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Healthcare staff's views on responding to suicide and self-harm: Part II

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Abstract

Purpose: To report on healthcare staff's views of the barriers to preventing suicide and self-harm.

Design and Methods: Using a qualitative approach, data were collected through "World Café" discussion forums and written submissions, and analyzed using reflexive thematic analysis.

Findings: Healthcare staff, including psychiatric nurses, perceived that a whole of society approach was needed for suicide and self-harm prevention. Support for those at the front line is needed as well as clear referral pathways and interagency working.

Practice Implications: Formalized support for staff working in healthcare should be given with a flexible and inclusive approach to service delivery adopted.

KEYWORDS
healthcare staff, qualitative research, self-harm, suicide, world café

1 | INTRODUCTION

Suicide and self-harm are leading causes of mortality and morbidity worldwide. The World Health Organization[1] estimates there to be almost 800,000 deaths annually from suicide, reflecting an annual global age-standardized suicide rate of 10.6 per 100,000 population. Suicide is the 10th greatest cause of mortality in the United States among all age groups but is ranked 2nd in those aged 10–34 years.[2] In Ireland, there are 10 deaths per 100,000 population each year from suicide, comparable to the European Union (EU) average of 11 per 100,000.[3]

There are several risk factors for self-harm and suicide, including previous suicide or self-harm attempts, history of substance misuse or trauma/abuse, and financial or social losses.[4] Although it has been argued that self-harm and suicide serve distinct functions,[5] self-harm remains the single biggest risk factor for suicide.[6] In the United States, self-harm data are not centrally collated; however, the Centers for Disease Control and Prevention (CDC) collects survey data, as well as hospital data on nonfatal injuries from self-harm. In 2018, The CDC[7] estimates approximately 575,000 people attended a hospital for injuries due to self-harm. In Ireland, there were 12,588 recorded presentations to hospitals due to self-harm in 2018, involving 9785 individuals. This represented a rate of 210 per 100,000, and reflected a 7% increase in presentations for males and a 5% increase for females from the previous year.[8] Data from the National Suicide Research Foundation[8] also indicate that although almost three-quarters of patients that present to Irish hospitals due to self-harm receive a mental health assessment, there is considerable variation in the level of care received upon discharge from the Emergency Department (ED).

Assessment of suicidal ideation and self-harm may be hindered by several factors, including acute medical issues or misuse of substances. Furthermore, healthcare staff have reported a lack of training can result in "fear" and "discomfort" when assessing for suicide and self-harm.[9] Indeed, it has been suggested that the presence or absence of training and education can positively or negatively influence healthcare staff attitudes towards suicide and self-harm.[10] In 2016, the Irish Health Service Executive (HSE) published the *National Clinical Programme for the Assessment and Management of Patients Presenting to Emergency Departments Following Self-Harm*.[10] This policy document made a series of best practice care recommendations, including the need for training for key mental health staff delivering services.

Another Irish national strategy document, Department of Health,[4] aims to gain a better understanding of suicidal behavior, develop targeted approaches for those vulnerable to suicide and self-harm, and generate evidence-based research. Research to date has focussed on service users' perspectives of services that care for people with suicidal ideation (SI) or thoughts of self-harm (TSH; e.g., 11,12), rather than on the perspectives of healthcare staff. Furthermore, while there is some evidence examining mental health staff's experiences of caring for people with SI or TSH (e.g., 13), there is very little data focusing on ancillary staff or those working within the wider health and social care services with whom vulnerable people may come into contact.

2 | PURPOSE OF THE STUDY

The overall aim of this study was to explore healthcare staff's views on awareness of and response to suicide and self-harm. This study reports on staff's views of the barriers to preventing suicide and self-harm.

3 | DESIGN AND METHODS

A qualitative descriptive design was utilized. This approach facilitated the creation of a space where participants could express their views, opinions, and experiences without being limited by a particular philosophical framework or theoretical perspective.[14]

3.1 | Data collection

A World Café format was adopted. World Cafés are a form of participatory action research and are useful in generating free-flowing conversations in social research that can shape future direction. In a World Café, all participants are regarded as experts due to their diverse experience and knowledge. World Cafés follow a prescribed format, including small group "round table" discussions and large group "harvesting" of ideas.[15] In this study, the "host" introduced the purpose of the research. Consent forms were explained and signed, and each participant was assigned to one of four tables. At each table, a secondary host (researcher) asked a series of questions relating to suicide and self-harm. The question guide was developed in consultation between the research team, clinical experts in self-harm and suicide, and Experts by Experience (i.e., those with lived experience of mental health service use).

World Cafés were held in five separate sites across Ireland: three urban and two rural areas. Participants (between 4 and 6 per table) were randomly assigned to tables to ensure the views of a wide range of staff were reflected. After 15 min, participants moved tables; every participant contributed to discussions at all four tables. Responses were recorded on flip-charts and participants also wrote individual thoughts on "post-it" notes. Where feasible, an additional researcher sat at each table and recorded verbatim quotes from participants. Harvesting of ideas then occurred with the entire group, allowing for misunderstandings to be clarified and further information to be added. Each World Café ran for approximately 90 min.

3.2 | Recruitment and participants

All individuals employed by the HSE were eligible to participate. This included allied health and social care staff, administrative and management staff, nurses, midwives, medical staff, dental staff, general support staff, and patient and client care staff. Staff of all grades were eligible, and participants had to be over 18 years of age.

A purposive sampling strategy was used. An email was sent to the Heads of Services to inform them of the study, as well as a general broadcast email to all HSE email account holders. An invitation to participate on a voluntary basis was included, along with a participant information leaflet, a list of personal supports available to staff, and a consent form. Those interested in participating were asked to contact the project team via email/telephone. As the number of interested participants exceeded the number that could be facilitated at each site, potential participants were offered the

TABLE 1 Sample characteristics

Role	N	(%)	Setting	N	(%)
Allied health and social care	59	(41.3)	Mental health	56	(39.2)
			Primary care	36	(25.2)
Management/ administration/ICT	32	(22.4)	Acute care	19	(13.3)
Nursing and Midwifery	31	(21.7)	Corporate	12	(8.4)
Medical and dental	7	(4.9)	Social care	11	(7.7)
General support staff	7	(4.9)	Health and wellbeing	5	(3.5)
Patient and client care	7	(4.9)	Multiple settings	4	(2.8)

opportunity to email a written submission; separate guidelines and consent forms were available to those who chose this option. No names, email addresses, or demographic details were recorded.

The final sample included 143 participants ($n = 119$ female, $n = 24$ male) for the World Cafés (see Table 1). Written submissions from 10 individual staff were also received and analyzed.

3.3 | Data analysis

Data comprised the content of the roundtable and harvest flip-charts, post-it notes from the roundtable discussions, and written submissions. Data were analyzed by two researchers (John Goodwin and Caroline Kilty) using reflexive thematic analysis.[16,17] The analysts immersed themselves in the data and then coded the data. Potential themes were generated; these were then reviewed by other analysts (Aine Horgan and Elaine Meehan), defined and named. The analytical narrative was then written up, supported by verbatim quotes recorded by scribes.

3.4 | Ethics

Ethical approval was obtained from the relevant Institutional Review Board (Log: 2019-121).

4 | FINDINGS

Six themes were identified overall. The first three themes are reported in part 1 of this study.[18] Three themes are reported here: (1) supporting staff working in healthcare settings, (2) accessing healthcare services, and (3) adopting a whole-society approach to suicide and self-harm. Results are illustrated using participants' quotations. Written submissions are numbered based on the order in which they were received by the research team, while quotations from World Cafés are identifiable by a number only to protect the anonymity of participants.

4.1 | Supporting staff working in healthcare settings

It was evident from participants' accounts of their personal experiences that working with people experiencing SI or TSH can be challenging for healthcare staff, and many participants expressed feeling a level of personal vulnerability at times due to their own personal life experiences. They acknowledged that when addressing the needs of people who present with SI or TSH, their professional role resulted in them trying to conceal this. One participant likened this to putting on a "mask":

> *"We're just ordinary members of the public and suicide affects us too" (World Café [WC] 5)*

> *"Put your mask on first before you help the person alongside you" (WC4)*

For some participants, their vulnerability was amplified by the stress they experience in their everyday lives. Owing to this many participants felt that their ability to engage with people in distress was limited, as was their potential for identifying signs of self-harm and SI.

> *"If staff themselves are stressed out there's no way they can help vulnerable people" (WC1)*

> *"Vulnerable adults caring for vulnerable adults" (WC5)*

It was suggested that a supportive, inclusive workplace environment is needed to enhance their ability to respond to those in crisis. Some participants felt that an emphasis on paperwork, policy, and procedure in today's healthcare environment left little time to offer emotional support to staff working on the frontline.

> *"We need a culture shift in our services particularly for staff under stress" (WC2)*

> *"I think we have empathy for patients but not empathy with colleagues" (WC5)*

4.2 | Accessing healthcare services

Participants identified several areas which they perceived to have a direct impact on the care of people experiencing SI or TSH. There was a feeling that members of the general public were often not very well-informed about the structure and operation of mental health services. A number of participants commented that mental health services can be difficult to navigate for those working within the health services, meaning that non-healthcare staff could be at a further disadvantage in times of crisis.

"Currently, I feel it is quite difficult for someone to access professional services" (Written Submission [WS] 8)

"When you work in the service and you can't navigate it, what hope have you if you don't?" (WC1)

The issue of mental health services mostly operating on Monday to Friday, 9 a.m. to 5 p.m. basis, with a limited number of supports available out-of-hours, was raised by many participants. Other issues raised included a perceived lack of resources to accommodate people's needs around counseling services, psychotherapy, and talk therapies, as well as long waiting lists to avail of privately funded supports and services.

"I imagine that a major issue for most people is the waiting times for accessing mental health/psychological/counseling services […] due to chronic underfunding in this area" (WS4)

Many participants felt that some regions are better serviced than others. Participants from rural areas believed that they were at a disadvantage due to the lack of services that are often centralized in urban areas. Due to the wide geographic spread of services in Ireland, participants noted the inconsistent approach taken to the provision of mental services nationally.

"A lot of inconsistencies throughout this small island" (WC2)

"A lot of places wouldn't provide a suicide specific service" (WC4)

There was an acknowledgment that many excellent quality services exist, it was also stated that in some areas there are limitations in terms of crisis options. There was a sense that crisis service access should be more responsive, with rapid access, and drop-in facilities made available. It was also recommended that services should be accessible 24-h a day and via a number of means, such as text message supports. It was also felt that there should be greater access to services such as counseling (primary care) and clinical teams (day hospitals).

"You should be able to get emergency support straight away" (WC1)

4.3 | Adopting a whole society approach to suicide and self-harm

Participants identified that one of the barriers to preventing self-harm and suicide was as a lack of awareness among members of the public; it was suggested that a whole society approach to suicide and self-harm prevention needs to be taken.

"This is a societal issue" (WC2)

It was perceived that there is still a stigma attached to suicide and self-harm. It was recommended that steps be taken to ensure that communities begin to have open conversations around these topics. Such conversations would encourage the "normalization" of sensitive topics and reduce people's fears around speaking about suicide and self-harm. It was suggested that this approach would also make people less afraid to talk about their experiences within their local communities, thus increasing people's likelihood of seeking help.

"Open the conversation about your experiences, making the conversation normal" (WC1)

It was considered that education around suicide and self-harm should be given to the general public through schools. It was recommended that teachers should receive education on suicide and self-harm as part of their university courses. This information could then be translated into practice workshops with the students for whom they end up having responsibility. Participants suggested a focus on educating students about how to access services, but also on the development of personal coping strategies. It was believed that, by introducing people to these concepts in childhood (e.g., primary/elementary school), the general public would be much more aware of how to manage mental distress in adulthood.

"Prevention of suicide—like measles—should begin with inoculation [in childhood]" (WC2)

"I think it has to be done in schools to make students aware that it's okay not to be okay" (WS7)

In addition to stigma reduction and "normalization", the importance of communities becoming aware of how to recognize and respond to suicide and self-harm was emphasized. A number of training programs—such as safeTALK and Applied Suicide Intervention Skills Training (ASIST)—were cited as being very relevant to the general public, and it was strongly recommended that communities undertake such programs.

"Everyone should have a basic level of training or awareness" (WC1)

"Make ASIST training mandatory even in bar staff, hairdressers, taxi drivers" (WC4)

Several participants highlighted the number of good anti-stigma and suicide and self-harm education media campaigns with which the general public would be familiar. However, they commented that media campaigns did not often provide sufficient information for people experiencing distress, with a focus on awareness rather than practical suggestions for what to do in times of crisis. Furthermore, participants expressed that joined up thinking in relation to the various media campaigns from the health services and voluntary sector is needed to maximize the impact on the general public.

"Campaigns raise awareness but not tools for people in distress" (WC4)

"There's a day for everything now, that's a problem. Everything's so fast and you forget afterwards" (WC5)

It was perceived by healthcare staff that the general public may be over-saturated with information, due to the many ways information is disseminated (e.g., leaflets and websites). As such, it was suggested that people in crisis or family members looking for support or advice need a singular point of access to information.

"It's overwhelming, there's too much information on mental health supports" (WC2)

"There is unfortunately a plethora of information at present on online, etc., so it takes somewhat from its take up and effectiveness" (WS9)

Participants highlighted that healthcare staff are also exposed to large volumes of information, with email being their primary mode for receiving information related to suicide and self-harm. This communication mode perceived as not effective because information can become easily lost, and staff who need to have access to such information may miss relevant emails.

"Information gets lost in email" (WC2)

For both staff and the general public, the importance of a more consolidated approach to information dissemination was recommended by healthcare staff. Rather than there being a range of websites being available covering the same topic, it was suggested that one comprehensive website be developed. In relation to print media, instead of large volumes of information leaflets, a one-page summary was recommended; it was suggested that this should clearly list referral pathways for those in distress.

"Personally, I find the less is more approach better for me when explaining resources, help, supports of new information" (WS1)

"It would be great if the HSE had one website where you could type in an area and search for a service" (WC4)

5 | DISCUSSION

The overall aim of this study was to explore healthcare staff's views on awareness of and response to suicide and self-harm. This study reported on staff's views of the barriers to preventing suicide and self-harm. Many participants expressed concerns about working with those presenting with SI or TSH due to their own personal stress. Several studies have reported that service users who experience SI or TSH are often not satisfied with the care they receive from mental healthcare staff.[19–22] In all these studies, service users felt staff, such as psychiatric nurses, did not have adequate knowledge or were unequipped to engage with people who experience SI or TSH. Findings from the current study shed new light on previous research: observations about how staff (in mental health care and otherwise) engage with service users may be less as a result of their competence, and more as a result of their own stress. Further research is warranted to explore if and how working in healthcare settings impacts on the mental health of staff and how this in turn affects how they engage with, and meet the needs of service users. This is important, as those who have had negative experiences with healthcare services following an attempted suicide or episode of self-harm often disengage from healthcare services.[20]

Perceived barriers to accessing services by the general public were also highlighted. Participants highlighted that mental health services can be difficult to navigate. In Ireland, the HSE provides public mental health services that offer a range of community and hospital-based supports. To access services, people are advised to first contact their General Practitioner, or, in case of emergency, to present at the Emergency Department; a referral can then be made to the mental health services.[23] Private services are also available to people, which are supported by health insurance

Faedo, Normad ($year$).[24,25] Despite the availability of such services, several studies have highlighted that people who self-harm or experience SI rarely seek help.[26–29] While such poor help-seeking attitudes have been linked with stigma,[28,30] there is some limited evidence to suggest that the general public are not aware of how relevant services may be accessed.[31] Globally, there has been a concentrated effort through educational initiatives and campaigns to improve the public's knowledge of mental distress[32,33]; however, there is also a need to enhance the public's knowledge of mental health services to ensure that adequate support can be provided.

For those who did access services, perceived problems such as limited opening hours, lack of equity between services, and long waiting lists were reported. Internationally, other studies also suggest that certain geographical areas are better serviced than others,[34] and that people experiencing mental distress are often faced with extended delays in accessing care.[19,35] Opmeer et al.[36] reported on a UK service that, following an investment of £250,000, extended its opening hours beyond Monday to Friday, 9 a.m. to 5 p.m., to a 7-day week service operating from 8 a.m. to 10 p.m. Statistically significant decreases were observed in waiting times, while significant increases were observed in the number of assessments performed. Owing to more efficient assessment procedures, the authors commented that the cost of extending staff's hours may be offset. There have been recent developments in this area (such as the introduction of 24-h mental health information lines in Ireland,[37] in addition to the extension of adult community public mental health services to a 7-day week, again in Ireland, provided by the national health service (the HSE),[38] there is a need to continue to extend healthcare services beyond traditional working hours to meet society's current needs.

It was suggested that every member of society should receive some form of education or training around suicide and self-harm. Several studies have evaluated the implementation of such education or training programs. In the United States, 51 college employees who engaged in ASIST demonstrated significant improvements in responding to people in distress when compared to a control group.[39] Both Asarnow and Wang[40] and Lai et al.[41] found that community engagement in suicide prevention programs resulted in significant decreases in suicides in the United States and Hong Kong, respectively. Considering the positive effects of such programs, it is recommended that communities promote some form of suicide and self-harm education or training. Of note, the World Health Organization[42] provides a freely available online toolkit for communities to become more suicide aware.

Many participants recommended that such education should begin in school. Several studies have evaluated the effectiveness of school-based interventions in this area. In a multicountry randomized control trial, Wasserman et al.[43] found that students who engaged in the Youth Aware of Mental Health Programme reported significant reductions in suicide attempts when compared to a control group. Kinchin et al.[44] found that students who engaged in safeTALK demonstrated improvements in suicide-related knowledge and willingness to seek help; however, help-seeking intentions did not sustain at 4-week follow-up. Longitudinal approaches are warranted to determine the effectiveness of engaging youths in such programs, and to inform the development of future programs.

To enhance community awareness around suicide and self-harm, participants recommended improving the way in which information is disseminated. Mass media campaigns have been used for decades as a tool to promote healthy behaviors; however, suicide and self-harm prevention campaigns are a much more recent development, meaning there is little evidence available to support their effectiveness.[45] Daigle et al.[46] found that exposure to a media campaign during Suicide Prevention Week did not influence attitudes around suicide and did not improve help-seeking intentions or help-seeking behaviors. Both Song et al.[47] and Pirkis et al.[48] found that exposure to such campaigns significantly improved people's knowledge about suicide but had no effect on attitudes. Although participants in the current study felt that there was an over-abundance of suicide and self-harm-related information available to the general public, Torok et al.[45] commented that campaigns that adopted a multicomponent strategy were more successful than those that relied on singular strategies. However, the authors also noted that more passive approaches (such as use of billboards, posters, TV, or radio) were much less successful than campaigns that actively engaged people. Given these findings, the suggestions of participants in the current study, and the dearth of evidence available, there is a need to conduct further research into how best to disseminate information about self-harm and suicide without minimizing its effectiveness, or overwhelming people.

This study has limitations. Each World Café was of only 90-min duration, with each roundtable discussion lasting 15 min. Had extra time been permitted to participants, a more in-depth approach could have been facilitated. Second, data collection only took place across five sites; it is possible that staff in other sites may have alternative perspectives to those presented here.

6 | IMPLICATIONS FOR PSYCHIATRIC NURSING PRACTICE

The findings from this study will contribute to the evidence base and inform future national guidelines for assessment of and response to suicidal ideation and self-harm in the Irish health services. To enhance service delivery, and to support healthcare staff, including psychiatric nurses, in meeting the needs of patients presenting with SI or TSH, it is recommended that efforts be made to ensure staff feel fully supported in their roles. Furthermore, it is recommended that healthcare organizations adopt a more inclusive and flexible approach to ensure that people who experience SI or TSH can receive adequate and timely support. Communities should endeavor to become more suicide-aware and become actively involved in suicide prevention programs. Given their effectiveness, such programs should be introduced at the school-level; longitudinal research needs to evaluate their success over longer periods of time. Such programs should be informed by psychiatric nurses and other healthcare staff. Given the problems with current approaches, research is also warranted around how to effectively disseminate suicide and self-harm information to the general public. It is crucial that a concentrated effort is made to reduce instances of self-harm and suicide, and a whole-society approach is key to achieving this.

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CONFLICT OF INTERESTS

The authors declare that there are no conflict of interests.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author (Áine Horgan). The data are not publicly available due to restrictions (e.g., their containing information that could compromise the privacy of research participants).

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