Journal of Clinical Nursing 1999; 8: 66–72

The assessment and management of self-harming patients in an Accident and Emergency department: an action research project

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Accepted for publication 9 June 1998

Summary

• The Government, in *Health of the Nation* (DoH, 1992), set targets for health authorities to introduce specific interventions intended to reduce the rates of suicide in the districts for which they are responsible.

• Those who deliberately harm themselves are an important group for interventions aimed at suicide prevention.

• Self-harming individuals are known to seek help from a range of care providers, not just those specifically intended to meet their needs.

• Individuals with problems of self-poisoning and self-injury have placed increasing pressure on general hospital staff involved in their care. There should therefore be adequate services for suicide attempters in every general hospital.

• Policies and protocols must be introduced and evaluated, to ensure that the self-harmer's experience during crisis is not a catalogue of unhelpful encounters.

• This paper is an account of an action research project concerned with the assessment and management of self-harming patients in one accident and emergency department.

• The project aimed to enhance departmental policies and procedures for managing this group of patients.

• Practical problems can inhibit the introduction of even the most desirable of innovations. Action research provides a way of overcoming these problems whilst doing research at the same time.

Keywords: action research, deliberate self-harm, general hospitals, risk assessment, suicide.

Introduction

Suicide remains one of the major causes of death. In highlighting this tragedy, the government, in Health of the Nation (DoH 1992), set targets for health authorities to introduce specific interventions intended to reduce the rates of suicide in the districts for which they are responsible (Palmer, 1993). In response to this an action

research project was initiated as a collaborative venture between the South Buckinghamshire NHS Trust and the University of Luton to evaluate and enhance multidisciplinary assessment and management of deliberate self-harm (DSH) within South Buckinghamshire. Essentially the project asked a range of practitioners how they assess and manage self-harming patients, and how well they work together. Their responses were analysed and related to current literature which indicates how assessment and management should *ideally* be carried out. Following the analysis changes in policy and practice were introduced and evaluated.

This article describes how the methods of the project were applied in an accident and emergency department.

Background to the study

Despite those who deliberately self-harm being a distinct group from those who complete suicide, there is an overlap, with a significant proportion (35%–50%) of those who self-harm going on to kill themselves in the future (DoH, 1994). Those who harm themselves are therefore an important group for interventions aimed at suicide prevention. Self-harming individuals are known to seek help from a range of care providers, not just those specifically intended to meet their needs. Armson (1994) points out that 'many of those at the highest risk of suicide never come into contact in any way with the statutory services designed to help them' (p. 97). The finding that 66% of those who commit suicide are not in current contact with psychiatric services demonstrates the need for collaboration amongst a variety of agencies and services (Barraclough *et al*., 1974). The prevention of suicide should therefore be a priority for *all* potential providers (Appleby, 1992).

Deliberate self-harm (DSH) in general hospitals

Problems of self-poisoning and self-injury have placed increasing pressure on general hospital staff involved in their care. Deliberate self-harm in England and Wales is a common event, with a conservative estimate of 100 000 cases seen in general hospitals every year (Hawton & Fagg, 1992). A general hospital serving a population of 250 000 would therefore expect to see ≈ 500 cases each year.

Assessment and management is not, however, always a therapeutic encounter. Palmer (1993) noted the ambivalent feelings that nurses can have toward the self-harming patient and Pyke & Steers (1992) indicated that professionals have difficulties in establishing relationships with suicidal clients more often than with other groups. According to Alston & Robinson (1992) these patients may evoke in the nurse negative attitudes, such as anxiety, anger, and an absence of empathy. Boyes (1994) suggests that repetition may represent the development of maladaptive coping patterns and often provokes frustration in staff at their inability to 'cure' the patient.

Although these attitudes may be unconscious, patients may sense rejection through the nurse's demeanour and manner. These findings are particularly important as it has been claimed that a response of rejection or hostility may prompt further suicidal behaviour (Costigan *et al*., 1987).

Suokas & Lonnqvist (1989), whilst agreeing that the attitudes of staff towards patients who attempt suicide are often negative, suggest that an increase in knowledge makes it possible to treat these patients in a more professional way.

Clearly, there should be adequate services for suicide attempters in every general hospital (Hawton & James, 1995). Policies and protocols must be introduced and evaluated, to ensure that the self-harmer's experience during crisis is not a catalogue of unhelpful encounters.

As a first stage in this project, an analysis of current practice within the accident and emergency department of one general hospital was undertaken. This 'local diagnosis' is important in order to ensure that solutions are realistic and development activities are based on clearly identified need.

Action research

The ways in which A&E staff manage this particular patient group cannot be fully understood by using research methods which attempt to separate out specific aspects of care (attitudes, for example) and study them in isolation. The treatment an individual patient receives will be the product of a highly complex social system, where numerous interacting factors, ranging from staffing levels to the physical structure of a department, combine to create a 'unique' service.

Whyte (1989) states that the complexities of such organizations are too great to extract principles from experiments in which one, or only a few, variables are manipulated whilst others are held constant. In other words, to explain the outcomes of procedures and interventions targeted at self-harming patients in a particular department, we have to begin by discarding the logic of the controlled experiment.

As an alternative to traditional research methods, action research follows a familiar problem-solving cycle (Fig. 1).

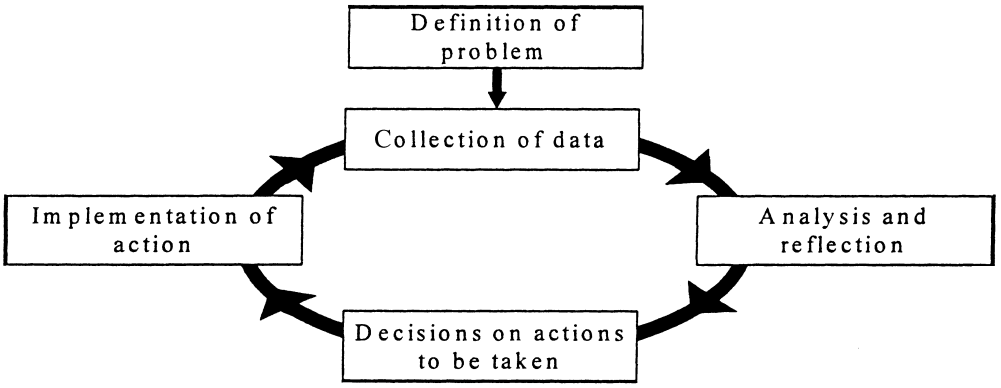

Figure 1 The action research cycle.

Data collection and analysis represent a diagnostic stage, which operates in conjunction with relevant theory to produce the recommendations for change; this is followed by action and evaluation stages.

A unique and sometimes controversial feature of action research is that it involves practitioners in all aspects of the research process, from the initial design of study, through data gathering and analysis, to final reports and actions arising out of the research. Agreement amongst those involved becomes the main criterion by which to determine validity. In this study, the two authors acting as the researchers formed a small project team with two nurses, a junior doctor and one consultant. The team then took responsibility for deciding the objectives, methods and approaches used throughout the cycle.

Research objectives

- To determine the current status of knowledge and attitudes of A&E staff providing clinical care for self-harming patients;
- To identify and develop departmental policies and procedures for managing cases of self-harm.

Data collection

Twenty-two medical and nursing staff, representing 90% of the establishment, participated in individual interviews structured around four cases studies (vignettes) deemed to be representative of patients who commonly present.

By using the same vignettes in each of the interviews it was possible to establish whether management procedures and assessment criteria were employed consistently by all staff in decision making, i.e. by following agreed protocols, or whether judgements were being made on the basis of intuition and personal preference.

In addition we were able to explore the level of competence with which A&E staff approached the assessment and management of self-harming patients. The notion of competence is not a straightforward matter of being able to give the right answers, but includes abilities such as the integration of theory and practice, self-confidence and critical thinking (Hittleman, 1976). The level of 'actual' performance would be indicated by the degree of confidence with which participants responded. Abridged versions of the vignettes are shown in Appendix 1.

The interviews, which lasted ≈ 45 min, took place over a two-week period. In order that staff could be interviewed whilst on duty, interviews were conducted in a room adjacent to the department; this ensured minimum disruption to staffing levels. Interviews were audio-taped and transcribed before being subjected to thematic and content analysis (DePoy & Gitlin, 1994). Themes and categories related to assessment and management were identified by focusing on the use of key words and phrases; subsequently, patterns and trends were noted. Once these had been distinguished and developed, illustrations were given through the use of verbatim quotations.

The data were validated by reference to the original transcript and by distributing a draft report of the analysis to all participants and allowing them to comment in any way they wished regarding accuracy (Lincoln & Guba, 1985). There was no intention to quantify the data.

In addition, the responses were compared to current literature which indicates how assessment and management should *ideally* be carried out. The literature is prolific in this area but a number of key documents served as the main texts. In particular the Royal College of Psychiatrists (1994) have issued guidelines on the management of self-harm in general hospitals and the Department of Health (1994) has produced 'Suicide Prevention: the Challenge Confronted' which also relates to deliberate self-harm.

Summary of findings and outcomes

The confidence and conviction with which staff approached assessment varied considerably, and was often dependent upon time, intuition and personal bias; hence, in general, the process was neither consistent nor comprehensive. It was therefore recommended that procedures be introduced to ensure that a systematic psychosocial assessment of *all* patients was undertaken and recorded.

A number of assessment tools were considered and piloted, based on the premise that the A&E staff must focus their attention primarily on risk assessment, i.e. determining whether or not an individual is likely to commit suicide or perform further acts of self-harm. Such assessment guides are useful as an aid to risk assessment, but the final decision is inevitably a complex judgement, based on the patient's perceived psychological state at the time of the interview. This can be determined as much by the way in which answers are given as by the content of what is said.

The assessment tool (Appendix 2), which has now been adopted by the unit, combines actuarial factors such as age, sex, level of social support, and variables known to be statistically significant in predicting suicide, with a modified version of Beck's intent scale (Beck *et al*., 1974), which requires obtaining a detailed account of the incident itself.

The study did not support the view that assessment should only be undertaken by senior medical staff. By their own admission they are the least likely to have significant contact with these patients. Instead it was recommended that nursing staff should increasingly undertake this role as they often spend more time with patients and stay in the department for longer periods. Nor was there any evidence in this study that their skill and motivation to undertake this role are necessarily inferior to those of the senior medical staff.

Despite the cause of self-harm and the associated management problems often being identified as social or alcohol related, the only resource to be cited consistently by interviewees was the psychiatric service. This was seen as problematic, in that a comprehensive assessment could indicate the need for referral to a variety of resources, including social, drug and alcohol services, and other local facilities, including those from the voluntary sector.

It was therefore recommended that, to achieve a more uniform approach to, and understanding of, all possible services and available options, a multidisciplinary 'self-harm planning group' should be established. This group would take responsibility for developing self-harm services and intra-agency co-operation.

Attitudes of the staff interviewed were mixed and appeared to be the result of personal history rather than professional background. In most cases there were expressions of sympathy, but typically staff did not see this group of patients as rewarding nor as making an appropriate use of the department. However, a number of staff commented that they very rarely received any follow-up information regarding these patients and that this lack of feedback negatively affected attitudes. As a result, it was recommended that information concerning patient progress and outcomes be incorporated into departmental communication systems, such as team briefing.

Summary of recommendations

- A 'self-harm planning group' should be established, to include at least social services, primary care and representatives from the voluntary sector;
- A standardized questionnaire and interview procedure should be developed and evaluated to include all aspects of psycho-social assessment;
- A training programme should be designed that ensures that staff are comfortable and confident in undertaking such assessment.
- A system that informs staff of patient progress and outcomes should be introduced.

Conclusion

The recommendations have now been implemented and regular half-day workshops are arranged for new staff, in order to familiarize them with the assessment procedures and address any difficulties that might be experienced in their implementation.

As a result of the study, a foundation has been laid which enables various aspects of the service to be evaluated. Information taken from the assessment tool can be used, either as part of an audit or in more formalized research, to address questions such as how accurately are we able to identify those at greatest risk, and which resources or services are used most often.

It has to emphasized that, unlike experimental research, the purpose of the project was to bring about change, which Whyte (1989) defines as any 'attempt to alter or replace existing knowledge, skills, attitudes, norms and styles of individual groups' (p. 6).

Chinn *et al*., (1976) note that change has to be managed, and suggest that those required to use an innovation should be intimately involved in its development and implementation. Ottaway (1976) emphasizes that change

should begin with the 'doers', who must participate fully in the change process. He suggests that 'top down' approaches often result in temporary change only, and highlights the need for a continuous cycle of education and change if new skills and knowledge are to be internalized. Even so, practical problems can still prevent the introduction of important innovations. Action research provides a way of overcoming these problems, whilst doing research at the same time (Webb, 1989).

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Appendix one

THE VIGNETTES

Case A: Jane, a 19-year-old who has taken an overdose of paracetamol following an argument with her boyfriend. This is the second time she has attended the department this month following an episode of deliberate self-harm.

Case B: James, a 50-year-old who has recently been made redundant and discovered that his wife is leaving him. He was found unconscious in his car, in the garage, with a hose pipe connected to the exhaust.

Case C: Sally, a 30-year-old publican's wife with a history of marital problems, largely attributed to her husband's heavy drinking. She has taken an overdose of prescribed sleeping pills.

Case D: Arthur, a 40-year-old with no fixed abode, a history of alcohol abuse and downward social mobility. He is believed to have taken an overdose of paracetamol mixed with alcohol. He appears drunk and is refusing help.

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SELF-HARM RISK ASSESSMENT FORM

Appendix 2

Surname _____ **First Name** _____ **Date of assessment** _____
Sex M ~ F **Age** _____ **A&E No.** _____

CIRCUMSTANCES RELATING TO THE ATTEMPT ***(Please circle appropriate response)***

1. Isolation:
(was anyone known to be near by at the time?)
0 someone present
1 someone nearby or in visual or vocal contact
2 no one nearby in visual or vocal contact.

2. Timing:
(how did timing of attempt effect intervention?)
0 discovery probable
1 discovery unlikely
2 discovery/intervention highly unlikely.

3. Precautions:
(how easy/difficult would it have been to prevent the attempt if discovered?)
0 no precautions
1 passive precautions, e.g. alone in room with unlocked door.
2 active precautions, e.g. locked door.

4. Acting to get help during/after attempt:
(e.g. phoned an ambulance or friend.)
0 notified potential helper regarding attempt
1 contacted but didn't specifically notify potential helper regarding attempt
2 did not contact or notify potential helper.

5. Final acts in anticipation of death:
(e.g. will, gifts, insurance.)
0 none
1 thought about or made some arrangements
2 made definite plans or completed arrangements.

6. Preparation for attempt:
(was this impulsive or had, for example, tablets been gradually collected?)
0 no preparation
1 minimal to moderate
2 extensive preparation.

7. Suicide note/message:
0 no note or message
1 note thought about, or if written torn up
2 presence of note/message.

8. Communication of intent:
(was anything said or done indicating attempt was to occur?)
0 none
1 ambiguous communication, e.g. "I might not be here tomorrow"
2 unambiguous communication, e.g. "I'm going to kill myself".

Report from patient

9. Alleged purpose of attempt:
0 to affect others, e.g. get attention, revenge
1 components of 0 and 2
2 to escape, solve problems.

10. Expectations of fatality:
0 thought that death was unlikely
1 thought that death was possible but not probable
2 thought that death was probable or certain.

11. Understanding of lethality of chosen method:
0 did less to self than thought would be lethal
1 was unsure if action would be lethal
2 equalled or exceeded what s/he thought would be lethal.

12. Seriousness of attempt:
0 did not seriously attempt to end life
1 uncertain about seriousness to end life
2 seriously attempted to end life.

13. Degree of premeditation:
0 none, impulsive
1 contemplated for 3 hours or less before attempt
2 contemplated for more than 3 hours before attempt.

Total Score =

PLEASE ENSURE COMPLETED FORM IS *COPIED* AND LEFT IN A&E. THANK YOU.
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SELF-HARM RISK ASSESSMENT FORM

Please tick one or more boxes

Time of attempt (approx.)→	00:01–08:00	☐
	08:01–16:00	☐
Date of attempt	16:01–24:00	☐
	Unknown	☐
Nature of self-harm	Poisoning, e.g. drugs, gas, exhaust, other ingested substances	☐
	Self mutilation/cutting	☐
	Violent harm, e.g. hanging, drowning, shooting	☐
	Other	☐
Please specify nature of self-harm:→		
Reason for attempt	Relationship difficulties	☐
	Psychiatric problems	☐
	Social circumstances, e.g. jobless, financial worries, housing problems	☐
	Other	☐
Please specify reason for attempt:→		
Has reason for attempt resolved?	Yes	☐
	No	☐
	Unclear/uncertain	☐
Previous episodes of deliberate self-harm	None	☐
	One or two	☐
	Three or more	☐
Social Support	Isolated	☐
	Healthcare, social services, volunteers available	☐
	Family, friends available	☐
Reaction to surviving attempt	Glad to have recovered	☐
	Uncertain whether s/he is glad or sorry	☐
	Regrets s/he is still alive	☐
Alcohol before or during the attempt	Yes No (please circle)	
History of alcohol/drug abuse	Yes No	
Appeared intoxicated during assessment	Yes No	
Past psychiatric history	Yes No	
Thoughts of self-harm after attempt?	Yes No	

Overall impression

_____

_____

_____

_____

_____

Outcomes (please tick)

GP review or no review	☐	**Psychiatric assessment**	☐
Medical admission	☐	**Other (please specify)**	☐

The guidelines for the management of self-harm should be read and understood before assessment and completion of this form is undertaken. Copies of the guidelines are available in the department.

Name of Assessor: **Signature:**

Designation:

PLEASE ENSURE COMPLETED FORM IS *COPIED* AND LEFT IN A&E. THANK YOU.
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