emergency Department being the place people are advised to go to if in a suicidal crisis, whether or not they have self-injured, it was clear that some ED staff did not believe they belonged there:

Was told to 'stop crying' and was repeatedly asked why they had come if they were not injured.
(P8: gender not disclosed, friend)

Disgraceful treatment to the patient who was smirked at by a doctor because patient expressed they desperately needed help or a bed and wouldn't go home. Dr smirked at the idea of wanting to stay in A&E for this. No psychiatrist was called patient left in waiting room on a chair was told A&E is only for emergencies to which we said mental health is also an emergency! Overall disgraceful treatment by doctors and patient left feeling completely distraught and feeling there is nowhere to go for help.
(P102: female, friend)

6.4 ED Staff Understanding of Mental Health Difficulties

It was also apparent that some staff within the ED had a poor level of knowledge and understanding about mental health difficulties:

First time we presented, the care wasn't there. Even one nurse commented that "you don't look like you've mental health problems".
(P166: female, parent/guardian to a child under 18)

Nurses said some very inappropriate comments about mental health.
(P19: female, adult child)

Some participants had positive experiences of mental health staff within the ED while other staff in the ED had poorer understanding of self-harm:

The psychiatrist was sympathetic and helpful, but all the other staff had very poor awareness of self-harm. Other staff appeared to just think it was attention seeking behaviour that he needed to snap out of.
(P116: female, parent/guardian to a child under 18)

The surgeon was highly confrontational and unnecessarily aggressive to my spouse, shouting at them, asking why they would do this. The doctor supporting us was apologetic about this, and the nurse liaison intervened, providing support for my spouse for over 2 hours when they heard the surgeon's interaction.
(P69: female, spouse)

As a result of negative attitudes and poor understanding of self-harm and suicidal behaviour experienced in the ED some participants reported that the patient felt worse leaving the ED than when they went it:

The regular staff need to treat these patients with more respect and empathy. My daughter came out and felt worse than ever because she was made to feel as if she should pull herself together.
(P231: female, parent to an adult child)

Section 7:
Positive Experiences in the Emergency Department

7.1 Introduction

It is important to note that positive experiences were reported by some participants which ranged across several domains including the provision of expert physical treatment and the compassionate care provided by some staff. These findings are set out in this section.

7.2 Positive Experiences

Responses were received from 187 participants on what aspects of the care of a family member or friend was beneficial. Half of the participants who answered this question, however, reported that there was no aspect of care that was beneficial (n=84, 50%). The majority of these participants replied with only one word, 'none' or 'nothing' to report that there were no beneficial aspects. Some participants who could not report any beneficial aspects of treatment in the ED were able to identify positive aspects of care either on the pathway to the ED or following presentation to the ED:

The Gardai were very helpful.
(P170: female, sibling)

The Guards provided better care, with greater understanding, than any hospital staff.
(P115: gender not disclosed, friend).

None from the hospital, Ambulance staff were much more caring and supportive.
(P33: female, friend)

The remaining half of the participants were able to report aspects of care of their family member/friend that they found beneficial. Some reported positive comments about staff without identifying what aspects were positive:

The nurses and doctors do an amazing job in the ED.
(P177: female, partner)

For most who reported positive aspects of care, this centred around interpersonal interactions and the provision of treatment in a caring, compassionate, and empathetic way and this was reported across healthcare and support staff within the ED:

Honestly, one nurse with compassion…and a dinner lady….
(P82: female, parent/guardian to a child under 18).

The reception staff were understanding.
(P 145: female, parent/guardian to a child under 18)

For the first time ever concerns about his mental health were taken seriously. He was treated with compassion.
(P174: female, parent to an adult child).

The staff I saw were actually lovely in the ED. I couldn't complain about them. They were kind to me and my sister.
(P127: female, sibling)

Listening, communicating, and engaging with the patient were identified as being an important aspect of compassionate care:

I feel that the compassionate nurse that kept my sister company on watch was what helped the most, rather than sitting there in a room with no communication the nurse actually spoke to her and engaged with her, while none of the others did that.
(P14: female, sibling)

The psych Doctor was excellent, built up a great rapport with my son.
(P 159: female, parent to an adult child)

Some participants reported that multiple staff were helpful to them across a range of different domains from facilitating a rights-based approach to the care of their loved one, to practical interventions that were deemed helpful:

The ED Social Worker was remarkable, and their rights-based approach sought to have the voice and consent and wellbeing of my family member at the centre of a very complex process for staff and the hospital. The ED Consultant was warm, honest, and was transparent about his limitations from the very beginning of the process of being stuck in ED with a young suicidal teenager. The ED Consultant encouraged me to order a pizza and to try and get some sleep, even bringing blankets. The social worker dropped off cans of fizzy drink. The nurses popped by the cubicle and were warm and empathetic.
(P 24: female, sibling).

Others identified positive experiences across a range of domains which was precipitated by presentation to the ED:

The CNS [Clinical Nurse Specialist] was amazing, and I truly believe she saved my wife's life that day. Her safety plan and referral triggered an entire network of support, psychiatrist, psychologist, a diagnosis and medication review that got her through the crisis to where she is fully recovered now and while she still struggles from time to time, she has the capacity to overcome the dips in mood.
(P45: female spouse)

For many of those whose loved one had self-harmed or attempted suicide, the physical treatment provided to the patient was reported to be a beneficial aspect of the care they received. Participants spoke of the expertise of the ED staff in assessing physical health needs and administering the relevant treatments in a timely manner:

The A&E team were knowledgeable about her care, were prompt about getting her bloods taken, trying to find how the medication she took would affect her liver. Received a bed that night just three hours after attending A&E. The doctors were efficient.
(P 219: female, parent/guardian to a child under 18)

Immediate physical treatment and admittance to unit was beneficial.
(P 74: female, cousin).

The physical care of my friend was excellent.
(P2: female, friend)

A number of participants who reported good physical care identified that this was not the case for the mental health care the patient received:

Medical care was excellent. Mental health care was inadequate.
(P194: female, parent/guardian to a child under 18)

For some, the positive aspects of care were centred on the point that the ED provided a safe space for the person to be, and for others it provided respite for being solely responsible for their loved one:

Admitted to a room with someone with her at all times. This gave her a chance to reflect and a chance for me to know she was safe, and I could focus on my other children.
(P78: female, parent/guardian to a child under 18).

Honestly, it got us nowhere other than it was a safe place to sit while he was feeling suicidal.
(P72: female, parent/guardian to a child under 18).

A few hours where I wasn't solely responsible for my partner's safety.
(P 56: female, partner)

For some, the feeling of safety the ED provided was short-lived:

A holding place for the night was basically all it was. Trying to reassure myself that they had been assessed and maybe were going to be safe though that didn't last long.
(P157: female, parent/guardian to a child under 18)

Consideration of the needs of the participant, in addition to the patient, was identified as important by some:

The nursing staff ensured I slept and had someone watch my child as they were under 24-hour supervision. The catering staff also looked after us both.
(P117, female, parent to a child under 18)

A number of participants reported that despite the high activity levels and over-crowding in the ED, staff tried to find them a quiet place which was beneficial:

They kept her observed in a room in A&E which at some stages was private, which I suppose was good.
(P41: female, professional carer).

Patient placed in quiet area awaiting ambulance to transport her to psychiatric unit.
(P239: female, parent to an adult child).

Participants reported that even though the ED was very busy, staff checked in with patients:

Staff were extremely caring and constantly checked in on us even though there were busy.
(P 177: female, partner)

Despite the busyness, participants reported that staff took the time to undertake an assessment:

The doctor was clearly very busy but made sure to take plenty of time to assess the situation and ensure the patient's safety.
(P114: female, parent to an adult child).

I liked the fact that she was transferred from the ED to the Psych Dept, that after the long wait and numerous attempts at convincing her to stay and be seen, I was glad she was provided with an assessment.
(P47: male, sibling)

Some participants reported that the ED staff had a role to play in encouraging the patient to stay and wait to be seen and assessed and this was identified as a beneficial aspect of care:

The attendance of a consultant psychiatrist, and the support of them and some of the A&E staff to stay.
(P208: female, parent/guardian of a child under 18)

Some participants did not provide specific examples of what was beneficial about the care and treatment the person received, however they were happy with the overall experience:

They saved her life.
(P93: female, parent of a child under 18)

Hospital was A1. They did everything they could do.
(P222: female, parent of a child under 18)

Section 8:
The Impact of the Experience for Family Members/ Supporting Adults

8.1 Introduction

This section sets out findings relating to the impact of the experience of accompanying someone to the ED, and the experiences preceding and following this presentation. Findings here make reference to both emotional and practical impacts on the participant but also on wider family units.

8.2 Emotional and Practical Impact on Participants

Throughout several of the open-ended questions participants outlined, sometimes in great detail, the impact of supporting someone who presented to the ED with self-harm/suicidal behaviour. Several distinct emotions came across strongly in these accounts. The strongest one was how much they cared for the person they were accompanying, and their sense of desperation in searching for a cohesive service that meets their needs and although this was reported for all groups of accompanying relatives and friends, it came through particularly strongly from parents who were supporting a child, with one parent referring to it as 'the loneliest time in any parent's life' (P158: female, parent/guardian to a child under 18). There was also a strong sense of frustration at the often disjointed and cumbersome service provision and the perceived lack of adequate assessment and treatment for mental health difficulties. Participants reported being hypervigilant, exhausted, fearful, unsafe and unsure of what to do when supporting a person in crisis. These impacts are evidenced in more detail here:

> *She was assessed and then referred to a mental health team, but they didn't know how long it was going to take to get seen by them. And this was our problem when we were in there. The uncertainty of knowing how long it would be. In the end it was 4 weeks, but they were very scary weeks for us as family members.*
>
> (P127, female, sibling)

Someone spoke to him. Then a nurse came and spoke to me to tell me they were sending him home and referring him to a home care crisis intervention team. I didn't feel safe as he was very hostile. I was told to call the gardai if I felt in danger.

(P147, female, spouse)

Some participants reported a sense of distrust by healthcare staff towards the patient and the accompanying adult, while others reported not being heard or believed:

It is a very, very hard situation to be in. You know your loved one needs immediate care and help yet it isn't being offered. We think medics know best! I am educated in the area and found the distrust in someone's intent horrifying. Pleaded for help and stated if she was sent home (which she was) she would reattempt (which she did).

(P170: female, sibling)

I didn't feel heard or believed.

(P80: female, friend)

Hypervigilance was reported by a number of participants. For some, this was in the ED itself when the patient was waiting for assessment and treatment:

I think that the ED waiting room is no place to be when someone has just gone through such a traumatic experience. There was no privacy, and it was very hard not being able to sit right beside my son. It was hard on my husband too that he had to wait outside all day. There was the added stress of every time my son went to the bathroom that I couldn't accompany him to make sure that nothing happened. I was in fear every time he went to the toilet. I couldn't leave to get a snack and was afraid to go to the bathroom myself in case something happened my son.

(P121: female, parent/guardian to a child under 18)

For others, the hypervigilance continued at home, when the patient was discharged from the ED:

Occasionally it would be wonderful to have a break from the constant vigilance. My husband and I slept in shifts, and I still find it hard to go to my bed, I sleep downstairs in case I am needed. The first time I actually said I was going to bed my daughter overdosed within an hour.
(P207: female, parent to an adult child)

1 year later we still can't sleep properly in case he doesn't come home. Our lives will never be the same.
(P159: female, parent to an adult child)

For some participants, particularly parents of children, the requirement for constant supervision meant that they had to leave their jobs to care for their loved one:

My daughter was let down by the health system, this had a huge impact on the family. My husband gave up work to be on suicide watch for 3 years.
(P212: female, parent to an adult child)

I had to retire from my job to look after my teen.
(P221: female, parent to an adult child)

The difficulties of being 'on alert' were particularly felt by single parents who did not have another adult to support them and were often trying to support other children in addition to the patient. Participants reported that extra support was required in these circumstances:

[I need] support to manage 24-hour supervision which is impossible for a single parent to do.
(P213: Female, parent to a child under 18)

More support for the carer or information re same. I'm a single parent and had to deal with this on my own.
(P198 Female, Parent to a child under 18)

The need for supports for family members was reiterated here:

Parents are afraid and scared and need someone qualified to help support them. Your mind goes so fast, it's like a dream and you're all alone.
(P93: female, parent/guardian to a child under 18)

Their caregivers in many cases will be struggling themselves with stress, anxiety etc. It is extraordinarily difficult to live with and support someone who is going through a mental health crisis.
(P147: female, spouse)

Very sadly, a number of participants reported that their family member had died by suicide since their presentation to the ED. This was a hugely traumatic experience for the participants and was compounded by the perception by some that this could have been prevented if appropriate service provision had been in place:

My mum attended A&E due to a suicide attempt in [names date]. She died by suicide on [names date 6 weeks later]. She received home support for 5 days but that was all. No onward referral for support. We received no family support or education. Her psychiatrist said they could not have known the risk as she said she was fine. I cannot accept this. Someone who is not well might not feel able to tell you the truth. She needed help and just couldn't ask for it. And I wasn't told how to support her. None of this should have happened.
(P38: female, adult child)

My son was let down. He should have been seen by a psychiatric doctor. I feel they didn't give him any sort of second thought…wanted the bed back as soon as…I will never know…maybe he could still be with me if he was given that opportunity of treatment.
(P118: female, parent to an adult child)

Section 9:
What Can be Done to Improve Responses in the ED for the Patient and the Accompanying Adult?

9.1 Introduction

A number of open-ended questions focused, in slightly different ways, on what could be done to improve responses to people who present to the ED with self-harm, suicide-related ideation and suicide attempt, and their accompanying family member or supportive adult. Three open-ended questions in particular focused on this:

1. Based on your experience accompanying the patient, what would you have liked done differently and for what reasons?

2. What do you think could be done to improve the services for those presenting to the ED with self-harm/suicide attempt or suicidal thinking?

3. How do you think family members/accompanying adults can be better prepared to support someone with self-harm/suicide attempt or suicidal thinking?

These three questions drew a large number of responses, with 456 individual answers. While some responses were brief consisting of a few words, or 1-2 sentences, many were very long and detailed, with participants drawing on their own experiences when answering these questions.

9.2 Better Assessment and Patient-Centred Care

A number of participants identified that focusing on improved responses and interaction between the healthcare professional and the patient was important in improving the overall experience for them and the person they were supporting:

By treating the patient with care and compassion, that would definitely help the family members/carers.
(P153: female, parent/guardian to a child under 18)

I think taking my partner seriously, and honestly mental health services that are patient centred, well-staffed, interested and actively listen to their patients. This would have relieved the pressure on us. Partner felt entirely unsupported by the mental health team.
(P56: female, partner)

A more understanding and empathetic approach to the patient and their family where they were really listened to was identified as important by many participants:

Parents really need to be heard, not just listened to. Their concerns are real and should be addressed before things spiral out of control.
(P220: female, parent/guardian to a child under 18)

Better empathy and listening skills.
(P125: female, professional carer)

Listen rather than just interview on a set format of questions.
(P236: male, spouse)

Participants also referred to the need for a broader consideration of mental distress:

A trauma informed approach by all staff from reception on…better care and attention.
(P49: female, sibling)

There needs to be specialised 24/7 mental health crisis presentation points where all the nurses are trained in trauma-informed patient-centred care with appropriate understanding of self-harm and suicidal ideation.
(P26: female, friend)

9.3 Better Information, Support and Guidance for Accompanying Adult

A large number of responses focused on better supporting the accompanying adult in a number of ways, highlighting a perceived deficit in the provision of this information currently:

> *Aside from the training I have pursued myself through my career I cannot think of a time when I had someone to talk to me, who could give me advice on how best to manage a suicidal person.*
> (P92: female, professional carer)

Similar to the responses detailed earlier on what information accompanying adults would have liked to receive from the ED, one of the most prominent suggestions to improve supports was the provision of information. While many responses here were short or single-word responses e.g. 'educational information', many provided more detail on the type of information that was required and the context in which it was required:

> *I feel the health service should provide leaflets and information to families to aid them in supporting their family member. Whether it be via classes, zooms, phone calls, or post I think all persons accompanying someone to the ED should be given adequate information on how to support them when they're home.*
> (P47: male, sibling)

> *Education and supplying information on the help that is available and making them and the patient aware of the pathways available.*
> (P234: male, parent to an adult child)

> *Give better guidance and practical suggestions. And a plan for the next 24/48 hours.*
> (P174: female, parent to an adult child)

Similar to findings presented in Section 8 of this report on the impact on the accompanying adult, there was a perception from some participants that family members and friends were often 'left with the burden' of caring for a distressed person when healthcare staff discharged the person home to the care of this person, and that this left a huge responsibility on the family member/carer/friend. In this context, more information and guidance are required on how best to support someone in this situation:

> *More time given to speak to the carers and advise them on how to deal with the patient when they are released as it is a frightening and confusing time enough without being left with someone who wants to seriously harm themselves and has not had the mental health treatment they require. Family members and carers are left dumped with the responsibility and no idea what to do.*
> (P91: female, adult child)

Participants reported that they were not experts in assessing self-harm and suicidal behaviour and so needed guidance on the specific signs to look out for as signs that they had considered important were not considered important by the mental health professionals assessing their loved one:

> *We should be told much more specific information. What to watch out for specifically, not just to keep an eye out. But also recognise that this is not our job or expertise. I don't know if what I am seeing is something relevant. I thought my daughter was exhibiting serious signs of self-harm and suicide, but the hospital didn't think there was a serious cause for concern but maybe this is because I am alarmed to see my daughter like this. I don't have the expertise to assess this. I only have the capacity to love her and worry about her and this is what I do every day. Some more family support would be really fantastic which is why I am interested in this study.*
> (P172: female, parent to an adult child)

There was recognition that the distress of a family member impacts the whole family, and that healthcare responses and follow-up needed to be inclusive of the wider family. In addition to information and guidance, participants reported needing support on how to manage their own reactions and responses to the person in distress:

> *Understanding how to care for your loved one in crisis without personalising their pain.*
>
> (P165: female, friend)

> *I think sometimes mental health issues are very much focused on the person affected; family members involved are just as important as their needs can sometimes be forgotten.*
>
> (P31: female, adult child)

A significant proportion of participants referred to support groups for family members/carers. Some had positive experiences of these already while most were calling for information about these supports to be provided to them:

> *We did the DBT[9] programme for support people and it was the first time in 8 years of service that we had a voice, and we got direction, and it really helped. We still keep in contact with a family who attended.*
>
> (P191: female, parent/guardian to a child under 18)

> *Support services need to be in place. There are none. Even if the voluntary sector had some services they weren't mentioned. I wasn't asked about what support I had, nor was I given advice or information about what I could access.*
>
> (P147: female, spouse)

Some participants felt that the demand was already too great on family members, and they should not have to be better prepared to support someone presenting to the ED in suicidal crisis:

> *It's too much to ask anyone. We are not able or don't have the knowledge and we are broken down ourselves from looking at family members not getting the help they need.*
>
> (P226: female, sibling)

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[9] Dialectical Behaviour Therapy

A number of participants suggested that education needs to be wider than that provided in the ED or mental health services and should be available through mental health first aid courses or the provision of information to the public through mainstream and social media:

> *In my case I had completed a Youth Mental Health First Aid training. This was very helpful for me to remain calm and know how to address the situation. I think this type of training needs to be freely available to all.*
> (P142: female, parent/guardian to a child under 18)

> *Perhaps a monthly half hour slot at the same time on national TV i.e. after the news.*
> (P236: male, spouse)

> *More media and social media information of what to do and say to the person who is suicidal.*
> (P124: female, sibling)

9.4 Inclusion of Accompanying Adult in the Person's Care

A common response received in relation to how improvements could be made in the ED focused on the need to include family members or other accompanying adults in the patient's treatment in the ED and in decisions about referrals and onward treatment. For many, inclusion was important to get a fuller picture of the patient, their history and their home situation:

> *Families need to be included. People who are in crisis are not reliable sources of information. They are also not the only people at risk of experiencing harm due to their mental health crisis.*
> (P147: female, spouse).

Some participants commented that inclusion needed to be broadened out to ‘chosen’ family, in addition to next of kin:

> *There need to be measures to ensure ‘chosen’ families are recognised as support too. A person could be the primary source of support but not blood/ legally related for a variety of reasons. There are many immigrants, LGBT+ persons, or even people who are estranged from blood family who have created ‘chosen’ families of their own and those relationships are equally, if not more, important.*
> (P26: female, friend)

9.5 A More Conducive Environment/Alternative to the ED for Acute Mental Distress

A number of different issues were explored within this section. A frequently reported suggestion was to have a safe, quiet and private space within the ED. As previously reported, participants identified that the busyness, noise and high level of activity within the ED did not make it a good place for those experiencing significant mental distress. In particular, the long waiting time was reported by many participants as a significant issue and as a result many had suggestions for improvement that focused on reducing this waiting time:

> *We were waiting a long time, and my friend was getting increasingly frustrated and got aggressive and ended up being restrained physically. Where there is a situation like this a person needs to be seen a lot more urgently.*
> (P73: female, friend)

A dual approach to assessing and treating physical and mental health problems was also advocated:

> *Stop waiting for medical clearance until mental health review. Why can’t they work together?*
> (P43: female, friend)

Many recommended the provision of quiet spaces within the ED, that are separate from the main ED:

> *Separate area where people in mental anguish can be separate from [people who present with] injury/alcohol and a maximum waiting time before they are seen by someone who is checking more than their bloods.*
> (P140: female, parent to an adult child)

> *Not to have to go through the general hospitals ED. Present at the psychiatric dept instead and have comfortable and safe waiting room.*
> (P96: female, friend)

There were also some recommendations for small changes to the existing ED environment that could make a difference:

> *Even something as simple as putting positive quotes on the wall in the waiting rooms, all you see is helpline numbers and emergency related information. A bit of colour, a friendly smile…*
> (P47: male, sibling)

The impact on patients of waiting long times while other patients triaged as a higher priority were seen first is eloquently portrayed by one participant:

> *A separate waiting area with trained and compassionate staff. With mental illness my brother looked at others in the waiting room and felt like he didn't matter as others were going in before him because he was seen as a low priority. This reinforced his feelings that he was useless, unwanted, unloved and had no place in this world. I understand patients with open wounds, heart attacks etc. are a higher priority but it does not help the person with mental illness.*
> (P61: female, sibling)

However, others recommended alternatives to the ED entirely for those who were presenting with mental health problems who did not require medical assessment and treatment:

> *I think people attending with suicidal thoughts would be best served by directly accessing the adult mental health building than taking up A&E time, particularly when they are already mental health patients.*
> (P207: female, parent to an adult child)

For some, this specialist mental health setting would offer a more holistic response:

A welcoming facility which is still a healthcare setting but has a holistic approach that is empathetic and safe. A place to have an intervention and get a break from themselves and allow the professionals to get a better idea of the best way forward in conjunction with the patient and their existing mental health team/GP/family/carers without being admitted to a ward.
(P92: female, professional carer)

A key point that was raised by many participants was the difficulty in persuading someone to stay and be assessed and treated in the ED and this is captured in the response below:

He was waiting so long to be seen that he walked out of the ED several times, and myself and another friend had to coax him back. He had a laceration on his head from the fall so we managed to convince him to come back so he could get that stitched up. In the meantime, we were trying to get the clinical staff to understand how bad the situation was and that he needed urgently to see a psych consult. He kept telling us that he was going to leave and finish the job.
(P73: female, friend)

Recognising this, participants had a number of recommendations including that staff, family members or peer support workers sit with the person:

If an unaccompanied patient, the assistance of a peer support worker would be of great benefit, especially out of hours.
(P96: female, friend)

Peer support workers in ED so that they could sit with the patient and keep them company while they wait the long periods for assessment or to relieve family doing the same.
(P106: female, extended family member)

One aspect that was commented on by a number of participants was the need to repeatedly tell their story to several different staff in the ED which was exhausting, frustrating and distressing. It was suggested that this would not happen in an environment alternative to the ED:

> *Explaining again and again at every step what is happening is difficult. It should be enough to say it's self-harm to the receptionist of A&E and then it should be noted in the file and not have to say this again until you see the end doctor. Having to repeat it to every single face you meet though the hospital is extremely upsetting.*
>
> (P56: female, partner)

9.6 Training of Staff

As reported earlier there were mixed responses from participants in relation to their interaction with healthcare staff in the ED. However, many participants called for healthcare professionals to have a greater knowledge and understanding of people who present with self-harm and suicidal behaviour and believed that staff training may help with this. Some participants spoke about training generally:

> *Psychiatric training for all medical professionals.*
>
> (P191: female, parent/guardian to a child under 18)

While others identified specific aspects of care that healthcare staff need to consider:

> *More caring doctors who at the very least seek consent. Building a slight rapport with patient before asking to see self-harm (first question, followed by an accusation that they were lying, it was shocking)…better training, maybe with input from family and service users.*
>
> (P56: female, partner)

> *Training, empathy, communication skills training, meeting with people with lived experience of this, feedback from anyone who has experienced this.*
>
> (P60: female, friend)

The need for compassionate care was also highlighted:

> *Compassion needed. No unhelpful questions like 'why did you think you needed to do this'. Stop judging people and treat as they are sick too.*
> (P153: female, parent/guardian to a child under 18)

> *Sensitivity guidelines for some staff wouldn't hurt. I know they are overworked and underappreciated a lot of the time but being kind makes a huge difference. Being treated like you as a patient are the cause/problem causing the attempts is unfair, judgemental and incorrect.*
> (P207: female, parent to an adult child)

A number of participants also identified the need for having mental health staff located within the Emergency Department:

> *Have trained mental health care worker the Emergency Department for both adults and children who can speak to and advise both patient and family alike.*
> (P153: female, parent/guardian to a child under 18)

9.7 Better Link up to Aftercare Services

The need for a better integrated mental health service was a recommendation that came from a number of participants. One aspect of this was improved communication about the patient's treatment between services involved in their care which could facilitate greater continuity of care:

> *Referrals made and care plans created at the hospital, shared to associate services and updated from them to the hospital system so that when repeat service users come in, there is a clearer picture.*
> (P191: female, parent/guardian to a child under 18)

Participants commented on the futile nature of providing an emergency response to the presentation in the ED without any follow-up care:

Follow up care is most important. No point in making a hasty trip to the emergency room only to walk out the door bandaged up but no follow up support or you're back there again in a few days, weeks etc …if you're lucky and not at the graveyard.
(P219: female, parent/guardian to a child under 18)

Although participants across the board spoke about the need for improved services, this was particularly prevalent from parents and others supporting a child/adolescent, and frequent mention was made of the need to improve access to and provision of Child and Adolescent Mental Health Services:

The mental health service for under 18s is shocking. Not much better for over 18 either but at least you are taken seriously.
(P75: female, parent/guardian to a child under 18)

The person should have an appointment the next day with a support service, in the case of a child, CAMHS. It shouldn't be a case of 'we'll send a referral letter' and then you wait three months to be seen.
(P157: female, parent/guardian to a child under 18)

The inconsistent provision of care to adolescents was also highlighted:

CAMHS are so overrun. They are brilliant but I realise that we were lucky to get a quick referral. I happen to work as an SNA[10] *in a school with at least 3 teenagers who have also been to the ED for self-harm. The supports they are being offered are so inconsistent. It is like a lottery as to how different teenagers are treated.*
(P167: female, parent/guardian to a child under 18)

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[10] Special Needs Assistant

9.8 Greater Recognition and Prioritisation of Mental Health

Responses here focused on the bigger picture in terms of the provision of mental health care. They suggested that if greater prioritisation was given to mental health, it would decrease the need for in-patient beds. A lack of funding for public mental health services was also noted:

I really wish our government would prioritise mental health. I feel we would have less people taking up beds in hospital if we had proper resources accessible and available to those who really needed it.
(P135: female, parent to an adult child)

Irish public mental health services are catastrophically under-resourced. The ED should not have to be a safety net for someone in a crisis but that's all we have.
(P79: female, friend)

Participants also suggested that there was a reliance on mental health charities to help bridge the deficits in service provision:

It is a national disgrace that the country of Ireland is relying on charities that are seriously overwhelmed to help support people who are struggling with their mental health.
(P21: female, sibling)

We had to reach out to Pieta House[11] *for resources because the internal referral to a HSE mental health team took so long to be acted upon.*
(P69: female, spouse)

A recurring theme from participants was the recognition that while there were many public awareness campaigns focused on the importance of asking for help when distressed, when people did seek this help, it was not there:

I can't understand how there is so much campaigning about mental health and 'ask for help' but yet every time we went to the hospital it was a waste of time.
(P53: female, partner)

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[11] A suicide and self-harm charity

> *I think it's appalling that our children are suffering, and they are not getting the help they need. The TV and Radio say to reach out, but there's no services available!*
>
> (P231: female, parent to an adult child)

> *It's all over the media. Talk and listen…but when you go for help you get shown the door.*
>
> (P228: male, extended family member)

A number of participants commented on the need for parity in the treatment of physical and mental health issues:

> *They should get the same treatment as someone who has an illness you can see…change in the way mental health is treated so it is like any other illness and not a taboo subject. Take the stigma away.*
>
> (P84: female, partner)

This resonates with findings from section 4.2 which reported that physical health needs were dealt with quickly and expertly in the ED while the same could not be said for mental health needs.

Section 10:
Advice for Others Accompanying Someone to the ED

10.1 Introduction

Participants were asked to identify what advice they would give to another person accompanying a patient to the ED following self-harm or suicidal behaviour. In total 179 responses were received to this question, again ranging from a few words to a large number of very long, detailed and considered responses. Responses here ranged from providing practical advice on managing the long wait time in the ED, to advice around the need to inform oneself on options available, and the need for advocacy and insistence in ensuring the person receives the care they require.

10.2 Advocacy and 'Speaking Up'

Advocacy was identified as important by participants – recognising that they are often the advocate for their family member/friend who may not be in a position to speak up for themselves:

Advocacy skills are important, often because the person is so ill, they can't do it for themselves and navigating the health system is tricky at the best of times. Mental health supports are not great, and it's often left to family/friends…family/carers have to be able to recognise what will and won't work for their loved one, know not to push something that they don't want to do and be supportive.
(P73: female, friend)

ADVOCATE. ADVOCATE. ADVOCATE. Don't be dismissed.
(P38: female, adult child)

Some participants reflected back on their experiences in the ED with regret about not having spoken up in support of their loved one at the time:

> *To be an advocate for your spouse. When the ED consultant shouted at my wife, I remained silent as I did not want to escalate the situation. But my wife was not in a position to advocate for herself. I wish I had of spoken up.*
> (P45: female, spouse)

> *Don't let the doctors or nurses brush you off. Stand your ground and demand to be listened to, I only wish I'd done that.*
> (P146: female, spouse)

Included within advocacy was the need to ask questions of the staff in the ED so that they were armed with the information they needed to support the patient:

> *Ask as many questions as you can to keep yourself informed about your loved one. Ask what other services are available.*
> (P91: female, adult child)

> *Ask questions and to be kept in the loop of future care plans.*
> (P177: female, partner)

A strong theme which emerged in these responses was the advice from participants for the accompanying person to speak up for the patient, to not leave until help was secured. Many identified how in their experience, the only way they secured help was to secure it themselves:

> *My son would probably be dead now if I hadn't researched psychology-based techniques and approaches. If I had no education or research skills, I don't know how we would have improved his mental health. Many parents are not fortunate enough to understand and operationalise support personally.*
> (P81: female, parent/guardian to a child under 18)

Many participants wrote about the need to 'fight'; fight to ensure the patient was seen and assessed, that they would be included in that assessment, and that appropriate treatment and follow-up was provided:

> *As I tell all parents, fight to be seen.*
> (P170: female, sibling)

Be prepared to fight for services, for any help at all. Don't expect any help without a massive struggle.
(P163: female, parent/guardian to a child under 18)

Speak up and fight harder, if you're not happy with who you see the first time, ask for someone else. Don't give up until you have got the help necessary.
(P64: female, partner)

For some, this persistence and 'fight' paid off:

Keep fighting for them, it'll take a few tries and numerous doors shut but they will get the help.
(P47: male, sibling)

For others, the persistence did not result in being listened to:

Do not take no for an answer if the hospital will not admit the patient. I begged and begged but they wouldn't listen to me.
(P94: female, spouse)

Participants also identified the need to ensure they, and the patient, were taken seriously:

Make sure your doctor is taking you seriously and you feel as though you and the person you're accompanying is being heard and listened to.
(P6: female, spouse)

Ask all questions and make sure you are happy with the answers. Don't let doctors gaslight you or brush it off as attention seeking.
(P82: female, parent/guardian to a child under 18)

Make sure the person is seen and not dismissed.
(P184: female, sibling)

10.3 Response to the Patient

Many participants provided advice on how the accompanying adult should interact and respond to the person they were accompanying. This included advice focusing on asking the person directly if they were experiencing suicidal thoughts and what not to say to someone who was in a suicidal crisis:

I would advise them not to avoid the elephant in the room and if they suspect someone is feeling low or having suicidal thoughts, to have the confidence to ask them outright if they are suicidal and to NOT remind them of the good things/people in their lives and the reasons they have to not feel this way.
(P92: female, professional carer)

Listening to the person without judgement was also advised by many participants:

Just listen without judging and let them know you support them.
(P114: female, parent to an adult child)

Don't blame or guilt trip your child. You wouldn't do that if they had any other life-threatening disease. It is literally a DISease that they are trying to overcome. Sometimes they run out of strength. Lend some of yours.
(P207: female, parent to an adult child)

Remaining calm was also identified as important:

Try not to panic and stress the patient more. Be as reassuring and loving as possible.
(P235: female, parent to an adult child)

Keep calm and hold the person's hand and tell them they are not being judged and that you love them.
(P135: female, parent to an adult child)

Participants also provided advice on how to cope in the days after presentation and how to help the person find alternatives to self-harm:

Let them have space, the days after they will most likely be very distant and reclusive. That's okay. It's easier for them to be around friends than family so respect that choice.
(P2: female, friend)

Encourage the young person to talk and be empathetic. Self-harm needs to be physically attended to but be very calm and accepting that until the child is ready to stop you can't make them. Look for safer ways i.e. use ice or marker pen.
(P213: female, parent/guardian to a child under 18)

10.4 Self-Care

Throughout the responses in this survey participants wrote about the personal impact on them of presenting to the ED with a loved one in suicidal crisis. In this section, many took the opportunity to advise on the need to 'mind yourself':

Mind your own mental health and be aware of the impact that being present during a crisis can have on you.
(P24: female, sibling)

At times I felt more distressed than my son so know how to calm yourself.
(P140: female, parent to an adult child)

Tell someone that you're going to the ED. Don't feel that you have to keep a secret as that draws you into an unhealthy situation whereby you are isolated. You're in the best position to help others when you are supported.
(P160: female, sibling)

Also included here was the advice to be aware of the extent of their own coping abilities and their ability to provide supports for the patient if they were to be discharged home:

Assess your own coping abilities to take the person back to the environment where they just tried to kill themselves only a few hours before. If you feel you can't cope, refuse to take the person home and stay at the hospital until the person has been admitted or has been properly assessed and some formal action taken to preserve their life.
(P158: female, parent/guardian to a child under 18)

Participants also wrote about the need not to feel guilty or to blame themselves for finding themselves in this difficult situation:

Not feel guilty that you are betraying your relative.
(P211: female, parent to an adult child)

Don't feel guilty about sectioning someone. It's better to section them than to bury them.
(P200: female, parent to an adult child)

It's not your fault, it's the systems fault. We can't do anything by ourselves to change the system, we have to come together and make change as a group.
(P21: female, sibling)

10.5 Practical Advice

A large proportion of responses focused entirely or in part on the provision of practical advice. Recognising the long wait times in the ED, this advice included having enough food and drinks for the long wait for themselves and for the patient and bringing items of comfort:

Bring snacks and comfort items, spare change and phone chargers. It's a long process.
(P74: female, cousin)

Be prepared to wait hours. Bring water or something for the patient to drink.
(P170: female, sibling)

Be prepared, coins for vending machines, bring things that comfort the person. Favourite hoodie, blanket, anything to help keep them calm.
(P140: female, parent to an adult child)

Recognising the often-chaotic ED environment and the impact upon a distressed person, there was also advice to try to source a quiet room for the patient to wait to be seen:

Insist on a private room as the young person will be in a very anxious state and unable to deal with being in a busy, noisy waiting area. Insist on being allowed back to this private room after triage and NEVER into a waiting area.
(P192: female, parent/guardian to a child under 18)

Participants also spoke about the need to source other sources of help outside the Emergency Department:

Get prepared as there is no help available in the hospital system so prepare yourself to do your own research and find voluntary organisations that can help.
(P102: female, friend)

10.6 Manage Expectations

Many participants wrote about the need to manage expectations. For some who had not received the help they hoped for their advice reflected this:

Be prepared to be sent home with nothing.
(P19: non-binary, friend)

Be prepared to leave feeling more hopeless than they did when they first went in. Be prepared to be discharged without help.
(P40: female, partner)

Have no great expectations…the system is not fit for purpose.
(P237: female, parent to an adult child)

There was a perception that even with assessment and treatment in the ED, there was still a difficult path to walk in the recovery of their loved one:

> *Don't really expect much resolution apart from lifesaving procedures. Attending an ED does not change the fact that your loved one is still suicidal so be prepared for that. Also, be prepared to leave the hospital with no answers and no follow up.*
>
> (221: female, parent to an adult child)

Others noted the often-slow pace of progress and advised people to be prepared for this:

> *Be patient and don't expect too much to change quickly.*
>
> (P137: female, social care worker)

> *It's not a quick fix. We presented three times before we got supported from CAMHS.*
>
> (P166: female, parent/guardian to a child under 18)

10.7 General Advice

Many participants wrote detailed responses covering several key points they felt the accompanying adult should know:

> *Know how to talk about suicide and self-harm – understand the nuances and intersectionality. Advocacy training – know your rights and their rights. Understand the options out there for mental health supports so you/they know what to ask for. Clear guidance on where to go and when. When the person is in a more level state write everything a doc/nurse would need to know and keep it in a folder ready to go – then even if you are blocked from going in the person will have information about their medical history, previous episodes etc. and don't have to worry about their inability to verbalise in the moment.*
>
> (P26: female, friend)

A number of participants took this opportunity to provide broader advice on how to support mental health for their loved one:

From an early age normalise talking about feelings, naming/identifying feelings for better mental health in youth.
(P155: female, parent to an adult child)

I would advise them not to avoid the elephant in the room and if they suspect someone is feeling low or having suicidal thoughts to have the confidence to ask them outright if they are suicidal.
(P92: female, professional carer)

Some participants noted the positive aspects of presenting to the ED which often centred on it being a safe place for the person:

It is a safe place.
(P71: female, parent/guardian to a child under 18)

Know that even if you feel you are not getting the help you need, you are in a safe space with your loved one.
(P72: female, parent/guardian to a child under 18)

However, many others advised seeking alternatives to the ED believing it was not the place where help was to be found. This was portrayed very simply by many participants saying ‘don’t go’ [to the ED], while others provided more detailed responses:

Avoid hospital at all costs as when help is not given it makes them feel worse. ED is not a place for any young person experiencing mental health issues.
(P107: female, parent/guardian to a child under 18)

Don’t expect help. They’ll cover the medical stuff but not the mental stuff.
(P43: female, friend)

Don’t go to the local hospital. Find out where mental health services are for your location.
(P209: female, friend)

Don’t. Just call Pieta. Unless the self-harming needs medical attention, otherwise it’s not a medical issue and will be treated as such in the ED.
(P60: female, friend)

Section 11: Final Points

Participants were given the opportunity at the end of the survey to make any additional points, and 104 responses were received here. Most of these responses were long and detailed, and focused on issues such the inappropriate environment of the ED and the long wait times, the lack of aftercare and the need for further training of staff. These points are included in this report under the appropriate headings. Some participants used this space to provide a summary comment on their experience in the ED:

The second nurse we saw was a mental health nurse and she was very nice, but ultimately the experience was awful for both me and my partner. We both left feeling that no one cared or wanted to help. We knew ED would be busy and distressing, thought a GP letter would help give context that we needed support, definitely not the case. 6hrs and much upset later partner was more suicidal than when we went in and there was no help, I'm glad I was there, if they'd gone alone I've no doubt they'd have attempted [suicide] that day after being told walking, meditating and breathing was the answer.
(P56: female, partner)

The services for adolescents are seriously deficient. I have my daughter (who is well and now 22) largely because I knew enough not to give in to pressure to leave the ED because there was no bed available. The deficiencies in the provision of adolescent beds is not the fault of the ED but the pressure I came under to free up a space was unacceptable.
(P208: female, parent/guardian to a child under 18)

Many other participants took the opportunity to provide an overall commentary on the provision of mental healthcare in Ireland with a call for more resources in terms of funding, specialised staff, and inpatient beds:

Serious lack of care, ambiguous guidelines for staff to follow, everything open to interpretation, need to involve family members to gain better understanding of individual's behaviour. Treated like a number and not a person.
(P111, female, sibling)

Mental health is grossly underfunded. My daughter needed hospitalisation on 2 occasions when under 18. The state could not provide a place for her in the

public system.
(P153: female, parent/guardian to a child under 18)

The services and care for people having mental health emergencies are far from adequate, and do not seem to be viewed as the emergency that they should be. Mental health is not seen as equal to physical health and there needs to be huge improvement in this, especially post pandemic where the needs of the population have increased greatly.
(P63: female, sibling)

This may seem like an incredibly negative submission, and it is all true. My friend was made out to be a liar of their own experience, because it's easy to say "they're a difficult patient" when they cause a fuss, rather than complaints being taken seriously. I have absolutely no hope in the mental health services in Ireland currently. We spend 40 times more on medications than talking therapies. I have no idea and panic inside when a friend feels they need to go to A&E. I have personally supported 4 family members/friends to A&E, and never was a family member taken seriously and given support. What are we meant to do?
(P19: non-binary, friend)

The system is broken for people with mental ill health - it was incredibly hard for my friend and she has a tight-knit support circle who also work in mental health and understand much of the system...I don't know how someone without a support network and/or a bit of insider knowledge could cope.
(P26: female, friend)

Finally, within this section a number of participants identified the benefits of taking part in this research and having their voices heard:

This research survey is highlighting a critical issue. Accompanying my sibling to the ED was a traumatic experience for me that will stay with me forever. I am so relieved to see action and exploration of this issue.
(P24, female, sibling)

I am really happy this research is being conducted. I hope it paves the way for some much needed developments in mental health in Ireland.
(P92: female, professional carer)

Section 12:
Summary of Key Findings, Recommendations and Conclusion

12.1 Summary of Key Findings

In total, 239 participants completed this survey and reported their experiences of accompanying someone to the ED with self-harm, suicidal-related ideation and suicide attempt. That the vast majority of participants were female (88%), despite concerted efforts to target males during recruitment, is of note and is perhaps somewhat reflective of the additional caregiving role of females. As there are no data recorded on who accompanies a patient to the ED when they present with self-harm, suicidal-related ideation and suicide attempt it is not possible to say whether our survey is reflective of the national picture. Parents, both to children under 18 and to adult children, constitute a significant cohort of this sample (43%) and their experiences and concerns are prominent in the findings of this survey. The majority of participants (54%) presented to the ED with someone in the preceding 3 years reflecting relatively recent experiences. Attempted suicide accounted for 56% of presentations, followed by suicidal thoughts (52%) and self-harm (38%) representing a spread across the suicidality continuum.

It was a promising finding that over two-thirds of participants (68%) reported that the person they accompanied received an assessment from a mental health clinician while in the ED. This closely mirrors the most recent findings of the National Self-Harm Registry which report that 66% of people who presented to the ED in Ireland in 2022/2023 received an assessment from a mental health clinician in the ED (Joyce et al 2025). In our study however, over one-quarter reported that the person did not receive a mental health assessment as they were not offered one or the person left without being seen. This remains an important area to target as a thorough biopsychosocial assessment is a key component of the National Clinical Programme for Self-Harm and Suicide-Related Ideation (NCPSHI), and an important opportunity for suicide prevention. Another important component of the NCPSHI is the inclusion of a family member/supportive friend in the assessment and management of the presenting patient. In this study, just over half of the participants (52%) reported that they were included in the assessment of the person they were accompanying, with 44% reporting that permission was sought from the patient for their inclusion. The majority of those included in the assessment reported that the environment in which the assessment took place allowed for privacy (67%). Finally, the provision of an emergency safety plan is also a recommendation of the NCPSHI and in this study the vast majority of participants (72%) reported that no safety plan was developed with/for the patient. This was a recommendation for improvement from participants who reported the need for some instruction both for the patient and the accompanying adult on how to navigate the days following ED presentation particularly while waiting for referral to other services.

When it came to the issue of treatment provision to the patient in the ED the experiences and perceptions of participants were generally negative. Over half of the participants reported that they did not believe that staff had the required confidence and skills to care for the person’s mental health presentation, with many providing examples of negative attitudes and poor understanding of self-harm and suicidal behaviour. While there was a recognition of the busyness of staff and the high level of activity, the noisy and crowded environment and long wait times to be seen by a mental health professional were identified as having a negative impact on the patient in distress. The inappropriateness of the environment for adolescents in particular was identified by parents/guardians and other family members of those adolescents who tried, sometimes in vain, to convince the person to stay for assessment and treatment. Participants expressed frustration and despair at what they perceived to be a lack of appropriate mental health treatment within the ED. Almost one-quarter of participants reported that the patient received no referral to other services and when referrals were made, they were often circuitous and with a long lead-in time. It is important to document that positive experiences were also identified by some participants and where these occurred, they focused around expertly delivered physical care, compassionate and empathetic interpersonal interactions, and being listened to and taken seriously.

Most participants reported that they did not receive any information on suicide prevention (72%) or information on how to support the person following discharge from the ED (71%). Where information was provided it was predominately verbal information with a small proportion also reporting that they received information leaflets. When asked what information should have been provided to them, responses detailed the need for information on signs to look out for which would suggest deterioration of the person's mental health, specific detail on what to do and who to contact if this arose, and the provision of information on support services for family members to help them cope with the impact of caring for someone in suicidal crisis. Both the practical and emotional impact of this caring role was clearly identified by participants who reported heightened anxiety, fear, hypervigilance, distress and frustration. Sadly, a number of participants detailed the impact of the subsequent completed suicide of the person they accompanied to the ED and reported that this traumatic experience was compounded by the perception that the loss of their loved one may have been prevented if appropriate service provision was in place.

Participants provided in-depth responses on what could be done to improve the care in the ED for the patient and the person accompanying them. Improved assessments, more patient-centred care, inclusion of supporting adults in assessment and patient management and the provision of relevant information to accompanying adults were identified across many responses. Participants also identified the need for improved staff training, a more conducive environment for people in acute mental distress and better link-in and referral to aftercare services. The key advice participants proffered to others in the same position focused on vocal patient advocacy, 'fighting' for service provision and managing expectations around that service provision, and importantly ensuring that self-care was also prioritised.

12.2 Recommendations

Based on the findings of this report, and building on recommendations identified in our previous report (Doyle et al., 2020), a number of key recommendations can be made relating to service delivery, practice and research.

12.2.1 Recommendations for services

- Continued implementation of the NCPSHI programme in all hospitals nationally and extension of the hours of its delivery.

- Increase the range of unscheduled and crisis mental health services in the community for those presenting with self-harm, suicide-related ideation and suicide attempt, who do not require medical intervention in the ED or following this intervention in the ED. Increase the capacity of Community Mental Health Teams to respond to urgent referrals of new and existing patients.

- In line with Ireland's Mental Health Policy 'Sharing the Vision' support and invest in primary care to provide an increasing role in the provision of accessible mental health supports. This should include increased access to a Suicide Crisis Assessment Nurse in line with recommendations of the NCPSHI.

- Improve collaboration and communication between the ED, primary care, secondary and specialised mental health services, including Child and Adolescent Mental Health Services.

- In light of evidence of inappropriate and prolonged placement of children and adolescents in adult Emergency Departments, there is a requirement for timely CAMHS referrals and a prioritisation of services available to children and adolescents presenting to Emergency Departments.

12.2.2 Recommendations for practice

- Continued and mandatory implementation of and adherence to the principles of the NCPSHI which aims to develop a standardised and effective process for the assessment and management of individuals of all ages who present to ED. In relation to assessments, the following recommendations are made:
    - All people who attend the ED with self-harm, suicide-related ideation or suicide attempt should receive a mental health assessment.
    - Family members/supportive others should be included in the assessment.
    - A coproduced emergency safety plan should be developed and includes a family member/supportive other where possible and details how to provide a safe environment for the person, who to contact in an emergency and details of the next professional contact.

- Timely follow-up and referral following attendance and discharge from the Emergency Department should be prioritised.

- In light of the finding that most participants did not receive information on suicide prevention or information on how to support the patient:
    - Mandatory provision of clear, instructive information provided to accompanying adults which provides guidance on signs to look out for, guidance on how to support the person, and contact numbers for who to contact if the person’s mental health deteriorates.
    - Clear information provided on the next steps of care for the presenting patient.
    - This information should be provided both verbally and in written format.

- Continued and mandatory training of ED staff on mental health, suicide awareness and engaging empathetically and compassionately, even in brief interventions, with distressed service users and their families.
- Clear communication from staff in the ED as to their role when engaging with the patient and accompanying adult.
- In keeping with national and international recommendations, there should be parallel assessment of medical and psychiatric need.

12.2.3 Recommendations for research

- Considering the specific circumstances and needs identified by parents of children and adolescents who presented to the ED it is recommended that an in-depth qualitative study of parents' experiences and needs be conducted.
- The experiences, training needs and support needs of non-mental health staff working in the ED should be elicited to understand how best to support them in their role when working with people who present with self-harm, suicide-related ideation and suicide attempts.
- As practitioners in primary care have an important role to play in referring patients to the ED and supporting patients after their ED presentation, their experiences of this process, and their perceptions of how these processes can be improved should be elicited.
- Considering the call for urgent mental health care to be delivered outside of the ED setting, a study of the views of multiple key stakeholders on alternatives to the ED, including a review and analysis of emerging trends worldwide should be conducted.

12.3 Limitations

The results of this study need to be interpreted in light of the following limitations:

- As this was a volunteer sample, there is a potential for response bias where those who have had a very negative or very positive experience are more likely to come forward.
- Despite a concerted effort to increase male participation, there was an over-representation of female participants in the study (88%).

12.4 Conclusion

The Emergency Department remains the first port of call for many people with self-harm, suicide-related ideation and suicide attempt, and the family member or other adult who accompanies the patient to the ED has a crucial role to play in supporting the person during this critical period. The results of this survey and in particular the depth of qualitative responses received highlight significant issues in how family members, friends and carers are themselves supported to in turn support their loved one. These findings build on those from our previous study focusing specifically on the experiences of service users, with many similar themes identified. Common to both studies were the perception of the ED as an inappropriate environment for a person in suicidal crisis with long wait times exacerbating mental distress, negative experiences of interpersonal interactions with ED staff, and a lack of accessible and timely follow-on care. Findings specific to this study highlighted a significant gap in the information provided to accompanying adults on how best to support the patient on discharge from the ED, leaving them feeling insecure and uncertain about their ability to support the person. In turn, the negative impact this takes on the family member/accompanying adult and wider family unit was clearly identified, reinforcing the importance of supporting them, so that they can, in turn, support the presenting patient. Positive aspects of care and support are also identified in this study, and they are important to highlight as they demonstrate that despite the general inappropriateness of the ED environment, pockets of expert care can still be delivered to the patient presenting following self-harm, suicide-related ideation and suicide attempt, and their family member. Capturing and disseminating these findings will offer the potential to directly influence both policy and practice in the response to people, and their families, who present to the ED following self-harm, suicide-related ideation and suicide attempt.

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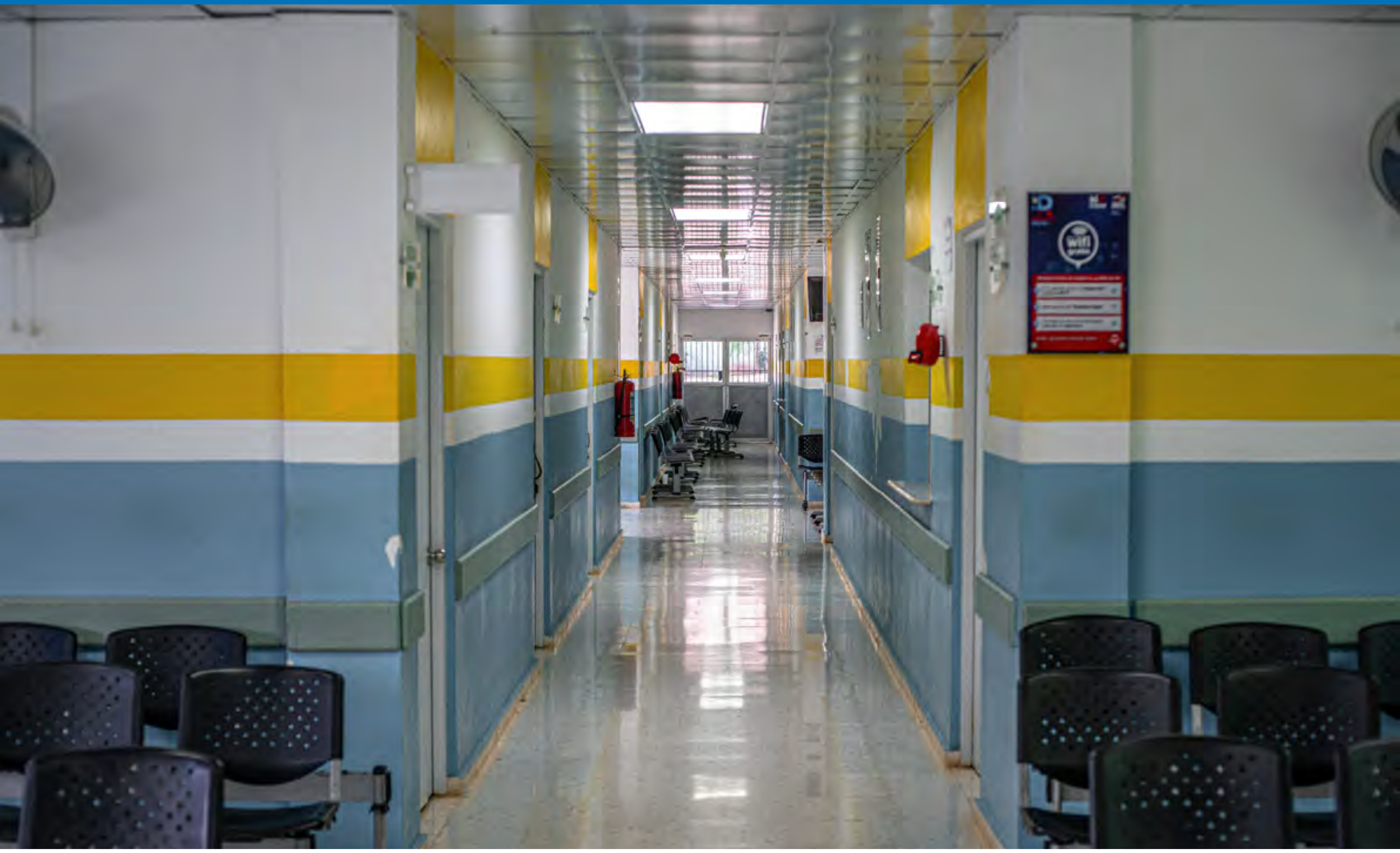

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