Enhancing acute hospital care for patients who have self-harmed

People who self-harm often turn to accident and emergency (A&E) for support, but the care they receive in the emergency setting is not necessarily helpful. In 2004, the National Institute for Health and Care Excellence (NICE) recognised that the care of people who self-harm needed to be improved, and called for more research into users’ experiences (National Collaborating Centre for Mental Health, 2004).

To drive change, NHS England has made the improvement of services for people with mental health needs who present to A&E a national Commissioning for Quality and Innovation indicator for 2017-19. A recent study at the Royal Blackburn Teaching Hospital has conducted semi-structured interviews with 40 participants to explore the experience of patients on the emergency pathway after an episode of self-harm. This article discusses the study and its findings.

Alarming figures
In the UK, where the rates of self-harm are the highest in Europe, over 25% of 16-24-year-olds self-harmed in 2014 (McManus et al, 2016). Among all people aged between 16 and 74, the percentage who report self-harming increased from 2.4% in 2000 to 6.4% in 2014 (McManus et al, 2016). There is a close link between self-harm and death by suicide: in the 12 months after a self-harm episode, people are 100 times more likely to die from suicide than the general population (National Collaborating Centre for Mental Health, 2004).

Many people who self-harm receive no support: in 2014, 66% of 16-34 year-olds who self-harm reported not having received any medical or psychological support. In the same year, only 50% of people who made a suicide attempt received help (McManus et al, 2016).

For those who do seek help, A&E is often the first and only port of call (Pearsall and Ryan, 2004). Staff in the emergency setting therefore play a crucial role in caring for this patient group. However, there is evidence that, in many cases, care received in that setting is unhelpful. For example, research conducted by the Royal...
College of Psychiatrists (Blackwell and Palmer, 2008) shows that, in 2007, 43% of patients had avoided emergency services because of previous negative experiences.

The study Population
To participate in the study, patients had to be over the age of 16 and have been admitted to the acute medical assessment unit via A&E in the previous 48 hours, with self-harm as the primary reason. The NICE definition of self-harm – “intentional self-poisoning or injury, irrespective of the apparent purpose of the act” (National Collaborating Centre for Mental Health, 2004) – was used.

Among the 40 participants, 90% (n=36) had been admitted after deliberate overdose or intentional self-poisoning; 5% (n=2) had been admitted after intentional cuts to their arms or legs; and 5% (n=2) had been admitted after attempts to end their life by hanging.

In total, 42 patients had been invited to take part and 40 had chosen to do so. The sample of patients invited to participate was entirely random so it would most accurately represent those admitted to the hospital due to self-harm. However, the study only shows the views of people admitted to hospital through A&E, not those who only attended A&E. Many patients who self-harm are treated in A&E and then discharged. This is why the vast majority of participants in this study had been admitted to hospital after self-poisoning or deliberately taking overdoses, as opposed to using other methods of self-harm such as cutting.

Methods
Semi-structured interviews were conducted with the 40 patients as they were awaiting discharge, after they had been identified by the unit’s medical coordinator as medically stable in physical terms and mentally well enough to participate. Patients were not interviewed if they were awaiting admission to a secure mental health unit.

Patients received an information sheet explaining the purpose and nature of the research, along with details of how the data would be used. They were given time to read it and ask questions, before being asked to provide written consent. The interviews, which comprised six questions (Box 1), lasted between eight and 21 minutes and were conducted between 1 December 2016 and 22 February 2017.

All the interviews were recorded except for three, during which, notes were taken instead at the participants’ request. The interviews were transcribed and Sanders and Wilkins’ model of thematic analysis (2010) was used to identify emerging themes – either themes that featured in a majority of accounts, or themes that had triggered high emotions, even if featuring only in a minority of accounts.

The project received ethical approval from the University of Cumbria, which also provided supervision alongside the research department of East Lancashire Healthcare Trust (ELHT). The study was a service evaluation and so did not require ethical approval, although it did receive management permission.

Findings
Feeling guilty
The most common single feeling, expressed by 63% of participants, was a reluctance to attend A&E. Participants spoke movingly about how they attended hospital only at the point where they felt “really desperate” or had no other choice. They were acutely aware of the pressures on A&E departments and tried to obtain help from other sources first. Some had phoned 111, but had been told that the service was only for physical health issues and redirected to A&E.

One participant had contacted their mental health crisis team and, upon explaining that they felt “very suicidal”, was told that the team was “really busy” and was asked to “call back in a few hours”. As one participant said, “it is like wherever you are trying to reach out for help, you are hitting a wall”.

Upon attending A&E, participants spoke of feeling selfish, being a burden and “wasting everyone’s time” for being there due to a self-inflicted act. They tended to consider themselves less worthy of care than other patients. One said: “When they are taking time out to talk to me, they are not getting [a] chance to talk to the patients”.

Participants said that A&E felt like the wrong place for them to be, but that there was nowhere else they could go to find safety.

Feeling looked down on
For 30% of participants, the feeling of being a burden was made worse because of negative experiences with staff. They explained...
Feeling listened to

Overall, 68% of participants were positive about the care they had received, describing staff as “perfect”, “polite”, “friendly”, “attentive”, “helpful”, “understanding”, “fantastic” and “brilliant”; 58% valued the hospital as a place of safety (“I felt reassured that somebody was around”). Reflecting on their care, 58% of participants spoke of non-mental health staff talking and listening to them (“They were there, and they just listened, whether I was talking rubbish or not”). Participants explained that it was helpful talking to people they did not know, in particular people who were not there to ask them lots of questions, or who did not keep asking “the same bloody assessment questions every time”. Participants made a distinction between the mental health team – with their “generic phrases”, “standard list of questions” and “textbook responses” – and nurses who simply talked to them, saying the latter were more helpful.

Feeling cared about

The participants who expressed the most emotion were those who had experienced staff touching them in a caring manner. Only six recounted the use of touch by staff in this way, but all of them cried as they recalled these moments, showing the deep impact it had had on them. One participant said: “When I was talking to the doctor, she was holding my hand. It was just so nice”. Another one said: “She gave me a hug and it meant everything”.

Instances when staff expressed a high level of compassion and commitment were linked to improvements in self-perceived mental wellbeing in 35% of participants, of which 46% reported an increased sense of hope. One participant said: “It made me feel better, more relaxed, like I can actually get through it, as opposed to it is going to end?”. Others spoke of how such positive encounters decreased their anxiety and increased their sense of self-worth. As one of them put it, “It makes me feel more like a person than a bed number”. Four participants directly linked positive encounters with nursing staff or student nurses with no longer wanting to end their lives.

Discussion

Some participants had an experience of care that was well below what we, as healthcare staff, would hope all patients had: 30% of them had had a negative experience of care. This is significantly less than found by Owens et al (2016), Taylor et al (2009) and Horrocks et al (2005). One reason for this could be the higher participation rate (95%), which could have made this study more representative. However, the fact that 30% of participants experienced care as negative and discriminatory is still unacceptable, and suggests that a culture of stigmatising patients who self-harm exists among some staff.

Human contact

In contrast with the literature (Saunders et al, 2012; Taylor et al, 2009; Horrocks et al, 2005), this study suggests that what is needed to improve care is not better staff training in mental health, but staff ability and willingness to show themselves as human beings.

In their systematic review of mental health education programmes for non-mental health professionals, Booth et al (2017) stress that training has little positive effect on patient experience: it produces some short-term positive changes in staff behaviour, but little or no evidence of benefit for patients.

In this study, positive care was not linked to knowledge of self-harm or mental health, but to expressions of kindness, compassion and friendliness. Participants noted this in a variety of ways and were acutely aware of whether these expressions were genuine or not.

Participants valued staff who related to them not as doctors or nurses, but as humans, sharing something of themselves, no matter how brief the encounter. Human contact was valued above specialist knowledge; participants often commented that staff who helped them most were those who were “simply themselves”. It is striking that participants found a great deal of value in talking to student nurses, the least qualified and experienced of all nursing staff on the wards.

Self-disclosure

Participants valued being cared for by a fellow human being and viewed health professionals disclosing something about themselves as enhancing that relationship. For example, staff sharing their own experiences of loss or grief gave participants hope and brought about a sense of closeness within the relationship. It normalised their feelings and made them feel that they mattered. This is echoed by O’Brien (2000) and Stuart (2012), with the latter saying that self-disclosure is seen as “an expression of genuineness and honesty by the nurse and an aspect of empathy”.

Self-disclosure must, however, always be carefully considered before being undertaken. Staff must reflect on why they are disclosing information about themselves – and for whose benefit – and ensure
that professional boundaries are always maintained.

Professional boundaries create an atmosphere of safety for patients within which they can express their feelings; however, as Stuart (2012) helpfully reminds us: “As a general rule, whenever the nurse is doing something special, different, or unusual for a patient, often a boundary violation is involved.”

Seeking to uphold professional standards, however, is not akin to abandoning our humanity; as Wendleton et al (2016) highlights: “If we feel compelled to lead with our roles and not ourselves, we are not truly invested in the care of others”.

This raises important questions around professional boundaries, and self-disclosure requires careful consideration of the risks and benefits, as explored by West and Turner (2009).

**Talking to staff**
In the emergency setting, care is focused on active interventions, and in a busy A&E department or acute ward, the first thing that staff drop is talking to patients (Crowley, 2000). However, half of all participants expressed the wish to have more opportunities to talk to staff, and described this as the greatest help the hospital could provide. For patients who self-harm, it seems that simply being in contact with caring fellow humans can be just as important as therapeutic interventions, if not more so. “By enabling us to communicate our feelings, language can replace isolation with community; it can relieve our suffering, which psychotropics cannot” (Biro, 2010).

**Touch**
This study highlights the power of touch as a means of expressing care and sympathy. Touch had a profound and emotional effect on participants, reinforcing the notion of presence. Touch can help people “feel valued, safe, comfortable, understood, accompanied and restored in ways beyond those who verbal responses alone can convey” (Wosket, 2016). As Stuart (2012) notes: “Touch continues to be the hallmark of nursing with its therapeutic, comforting effects. It is a universal and basic aspect of all nurse-patient relationship”.

It must be stressed, however, that some people may perceive touch as an invasion of space or even a threat. Many factors – culture, gender, setting and past experiences, including abuse – determine how patients will receive touch, so we must be mindful of the potential risks (Videbeck, 2016).

**Box 2. Recommended changes**
- Train staff to provide care with a human touch rather than simply equipping them with specialist knowledge on self-harm
- Educate staff to interact with patients as people, rather than seeing only their mental health conditions
- Encourage staff to recognise and value the positive impact they can have on patients with mental health issues, including those who feel suicidal
- Ensure that there are opportunities for staff to talk to patients, even if these do not require any interventions for their physical health

**Limitations**
This study was undertaken at one hospital experiencing acute pressures in A&E, during the busiest period of the year (December to February). Further research would be needed to conclude that the findings are applicable to other hospitals, or to the Royal Blackburn Teaching Hospital at other times of the year.

The second limitation is that the study population is not representative of all people attending A&E due to self-harm. Further research is being conducted to assess whether the views expressed in this study are representative of the broader population of patients attending A&E due to self-harm – including those who are not admitted to hospital.

**Making changes**
This study supports the need for a number of changes (Box 2). We need to invest ourselves in our encounters with patients and recognise that these encounters can be as important as any other intervention taking place in a busy acute ward.

Enhancing the experience of patients with mental health issues has been adopted as a quality improvement target at the Royal Blackburn Teaching Hospital. Staff across the hospital now meet former patients, listen to their experiences of care, and reflect on their own feelings and perceptions. Feedback has been positive, but we intend to interview patients in the autumn of 2018 to assess whether this initiative has brought about actual change in the emergency setting. For, as Coulter et al (2014) write, “it is unethical to ask patients to comment on their experiences if these comments are going to be ignored”. 

### References


Coulter A et al (2014) Collecting data on patient experience is not enough; they must be used to improve care. British Medical Journal; 348, 15-17.


