FORMAT

Instructions for attendees were provided after the introductory presentation on the project background. Tables had three separate A3 sheets of paper, one for each question, with the question printed in the middle, surrounded by space to write with provided markers. The groups discussed the questions Q1, Q2, and Q3 as outlined below.

DURING THE SUBGROUP DISCUSSION SESSIONS:

Each question was discussed among the subgroup for 10 minutes, then groups summarized the answers for 5 minutes (one volunteer notetaker per table). Each table's volunteer notetaker/speaker shared the summary of their subgroup's answers.

TAKEAWAYS

Barriers and Facilitating Factors to Using a CDSS in ED Self-Harm Assessments

Barriers

1. **Stigma around Technology**– Patients may distrust technology-based assessments; stigma affects disclosure and engagement.
2. **Training and Role Clarity** – Inconsistent training, particularly for junior staff, may limit effective use. Guided and robust training manual required.
3. **Technical and Data Limitations** – Lack of interoperability, infrastructure constraints in relation to the country.
4. **Risk of Overreliance** – Potential for healthcare professionals to rely on the CDSS as a substitute for direct clinical judgment.
5. **Limited Resources** – Limited time, staffing, and access to integrated systems in high-pressure ED settings.

Facilitating Factors

1. **Continuity of Care** – Facilitates follow-up and data sharing across services.
2. **Task Delegation** – Nurses or trained junior staff can collect data before clinician assessment.
3. **Standardization** – Supports consistent, structured assessments.

Acceptability and Feasibility of CDSSs for Self-Harm and Suicide

1. **Training and Support** – Essential for all levels of healthcare staff, with emphasis on building confidence and reducing "algorithm aversion."
2. **User-Centred Design** – Must be intuitive, integrated into existing ED systems, and adaptable.
3. **Trust and Communication** – Clear messaging that CDSSs guide rather than replace clinical decision-making; need to build trust among both clinicians and patients.
4. **Privacy and Ethical Considerations** – Address GDPR compliance, insurance implications, and public–private sector cost differences.
5. **Cultural and Language Adaptation** – Interface and outputs should be adaptable to local language, cultural contexts, and patient comprehension levels.
6. **System Overload** – Avoid contributing to "software fatigue" from multiple unintegrated digital tools in ED environments.

Requirements for Implementation and Evaluation of a CDSS in EDs

1. **Robust Clinical Trials** – In the future, include clearly defined outcomes such as usability, clinical impact, and cost-effectiveness if the small-scale testing is successful.
2. **Integration into Existing Systems** – Compatibility with hospital IT infrastructure is crucial so that the learning curve is minimal.
3. **Decision Support** – Mitigate risks of overreliance and ensure clinical judgment remains central.

Conclusion

- A CDSS for self-harm assessment in EDs has clear potential to **improve consistency, support decision-making, and enhance continuity of care**, but success depends on **training, resources, and integration** into existing clinical workflows.
- **Barriers** include stigma (related to technology), interoperability issues, training gaps, and risks of overreliance.
- **Facilitators** include role-specific use, standardization, and wider applicability beyond Eds in the future.
- To move forward, **scalability testing and clinical trials** should focus on usability, integration, cultural adaptation, and sustained engagement from both clinicians and patients.