Understanding prehospital care for self-harm: views and experiences of Yorkshire Ambulance Service clinicians

Self-harm is one of the most common reasons for people to present to EDs.[1] Ambulance clinicians are often the first professionals involved in their care. This encounter affects immediate actions and long-term outcomes by influencing future help-seeking behaviour.[2] Little is known about prehospital care for people who self-harm,[3] although assessing and managing this group represents a unique challenge for ambulance clinicians.[4] This study aims to explore the views and experiences of Yorkshire Ambulance Service (YAS) clinicians of prehospital care for self-harm.

This is a cross-sectional questionnaire using an online platform (Online Surveys, www.onlinesurveys.ac.uk; Jisc). The questionnaire was designed by the research team and piloted by four YAS academic paramedics (see online supplemental file 1). It was open from 5 to 30 September 2022 and shared with ambulance clinicians (clinicians working on ambulances) employed by YAS using social media and email bulletins. Multiple-choice answers were analysed using descriptive statistics; free-text responses were analysed independently by two researchers (DR, EG) using thematic analysis.[5]

Twenty-six clinicians responded to the questionnaire, representing a 0.9%–1.0% response rate. Seventeen (65%) were female and 16 (62%) were paramedics. Seventeen (65%) reported not receiving specific mental health training in their roles. Self-harm was a common presentation in their experience; 19 (73%) indicated that they were called to assess or manage a patient who had self-harmed in the previous 2 weeks. Only nine (35%) felt confident caring for this group, and four (15%) felt that their training and education had adequately prepared them. Table 1 summarises the responses to the multiple-choice questions.

Table 1 Responses to multiple-choice questions

Variable	Category	Number (%)
Gender	Male	9 (35%)
	Female	17 (65%)
Job role	Paramedic	16 (62%)
	Emergency care assistant	5 (19%)
	Emergency medical technician	2 (8%)
	Ambulance practitioner or associate ambulance practitioner	3 (12%)
Years of experience working in ambulance services	0–5	6 (23%)
	6–10	7 (27%)
	11–15	4 (15%)
	16–20	6 (23%)
	21+	3 (12%)
Received specific mental health training	Yes	7 (27%)
	No	17 (65%)
	Unsure	2 (8%)
Number of calls to assess/manage a patient who has self-harmed in the past 2 weeks	0–2	17 (65%)
	3–5	8 (31%)
	6–10	1 (4%)
Confidence in assessing/managing patients who have self-harmed	Very or somewhat unconfident	8 (31%)
	Neither confident nor unconfident	9 (35%)
	Very or somewhat confident	9 (35%)
Felt prepared by training and education to assess/manage patients who have self-harmed	Very or somewhat inadequately	18 (69%)
	Neither adequately nor inadequately	4 (15%)
	Very or somewhat adequately	4 (15%)
Ease contacting colleagues for advice on management of patients who have self-harmed	Very or somewhat difficult	21 (81%)
	Neither easy nor difficult	3 (12%)
	Somewhat or very easy	2 (8%)
Access to useful resources for the assessment/management of patients who have self-harmed	Yes	7 (27%)
	No	9 (35%)
	Unsure	10 (39%)

Listed facilitators to good clinical care for people who have self-harmed included previous clinical experience, training in mental health and injury management, availability of mental health services and advice, verbal and non-verbal communication skills, online resources and support from senior colleagues. They were then asked to identify barriers to good clinical care for this group. The following themes emerged: lack of mental health pathways, services and support, lack of mental health education and training and patient factors.

Respondents were asked about their views on the future of emergency care for self-harm. They indicated that confidence and competence in mental healthcare among ambulance clinicians could be improved by mental health training and education, improved availability of mental health and wound care services and better access to senior support and advice. The following themes emerged among suggestions for improvements to the acute care pathway for self-harm: alternatives to EDs, increased availability of mental health support, more staff and resources, mental health training and guidance for the management of patients declining to attend hospital.

All participants responded to all free-text questions. Table 2 summarises the results of the free-text questions, including key themes, supporting quotations and number of respondents belonging to each theme.

This preliminary study was limited by the low response rate but strengthened by the breadth of qualitative data. The findings show that the clinicians who responded do not feel confident or prepared when assessing and managing patients who have self-harmed. Improvements in mental health training for ambulance clinicians and greater availability of mental health services are needed to improve prehospital care for people who self-harm.

We have begun to address the literature gap in paramedic care for self-harm. Respondents support the National Institute for Health and Care Excellence recommendations that alternative services to EDs, such as specialist mental health services and primary care, could improve patient satisfaction and engagement.[6] This should be considered by commissioners and policymakers.

Table 2 Thematic analysis of free-text questions

Free-text question	Theme	Supporting quotation	Number of respondents (%)
Facilitators to good clinical care for people who have self-harmed	Previous experience	*"Clinical care for the wounds is based on my wound care experience as I have never had minor injury/self-harm training"*—Respondent 21	10 (38.5%)
	Training in mental health and injury management	*"Due to a lack of formal training in mental health first aid, I have found experience has been the main thing that has helped when dealing with self-harm patients. Unfortunately now with less experienced staff in the service this will be lost—so formal mental health training becomes even more important"*—Respondent 10	6 (23.1%)
	Availability of mental health services and advice	*"Availability of MH services providers"*—Respondent 9	6 (23.1%)
	Verbal and non-verbal communication skills	*"Respect, empathy, understanding, non-judgmental approach"*—Respondent 8	6 (23.1%)
	Online resources	*"JRCALC guidelines, MH CPD"*—Respondent 23	3 (11.5%)
	Support from senior colleagues	*"Senior paramedic input and advice"*—Respondent 11	2 (7.7%)
Barriers to good clinical care for people who have self-harmed	Lack of mental health pathways, services and support	*"Referral pathways (lack of), lack of out of hours assistance/help for people who have self-harmed. Regularly been told to 'take a patient to A&E' by crisis team, when it's not always the appropriate place for them or makes them more agitated"*—Respondent 13	17 (65.4%)
	Lack of mental health education and training	*"Given that I have received no mental health training/lack of CPD in this topic there is a lack of confidence dealing/ treating with these patients who have self-harmed"*—Respondent 21	4 (15.4%)
	Patient factors	*"Bystanders/family/NOK, hostile or dangerous environments, the self-harmer"*—Respondent 24	4 (15.4%)
Suggestions to improve confidence and competence in mental healthcare among ambulance crew	Mental health education and training	*"Having proper training delivered by mental health professionals"*—Respondent 20	19 (73.1%)
	Increased availability of mental health and wound care services	*"More robust and effective policies and procedures, better and more constructive input from other services, especially specialist MH providers"*—Respondent 1	8 (30.1%)
	Better access to senior support and advice	*"Colleagues that are genuine… For TLs/managers/ seniors to be fair and conditional… Reliable seniors"*—Respondent 24	3 (11.5%)
Suggestions to improve the acute care pathway for self-harm	Alternatives to EDs	*"Alternative 'safe' places for patients to be taken to other than A&E"*—Respondent 5	9 (34.6%)
	Increased availability of mental health support	*"Access to MH services is notoriously hard, and if it's out of ours it's nigh on impossible. AMHPs need to be availing EDs rather than waiting for the one on duty to be available to go to the patient, tying crews up for many hours"*—Respondent 17	14 (53.8%)
	More staff and resources	*"More services, more staff, less hurdles to access"*—Respondent 3	2 (7.7%)
	Mental health training	*"Increased training to help staff understand the reasons behind self-harm"*—Respondent 4	2 (7.7%)
	Guidance for the management of patients declining to attend hospital	*"Specific signposting leaflets for patients who wish not to attend ED"*—Respondent 8	2 (7.7%)

AMHP, Approved mental health professional; CPD, Continuing professional development; JRCALC, Joint Royal Colleges Ambulance Liaison Committee; MH, Mental health; NOK, Next of kin; TL, Team leader.

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REFERENCES

1 Royal College of Psychiatrists. *Self-harm and suicide in adults: final report of the patient safety group*. 2020.
2 Zayed MG, Williams V, Glendenning AC, *et al*. Care-pathways for patients presenting to emergency ambulance services with self-harm: national survey. *Emerg Med J* 2020;37:752–5.
3 Rees N, Rapport F, Snooks H. Perceptions of paramedics and emergency staff about the care they provide to people who self-harm: constructivist metasynthesis of the qualitative literature. *J Psychosom Res* 2015;78:529–35.
4 Rees N, Porter A, Rapport F, *et al*. Paramedics' perceptions of the care they provide to people who self-harm: a qualitative study using evolved grounded theory methodology. *PLoS One* 2018;13:e0205813.
5 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77–101.
6 National Institute for Health and Care Excellence. *Self-harm: assessment, management and preventing recurrence [NG225]*. 2022.