# If You Could Change 1 Thing to Improve the Quality of Emergency Care for Deliberate Self-harm Patients, What Would It Be? A National Survey of Nursing Leadership

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CE Earn Up to 8.0 Hours. See page 730.

### Contribution to Emergency Nursing Practice

- The current literature on the ED management of patients with deliberate self-harm indicates that this is a growing patient population, which is putting increasing strain on emergency department staff, space, and resources.
- This article contributes research findings from nursing leadership—across a broad range of hospital types—who have prioritized similar ways to improve the care for patients who deliberately self-harm and present to emergency departments.
- Key implications for emergency nursing practice found in this article are that additional training, resources, and policies could enable emergency nursing staff to assess, treat, and advocate more effectively for deliberate self-harm patients, resulting in more comprehensive care for these patients.

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## Abstract

**Introduction:** Emergency departments increasingly treat patients for deliberate self-harm. This study sought to understand emergency department nursing leadership perspectives on how to improve the quality of emergency care for these patients.

**Methods:** ED nursing managers and directors from a national sample of 476 hospitals responded to an open-ended question asking for the 1 thing they would change to improve the quality of care for self-harm patients who present in their emergency departments. We identified and coded key themes for improving the emergency management of these patients, then examined the distribution of these themes and differences by hospital characteristics, including urbanicity, patient volume, and teaching status.

**Results:** Five themes regarding how to improve care for deliberate self-harm patients were identified: greater access to hospital mental health staff or treatment (26.4%); better access to community-based services and resources (26.4%); more inpatient psychiatric beds readily accessible (20.9%); separate safe spaces in the emergency department (18.6%); and dedicated staff coverage (7.8%). Endorsement of findings did not differ based on hospital characteristics.

**Discussion:** ED nursing leadership strongly endorsed the need for greater access to both hospital- and community-based mental health treatment resources for deliberate self-harm patients. Additional ED staff and training, along with greater continuity among systems of care in the community, would further improve the quality of emergency care for these patients. Broad policies that address the scarcity of mental health services should also be considered to provide comprehensive care for this high-risk patient population.

**Key words:** Emergency department management of self-harm; Mental health care; Emergency nursing care

## Introduction

Each year approximately three quarters of a million patients present to US emergency departments for the treatment of deliberate self-harm (DSH).[1] Up to a quarter of adults who die of suicide have an ED visit for DSH in the preceding year,[2] making this the most common final, nonfatal visit to an emergency department before suicide.[3] Emergency departments treating DSH patients are tasked with treating any physical injury as well as assessing and managing acute risk of future self-harm. Unfortunately, emergency departments are thought to be inadequately resourced to provide effective behavioral health assessments and management.[4] An increasing volume of ED visits related to suicidal behavior[5-7] has contributed to patients with psychiatric needs "boarding" (time spent waiting for an inpatient psychiatric bed) longer than other patients in the emergency department.[4,8] Psychiatric boarding is associated with lower quality of care and overall ED crowding.[9,10] Thus, improving the care of DSH patients has implications not just for these patients, but also for the entire emergency department.

Equally important to time spent in the emergency department is what happens to patients after discharge from the emergency department, particularly as most DSH patients are discharged to the community and often do not receive follow-up outpatient mental health care.[11] Providing linkages with appropriate inpatient and outpatient mental health care thus also requires continuity of care among emergency departments, hospitals, and community health care professionals.

Although research has identified some of the shortcomings in the ED care of DSH patients (eg, lengthy boarding times,[9,10] limited access to mental health specialists[12]) few studies have sought to understand ED nursing leadership perspectives on assessing and managing DSH patients. Among the research focused on how ED providers perceive DSH patients, 1 study at a large emergency department, composed of semistructured interviews with 15 providers, identified the belief that the emergency department should focus only on the presenting physical injury and not on the mental health aspect of care required by DSH patients.[13] This study, along with another survey of 43 emergency nurses from an Australian hospital, found that many ED providers believe that they do not have adequate training or education on how to care for DSH patients and that staff members who have had more specific training on how to work with these patients felt not only better prepared but less judgmental toward them.[14] Other qualitative inquiries with providers have identified a number of obstacles treating DSH patients, including a lack of privacy afforded by the ED setting and insufficient mental health resources in the hospital and the community,[15,16] leaving providers with a sense that the system fails these patients. Although these studies have begun to shed some light on the experiences of ED providers treating DSH patients, all were conducted at 1 or 2 hospitals or systems of care with smaller samples of frontline staff, limiting the generalizability of these findings. The purpose of this study was to bridge this gap by providing a representative perspective of nursing leadership on how to improve the quality of emergency care for patients who present with DSH.

## Methods

### STUDY DESIGN

Between May 2017, and January 2018, a management of self-harm survey assessing the availability of key mental health services for ED patients was sent to a random sample of ED nursing leaders. Defining self-harm as an act of nonfatal self-poisoning or self-injury with or without suicidal intent (ICD-9: E950-E959),[17] the survey modified components of the Safety Planning Intervention (SPI), designated as a best practice by the Suicide Prevention Resource Center and American Foundation for Suicide Prevention,[18-20] to examine ED safety planning, assessment, and discharge practices with DSH patients. Additional questions regarding ED staffing and linkages with mental health care were included, along with an open-ended question designed to elicit the preferred way in which these leaders would improve care for this population: "*Given the existing resources, if you could change one thing to improve the quality of emergency care for your deliberate self-harm patients, what would it be?*"

### SAMPLE

Using national Medicaid claims data received from the Centers for Medicare and Medicaid Services,[21] we identified hospitals with ≥5 self-harm visits in 2012. From this sampling frame, we selected a nationally representative sample of 665 hospitals that received the survey via mail and/or e-mail. The study had a 77.1% response rate (n = 513), and, of these, 93% of respondents completed the open-ended question, yielding a total sample of 476 hospitals. The study team initiated a coordinated recruitment strategy of key leadership staff (nurse directors or managers) at each emergency department. Participants were sent hard copies of the survey unless they explicitly asked to receive the

survey via e-mail; responses were submitted via mail or a web-based version of the survey. Respondents received $100 gift cards upon completion of the survey, unless they could not accept incentives because of hospital policy. The study was approved by the University of Pennsylvania Institutional Review Board. This research did not meet the National Institutes of Health definition of a clinical trial, and, thus, the trial protocol was not registered.

### DATA ANALYSIS PROCEDURES

An inductive thematic analysis approach[22] identified themes in the open-ended quality of care item. If more than 1 response was included, only the first answer was included so that there was 1 response per hospital. All responses were read to gain familiarity with the data before starting initial coding to identify notable concepts. Interview data were coded in stages by 2 team members: 1 with knowledge in mental health patient safety and the other with extensive mental health services research expertise. The data were coded separately and then discussed together. Codes were compiled and organized into 5 unique themes. Intercoder reliability[17] was assessed during the coding process, and discrepancies were resolved with team discussions until consensus was achieved. It was noted that the 5 themes fell loosely into 2 broader categories of hospital and community characteristics.

The frequency with which each theme was mentioned was examined alone and then across strata of hospital characteristics including admission volume, urban/rural, teaching status, ownership, and presence of a psychiatric emergency department. Using a survey question estimating total annual census, patient volume was split by percentiles into low (<23,000), medium (23,000 to 64,000), and high (>64,000). Based on data from the national American Hospital Association annual survey of hospitals from 2016 (or the most recent year available if data were missing for 2016),[23] hospitals were coded as urban or rural; teaching or nonteaching; and private not-for-profit (NFP), private for-profit (FP), or public/government. Finally, presence of a psychiatric emergency department was determined from the survey question "Does your hospital have a separate psychiatric emergency department that is physically distinct from the medical emergency department?" To ensure that respondents were representative of all hospitals in the sampling frame, analyses included survey weights in which hospitals were selected with probability proportional to their self-harm patient volume. Adjusted Wald F tests, which accommodated this survey design, examined differences in responses by these hospital characteristics at a $P < 0.01$ significance level. All statistical analyses were conducted using SAS 9.4 (SAS Analytics, Cary, NC). Also, before initiating the study, we conducted a power analysis, which showed that, with our selected sample, we have 80% power with 2-tailed test (alpha = 0.05) to detect effect sizes of Cohen's d = 0.31.

## Results

Although the survey was typically sent to ED nursing directors, in some cases, they were completed by other hospital staff members. More than three quarters (78.4%) of surveys were completed with input from nursing leadership. Respondent breakdown was as follows: 59.8% were completed by only ED nursing directors or managers (n = 285); 21.2% were completed by more than 1 staff member in the emergency department (eg, nursing director and social worker; n = 96; 88 of the 96 included nursing leadership); 1.7% were ED medical directors (n = 8); 3.1% were social workers (n = 15); 8.6% were "other" (eg, RN, behavioral health director, clinical supervisor; n = 41); and 6.5% did not indicate who had completed the survey (n = 31). The majority of hospitals were urban (72.9%, n = 386) and nonteaching (57.9%, n = 215). Hospital ownership was 74.5% private (n = 348), 14.9% private NFP (n = 68), and 10.6% public (n = 56). Only 11.2% had separate psychiatric emergency departments (n = 81; Table 1).

The results of the thematic analyses revealed 5 broad categories, which, in decreasing order of endorsement, were as follows: greater access to mental health care and staff for the patient while in the emergency department; more or faster access to community-based resources, including outpatient services; greater number of or access to inpatient psychiatric beds; designated or separate space for psychiatric evaluations and treatment; and dedicated staffing for DSH patients in the emergency department. These categories are described below and illustrated with quotes selected as representative of a common/typical answer or for their unique perspective on a theme. Across the strata of hospital characteristics, there were no statistically significant differences in the identification of hospital factors or community factors overall or in the selection of each of the 5 specific themes (Tables 2 and 3).

### THEME 1: ACCESS TO MENTAL HEALTH CARE AND STAFF WITHIN THE HOSPITAL

Many participants wished they had mental health staff in the emergency department to work with DSH patients. For instance, 1 respondent at a small rural, nonteaching hospital

TABLE 1
**Hospital characteristics (n = 476)**

| | N | Weighted % |
|---|---|---|
| Volume based on admissions per year | | |
| Low volume (<23,000) | 81 | 26.5 |
| Medium volume (23,000-64,000) | 226 | 48.3 |
| High volume (>64,000) | 169 | 25.3 |
| Urban/rural status | | |
| Urban | 386 | 75.7 |
| Rural | 86 | 24.3 |
| Teaching status | | |
| Teaching hospital | 257 | 42.1 |
| Nonteaching hospital | 215 | 57.9 |
| Ownership | | |
| Private not-for-profit | 348 | 74.5 |
| Private for-profit | 68 | 14.9 |
| Public (government) | 56 | 10.6 |
| Psychiatric emergency department | | |
| Has a separate psychiatric emergency department | 81 | 11.2 |
| No separate psychiatric emergency department | 395 | 88.8 |

wanted "more access to mental health professionals. Although we provide the best care we can, we do not have a psychiatrist, psychologist, or psych nurse…employed at our facility." Others hoped for greater attention from, or collaboration with, psychiatry within their hospital. One ED manager from a large urban, nonteaching hospital wanted to "have psych rounds more in the emergency department. It is such a disservice to these patients to sit in the emergency department for days at a time…," whereas a respondent at a medium-sized urban teaching hospital wished for more collaboration with psychiatry, stating, "We medically clear the psychiatric patients, and at that time, psych takes over. We are often left out of the picture in regard to the care and placement."

Of the respondents seeking greater access to mental health care, approximately 15% thought this should come in the form of additional training, policies, or resources to better prepare ED staff to be able to provide mental health care for DSH patients. One respondent from a medium-size urban, nonteaching hospital would prefer training to "educate nurses on identifying patients at risk and establishing a therapeutic rapport," whereas another respondent from a large urban hospital with a psychiatric emergency department would rather have systemic policy changes, such as "standardized discharge information. The questions [in the survey] led me to recognize the information that we send patients home with…perhaps should be entered into our formal form to be certain the same information is being covered for all." Another participant from a medium-sized urban hospital also expressed a desire for formal processes, such as "clear accreditation guidelines on what is required for interval assessment and documentation on self-harm patients…guidance and training…if an ED provider is to ever be 'releasing' a involuntary psych-hold patient before the expiration of that hold. Also, if an ED stay awaiting an inpatient bed extends over the 24-hour time frame, are there required expectations of the ED provider?"

### THEME 2: ACCESS TO MENTAL HEALTH CARE IN THE COMMUNITY

A respondent from a large urban hospital with a psychiatric emergency department noted the importance of fast, appropriate follow-up care to avoid a patient's cyclical return to the emergency department: "Immediate referral to an OP facility with follow-up by a case worker/case manager… I feel we do excellent emergent care and work diligently to get patients referred to an appropriate location, but then they are no longer followed by anyone…until they return to the emergency department, and the cycle begins again." Others noted a broad range of services needed in the community, including "more availability to inpatient detox, safe shelters for homeless psych patients, access to care for the noninsured" access to "prehospital resources to prevent ED visits; often the ED setting & delays result in (patient) escalating," and "a bridge clinic that would allow us to make follow-up appointments prior to discharge from the emergency department." Several respondents from large urban teaching hospitals preferred community-based services to divert DSH patients from coming to the emergency department, such as an "outpatient crisis center so they aren't in the emergency department" or "a true intake center in our city."

### THEME 3: ADDITIONAL INPATIENT MENTAL HEALTH SERVICES

Respondents wanted greater inpatient psychiatric care to reduce ED boarding and patient disengagement. A participant from a medium-sized urban hospital wanted "improved

TABLE 2
**Distribution of hospital and community factors identified by ED providers, stratified by hospital characteristics (total n = 476)**

| Hospital characteristics | Hospital factors overall | Community factors overall | Adjusted Wald F, (df)* | *P* value |
|---|---|---|---|---|
| Overall % (weighted N) | 52.8 (1106) | 47.7 (989.5) | | |
| Volume | | | 0.51, (2,474) | 0.603 |
| Low (%) | 49.6 | 50.4 | | |
| Medium (%) | 52.1 | 47.9 | | |
| High (%) | 57.3 | 42.7 | | |
| Urbanicity | | | 0.01, (1,471) | 0.972 |
| Urban (%) | 52.6 | 47.4 | | |
| Rural (%) | 52.9 | 47.1 | | |
| Teaching | | | 0.04, (1,471) | 0.839 |
| Teaching (%) | 52.0 | 48.0 | | |
| Nonteaching (%) | 53.2 | 46.8 | | |
| Ownership | | | 1.26, (2,470) | 0.284 |
| Private not-for-profit (%) | 50.0 | 50.0 | | |
| Private for-profit (%) | 61.7 | 38.3 | | |
| Government/Public (%) | 58.9 | 41.1 | | |
| Psychiatric emergency department | | | 3.99, (1,458) | 0.046 |
| Has psychiatric emergency department (%) | 67.8 | 32.2 | | |
| No psychiatric emergency department (%) | 50.9 | 49.0 | | |

*Adjusted Wald F-tests were used to accommodate the weighted, complex survey design.

access to adult inpatient facilities. Normally, we hold these patients for 3 to 5 days seeking placement." Another participant from a small urban, nonteaching hospital noted the consequences of lengthy waits, noting that patients: "Often…get frustrated and leave while waiting on a facility to accept them for transfer." Interestingly, almost one quarter of respondents across all themes made mention of long wait times or expressed a desire for faster disposition times.

## THEME 4: DISTINCT SPACE IN THE EMERGENCY DEPARTMENT FOR DSH PATIENTS

A respondent at a medium-sized urban, nonteaching hospital noted that the emergency department would benefit from "a designated area that could provide for safety and offer some kind of therapy. Our treatment of the patient borders on inhumane while they are housed for multiple days awaiting placement at a facility that can provide services." In addition to providing therapeutic care for DSH patients, it was also noted that a safe space would provide "a more controlled environment to prevent runners from escaping the emergency department. Currently if we can't chase down and detain the patient they are out…patients…typically wait 3 to 55 days in our emergency department." Wanting a separate psychiatric emergency department was specifically cited by 7% of respondents. Finally, 1 respondent from a medium-sized urban, nonteaching hospital wished that their emergency department had "dedicated rooms for mental health patients but, more specifically, children. We currently put all mental health patients into 2 rooms and then utilize hallway spaces. We comingle those patients, which is less than ideal."

## THEME 5: DEDICATED STAFFING IN THE EMERGENCY DEPARTMENT

Dedicated staffing suggestions ranged from specialized clinicians to address the clinical needs of DSH patients (psychiatric nurses, psychiatrists, and social workers or other behavioral health workers) to nonclinical staff assigned to

TABLE 3
**Primary factor identified by ED providers to improve treatment of deliberate self-harm patients, stratified by hospital characteristics (total n = 476)**

| Hospital characteristics | Hospital factors | | | Community factors | | Adjusted Wald F, (df)* | *P* value |
|---|---|---|---|---|---|---|---|
| | Greater access to and collaboration with psychiatry, mental health staff or treatment | Distinct, separate or safe space in the emergency department | Dedicated staff coverage in emergency department | More, improved, or faster access to community-based resources (eg, outpatient services) | More or faster access to inpatient psych beds | | |
| Overall % (weighted N) | 26.4 (552.5) | 18.6 (389.5) | 7.8 (164.2) | 26.4 (989.5) | 20.9 (437.0) | | |
| *Volume* | | | | | | 0.61, (8,468) | 0.768 |
| Low (%) | 25.8 | 14.9 | 8.9 | 25.8 | 24.6 | | |
| Medium (%) | 24.0 | 20.8 | 8.7 | 27.5 | 20.3 | | |
| High (%) | 31.5 | 19.4 | 5.0 | 24.7 | 18.0 | | |
| Urbanicity | | | | | | 0.02, (4,468) | 0.885 |
| Urban (%) | 26.2 | 18.7 | 7.7 | 26.8 | 20.6 | | |
| Rural (%) | 26.5 | 18.6 | 7.8 | 25.2 | 21.9 | | |
| Teaching | | | | | | 0.29, (4,468) | 0.885 |
| Teaching (%) | 25.5 | 20.0 | 6.5 | 28.0 | 20.1 | | |
| Nonteaching (%) | 26.8 | 17.7 | 8.6 | 25.3 | 21.5 | | |
| Ownership | | | | | | 1.85, (8,464) | 0.067 |
| Private not-for-profit (%) | 28.7 | 15.3 | 6.1 | 27.8 | 22.2 | | |
| Private for-profit (%) | 16.0 | 28.3 | 17.3 | 17.1 | 21.2 | | |
| Government/public (%) | 23.4 | 29.5 | 6.1 | 30.3 | 10.8 | | |
| Psychiatric emergency department | | | | | | 2.28, (4,455) | 0.059 |
| Has psychiatric emergency department (%) | 37.4 | 25.7 | 4.7 | 22.1 | 10.0 | | |
| No psychiatric emergency department (%) | 25.5 | 17.6 | 7.9 | 27.0 | 22.0 | | |

*Adjusted Wald F-tests were used to accommodate the weighted, complex survey design.

procure the disposition of DSH patients and the safety of the emergency department (eg, case managers, sitters, and security guards). A respondent from a large urban teaching hospital suggested a "24/7 psychiatrist hospitalist coverage and/or psychiatrist nurse practitioner dedicated for emergency department only," whereas a respondent from a small urban, nonteaching hospital preferred a "MSW available 24/7 to help with screening these patients; creating appropriate safety plans if patients are being discharged; and helping with placement and/or outpatient follow-up." Respondents from 2 small urban, nonteaching hospitals preferred staff focused on ensuring safety in the emergency department, such as a "full time security guard dedicated to emergency department" or "sitters who are specifically trained to watch behavioral health patients in the emergency department to ensure that there is no self-harm done in the emergency department."

## Discussion

Despite representing a broad range of hospital types, most respondents prioritized the same areas for improving the quality of care for patients with DSH. ED leadership stressed a desire for more, improved, or easier access to mental health resources, both in the hospital and in the community. In contrast, few mentioned a need for improving some basic aspects of clinical management including medical clearance, accuracy of suicide-risk assessment, or communication with family members.

A number of models have been suggested to improve access or connections to mental health care for DSH patients presenting in the emergency department, including creating nurse- or social worker-staffed crisis clinics or dedicated psychiatric emergency service (PES) units.[24] These types of units, which typically provide outpatient evaluation, treatment, and observation to stabilize acute symptoms and minimize psychiatric hospitalization, significantly reduce boarding time[25] and improve assessments and access to care.[26] Although having a distinct PES may be ideal for any given hospital, many do not have the patient volume or resources to support their own PES, particularly smaller, rural, or low-income–area hospitals.

Other efforts have included shifting the responsibility of mental health care from the hospital to the community at large, with improvements noted in ED and patient outcomes. One example is the Burke Center, which takes a comprehensive approach to serving residents in 12 rural Texas counties. The Burke Center pairs telepsychiatry with on-site nursing and mental health staff, as well as outpatient services and home visits upon discharge.[27] In California, the Almeda model expeditiously transfers psychiatric patients from local emergency departments to a regional psychiatric emergency hospital that provides 24-hour rapid stabilization services. By providing comprehensive psychiatric care, this model has resulted in more than an 80% reduced boarding time for patients awaiting psychiatric care, as well as having helped to alleviate the demand for inpatient psychiatric beds by stabilizing the majority of patients.[25] Although these programs create a continuous and unified care model, shifting the responsibility from the hospital to the community level requires policy shifts promoting regional cooperation among facilities and changes to billing practices.

## Implications for Emergency Nursing Practice

Until larger policy shifts address the scarcity of acute inpatient and subacute outpatient mental health services, hospitals could hire dedicated staff in the emergency department[12] or provide existing staff with relevant training and tools to care for this population more effectively. One example of evidence-based training is ED-SAFE, a brief intervention consisting of a secondary suicide-risk screening by an ED physician, safety planning, and postdischarge telephone follow-up by a nurse. An evaluation of ED-SAFE noted 30% fewer suicide attempts in the year after implementation.[28] Another alternative, the SPI provides written coping strategies and sources of support during a suicidal crisis as well as structured follow-up telephone contact. SPI has been found to reduce suicidal behavior and increase treatment engagement.[29]

## Limitations

First, the cross-sectional design does not capture trends over time. Second, nonresponse or incomplete responses at the survey or item level may bias results. Third, the study sample was derived from emergency departments with ≥5 self-harm Medicaid-financed patient visits and may limit generalizability. Fourth, we did not use a validated survey instrument. Fifth, responses were predominantly from nursing leadership, whose perspective may differ from frontline nurses. Finally, extracting only the first response to the open-ended question could have excluded ideas that may have been equally important to the respondent.

## Conclusion

In summary, across a wide range of hospital types, there is an overarching perception of insufficient access to specialized mental health care inside and outside the hospital, as well as a lack of resources for ED providers. Although innovative and promising models of providing psychiatric emergency services exist, given the prevailing resource constraints, training existing staff in the evaluation and management of DSH may be the most feasible short-term approach to address these pressing service needs. Relying on evidence-based and publicly available resources that provide structured guidelines for decision making, assessment, and treatment of DSH patients,[30,31] is a first-step that all emergency departments can take with minimal cost and effort. At the same time, advocacy for broader policies that address the scarcity of integrated inpatient and outpatient mental health services at the community and state level should also be pursued, with the goal of providing unified and comprehensive mental health care for this high-risk patient population while also reducing strain on local emergency departments.

## Author Disclosures

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