

**Evaluation of the
operation and effectiveness of the
“Card Before You Leave” scheme
in the context of other suicide
prevention initiatives within
Northern Ireland**

April 2013

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Executive Summary

The 'Card Before You Leave' (CBYL) scheme, was officially launched in Northern Ireland (NI) in January 2010 by the then Health Minister, Michael McGimpsey. The scheme provides a next day mental health follow-up service for patients who attend an Emergency Department (ED) with self harm or thoughts of suicide and who have been identified as low risk to themselves or others. The scheme aims to ensure that any patient being discharged from the ED receives a card prior to discharge, giving details of contact numbers for support and details of their follow-up care. It was envisioned that the scheme would help to reduce suicide rates and repeat episodes of self-harm which are key objectives of 'Protect Life', the NI strategy for Suicide Prevention.

The remit of this evaluation was to examine the operation and effectiveness of the "Card Before You Leave" scheme, in the context of other suicide prevention initiatives within NI. The evaluation addressed issues of concern identified previously i.e. non-attendance at next day appointments and reports of inconsistencies in the application of the CBYL scheme in various Trusts. The evaluation did not focus on discharge from acute psychiatric in-patient care as the seven day follow-up standard applies there, and compliance rates in NI are at world class levels (patients assessed as requiring more urgent follow-up receive it as part of their discharge plan).

The evaluation was undertaken in four separate stages:

- i) a literature review;
- ii) site visits to EDs to examine the scheme in practice;
- iii) analysis of data and information specific to the CBYL scheme; and
- iv) exploration of evidence of best practice from both a local and international perspective.

Several key themes emerged:

- ✚ There is strong evidence of commitment by staff at all levels to the CBYL scheme and a standardised approach to its implementation across ED's visited.
- ✚ There are no major inconsistencies highlighted in any of the processes or protocols between locations, however there are residual implementation issues with Child and Adolescent Mental Health services in one particular Trust.
- ✚ There is a general consensus in the literature that the scheme may have a positive impact on reducing further incidences of suicidal ideation, especially when used in conjunction with other suicide prevention initiatives such as assertive outreach, 24 hour crisis centres and multidisciplinary collaboration both within the Health service and with voluntary sector and community organisations.
- ✚ The data reveals that a very high proportion of those patients who present to the ED with suicidal ideation/self harm receive an assessment by the mental health team before leaving the hospital.

The data reveals that:

- ✚ 41.9% receive an immediate assessment by secondary care mental health services prior to discharge from the ED;
- ✚ 41.3% are admitted for observation and mental health assessment the next day;
- ✚ 16.5% are considered well enough to go home that night (CBYL patients) and are provided with a card and a next day appointment, or the promise of a next day phone call if a next day appointment is not acceptable to the patient;
- ✚ 0.3% refuse referral to the CBYL scheme or any other kind of follow up.

The scheme provides an important gateway into services for those who engage with next day follow-up appointments, with almost half of patients who attend receiving further follow-up by the mental health service. Non-attendance at next day appointments remains an issue that requires attention and recommendations are made to address this issue.

There are continuing issues about data coding and future data collection. This will remain a focus for the Health and Social Care Board and will be achieved through standardising the CBYL data collection and streamlining it with the data collected by the Self Harm Registry.

For some patients, consideration should be given to making mental health assessments available in an alternative location to the ED. This would have the dual impact of improving the environment for

carrying out the assessment process and reducing unnecessary pressure on the ED. Ensuring that patients are seen and assessed in the most appropriate environment should be a focus for future development of services and this may involve a more significant role for the voluntary and community sector. Any future redesign should incorporate due consideration to the findings highlighted by Evan Bates in his review of the Belfast Trust. Bates' 2008 report on the patterns and trends in the use of hospital services in Northern Ireland 1998 -2007 which demonstrated how those residing in deprived areas disproportionately access health care through the ED compared to access through GP services in more affluent areas.

The refreshed Protect Life Strategy and Action Plan recognises that the issue of alcohol and drug misuse is a factor associated with self harm and suicide. This issue needs to be addressed at a wider societal level with the involvement of a range of stakeholders. The DHSSPSNI document "A New Strategic Direction for Alcohol and Drugs" January 2011 highlights the importance of a competent and skilled workforce across all sectors that can respond to the complexities of alcohol and drug misuse. Early identification of alcohol and drug issues by staff coupled with improved care pathways between acute medical services and specialist substance misuse services could deliver better outcomes and potentially reduce re-attendance with self harm associated with alcohol/drug abuse. Joint working between those delivering drug and alcohol services and those working on suicide and self-harm already exists and building on this should help to further improve outcomes for those attending services.

In conclusion, the scheme appears to be effective for some patients, namely those that choose to attend the next day appointment and subsequent mental health care, if needed. The challenge lies in engaging more of these patients to attend next day appointments and also ensuring that appropriate assessment and support services are in place for those presenting to ED with alcohol and /or drug problems.

The following recommendations are made to enable further service improvements specific to the CBYL scheme and to the complete patient journey.

Recommendation One: The scheme should continue to be refined in light of emerging evidence within Trusts about effective methods of engagement (examples are given within this report on how to improve engagement and uptake). The HSC Board and PHA should seek to further refine data collection and rationalise this in light of the advent of the Self Harm Registry.

Recommendation Two: All Trusts should be asked to explore proposals for improving access to quiet room space within their EDs in line with NICE guideline (CG16) recommendations, particularly aimed at patients who would benefit from such facilities.

Recommendation Three: The HSC Board should begin to routinely monitor data on mental health service teams'

response times to patients referred from ED and should explore how to improve response times in this area so that all patients waiting in the ED for assessment are seen by mental health services as soon as possible.

Recommendation Four: In line with NICE guidance, the HSC Board and PHA should explore, in partnership with Trusts and the Ambulance Service, the need for a separate location for assessment of patients who require mental state assessment only i.e. for people who have no immediate physical health needs and thus no reason to be in an ED.

Recommendation Five: The HSC Board and PHA should explore the possible development of an appropriate community-based crisis centre to meet the needs of people presenting with suicidal thoughts or thoughts of self harm where such people do not require treatment in an ED.

Recommendation Six: All Trusts should ensure that patients do not return to the ED for their 'next-day' appointment but are advised of an alternative, appropriate venue.

Recommendation Seven: In line with NICE guidance, Trusts should implement regular joint ED/Mental Health team service planning meetings to improve collaborative working and the management of patients who are repeat attenders and/or people who are difficult to engage with follow-up services.

Recommendation Eight: An assertive outreach approach should be used to encourage engagement with services for patients who fail to engage and where it is believed there is a higher level of risk. In common with other aspects of service provision, flexible working arrangements for staff, for example, evening and weekend hours, should be introduced as part of this approach.

Recommendation Nine: Trusts should give a duplicate appointment card to any person attending with the patient. Patients and carers should also be provided with appropriate written information regarding self harm and crisis support. Consideration should also be given to implementing the measures outlined in Appendix One.

Recommendation Ten: In line with the DHSSPSNI consultation document “Strategic direction for alcohol and drugs in Northern Ireland 2011-2016”, Trusts should endeavour to develop a competent and skilled workforce across all sectors that can respond to the complexities of alcohol and drug misuse. Trusts should explore improving care pathways between acute medical services and specialist alcohol and drug services in the community.

Recommendation Eleven: In line with the Protect Life Strategy and NICE guidance, Trusts should make suicide prevention & self harm awareness training a priority for all staff who have contact with self harm patients. Trusts should consider exploring the potential of training some ED Nurses in solution

focused brief therapy (SBFT) as a means of improving the response to patients.

Recommendation Twelve: The HSC Board should stand down the CBYL Implementation Group and ensure continuity by asking the PHA/HSC Board Self Harm Working Group to oversee implementation of these recommendations. This group should be the recognised advisory forum to the HSC Board and PHA for collective decision making and action with regard to the assessment and management of self-harm.

1.0 Introduction and Context

1.1 The Card Before You Leave (CBYL) scheme was launched by the then Health Minister, Michael McGimpsey, on Wednesday, 13 January 2010. The idea for the scheme had come from a small group of parents and relatives, part of the Belfast Mental Health Rights Group (BMHRG)¹, who had lost a loved one to suicide and who were working with community and voluntary sector organisations. They conducted their own research and concluded that there was an important gap in service provision which they believed the CBYL scheme could address.

1.2 The scheme was intended for patients who presented no immediate risk to themselves or others and aimed to ensure that any patient being discharged from an in-patient acute psychiatric unit or an Emergency Department (often referred to as A&E or ED), who might require assessment or future care from a mental health team, would receive a card prior to discharge, giving details of contact numbers for support, and details of their follow-up care including, where agreed, a next day appointment.

1.3 The scheme was consistent with the broader aims of 'Protect Life', Suicide Prevention Strategy, launched in October 2006 and involving around £11.2 million to support its implementation. Amongst other things, Protect Life has led to the introduction of the Lifeline telephone help-line, the establishment of the Self Harm Registry (which is now being fully implemented regionally), introduction of media guidelines, the roll out of a range of

¹ <http://www.pprproject.org>

community gatekeeper training courses across the region, Depression Awareness training for all GPs in Northern Ireland, public awareness campaigns, community support packages and the commissioning of research into suicide and self harm in Northern Ireland. The scheme was also listed in the recommendations of the 2008 Report on the Inquiry into the Prevention of Suicide and Self Harm by the NI Assembly Health, Social Services and Public Safety.²

1.4 As the CBYL scheme evolved, Belfast Mental Health Rights Group, service users and carer representatives on the implementation group lobbied for a 'fixed' next day appointment for ED referrals as opposed to contact within 24 hours and this was agreed by all five Trusts and put in place in late 2011. This evaluation has been delayed in order to allow this development to become embedded and to allow for data collection performance to be improved.

1.5 It is intended that the recommendations will be presented to relevant bodies for implementation from early 2013 onwards.

1.6 There are four main elements to this evaluation and these are set out in the ensuing sections: - relevant literature from around the world, data collected from Trusts on the operation of the scheme, themes emerging from site visits carried out by members of the implementation group and finally, other relevant evidence submitted to the regional implementation group.

² http://archive.niassembly.gov.uk/health/2007mandate/reports/report27_07_08r.htm#summary

1.7 A number of appendices are provided (including a full list of the membership of the implementation group) as well as a bibliography of relevant references considered within the review of relevant literature.

2.0 Review of research and other literature relevant to the evaluation of the ‘Card Before You Leave’ scheme

Purpose

2.1 The purpose of this review of relevant literature is to provide a strong evidence base for the examination of the effectiveness of the CBYL scheme to date for the cohort of patients that it was intended for. It is not intended to be an exhaustive and fully comprehensive review and it is acknowledged that the evidence base in this area is constantly changing and improving.

Deliberate Self Harm

2.2 The National Institute for Clinical and Social Care Excellence (NICE) has issued two sets of guidance documents relating to the care of patients who self harm. These documents make a number of recommendations regarding both the acute and ongoing care of people who self harm. Data from the CBYL evaluation suggests that Northern Ireland (NI) is successful in providing specialist mental health assessments to a high proportion of people who self harm and is in line with NICE targets.

2.3 Approximately one in five people who attend an emergency department following self-harm will harm themselves again in the following year (Bergen et al., 2010a, UK) and a smaller percentage of this cohort will repeatedly self harm. It has been further

evidenced that following an act of self-harm, the rate of suicide within that population increases to between 50 and 100 times the rate of suicide in the general population (Hawton et al., 2003b, UK; Owens et al., 2002, UK).

2.4 The Royal College of Psychiatrists (1994) assert that an act of self-harm is probably the most powerful single predictor of subsequent suicide.

2.5 A significant concern is the evidence that one in six people who attend an emergency department following self-harm will self-harm again in the following year (Owens et al., 2002). The frequency of repeated self-harmers means that they are over-represented among those who present at an emergency department or receive psychiatric care.

2.6 There is no good evidence to support the anecdotal theory that people who harm themselves repeatedly, particularly by cutting, are less likely to die by suicide than those who harm themselves in other ways. Indeed one hospital-based study suggested that self-cutting may actually increase suicide risk (Cooper et al., 2005). However, a major difficulty is the current lack of long-term research looking at the effectiveness of intervention schemes for this particular group of patients.

2.7 Repetition of self-harm may occur quickly with up to one in ten repeat episodes occurring within 5 days of the index attempt (Kapur et al., 2005). This is a point reinforced by Dr Thomas Joiner whose theory indicates that some of the people who present at

Emergency Departments and who are initially considered 'low risk' are in fact becoming familiar with pain, overcoming the fear and making eventual death by suicide more likely. This lends great weight to providing the opportunity for all patients to have a specialist mental health assessment via the implementation of the CBYL scheme in Northern Ireland. This presents an opportunity to intervene and hopefully prevent the pattern of further or repeated self injury that according to Joiner (2005), may lead to acquiring the ability to kill oneself.

2.8 A review by Gunnell & Frankel (1994) concluded that there is no single easily identifiable group upon whom there could be focused intervention as a means of reducing the suicide rate. The one exception is the population of people who have harmed themselves already. Therefore the potential to target care as a mechanism for preventing further repeated attempts of self harm or suicide (for example, in a CBYL scheme) is supported within the evidence reviewed.

Non compliance with appointments

2.9 Australia operates a similar scheme to CBYL which is known as the “Green Card”. This scheme is aimed at patients who have presented to the ED with Deliberate Self Harm (DSH) who do not need to be admitted and similar to Northern Ireland the patient receives a card for a fixed next day appointment once they have been assessed by the ED staff and have received the necessary medical treatment. H.G Morgan, E.M Jones and J. H. Owen (1993), in a study of one such “green card” scheme found that the actual opportunity to make contact with care professionals resulted in a positive reduction in the incidence of self harm in the patients observed. They argued that the availability of the service can itself be very effective, even though patients may not need to access it at that current point. In our local context, this suggests that availability of a card and related contact information may have a positive effect in ensuring patient access to services in the future.

2.10 From its implementation in Northern Ireland, ‘did not attend’ (DNA) rates for CBYL were relatively high for fixed next day appointments. Some patients were contacted by telephone and persuaded to attend. Others could not be contacted or persuaded to attend. While this information was relayed to their General Practitioners for follow up and possible re-referral to Mental Health Services if necessary, the consequence was and is that professional assessment time was being diverted from other parts of the service to appointments which were not being kept by

significant numbers of patients referred. It should be noted that higher than average DNA rates are indicative of a broader trend within mental health services and are not confined to CBYL. Those with mental illness can be hard to engage with due to the vulnerable nature of their illness.

2.11 This problem is not exclusive to Northern Ireland and evaluations of schemes in England and internationally have observed similarly high DNA rates. The challenge is in providing methods of intervention that are effective and accepted by the patient.

2.12 Similar problems relating to DNAs have been observed in Australia during initial implementation but given the longer time frame in which the Green Card has been in operation there, some valuable best practice lessons can be gained from investigating service improvement developments.

2.13 In St Vincent's Hospital, Sydney, New South Wales, Australia, staff have been proactively attempting to tackle the problem of DNA rates by holding a weekly multidisciplinary 'engagement' meeting. This has enabled a more proactive approach to frequent deliberate self-harm presenters.

2.14 St Vincent's has also attributed higher attendance rates to arranging an appointment as soon as possible after the DSH attempts and assertive follow-up when necessary.

2.15 It was found that one of the commonest reasons for DNA is that the person had no recollection of the events (or of the follow-up appointments). This was also the reason cited in a study of a follow up clinic by Gudjonsson et al (2004) as the biggest reason for non attendance. They now recommend that, where possible, the details for the 'Green Card' are given to another responsible adult where possible (even if the person appears to be alert), that they are informed that a phone call will be made to the home or a home visit arranged in the event of a DNA. They also organised the clinic times to allow the person to sleep in, or made the appointment for the following day (i.e. 48 hours); if it was clear that they were likely to be asleep for most of the next day.

2.16 The literature also suggests that failure to attend follow-up appointments has also been attributed to disinterest or negative attitudes displayed by staff in EDs; a conscious desire by the patient to forget about the attempt and the precipitating circumstances; the effects of alcohol or other substances consumed; lack of sleep; inadequate instructions being given at the time; and lags between assessment and appointment. An empathetic and compassionate response from staff is critical in these situations and may be a factor in whether the service user engages with further services offered. This highlights the importance of training for all ED staff carrying out assessments as recommended by NICE.

2.17 In a 2007 article ("Why don't patients attend their appointments? Maintaining engagement with psychiatric services") Mitchell and Selmes propose various methods on how to better

engage with the patient to improve compliance with appointments. In the interests of brevity these are detailed in Appendix 1.

2.18 One method is to proactively outreach to those who fall within cohorts that are more likely to not attend. While few studies have examined the predictors of non-attendance systematically in mental health settings (Chen, 1991) some groups have been identified. Predictors can be divided into environmental and demographic factors, patient factors, illness factors and clinician factors. These are detailed in Appendix 2.

2.19 Alcohol and drug misuse has been repeatedly attributed as one of the reasons for the high DNA rates within the CBYL scheme. Misuse of alcohol and/or drugs is also known to be related to suicide. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (Appleby et al, 2008) found that the majority of suicide cases investigated involved alcohol misuse (58%), drug misuse (39%) or misuse of both (29%).

2.20 In relation to those patients presenting at the ED, the possibility of misuse or addiction to either substance should be explored and addressed. Staff often need to admit patients who are heavily intoxicated following an act of self harm because of their inability to undertake a comprehensive mental health assessment while the patient is intoxicated. In many of these cases the patient does not require urgent medical care but is admitted until mental health assessment can be carried out. Paradoxically, patients that are already in receipt of addiction services in relation to drugs and/ or alcohol may in the short term

be at an even higher risk of self harm, due to the psychological withdrawal of the drug. These issues are acknowledged in clinical guidelines (Department of Health (England) and the devolved administrations, 2007; National Collaborating Centre for Mental Health, 2007b).

2.21 A minority of patients find engagement with hospital-based services difficult or impossible. Recently, within Great Britain, dedicated assertive outreach teams have been set up with the aim of engaging with such patients, improving compliance and reducing hospital admission. There is evidence that this approach is accompanied by a significant improvement in patient engagement (Wharne, 2005). The principles of assertive outreach can equally be applied in routine settings, for other types of patient and by core teams. This approach may be helpful for some self-harm patients who find it difficult to engage with services.

Other interventions to complement CBYL

2.22 The National Confidential Inquiry, referred to above, compared the rates of suicide in NHS Mental Health Trusts before and after its central recommendations were adopted. They also compared suicide rates in Trusts that adopted few of the recommendations with those that adopted many.

2.23 It was found that the recommendations that produced the biggest drop in the incidence of suicide when implemented concerned:

- ✚ the introduction of 24-hour crisis teams
- ✚ implementation of multi-disciplinary reviews following a suicide
- ✚ good assessment policies for drug and alcohol misuse.

The first two of these are standard practice in NI but there is room for improvement in relation to alcohol and drug misuse assessment and follow-up services.

2.24 There is an opportunity to improve pathways involving direct referrals from GPs to mental health services, rather than via the ED, for patients who have self-harmed or who have thoughts of suicide but who do not require urgent medical care in the ED.

Summary

2.25 This examination of the available literature would suggest that CBYL scheme has the potential to assist in the reduction of repeated self-harm with this particular cohort of patients. However it should be stressed that any such service should co -exist with other forms of intervention to fully optimise the care pathway for patients and to assist in the reduction of repeated suicide attempts.

2.26 Other measures such as multidisciplinary ED reviews, assertive outreach and effective drug and alcohol policies on a wider social scale are all factors that should be considered within a holistic approach to addressing the incidence of repeated self harm/suicidal ideation related behaviour.

3.0 Card Before You Leave (CBYL) Data

The data displayed on the next few pages has been collated by the Performance Management and Service Improvement Directorate (PMSID) for the period April 2011 to May 2012. This data is presented for the purposes of this evaluation to take in the regional context. As with any data collection, there is a process of continuous refinement and improvement and there are continuing issues in relation to coding, collection discrepancies and data cleansing. In so far as is currently possible the data presented below has been thoroughly checked to ensure accuracy within the limitations outlined.

- Figure 1 shows that 42% of those attending EDs with self harm/suicidal ideation were referred for urgent psychiatric assessment because of the high risk posed. The Trusts aspire to provide such assessments within two hours of the referral being made by ED staff so that no-one should have to wait more than six hours in total with the majority of patients seen more quickly.
- Figure 1 also shows that a similar proportion (41%) are admitted for medical observation with follow up assessments carried out the next day. These patients often pose a lower order of risk but are not deemed suitable for discharge from the ED because of the need for medical intervention or to

wait for the effects of drugs and/or alcohol to wear off prior to psychiatric assessment.

- The remaining group (16%) of patients shown in Figure 1 are believed to be of low risk to themselves and others, and are offered a CBYL appointment for next day follow-up. A very small percentage of patients will refuse any form of follow up in the ED³. Some may leave the ED before a decision can be made and, in such instances, decisions are made on a case by case basis whether such individuals require immediate follow up.
- Figure 2 shows that CBYL patients represent around 16% of the total numbers of people who present to the ED with self harm or suicidal thoughts and that this proportion has been fairly steady over the monitoring period.
- Figure 3 highlights the numbers of patients who decline the CBYL service or who could not be contacted the next day. Any patient who cannot be contacted in these circumstances is notified to their GP where possible but this issue highlights the difficulties in engaging with some people in these circumstances and mitigating measures are discussed later in this report.

³ At initial presentation to the Emergency Department most patients accept a card/appointment. A small minority will refuse any form of contact. Note that this is a separate issue to the patients who decline a follow up appointment following a phone call for the next day appointment or further appointments following assessment with a mental health professional.

- Of those who required CBYL, almost everyone was offered an appointment within 24 hours. Figure 4 reveals that approximately half of those patients who are referred for CBYL require further mental health care follow up, suggesting that the CBYL 'gateway' is an important entrance point for potential service users and may help in reducing further episodes of self harm.
- Since the launch of the CBYL service, there have been concerns about the numbers of patients who DNA their appointments. Figure 5 shows that there has been little change during the course of this monitoring period and this continues to be an issue that requires attention. It should also be reiterated that DNA rates for Mental Health appointments will typically be higher than non mental health outpatients due to the nature of the illness.
- Figure 5 also shows the proportion of patients who cancel their appointment (CNAs). In these cases the appointment is rescheduled and a more suitable time offered. While the data fluctuates, it suggests that CNA rates have improved and the appointment times offered may now be more acceptable to the patient.

**Figure 1: CBYL Regional Assessment Outcomes
April 1st 2011 – May 31st 2012**

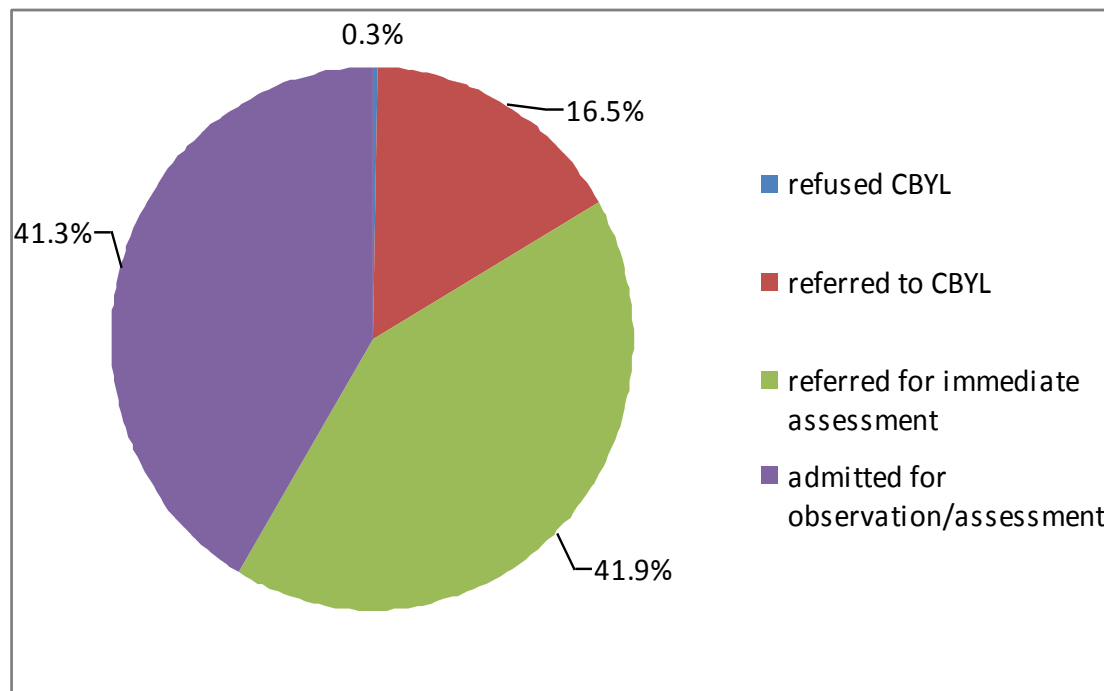
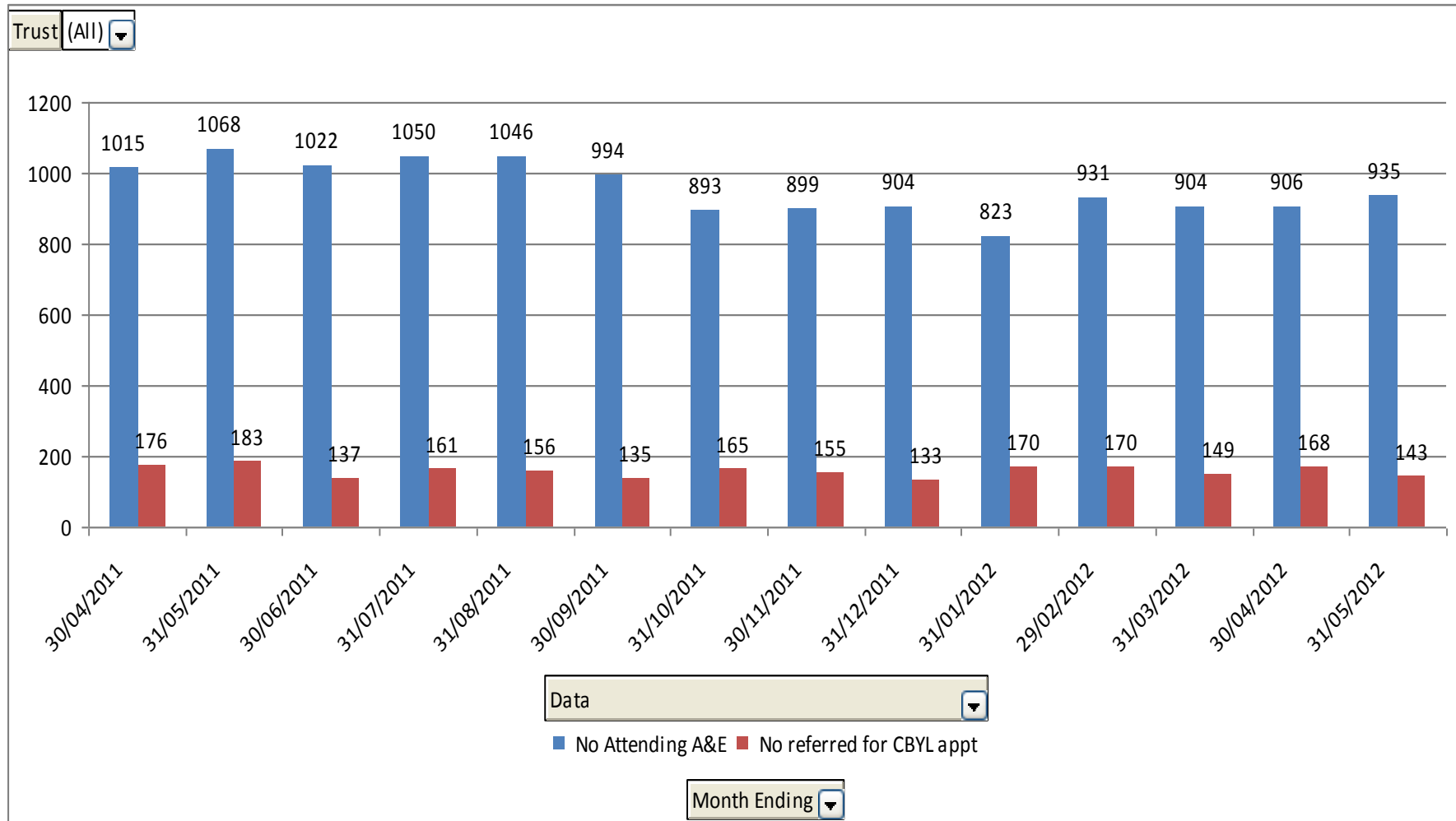
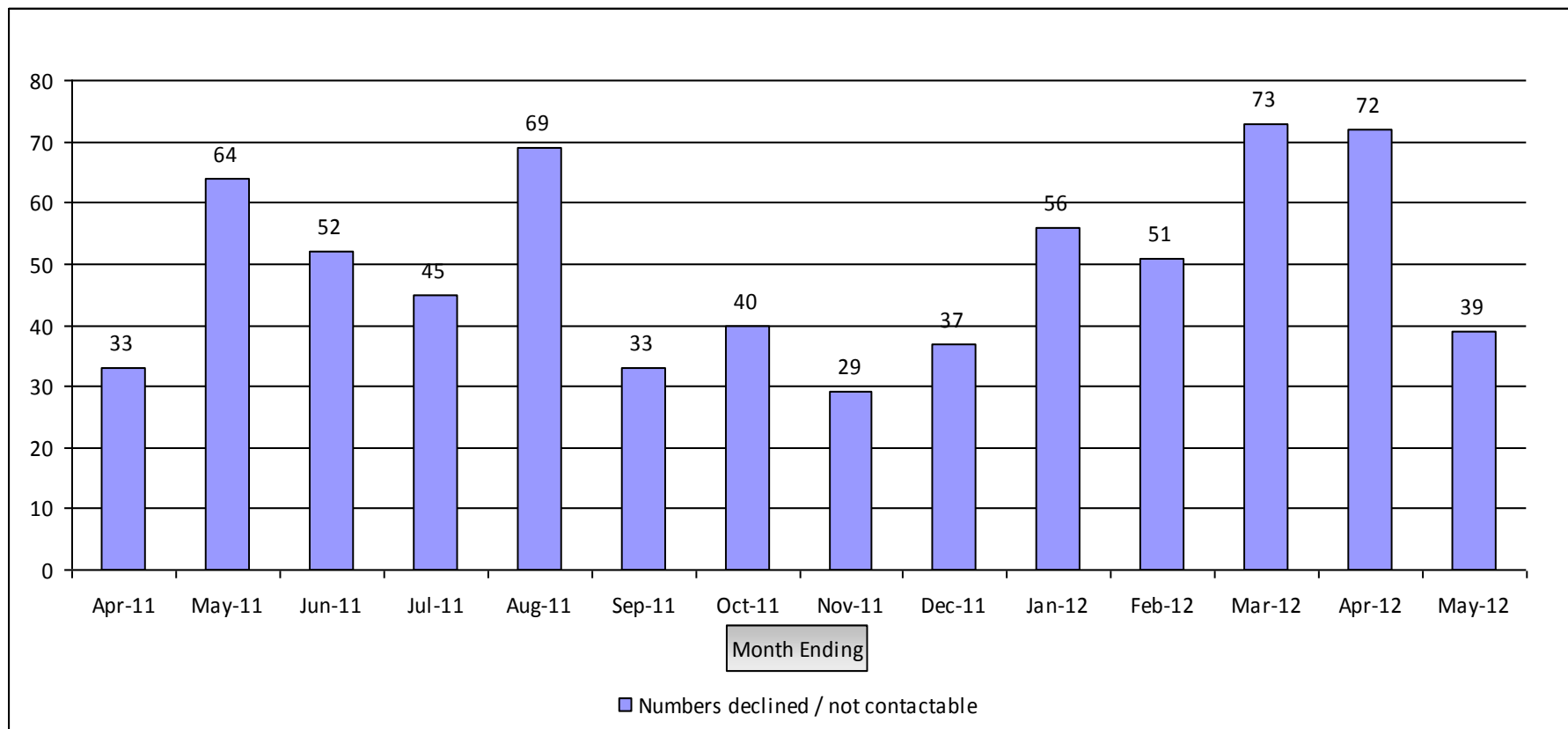


Figure 1 details the regional outcomes for those attending the ED with Self Harm/Suicidal Ideation over the specified time period. The information demonstrates that the majority of these patients are either immediately assessed or admitted for observation/assessment. The remainder of these patients (16.5%) are those that are considered well enough to go home with a follow up appointment for the next day (CBYL). A small percentage (0.3%) will refuse any form of follow up at the ED.

**Figure 2: ED Attendances and Referral for CBYL
April 1st 2011 – May 31st 2012**



**Figure 3: Number of people who declined an appointment or could not be contacted
April 1st 2011 – May 31st 2012**



*Discrepancies between Figures 1, 2 and 3 are likely to be attributable to coding issues

**Figure 4: CBYL Regional Outcomes Appointment
April 1st 2011 – May 31st 2012**

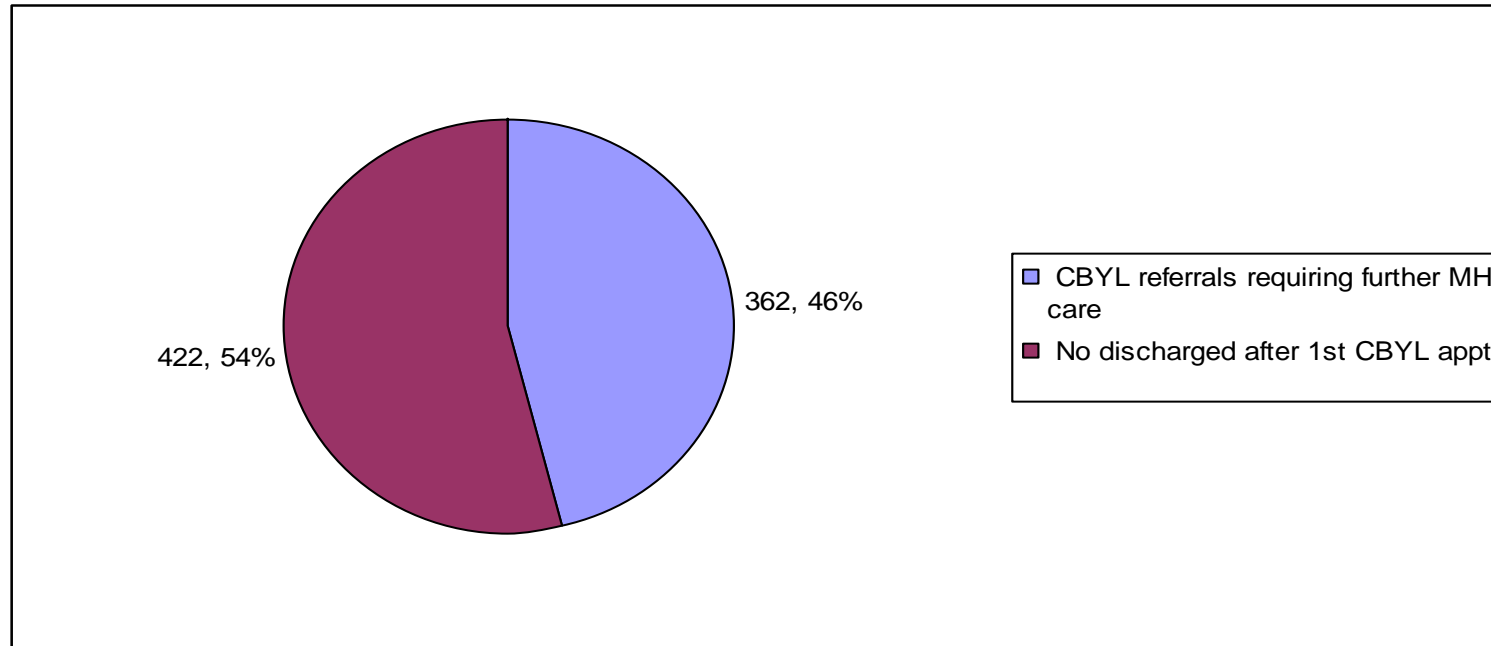
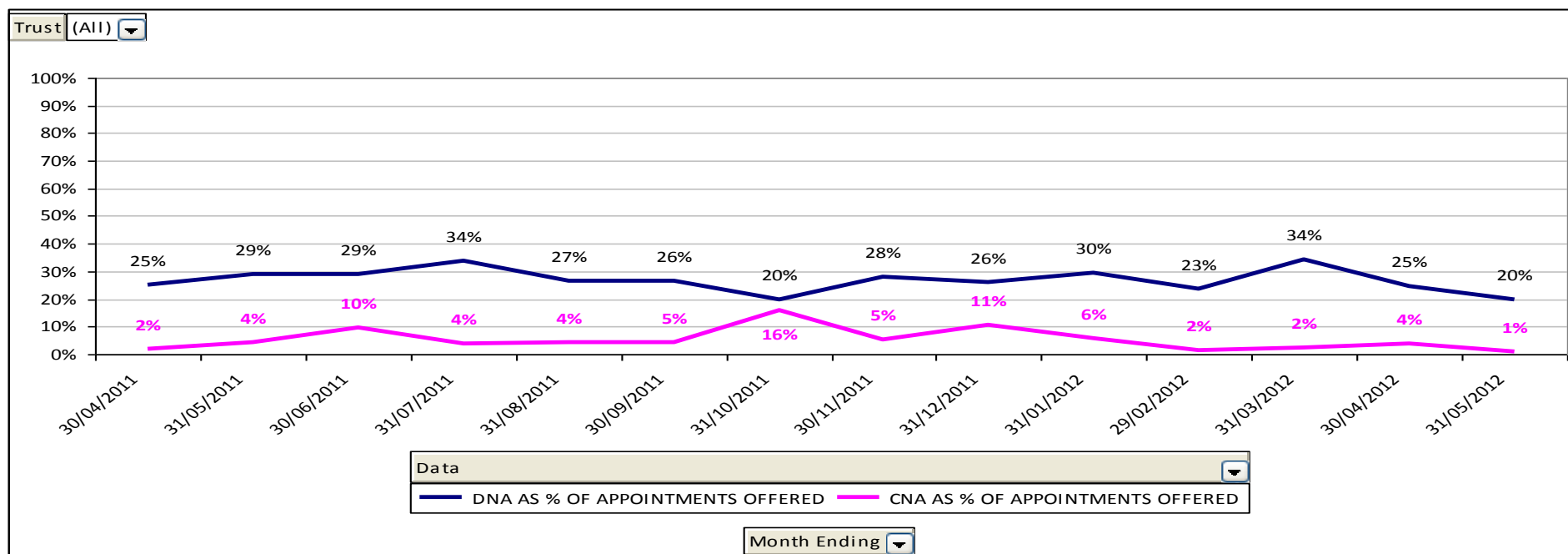


Figure 4 indicates that 46% of patients who attend their CBYL appointment will require further mental health appointments. Over the time period specified this is an average of 26 patients per month. 54% of those patients who attend their CBYL appointment will be discharged to the care of their GP; this is an average of 30 patients per month.

**Figure 5: DNA/C NA Split Regional Percentages
April 1st 2011 – May 31st 2012**



The average DNA rate for the time period across the region was 27%. The average C NA rate was 5%.

4.0 Site Visits

4.1 Following on from a suite of site visits carried out in the Belfast Trust in 2011, three further site visits were agreed by the Regional Implementation Group and these were undertaken by staff from the Health and Social Care Board, the Belfast Mental Health Rights Group and Trust managers with the assistance of staff from the EDs. The visits took place in the EDs listed below;

- Craigavon Area Hospital
- Royal Victoria Hospital
- Mater Hospital
- Altnagelvin Hospital

4.1 Details from the site visits were collated in a table format for ease of reference and members involved in the site visit are detailed below the table.

	Southern Trust	Belfast Trust	Western Trust
ED Waiting Room and Triage	Manchester Triage system used.	<p>Waiting area is the general waiting area for all patients, no side room was evident.</p> <p>Manchester Triage system is used however within BHSCT training is ongoing with ED Nursing staff on the implementation of an assessment tool for use at triage. This will enable early referral to the Mental Health Unscheduled Care Team from triage for certain groups of patients</p>	<p>Waiting room was busy however there was a small side room that could be used for those patients who appeared upset/anxious. This is not exclusively for use of mental health patients. Leaflets and posters were evident in the waiting room detailing information on voluntary organisations and alternate sources of help.</p> <p>The Manchester Triage system is used to determine level of risk.</p>
Evidence of intoxication	<p>If a patient presents with signs of intoxication, they are put under observation in a cubicle. They are then given a psychosocial assessment. If they show signs of distress due to the activity in the ward, they would be moved.</p> <p>If a patient arrives under the influence of alcohol, it would depend on the Doctor's clinical decision on what was to be done. They would be admitted for observation. If they expressed</p>	<p>If a patient attends with signs of intoxication/ under the influence of drugs that is expressing suicidal ideation, and is unsuitable for mental health assessment at that time, generally they will be admitted to the ED Short Stay Unit. Once the patient is suitable for mental health assessment then a referral will be phoned through to the Mental Health Unscheduled Care Team</p> <p>If the Short Stay Unit is not opened or is full, the patient will be admitted to the medical assessment unit when a referral will be made to the Mental Health Unscheduled Care Team once the patient is</p>	<p>Patients who appear to be under the influence of alcohol and or drugs are usually brought to a separate area of the ED and supervised until such time as they become coherent.</p>

	<p>suicidal thoughts they would be given a psychosocial assessment. If they were nearly unconscious, it would be a straightforward admission.</p>	<p>medically fit.</p>	
Mental Health Assessment	<p>A Psychiatry Senior House Officer performs a psychosocial assessment but A&E staff would also do it in A&E.</p>	<p>Mental health assessment is carried out in ED by the Mental Health Unscheduled Care Team. ED nursing staff and ED medical staff assess the patient in ED to determine if urgent mental health assessment is required in ED or if discussion is necessary with a mental health service that the patient is already known to. (The Mental Health Unscheduled Care Team is made up of specialist mental health trained nurses, junior medical staff which is overseen by a Psychiatric Consultant and team leader).</p>	<p>Mental Health assessment is carried out initially by the ED Doctor and appropriate referral made based on that assessment of risk.</p>
Absconded patients	<p>If patient had self-harmed, expressed remorse, and asked to leave, the hospital would want them seen by a doctor first, and given a psychosocial assessment. They would assess risk factors, including levels of family support, and if they were deemed to be low risk they would be discharged</p>	<p>If a patient had self-harmed, expressed remorse, and requested to leave, the hospital would advise the patient to be assessed by an ED doctor first so an assessment can be made to determine if referral to Mental Health Unscheduled Care Team is required. They would assess risk factors, including levels of family support, and if they were deemed to be low risk</p>	<p>Protocols are in place to identify patients that leave before assessment; the hospital would try and contact them. The hospital staff line manager would be informed, as would hospital security and police. The hospital would then want to speak with their GP the next day and refer to CBYL. The GP can refer to the primary Care liaison Service for Mental</p>

	<p>with CBYL.</p> <p>If a patient leaves before assessment, the hospital would try and contact them. The hospital staff line manager would be informed, as would hospital security and police. The hospital would then want to speak with their GP the next day and refer to CBYL that way. The GP would refer them back to the doctor at the hospital, who would then carry out the psychosocial assessment to ascertain high, medium or low risk.</p>	<p>they would be discharged with CBYL.</p> <p>If a patient leaves before assessment by the ED or prior to triage assessment by the Nurse, staff have guidance to advise them on the appropriate action to take. This will be determined by the reason for attendance, initial assessment, clinical presentation and other previous attendances at ED. If the staff are concerned about the patient and their risk of further self harm or suicide, they make every attempt to contact the patient. The hospital staff line manager would be informed, as would hospital security and police. If staff felt the patient was at significant risk, they would contact the patient's GP there and then. In situations where immediate assessment was not felt to be necessary, then the hospital would inform the patient's GP the next day and also phone the patient's details through to CBYL. The GP can refer patients directly to Mental Health Unscheduled Care Team, however if the patient required medical treatment, then a referral back to ED would be necessary and then referral to Mental Health Unscheduled Care Team once the</p>	<p>Health assessment, if not medically fit the GP will refer them back to the doctor at the hospital, who would then carry out the psychosocial assessment to ascertain high, medium or low risk.</p>
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		patient was medically fit would be made.	
Staff training on CBYL	An orientation pack with information on CBYL is available for staff, and evidenced during the site visit. Staff are required to tick a box on a form during their induction when they are made aware of CBYL. New staff are supervised by an experienced nurse who can advise on decisions made about treatment.	All new staff are trained on CBYL by an experienced staff member and written processes are evident on the information wall of the Emergency Department which all staff can refer to. New staff are supervised by an experienced nurse who knows about all decisions made about treatment.	All new staff are trained on CBYL and Consultants and staff on the day appeared to have good knowledge on the scheme. Assessment booklets are informative for staff and new staff members who are unsure of the process are able to liaise with an experienced staff member who will assist if they are unsure.
Next Day Appointment	<p>Through CBYL patients received an appointment for 2pm the next day Monday - Friday. They are assessed at A&E and then a psychosocial assessment is carried out.</p> <p>If a patient decides to leave they can be followed up. It is possible to do this for everyone –this would be done by the mental health team who would have the GP's contact information.</p> <p>If the patient is known to services,</p>	<p>Through CBYL patients received an appointment for the next day Monday - Sunday. The appointment Monday – Friday is delivered in Woodstock Lodge and Sat/ Sunday North and West GP out of hours service.</p> <p>ED staff phone a specific number and leave information including: patient's details, department attended, presenting complaint, contact number, name and address of GP and the name of the referring clinician. This information is picked up by a member of the Mental Health Unscheduled Care Team the</p>	<p>Next day appointments are made for those patients that are deemed to be low risk following Mental Health Assessment through CBYL. Monday – Friday patients are assessed in Oldbridge House by the Mental Health Team. Out Of Hours(OOHs) in ED or GP (OOHs) which is co-located.</p> <p>Weekend patients are seen in the ED at appointed times by the Mental Health Team.</p>

	they still may get CBYL. Whether they do depend on clinical assessment. Often it is more appropriate to refer them to the service that knows them.	following day. Belfast Trust does not ask patients to return to ED for their next day appointment.	
Evidence of card in ED	Yes	Yes	Yes

* Based on Information gathered during half day visit to the ED

* Site visit to Mater could not be completed due to ongoing renovation

* Site visit to the Northern Trust was not carried out

4.3 The key points emerging from the site visits are as follows;

- ✦ CBYL appears to be well embedded within the Emergency Departments visited
- ✦ Staff had knowledge of the scheme and a positive attitude on its benefits
- ✦ Processes are in place in all sites for follow up on patients who leave before assessment
- ✦ Further processes are in place to accommodate patients who are intoxicated (alcohol and/ or drugs) although the physical layout of the departments concerned varied and can be a significant consideration in managing such patients
- ✦ Existence of short stay facilities adjacent to all Emergency Departments to accommodate patients who require short term medical intervention/ observation prior to psychiatric assessment
- ✦ Dedicated quiet rooms for patients presenting with self-harm were not evident but each site manages within the physical constraints. Efforts are made to manage disturbed patients in suitable locations where these are available
- ✦ Waiting times for assessment vary across each site and can fluctuate within the general demand/risk priorities presenting at any point in time
- ✦ Some patients are assessed next day in the Emergency Department while others are offered appointments in community locations
- ✦ Emergency Departments are not necessarily the most suitable location to assess someone who is threatening self-harm or is feeling suicidal but has no immediate medical needs
- ✦ Appropriately designed cards are now evident in all locations and not only detail appointment times but also contain contact numbers for relevant voluntary organisations

✚ There was some evidence of voluntary organisations offering care and support to clients referred to the CBYL service; while this appears entirely appropriate, the visiting teams wondered about the extent of coordination, collaboration and joint working

5.0 Other relevant evidence collected

5.1 This section contains further suggestions for service development which can be found in the wider literature. Some of the proposals in this section are currently underway, for example, the development of the Self Harm Registry, while others may provide an opportunity to explore different methods for targeted intervention.

5.2 Pat McGreevy, a Service Improvement Manager from South Eastern Trust recently produced a report entitled, 'Exploring the application of current intervention and postvention theories to suicide prevention practice;. This report was based on his scholarship visit to the United States and Canada in which he explored various methods of intervention for suicide prevention. The findings in this report highlight other models which could be applied in Northern Ireland and these are recommended for consideration (amongst others) in both the immediate and future of service planning. For the purposes of brevity these have been summarised below but more extensive detail can be found in the full report.

5.3 Pat alluded to the work of Yvonne Bergmans who is a Suicide Intervention Consultant at the Suicide Studies Unit, St Michaels Hospital, University of Toronto. Yvonne has introduced a new group approach for those people who had made multiple attempts to end their lives. The intervention is called "Psychosocial/Psycho educational Intervention for Persons with Recurrent Suicide

Attempts (PISA). This novel approach is targeted at both men and women from inner-city populations who have made two or more suicide attempts at any point in their lives. This client group have been identified to have particular difficulties and deficits. According to Yvonne, PISA has a design that is “simple, portable, and flexible”. This person centred approach is carried out within a group environment and chaired by a therapist, the difference with this form of group intervention is that the client is deemed the expert and informs the session.

5.4 Pat McGreevy also advocated ‘the Social Network Scale’ as a tool which could be used in assessing and working with ‘failed belongingness’, Dr Thomas Joiner alludes to the need to belong as a ‘fundamental human motive’. Joiner maintained that failed belongingness occurs when individuals do not feel connected to anyone. Joiner contends that when failed belongingness comes to co-exist with burdensomeness then the desire for death emerges. It may prove fruitful then, at the point of referral to Mental Health Services, to measure the person’s social network. If it is found to be small, the assessing practitioner could negotiate with the patient on how this social network could be expanded in a way that provides better and deeper connections. This tool would also help the practitioner to learn how the patient perceives themselves to be connected to others.

5.5 Promoting positive mental health and emotional wellbeing for the entire population has the potential to reduce the levels of suicide in Northern Ireland. The Foresight report – “Five a day for your mental health” (Government Office for Science, 2008)

recommends that we all should: - *Connect* with those around us; *Be active*; *Take notice*; *Keep learning* and *Give*. Pat McGreevy concluded in his report that future mental health promotion campaigns could potentially help to counteract 'failed belongingness' and 'burdensomeness' through encouraging people to 'Connect' and 'Give' and thus assist in suicide prevention efforts. The 'recovery' ethos should promote these concepts to people with existing mental illness.

5.6 Novel forms of suicide prevention outreach work should be explored and this would include those media that have become a regular means of communication among young people. This includes social networking systems, the Internet, text messaging and or emails (Providing Meaningful Care: Using the experiences of young suicidal men to inform mental health care services; Dr Joanne Jordan, Professor Hugh McKenna, Dr Sinead Keeney, Professor John Cutcliffe, December 2011).

5.7 Trusts are now implementing the Self Harm Registry which will provide the health service with better data in this area, enabling insight to the patterns and actions of those who self-harm. This should enable more targeted mental health service interventions and suicide prevention services for those currently in need of help.

Solution-focused brief therapy was developed in the US from the work of Steve de Shazer (1985) and his colleagues. This form of therapy highlights that individuals have unique resources and the potential to find their own solutions to problems. These researchers believed that focusing on problems often obscures the

resources and solutions that clients often already have – they did not see therapists as the source of solutions (de Shazer, 1988).

The individual patient is acknowledged as the main activist in changing their situation. Within the sessions, clients are helped to identify the future they want as well as the things they are doing which are helpful in getting there – the problem story is used to identify resources, achievements and survival strategies rather than criteria for diagnosis. Techniques familiar to many therapists are used within a new framework to focus on achievable goals. Accurate description of these goals is the cornerstone of solution work (Iveson, 2002).

5.8 In 2002, the Psychiatry liaison team in St Luke's Hospital, Middleborough incorporated this therapy into the initial assessment within the ED to help engage with patients in a meaningful way after they presented with DSH. In practice the team found that, on implementation, the solution-focused questions yielded a positive response from patients and staff. The potential to engage with the person instead of the problem afforded staff and patients the potential to address the reasons for the self-harm instead of just focusing on the risks. It also ensured that patients were more meaningfully engaged from the outset which in turn improved their attendance at follow up appointments. Pat McGreevy also advocated in his report that all ED staff in Northern Ireland be trained in this method of intervention as it can be incorporated into the assessment and is not time intensive.

5.9 Professor Mike Tomlinson from Queen's University Belfast (War, Peace, Conflict, The Case of Northern Ireland, May 2012) examined death registration data over the last 40 years, and uncovered that the highest suicide rate is for men aged 35-44 (41 per 100,000 by 2010), followed closely by the 25-34 and 45-54 age groups. The research has shown that suicide rates have doubled since the Good Friday Agreement in 1998. The findings demonstrate that children who grew up in the worst years of violence between 1969 and 1977-78 are the group which now has the highest suicide rates and the most rapidly increasing rates of all age groups.

This research should have an important bearing on future strategies relating to suicide prevention, and targeted mental health campaigns should be developed both within the Trusts and community organisations.

6.0 Summary of Findings and Recommendations

6.1 The remit of this report was to evaluate the operation and effectiveness of the 'Card Before You Leave' scheme within Northern Ireland to determine:

- ✚ If the scheme is fully operational and embedded;
- ✚ If it represents the most effective use of scarce resources in this area;
- ✚ If the current scheme can be improved upon.

6.2 Whilst there are several recommendations noted, there are other initiatives mentioned throughout the report which should also be given due consideration in future service planning.

6.3 The site visits, coupled with the statistics provided by the Performance Management and Service Improvement Directorate, (HSC Board) evidence a commitment by EDs across the region to the implementation of the scheme. The scheme is a good example of early engagement and intervention with a known risk group, albeit of a lower order than those who are a danger to themselves or others.

6.4 During the site visits facilitated by ED staff in each Trust, clear evidence was shown about how the scheme is now embedded within the everyday ethos of the ED. Staff spoke very positively of the scheme with regards to the potential in helping the patient access mental health services. The relevant information and pathways were available within the ED for staff and training was provided to any new staff members. While there were no major inconsistencies in processes noted during the site visits there has existed some discrepancy in practice in one Trust within the Child and Adolescent Mental Health Service with CBYL. There has been recent investment by the HSC Board to help eradicate these issues and bring the practice in line with other Trusts.

In some locations, there may be opportunities for closer and more effective joint working with community and voluntary sector schemes that operate in the same general area.

6.5 In the context of the literature review, there are good grounds for believing that this scheme and similar schemes elsewhere offer real potential in helping to reduce further incidences of deliberate self-harm/suicidal ideation through the provision of appropriate contacts and information on how to access services. These schemes are even more effective in reducing the occurrence of repeated attempts at deliberate self-harm when used in conjunction with other pro-active measures, such as assertive outreach, multi disciplinary ED meetings, and crisis centres to name but a few.

Recommendation One: The scheme should continue to be implemented and refined in light of emerging evidence within Trusts about effective methods of engagement (examples are given within this report on how to improve engagement and uptake). The HSC Board and PHA should seek to further refine data collection and rationalise this in light of the advent of the Self Harm Registry.

6.6 A number of individuals and groups have recently proposed a 'quiet room' facility within the ED which could be used by the highly distressed or intoxicated patient as a calm and relaxing area, prior to being seen by staff. This facility is not yet available; however it was evident on the site visits that there were areas that could potentially be utilised as a quiet space.

Recommendation Two: All Trusts should be asked to explore proposals for improving access to suitable quiet room space within their EDs in line with NICE guideline (CG16) recommendations, particularly aimed at patients who would benefit from such facilities.

6.7 ED waiting times have been attributed in the past to patients leaving before they were seen. The ED sees a wide variety of patients who are triaged according to the Manchester Triage scale; these patients will be treated in accordance with the priority given at triage. Those that are in urgent need of medical attention will be seen as quickly as possible, however those who are not deemed urgent will inevitably have to wait. During periods of high demand this may be longer than the patient feels is acceptable. This wait

can be exacerbated at weekends as the highest prevalence of those presenting with self-harm coincides with the lowest level of Consultant cover within all Trust EDs. It may be that a response time of less than two hours could be delivered. The Board will wish to explore this and any associated implications.

Recommendation Three: The HSC Board should begin to routinely monitor data on mental health service team's response times to patients referred from Emergency Departments, the objective being that all patients waiting in the ED for assessment are seen by mental health services as soon as possible.

6.8 The issue of waiting times also poses the question as to whether the ED is the best place for the cohort of patients who may have talked of harming themselves or have harmed themselves but are not in need of any urgent medical attention. This leads on to the wider issue of accessing services at the appropriate 'point of access' so that patients do not have the added stress of attending the local ED unless this is necessary. The governance issues surrounding alternative pathways need to be explored.

Recommendation Four: In line with NICE guidance, the HSC Board and PHA should explore, in partnership with Trusts and the Ambulance Service, the need for a separate location for assessment of patients who require mental state assessment only i.e. for people who have no immediate physical health needs and thus no reason to be in an ED.

Recommendation Five: The HSC Board and PHA should explore the possible development of appropriate community-based crisis responses to meet the needs of people presenting with suicidal thoughts or thoughts of self-harm where such people do not require treatment in an ED.

6.9 A consensus has emerged during the production of this report that the Emergency Department is not a suitable venue for offering a CBYL follow-up appointment, for a variety of reasons but not least because it is not an attractive option for the client to revisit the scene of their attendance the previous day. For this reason, this evaluation concludes that EDs are not suitable for this purpose.

Recommendation Six: All Trusts should ensure that patients do not return to the Emergency Department for their “next-day” appointment but are advised of an alternative appropriate venue.

6.10 In addition to the support of ED staff for the CBYL scheme, other work has taken place at local level to ensure services are more readily accessible and responsive to the patient’s needs. For example, an assertive outreach approach is currently used by a number of Trusts and this could be extended in conjunction with multidisciplinary ED meetings to highlight repeat attenders and/or those who continually avoid engagement with mental health services.

Recommendation Seven: In line with NICE guidance Trusts should implement regular ED/Mental Health team service planning meetings to improve collaborative working and the management of patients who are repeat attenders and/or people who are difficult to engage with follow-up services.

6.11 The research evidence quoted in this report from the past three decades has highlighted the value of flexible working practices as a valuable method in reaching those who are particularly hard to engage with. Moreover it was this method that was found in the National Confidential Inquiry Report to have resulted in the biggest drop in completed suicide rates when implemented.

Recommendation Eight: An assertive outreach approach should be used to encourage engagement with services for patients who fail to engage and where it is believed there is a higher level of risk. In common with other aspects of service provision, flexible working arrangements for staff, for example, evening and weekend hours should be introduced as part of this approach.

6.12 Trust staff in ED departments have displayed admirable commitment to the implementation of the CBYL scheme. However, carers on the implementation group have particularly highlighted the need for continuing attention to informing the patient where the appointment will take place, the reason for the appointment and the inclusion of a family member or carer in the provision of

information. A further feature of improved implementation in their view would be the provision of an afternoon appointment. When these measures are applied, there is evidence to show that it can improve compliance with attendance at appointments (detailed in Appendix 1).

Recommendation Nine: Trusts should give a duplicate appointment card to any person attending with the patient. Patients and carers should also be provided with appropriate written information regarding self-harm and crisis support. Consideration should also be given to implementing the measures outlined in Appendix 1.

6.13 Alcohol and drug misuse is a wider issue that needs to be addressed effectively by several agencies. This issue needs to be taken into consideration within any initiatives aimed at reducing the incidence of suicidal ideation in Northern Ireland.

Trust staff should not rely solely on blood alcohol levels to ascertain as to when a patient should be assessed. This should be based on clinical judgement and on each individual patient's competency levels.

Recommendation Ten: In line with the DHSSPSNI consultation document "Strategic direction for alcohol and drugs in Northern Ireland 2011-2016", Trusts should endeavour to develop a competent and skilled workforce across all sectors that can respond to the complexities of

alcohol and drug misuse. Trusts should explore improving care pathways between acute medical services and specialist alcohol and drug services in the community.

6.14 Training some ED staff in Solution Focused Brief Therapy (SFBT) is worthy of consideration. ED staff attitudes have been highlighted in the literature as being attributed to one of the reasons for patients not attending for follow up appointments. SFBT training would equip staff to deal more effectively with mental health patients, thus engaging the patient and improving the potential of attendance at further arranged mental health appointments.

Recommendation Eleven; In line with the Protect Life Strategy and NICE guidance, Trusts should make suicide prevention & self-harm awareness training a priority for all staff who have contact with self-harm patients. Trusts should consider exploring the potential of training some ED Nurses in solution focused brief therapy (SFBT) as a means of improving the response to patients.

6.15 The PHA/HSC Board Self Harm Working Group brings together relevant stakeholders to plan services for people who self harm. The group's access to the data emerging from the Self Harm Registry alongside the existing CBYL data and their knowledge of evidenced based practice ensures that this group is best placed to take forward the implementation of these recommendations. The group will regularly update and advise the HSC Board and PHA on relation to this issue.

Recommendation Twelve: The HSC Board should stand down the CBYL Implementation Group and ensure continuity by asking the PHA/HSC Board Self Harm Working Group to oversee implementation of these recommendations. This group should be the recognised advisory forum to the HSC Board and PHA for collective decision making and action with regard to the assessment and management of self-harm.

Appendix 1: Measures to reduce Non-Attendance

(Adapted from [Pettinati et al, 2004](#))

Box 3

Simple measures to reduce non-attendance

Improving initial attendance

- Encourage referrers to explain the purpose of the referral
- Schedule the appointment as soon as possible
- Write to the patient with clear directions and explaining the mechanism of referral
- Offer the option of an afternoon appointment
- Offer the option of a community/home visit if the patient is too unwell to attend
- Consider a reminder telephone call the day before the appointment (if the patient has a telephone)

Improving follow-up attendance

- Give the patient a choice of appointment dates and/or locations
- Schedule the appointment as soon as possible
- Where possible, agree the duration of the treatment course at the start
- Work towards establishing and maintaining a good therapeutic relationship
- Involve the patient in treatment decisions

Response to missed appointments

- Contact the patient by letter or telephone
- Identify any patient-cited barriers to attending
- Confirm that the patient wishes to attend
- Affirm that the patient can still be seen without prejudice
- If possible convey hope that there is a definite prospect of improvement
- Reschedule the missed appointment as soon as possible

Appendix 2

Predictors of Non Attendance

Box 1 Key predictors of non-attendance

Environmental and demographic factors

Younger age

Lower socio-economic status

Not having health insurance (where health-care is not free at point of delivery)

Poor adherence to psychotropic medications

Homelessness

Transport problems, distance from clinic

Patient factors

Forgetting, oversleeping, getting the date wrong

Being too psychiatrically unwell

High trait anxiety

Lower social desirability scores

Dismissing attachment styles

Memory/cognitive problems

Dementia

Information and health beliefs

Poor insight into illness

Illness factors

Personality disorder

Substance misuse (alone or in combination with other psychiatric disorder)

Neurotic disorders

Diagnosis unclear or cannot be established

Clinician and referrer factors

Poor communication between the referring practitioner and the patient

Patient's disagreement with the referral

Referrer's skepticism about the value of psychiatry

Poor-quality referral letter

Longer delay between the referral and the appointment (or between assessment and treatment)

Early stages of treatment

Quality of therapeutic alliance

Non-collaborative decision-making

(From Selmes and Mitchell 2007: Why don't patients attend their appointments? Maintaining engagement with psychiatric services)

Appendix 3:

Implementation Group Members

Adrian Corrigan, Southern HSC Trust
Aimee Pollock, Northern HSC Trust
Beverley Fleming, Northern HSC Trust
Billie Hughes, Belfast HSC Trust
Bob Matson, Belfast HSC Trust
Bryan Rhodes, South Eastern HSC Trust
Cathal Killen, South Eastern HSC Trust
Christine Bateson, Northern HSC Trust
Deidre McGrenaghan, Western HSC Trust
Geraldine Byers, Belfast HSC Trust
Gerard McCartan, Participation and the Practice of Rights Project
Gillian McMullan, Patient & Client Council
John Mullan, Western HSC Trust
Laura Molloy, HSC Board
Maura Dargan, Northern HSC Trust
Nicola Browne, Participation and the Practice of Rights Project
Pat McGreevy, South Eastern HSC Trust
Paul Smith, Southern HSC Trust
Paul Devlin, Western HSC Trust
Peter Bohill, Belfast HSC Trust
Rhonda McLaughlin, South Eastern HSC Trust
Rodney Morton, HSC Board
Seamus Logan, HSC Board
Seamus O'Reilly, Southern HSC Trust
Shirley Dennison, Southern HSC Trust
Stephanie Green, Participation and the Practice of Rights Project
Yvonne McWhirter, Western HSC Trust

Site Visit Teams

Western Trust	Southern Trust	Belfast Trust
John Mullan	Lisa McCullough	Kathy Gilliland
Bobby Duffin	Nicola Browne	Grace Cassidy
Bette Graham	Gerard McCartan	Geraldine Byers
Laura Molloy	Geraldine Byers	Paul Smith
Isobel McClintock	Seamus Logan	Seamus Logan
Seamus Logan	Laura Molloy	

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