Cultural Humility:
A Collaborative Approach to Recruiting Patients with Deliberate Self-Harm into a Multi-Hospital Randomized Controlled Trial

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Objectives: The 'SMS SOS' Deliberate Self-Harm (DSH) Aftercare Study was conducted in Western Sydney, Australia (October 2017 to December 2020) across three large public hospitals. During this randomized controlled trial (RCT), it was observed that knowledge exchange between key stakeholders and their 'cultural' perspectives (for example, Mental Health Clinicians, Lived Experience Mental Health Consultants—Patient Representatives, Administrative Officers, and Researchers) was essential to effective recruitment of patients experiencing DSH. Knowledge exchange within and between cultural groups was maximised and assessed using a communication matrix. This process, transferable to other trials engaging multiple 'cultures', aimed to promote the early identification of wider-team strengths as well as active management of emergent issues that would otherwise impede patient recruitment, and to maximise funding and human resources.

Methods: A descriptive study was conducted with a convenience sample of team members who represented different cultures in the study. Qualitative data were elicited from a 'know and tell' matrix. Through an iterative process, themes were generated that encapsulated what team members needed to know from and tell to their colleagues concerning the study.

Results: Factors that impacted participation in the study included clinician workload, the level of motivation/commitment/confidence of clinicians to recruit patients, clinician-patient engagement, perception and expectations of study involvement, inter-cultural communication, and clinician training and support. The findings of this multidisciplinary consultation informed a composite model of knowledge exchange and the development of educational briefing/orientation modules that make explicit team members' roles and responsibilities to foster group member participation and enhance patient recruitment.

Conclusions: It is incumbent upon multidisciplinary team members of large-scale studies to adopt a similar 'knowledge exchange' strategy early in the planning and design stage. Adoption of such a strategy has the potential to mitigate risk of delay in project timelines, improve project outcomes, and ensure the efficient use of research funding, particularly in newly established research teams within clinical settings and with members newer to formal research collaborations.

Keywords: cultural humility; deliberate self-harm; engagement; participant recruitment; participatory research; randomized controlled trial

Introduction

The 'SMS SOS' (Short Message Service, 'Save Our Souls') DSH Prevention Study is a multi-hospital randomized controlled trial, which was designed to evaluate the effectiveness of short message service (SMS) text messaging in supporting patients who had previously presented to hospital due to DSH. Patient recruitment for our study occurred in emergency departments at three public hospitals (including Triage and Assessment Centres and Psychiatric Emergency Care Centres), across two Health Districts (Western Sydney and Nepean Blue Mountains) in Western Sydney, Australia, between October 2017 and December 2020. The methodological framework of this study is detailed in Stevens et al. (2019). Patients recruited to our study were allocated to either Intervention or Control Group (i.e. Treatment As Usual [TAU] Group). Patients in both groups received usual mental health aftercare, after being discharged from hospital. Patients in the Intervention Group were also sent a series of nine supportive text messages over a 12-month period. The three message types sent to clients and the message schedule are provided in Table 1. The effectiveness of the text messages was measured by the reduced frequency of re-presentations and increased median time to re-presentation to hospital.

Table 1
Full Message Set

Text message 1.

Dear [name].

We hope that things have been going well for you since we last had contact.

Just a reminder that the 24-h contact line (13 11 14) is there if you'd like to connect with someone and Helpline staff (1800 011 511) can put you in touch with your local health service if needed.

Best wishes. [Return SMS messages are unavailable from this service.]

Text message 2.

Hi [name].

We hope that you've been ok since our last contact. We're just checking in with you.

A 24-h phone line is there for you in case you'd like to connect with someone (13 11 14) or to contact your local health service (1800 011511).

Best wishes.

Text message 3.

Dear [name].

Just checking in with you.

A reminder that help is there if you need it. Just call (13 11 14) or (1800 011511) for support.

Best wishes.

Every Patient Counts

Anecdotal evidence gathered during our study at weekly clinical meetings in which patients' assessment and clinical management were discussed, suggested that relational strain and loss of meaning and hope are common reasons for DSH. This evidence is supported by large-scale international studies that show an association between "interpersonal conflict" (Arkins et al., 2013), "the loss of a close relative" (Guldin et al., 2017), a "clinical impression of hopelessness" (Steeg et al., 2016), and increased risk of DSH or suicide. These risk factors highlight the importance of engendering hope through an effective

clinician-patient connection, which is critical in obtaining informed consent from vulnerable patients to participate. Our study offered patients additional support options through text messaging, where they might not have previously thought that someone cared.

Moderating Influences on Patient Recruitment

Positive influences on the conduct of a research study and patient recruitment include support for less experienced staff, successful recruitment regarded as a team effort, pro-social behavior on the part of patients (Newington and Metcalfe, 2014), trust within the research team, active promotion of the trial through effective marketing, and endorsement by valued individuals and organisations (Hughes-Morley et al., 2015).

Negative influences include clinicians' negative views of the trial design (Walsh and Sheridan, 2016; Hughes-Morley et al., 2015); a low level of skill and confidence of the clinician in introducing the trial to patients (Hughes-Morley et al., 2015); and logistical problems (Newington and Metcalfe, 2014).

A way forward in the articulation of positive and negative influences and subsequent enhancement of patient recruitment is through knowledge exchange.

Knowledge Exchange Frameworks

Ward et al. (2009), in their narrative review of the knowledge transfer literature, identified five common components of the knowledge transfer process: "problem identification and communication; knowledge/ research development and selection; analysis of context; knowledge transfer activities or interventions; and knowledge/ research utilization". They also identified three types of knowledge transfer processes: a linear process; a cyclical process; and a dynamic multidirectional process." Horvath et al. (2017) recommend that project "stakeholders should be fully engaged in KTE [knowledge transfer exchange] and programme planning from its earliest stages, and ideally before planning begins". Kendall (2003) proposes that "networking with the relevant experts is

invaluable in the design phase [of large, randomized studies] and will contribute considerably to the final credence of the findings". Moreover, Foronda et al. (2016) recommend the "development of a framework for cultural humility ... to serve as a foundation for education and research purposes" (p. 215). We aimed to build on the work of these authors by engaging with experienced interdisciplinary representatives involved in the study to explore and make explicit knowledge within and between cultures.

Three key observations were made during the conduct of the SMS SOS Study and patient recruitment, namely:

1. Understanding the perspectives of representatives of the different stakeholder groups (Clinicians, LEMHCs/ Patient Representatives, Administrative Officers, and Researchers) was integral to the effective conduct of the study.
2. 'Research' was perceived by some clinicians as being anything from "boring" through to "terrifying". Such reactions, particularly among less experienced clinician-researchers, had the potential to undermine team cohesion, and ultimately compromise patient recruitment for the study.
3. Increased risk of project delay and variations to project methodology had the potential to impact financial and human resource allocation.

Based on these observations, we asked the questions:

1. How can team members be motivated to interact more confidently and effectively with team members of other 'cultures'?
2. How can RCT involvement foster research-minded clinicians to work in clinical, ostensibly 'non-research' settings?
3. How can academic researchers be more clinically sensitive in the design and implementation of RCTs requiring the recruitment of vulnerable patients?
4. How can good stewardship of publicly funded resources be maximised?

To answer these questions, explicit identification and greater understanding of the unique perspectives, expertise, and contributions that multidisciplinary team members make in the efficient and effective conduct of a large multi-hospital RCT, evaluation of a DSH prevention intervention and barriers to patient recruitment, was required.

Maximising Health Research Funding

A review of 73 publicly-funded multi-centre RCTs revealed that "[n]early half (45%) of [the] trials received an extension", and only about "half (55%) of [the] trials recruited their originally specified target sample size" (Sully et al., 2013). The authors noted that "both time and financial extensions [were] often requested". In the early stage of our study, a clinician suggested to a member of the research team that the proposed use of computer "tablets" to assist clinicians in patient recruitment and administration would actually be inconvenient for clinicians, compounded by the risk of loss or theft of the device. This informal interaction between two members of different cultures, which averted the potential waste of resources, underscores the need for formal knowledge exchange of team members' expertise, advice, and cooperation early in the study.

Cultural Humility

Approaches that seek to positively influence and enhance team members' roles within and between different cultures requires a certain level of humility. Without humility, behaviors such as professional superiority, relational-emotional manipulation, ambivalence or resistance to learning, and disengagement can undermine the research process, hinder or delay project-related procedures, and subsequently compromise patient recruitment. Such behavior could also potentially negatively impact team cohesion, and ultimately bring into question the credibility and reputation of the team.

'Cultural humility', defined as "having an interpersonal stance that is other-oriented rather than self-focused, characterized by respect and lack of superiority toward an individual's cultural background and experience" (Hook et al. 2013), provides an appropriate approach to multidisciplinary research in the context of DSH.

At the individual level, humility encompasses "both self-regarding and other-regarding" elements (Exline & Hill, 2012). A person who demonstrates humility:

1. takes feedback on-board and acknowledges when learning and development is required (Tangney, 2000),
2. is willing and able to "see oneself accurately", has an "appreciation of others", possesses the attribute of "teachability" (Nielsen & Marrone, 2018), and has a tendency to "self-regulate" (Owens, Johnson, & Mitchell, 2013), and
3. can reflect on "how one's knowledge is always partial, incomplete, and inevitably biased" (Wear, 2008).

Humility is also marked by positive attitudes, traits, and adaptive behavior (i.e., self-esteem via core self-evaluation, emotional stability, self-efficacy, performance improvement, learning orientation and engagement) (Owens et al., 2013). Moreover, a demonstration of humility is considered "imitable leader behavior" and an "important mechanism for influencing team performance" (Owens & Hekman, 2016).

At the organizational level, "humility" is associated with pro-social and relational behaviours, emotional well-being, learning, and successful performance outcomes (Nielsen & Marrone, 2018). It is also reflected in enhanced communication, cooperation, and partnership building (Hook et al., 2016). Such commitment to building "honest and trustworthy relationships" is an "essential foundation for clinical researchers" (Yeager & Bauer-Wu, 2013), which has an inevitable flow-on effect to patient recruitment.

Method

The conduct of our study was dependent on effective working relationships between the NSW Ministry of Health, which provided funding and direction; Western Sydney and Nepean Blue Mountains Mental Health Services, which has a goal of building a workforce and system that supports patients in their recovery; and the hospital executives and Steering Committee members who provided oversight, governance, guidance, and advice to achieve planned research outputs and outcomes. Within the three hospital emergency department settings, Clinicians, LEMHCs/ Patient Representatives, Administrative Officers, and Researchers worked together to recruit patients into the SMS SOS Study (Stevens et al., 2019). These different but interdependent relationships are represented in Figure 1 as "cultures within cultures" (Tervalon and Murray-Garcia, 1998).
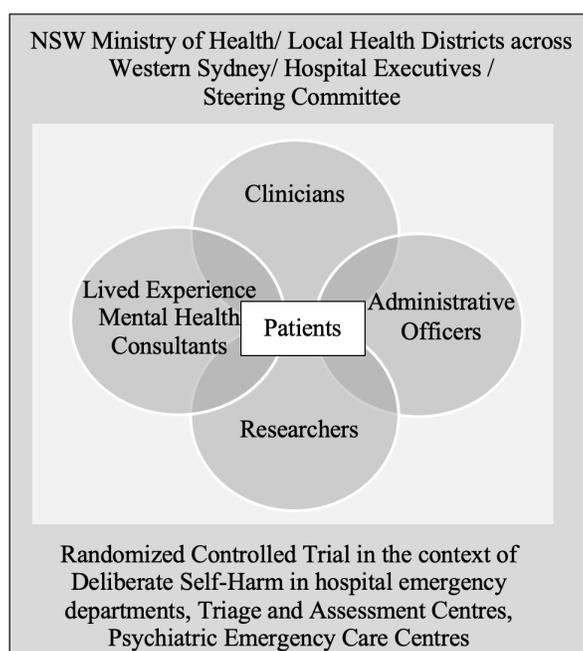

Figure 1. *'Cultures within Cultures': A randomized controlled trial evaluating a text messaging intervention in the context of deliberate self-harm.*

Team members from different cultures represented in the outer square border are distal to the patient recruitment goal of our study, but nonetheless integral to its successful conduct. Clinicians, LEMHCs, Administrative Officers, and Researchers, represented within the border, are proximal to patient recruitment. When embarking on a new project with team members from different cultures, it is often easy to assume that others are sufficiently informed about every aspect of the project. However, team members often do not know the questions they need to ask, nor what other team members need to know to efficiently perform their tasks. The level of interaction between the different cultures impacts, and is impacted by, the degree that cultures intersect, converge, and communicate.

Participant Selection

A convenience sample of team members from the different 'cultures' proximal to patient recruitment were selected to participate in a sub-study, including three Clinical Nurse

Consultants (2 males; 1 female; one from each hospital); one Patient Representative (LEMHC) (female); three Consultant Psychiatrists (2 males; 1 female); one Psychiatry Registrar (female); one Administrative Officer (male); and three Researchers (2 male; 1 female) including the Research Co-ordinator (female).

The representative team members were selected on the basis of their commitment to the study, their understanding and expression of the concept of 'humility', and their capacity and anticipated willingness to contribute to a 'knowledge exchange' matrix. The Co-ordinator (SB) met with the team members to provide an overview of the sub-study, to expand on the influence of 'cultural humility' on the conduct of the study, and to gauge their interest in contributing to a 'Know and Tell' matrix and ensuing educational material for the benefit of future clinical/ research teams. All team members who were approached agreed to participate in the sub-study.

Data Collection

'Know and Tell' process and outputs. A 'Know and Tell' matrix was distributed to participants, representative of each of the 'cultures' involved in the study to provide pertinent information relative to their unique roles and responsibilities.

LEMHC/ Patient Representatives have insight to factors associated with recruiting vulnerable patients. They are in a position to defend the autonomy of, and advocate for, patients, to input the design and development of patient-sensitive material, and to destigmatise DSH. They are also aware of issues that would have the potential to negatively impact patient recruitment. Clinicians perform a key role in identifying and engaging with and recruiting eligible patients, orientating non-clinical team members to a clinical setting, engendering confidence in other clinicians especially those less experienced, and enacting effective patient recruitment strategies. Administrative Officers

play a key role in recording patient details, reminding clinicians to recruit eligible patients when identified in the database of patient records, and communicating project-specific information to team members. They also develop and manage databases and systems. Researchers are able to provide expertise in research design, processes, and procedures, resource allocation, ethical considerations, and to report on research outputs and disseminate study findings.

The 'Know and Tell' matrix was used to elicit qualitative data focusing on information that team members from each culture needed to tell to and know from team members of the other cultures. Essentially, our research inquiry centred on the question, *What do Clinicians, Patient Representatives, Administrative Officers, and Researchers need to know from each other and tell to each other?* Team members were also asked to identify perceived challenges and facilitators to the recruitment of patients who had self-harmed.

Analysis

Participants' responses to the 'need to know from' and 'need to tell to' matrix together with perceived challenges and facilitators were grouped (by SB) under provisional themes generated from the qualitative data. A draft table was then circulated to all participants for their review, giving them the opportunity to add reflective comments and further input. This iterative process allowed experienced team members to confirm the knowledge that needed to be exchanged within and between each of the cultures that would ensure the efficient and effective conduct of an RCT and to enhance patient recruitment. The combined data were then reviewed and analyzed to inform and confirm the themes which are presented as a composite model of knowledge exchange (Figure 2).

A Collaborative Approach to Recruiting Patients with Deliberate Self-Harm into a Multi-Hospital Randomized Controlled Trial	
What do Clinicians, Patient Representatives, Administrative Officers, and Researchers need to know from each other and tell to each other?	▪ Research design ▪ Communication processes ▪ Consultation and collaboration ▪ Roles and responsibilities of team members ▪ Factors associated with recruiting vulnerable patients ▪ Processes, procedures, and protocols ▪ Concerns, challenges, and contingency plans ▪ Training and orientation sessions

Figure 2. *A composite model of Knowledge Exchange.*

Results

Representatives from different 'cultures' with an interest in the effective conduct and beneficial outcomes of an RCT in the context of DSH in hospital-based settings have a significant role in informing the study research design, strengthening processes and procedures, supporting team members, and enhancing patient recruitment.

Research Design

Essential information for all team members, and integral to the successful conduct of the study, is a realistic research question, clear aims, objectives, methods, overall purpose, impact, intended outcomes, and expected benefits of the study. Clarification of intervention group and control group documentation and recruitment processes is also essential, specifically patient inclusion and exclusion criteria.

Communication Processes

Regular team meetings, briefing sessions, and planned activities are effective communication processes and opportunities to provide project updates and statistics, to track and review deadlines, and to mark project milestones.

Consultation and Collaboration

Representation on the Project Steering Committee enables team members to be involved in major decisions influencing the conduct of the study within agreed timeframes, ensuring maximisation of research resources. Review and feedback by team members of research-related material, particularly the design of patient recruitment and informed consent forms, mitigates the risk of project delay, including ethics approval re-submission.

Roles and Responsibilities of Team Members

Articulation of roles and responsibilities early in the study prevents assumptions being made about them. It also promotes respect and the valuing of others' expertise which in turn fosters co-operation between team members, trust-building, increased confidence and commitment, and facilitates interaction and communication between team members.

Factors Associated with Recruiting Vulnerable Patients

The lived experience of patients who self-harm takes into account the physical, emotional, relational, and spiritual impact, and cultural norms. Voluntary participation in the study and accessibility to sensitive patient recruitment material can promote capacity-building, patient autonomy, and engender hope. Engaging patients as co-researchers also has the potential to destigmatise DSH, and the recruitment of patients can be part of the patient recovery process.

Procedures and Protocols

The design and efficient management of secure databases and information systems are crucial for accurate data collection procedures for recording, maintaining and analyzing patient details, and ongoing reporting. Team members also have input to patient confidentiality issues, and ethical standards and requirements.

Concerns, Challenges, and Contingency Plans

Team members' articulation of concerns, challenges, and perceived risks ensure that risk mitigation strategies and contingency plans are in place. Facilitators to patient recruitment include a system-enabling context for the conduct of the study, manageable clinician workload, enhanced clinician-patient engagement, team member confidence and commitment, patients' willingness to participate, positive reinforcement, incentives, encouragement, investment in and maintaining momentum and motivation to recruit patients.

Training and Orientation Sessions

Training, orientation, and briefing sessions cover positive and negative factors influencing patient engagement and recruitment, promote co-operation between team members and discussion concerning the successful integration and management of research in a busy clinical environment.

Essential elements of the RCT that team members 'need to tell to' and 'need to know from' other team members within and across the 'cultures' to ensure patient recruitment informed the education/ briefing modules, which are presented in Table 2.

Table 2
Training, Orientation, and Briefing Modules

Module	Topic	Aim	Team Member(s)
1	Introduction and project overview	▪ Acknowledgement/appreciation of involvement and contribution of team members ▪ Procedures, processes, and protocols	Researchers
2	Expected outcomes and benefits	▪ Project aim, objectives, outcomes ▪ Fostering research-minded clinicians, and clinically-sensitive researchers	Researchers Clinicians
3	Context/setting of the study	▪ Knowledge exchange (*Need to know from; Need to tell to*): perspectives, expectations, roles, and responsibilities	All team members
4	Clinician/patient engagement	▪ Strategies to motivate team members ▪ Managing clinician workload	Clinicians / LEMHC
5	Training and support	▪ Cooperation and commitment to patient recruitment ▪ Maintaining momentum throughout the study ▪ Marking milestones	Clinicians Researchers
6	Facilitators and challenges	▪ Communication processes ▪ Problem-solving	All team members
7	Questions and feedback	▪ Expansion, clarification, and encouragement	All team members

Discussion

Our research findings have the potential to assist other researchers when designing and conducting large-scale research studies (both RCTs and non-clinical), particularly facilitating 'knowledge exchange' between multidisciplinary team members.

Knowledge Transfer and Exchange

Knowledge transfer and exchange frameworks have been used in various contexts for different purposes, for example, in gathering evidence that would help improve preterm birth outcomes (Horvath et al., 2017). Our use of the framework in the context of RCTs in multidisciplinary settings involved "a dynamic, interactive and multidirectional process" (Ward et al, p. 6), engaging fully with "stakeholders" (Horvath et al. 2017). Our work is also aligned with the "equity lens" proposed by Nasser et al. (W.H.O., 2018-2020, pp.124-126) specifically, identifying and engaging with different stakeholders to input research design (including data collection materials), and with those who are likely to have an impact on and influence the outcome of the research, with those who have direct knowledge of the context and routine after-care, and with those who will benefit from the research.

We suggest that a ('need to') 'Know and Tell' matrix implemented early in the process would enhance co-operation between team members and patient recruitment and maximise human and financial resources. This dynamic process of knowledge exchange between representatives of the different 'cultures' facilitates:

- the articulation and setting of realistic goals and expectations,
- making more explicit team members' roles and responsibilities,
- critical thinking and review of data collection materials,
- questioning processes and procedures and providing answers,
- pre-empting and minimising pitfalls and barriers to recruiting patients,
- consideration and management of high levels of clinical workload,
- identification of different levels of experience, motivation, commitment and confidence in team members, and
- the scheduling of training and ongoing support for clinicians to recruit patients.

Careful planning of materials and the efficient allocation of resources are required to achieve research study objectives on time and within budget, hence the need for developing a knowledge exchange and project briefing strategy.

RCT Design

We propose an extension to the standard RCT design such that knowledge exchange is implemented early in the planning stage to assist future research teams intending to recruit vulnerable patients (see Figure 3).
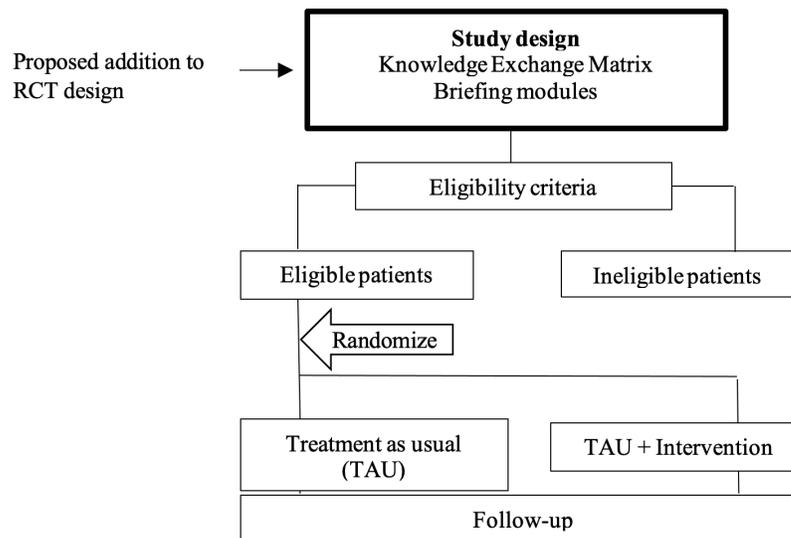
Based on Stevens et al. (2019)

Figure 3. *Research study design flow chart.*

A culturally-informed and inclusive multidisciplinary management framework allows team members to build into the RCT design the prospective use of surveys, feedback and knowledge exchange, which results in logical and practical outputs; to anticipate problems and manage and solve emergent ones, and to develop a framework for how a culturally-inclusive and effective planning and implementation process can proceed.

We believe it is incumbent upon researchers of RCTs and large studies to elicit the perspectives and unique contributions of members of each culture involved in the research and patient recruitment processes, early in the planning stage of an RCT. This consultative strategy would provide opportunities for team members to articulate and transfer interdisciplinary knowledge and expertise within and between the different cultures. This approach also has the potential to inspire the "bored" and engender confidence in the "terrified".

Scope and Limitations

The knowledge gathered from our team members informed the development of a knowledge exchange matrix specific to our two-year recruitment period (2017-2019). Other studies may generate different data based on patients' lived experiences, and the skills, roles and responsibilities of the clinical, research, administrative or other teams involved. Even though the sample size was relatively small ($N = 12$; 7 males; 5 females), team members' insider perspectives of the cultures involved in the conduct of the large research study provided sufficiently rich data to develop a composite knowledge exchange matrix.

Given the conceptual focus of our present article, the template could be used in other studies to help bring team members together in the early planning stages. Adopting this preliminary knowledge exchange and briefing strategy is likely to save time, maximise staffing input, and ensure the efficient use of health service resources.

Further Work

Further work would pilot and evaluate the knowledge exchange matrix and briefing modules in the planning stage of studies with a similar methodological framework.

Conclusion

Our objective was to develop and implement a "framework for cultural humility" (Foronda et al., 2016), and educational material based on team members' expertise for the benefit of future teams in designing complex RCTs and large research studies. Incorporating a knowledge exchange matrix early in the planning stage of an RCT is integral to reaching the common goal of, and maximising, patient recruitment and contributing to the "final credence of the findings" (Kendall, 2003). This process can positively impact research outcomes, such as achieving program goals on time, on budget and to the work satisfaction of all team members.

Moreover, an openness to engaging with and a willingness to learn from multidisciplinary team members with a view to fostering a culture of research-minded clinicians (research translates to practice), and clinically-sensitive researchers (patients are more than statistics) is, in and of itself, an expression and test of cultural humility.

List of abbreviations

DSH: Deliberate Self-Harm

LEMHC: Lived Experience Mental Health Consultant

NSW: New South Wales

RCT: Randomized Controlled Trial

'SMS SOS': Short Messaging Service 'Save Our Souls.'

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