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ORIGINAL ARTICLE

Emergency department staff experiences of working with people who self-harm: A qualitative examination of barriers to optimal care

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Abstract

For people who seek help for self-harm, emergency departments (ED) are often the first point of contact, making them a suitable setting for intervention. In Australia, base rates of self-harm presentations to ED are increasing, while the quality of care these people receive is often considered sub-optimal. This study used qualitative interviews to explore potential barriers ED staff face in delivering best possible self-harm care. Seventeen staff across two EDs in the state of Victoria, Australia, were interviewed regarding their perceptions of barriers to providing optimal self-harm care and suggestions for improvement. Three themes were identified: (1) system-related challenges when managing self-harm in ED, including the shortage of hospital resources, challenges of ED as a physical environment, and insufficient education, training and guidelines about self-harm care for staff; (2) human-related challenges regarding management of self-harm in ED, which encompassed the nature of a person's circumstances and presentation, and staff attitudes towards self-harm; and (3) staff suggestions for improving self-harm care in ED. Specific recommendations that were proposed based on these findings included introducing a separate ED area for mental health-related presentations, provision of specialised education and training about self-harm care to staff, better implementation of guidelines on treating self-harm in ED, and employing mental health educators to provide on-the-floor mentoring to nurses. The relevance of these barriers and recommendations to the wider healthcare sector is also discussed. Together, these findings may inform improvements to the quality of care provided to those who engage in self-harm.

KEYWORDS
emergency service, hospital, interview, mental health, self-injurious behaviour, suicidal ideation

INTRODUCTION

Suicide was the second leading cause of death among Australians in 2022 (Australian Institute of Health and Welfare, 2022). For every suicide death, nine Australians are hospitalised following self-harm and 127 more report engaging in self-harm in the community (Christensen et al., 2022). Self-harm, which refers to acts performed by a person to deliberately injure or poison themselves regardless of suicidal intent (Hawton et al., 2003), is one of the strongest predictors of suicide (Victor & Klonsky, 2014). In Australia, around 28 000 people per year are hospitalised for self-harm (Australian Institute of Health and Welfare, 2022).

For people who seek care from clinical services for self-harm, emergency departments (EDs) are often the first point of contact, largely because EDs are equipped to provide immediate, around-the-clock support (Duggan et al., 2020). EDs can also assist with safety planning (Stanley et al., 2018) and facilitate access to social supports and more specialised mental health care. However, studies report that the quality of care that people who self-harm receive in ED is often sub-optimal (Byrne et al., 2021; O'Keeffe et al., 2021; Østervang et al., 2022). This can increase the likelihood of further self-harm or suicide (Cully et al., 2022; Goldman-Mellor et al., 2019). As such, it is essential to understand how the ED experience can be improved for those who present with self-harm.

BACKGROUND

The state government of Victoria, Australia, published best-practice guidelines for ED management of self-harm in 2010 (Department of Health and Human Services, 2010), which were subsequently revised in 2015. These contained recommendations to improve the overall provision of care for those presenting to EDs after self-harm. However, evidence shows that although ED staff seek to provide the best possible care for people presenting with self-harm, numerous factors make this challenging (Richards et al., 2023). Australian EDs are often overcrowded and under-resourced, creating a shortage of available facilities and staff, thereby causing people who present with self-harm to have longer wait times and experience longer periods of treatment compared to people with other types of presentations (Duggan et al., 2020). Additionally, negative attitudes towards self-harm can be common among ED staff (Rayner et al., 2019) and can discourage people from seeking help in the future (Quinlivan et al., 2021). Negative attitudes can be addressed through specialist training and education on understanding the processes underlying self-harm and learning about best approaches to management (Karman et al., 2015). However, ED staff worldwide report a lack of such education and training (Mulhearne et al., 2021; Ngune et al., 2021; Østervang et al., 2022).

Literature on barriers to effective self-harm management has primarily utilised survey questionnaires which provide valuable data (Richards et al., 2023). The present study aimed to deepen the understanding of these barriers via qualitative methods. In particular, we sought to explore in detail what barriers are preventing ED staff from delivering best possible self-harm care. These findings will provide further insights into how service delivery can be improved to produce better outcomes for those seeking help.

METHOD

Design

This qualitative study utilised semi-structured interviews with ED staff. The interviews explored staff views on the processes, challenges, attitudes, resources, and clinical recommendations regarding the assessment and management of self-harm in the ED. The methodology and reporting were guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007).

Participants

Participants were recruited from two hospitals (one regional and one metropolitan) in Victoria, Australia. An email call-out was circulated to ED staff on behalf of the research team by the Assistant Nurse Unit Managers from both hospitals. Anonymous respondents to a related study about barriers to self-harm care (Richards et al., 2023) were also invited to participate in the present study by providing their contact details. Staff were eligible to participate if they worked in one of the participating EDs and had contact with individuals presenting for self-harm. Participants were recruited via convenience sampling, and roles that were under-recruited (e.g. senior clinicians) were purposefully sought to widen the range of perspectives. Participants were required to provide written consent prior to participation.

Data collection and analysis

Data were collected in 2020–2021. Following provision of informed consent, participants were interviewed one-to-one by telephone. Interviews lasted approximately 20–30 min and were audio-recorded and transcribed verbatim. Participant names were removed to preserve anonymity. Interview questions (Appendix A) were open-ended and developed specifically for this study using previous literature and clinical guidelines for managing self-harm in ED. Participants were given a $20 gift card following the interview and had an opportunity to review their transcripts. Data were coded in NVivo version 12 (QSR International Pty Ltd., 2018). Braun and Clarke's (2006) methodology was used to describe and interpret the participants' collective experience. The transcripts were first checked for accuracy, and then initial codes were generated. Codes were collated into preliminary themes, and then themes and subthemes were constructed through an iterative and collaborative process between authors. Finally, quotes from the transcripts were chosen to illustrate each subtheme.

Research team and reflexivity

Interviews were conducted by Authors A, B, and C, who were unknown to participants before the start of study. Authors A and D independently coded the transcripts. Author E provided guidance for data analysis and helped with formulation of themes. Any discrepancies were discussed until consensus was achieved. All researchers involved in data collection and analysis identify as female. A, B, and D are research assistants with limited experience in conducting qualitative research, while C and E are researchers with substantial experience in qualitative research.

RESULTS

Out of 24 ED staff who initially expressed interest to participate, seven subsequently declined or did not respond. The final sample comprised 17 participants (Table 1).

Three main themes were identified from the data (Table 2). Theme 1 centred around system-related barriers to effective self-harm care, which included the lack of hospital resources, the challenging nature of ED as a physical environment, and insufficient education, training and guidelines about self-harm care. Theme 2 focused on human-related barriers to optimal self-harm care, such as the nature of a person's circumstances or presentation, and staff attitudes towards self-harm. Theme 3 covered staff suggestions for improving self-harm management in the ED.

TABLE 1 Participant demographics.

Demographics	Metropolitan hospital	Regional hospital
Gender		
Female	4	5
Male	1	2
Other	1	–
Age		
26–35	5	4
36–45	–	3
46–55	1	–
Role		
Registered nurse	3	5
Enrolled nurse	3	–
Nurse unit manager	–	1
Associate nurse unit manager	–	1
Registrar	1	–
Clinical nurse supervisor	1	–
Nurse educator & Clinical supervisor	1	–
Senior clinician	–	1
Number of years worked in ED		
Less than 6 months	1	1
1–3 years	1	3
3–5 years	1	-
5–10 years	2	2
Over 10 years	1	1

[a]Not all 17 participants provided all demographics, so some columns have missing data.

System-related challenges when managing self-harm in ED

EDs often experience large patient loads that stretch the available resources, making it difficult to give people who present with self-harm the time, attention, and support they need. EDs are often overstimulating and lack privacy, which can further worsen a person's psychological distress. Additionally, education, training, and guidelines on self-harm care for ED staff are limited, leaving them to have to learn through exposure "on the job". Lack of specialised knowledge and skills may make some staff feel ill-equipped to manage self-harm, which impacts the quality of care that those who present with self-harm receive.

People who present with self-harm are not prioritised due to limited hospital resources

Participants emphasised that EDs often do not have sufficient resources, such as staff or beds, to accommodate the number of incoming people. As such, staff often must prioritise medical presentations over mental health presentations in any given triage category:

> We have other medical priorities for other patients that are potentially life-threatening and while someone's psycho-social or psychiatric crisis is really significant and important, there's time pressure associated with other people's presentations.
>
> (P7)

Staff acknowledged that people who present for self-harm or other mental health reasons often wait for a long time to receive care, especially if their injuries are not acute or life-threatening. P8 stated that these individuals "are waiting constantly. They're either waiting for a bed, they're waiting to see mental health, then they're waiting to be cleared medically, then they're waiting for an inpatient bed".

Due to high patient loads, ED staff must often manage multiple people concurrently. As such, staff may not have the time needed to build rapport and/or provide sufficient emotional support to individuals. Participants

TABLE 2 Overview of themes, subthemes, and their descriptors.

Theme	Subtheme	Descriptor
1. System-related challenges when managing self-harm in ED	1.1. People who present with self-harm are not prioritised due to limited hospital resources	Lack of hospital resources, such as staff or available beds, disproportionately affects those who present with self-harm because they often need additional time and emotional support
	1.2. The challenges of ED as a physical environment	EDs are busy, loud, bright, and set up in a way that lacks privacy, which can exacerbate a person's psychological distress
	1.3. Insufficient education, training, and guidelines about managing self-harm impacts the quality of care	Limited education, training, and guidelines about self-harm care in ED leave staff having to learn "on the job". This contributes to staff feeling ill-equipped or unsure about their role when treating self-harm, which affects the person's ED experience
2. Human-related challenges when managing self-harm in ED	2.1. A person's circumstances and presentation can complicate the provision of care	A person's self-harm presentation may be complicated by their past or current circumstances, or how and with whom they present, which can interfere with ED staff's ability to provide optimal treatment
	2.2. Staff attitudes towards self-harm and the impact on the quality of care	Staff attitudes towards self-harm are shaped by their personal and professional backgrounds, and the nature of the self-harm presentation. Negative attitudes can adversely affect the quality of care provided by the staff
3. Staff suggestions for improving self-harm management in the ED	3.1. Provision of tailored education and training about self-harm care	Detailed suggestions and specific examples relating to the content and delivery of education and training on self-harm care for ED staff
	3.2. Organisational and logistical recommendations	Recommendations relating to the specific resources needed or how the ED should be set up to achieve optimal outcomes for people who present with self-harm

perceived this to be particularly detrimental for those with self-harm, who often present with high levels of distress and might benefit from additional time and psychological support.

> I feel like people that are struggling mentally […] need the extra support. They need - what I would like to give them is for me to sit down with them and really listen and engage them. In the emergency department, that just - it's not facilitated like that.
>
> (P10)

The challenges of ED as a physical environment

EDs are highly stimulating environments with "lots of noise, bright lights on 24/7, constant movement of staff and patients" (P10). As such, they are not an ideal setting for a person presenting with self-harm who may need a calm and quiet space to help ease psychological distress.

Lack of privacy in the ED was another barrier described by staff. For example, people presenting with self-harm may see "someone really unwell being wheeled past their door" (P4), which could further worsen their psychological state. A person's psychological distress may be amplified by witnessing someone else being restrained or sedated. This could make the person less likely to engage with ED staff, which can diminish the quality of their experience.

> Unfortunately, they may see us grab out restraints and stuff. That would be a massive barrier, if they get to see all that, which will heighten their anxiety. Then, of course, I could imagine that they're probably thinking "the same's going to happen to me".
>
> (P4)

Participants acknowledged that the ED is the most suitable place for acute risk, but the needs of those presenting with non-life-threatening self-harm injuries may be better served elsewhere in the healthcare system. EDs are unlikely to be able to provide other important aspects of self-harm care, such as a calm environment, emotional support, and long-term assistance:

> It comes down to safety and if their life is in jeopardy, […] they're serious, they've got a plan and they're ready to go, definitely. I encourage anyone to call the ambulance or present to [the ED]. But then once they're

> there, I don't think it is the best place. We ensure their safety 100%, but in regards to their ongoing support we can't provide much in emergency.
>
> (P10)

Insufficient education, training, and guidelines about managing self-harm impacts the quality of care

Participants emphasised that ED staff do not receive sufficient education, training, or guidelines about managing self-harm. Self-harm-related content is minimal in nursing degrees and is often not included in professional development opportunities provided by the employer. As such, ED staff reported having to obtain the necessary knowledge and skills "on the job". Participants described their approach to managing self-harm as: "I feel like I'm learning it each time someone comes in. I'm teaching myself" (P1) or a combination of learning from their education, clinical experience, exposure, and coworkers.

While learning from other staff such as Emergency Mental Health Workers or more experienced ED nurses was identified as helpful, P8 (senior staff member) acknowledged that having extensive experience and exposure in managing self-harm "doesn't necessarily translate to me being current and evidence based and up to date", thereby emphasising the value of education and training.

Participants talked extensively about how their limited self-harm-related knowledge and skills can impact the quality of care that they provide. They expressed feeling under-skilled, particularly when providing emotional support:

> I guess the hardest thing with the self-harm is I don't feel like I'm qualified enough, or I know enough about it to give advice to those people when they're coming in. I'm sort of just a quick fix band aid, if that makes sense. I'm basically trained to see it as a wound, not as a product of a feeling.
>
> (P6)

As a result, participants reported that they would sometimes avoid managing self-harm presentations:

> I sort of went [into the room], did a little thing and then I'd be straight out of the room again. I'm like, "I'm not caring for her the way I'd like to, but I don't really know how". […] I just found that I was finding other people to do things.
>
> (P1)

Some staff reported feeling uncertain about the scope of their role in managing self-harm, regardless of their level of competence and comfort. P1 (a nurse) explained that she would like to discuss "the emotional side of stuff" with a person who has self-harmed but felt unsure if it is within her "scope of practice". P1 said: "I'd hate to ask all of these questions and then next minute, the mental health nurse is […] going to go and ask them all the same questions. That might just get frustrating for [the person] having to repeat stuff".

Human-related challenges when managing self-harm in ED

Participants spoke about human-related factors that can hinder the effective management of self-harm in ED. Complex circumstances surrounding a person's self-harm presentation can interfere with the delivery of care. Another factor is staff attitudes towards self-harm, which vary depending on the nature of the presentation and the staff member's professional and personal background. Negative attitudes held by staff can have adverse effects on the quality of self-harm care provided.

A person's circumstances and presentation can complicate the provision of care

The complexity of self-harm presentations can influence the optimal and timely provision of care. Participants identified several factors which can complicate the assessment and management of self-harm, including being under the influence of alcohol, other substances, or chemical restraint; lack of trust in health professionals; and presenting to ED with a family member, which can sometimes impact therapeutic engagement and rapport.

One participant explained that it can be so common for people to present to the ED for self-harm while intoxicated that one cannot "look at mental health in [ED] without looking concurrently at drug and alcohol presentation" *(P8)*. A person under the influence of substances may be unable to interact with staff or provide history, so assessment and management must be postponed until the substance effects have worn off. Consequentially, the time the person spends in the ED increases.

Similar delays in assessment and management can happen in cases where chemical restraint is required. A sedative may be provided by staff to a person who is acting in ways that endanger themselves or others, and it can take time for this to wear off. The use of chemical restraint, whilst sometimes necessary, creates an unequal power dynamic between the person and ED staff and diminishes rapport:

> It's kind of like a double ended sword. They're having an absolute crisis […] and maybe being aggressive. But then I go and physically restrain them and sedate

> them and then take away all their liberties, and then the power dynamic has shifted completely.
>
> (P8)

Sometimes people who present with self-harm "don't easily open up" or "feel like they could not trust [ED staff]" (P11). One participant said: "it's difficult to engage with a lot of young people sometimes, especially when they've had a lot of trauma in their childhoods", as they may be acting "withdrawn" or "just don't have any health literacy because they've had a rough upbringing" (P13). In other cases, the presence of a family member during assessment can influence how much the person is willing to disclose to ED staff, which can hinder engagement:

> It's hard for younger ones that come in with their carers/parents because they don't want to talk with them there. Sometimes I feel if we could talk to them on their own - I know that's legally not possible, but […] the reason that they're harming themselves can be sitting right next to them.
>
> (P17)

Participants said that sometimes individuals present to the ED regularly reporting that they have self-harmed or overdosed, but upon examination there is no evidence that this has occurred. When there is a discrepancy between a person's narrative and a staff member's assessment, participants explained that staff may begin to dismiss these people due to assuming that they are not being genuine: "It puts you in a position where you're probably 90% sure they haven't taken [an overdose], but then you don't want to risk the fact that this time could be real" (P14).

Staff attitudes towards self-harm and the impact on the quality of care

Attitudes towards self-harm can be shaped by the staff member's personal or professional background. For example, P5 expressed that their personal experiences of mental ill-health helped them become more understanding towards people who harm themselves. P5 reported feeling "frustrated when [other ED staff] see any sort of mental health as 'oh, it's just attention-seeking'".

Participants explained that negative attitudes can stem from feeling uncomfortable or ill-equipped to work with self-harm presentations:

> I just think it's people's level of comfort in managing a situation that is challenging. […] I think you have a whole broad range of people and attitudes and stuff, probably based on experience and based on training.
>
> (P7)

Another factor affecting staff attitudes is their perception of severity and frequency of the self-harm presentation. Self-harm and suicide attempts that are life-threatening are seen as "tragic and horrific" (P7) by staff. These views do not necessarily extend to self-harming behaviour that leads to superficial injuries, especially if the person presents frequently. P7 explained that these individuals "are probably not met with the same kind of grief response that I guess they would be met with if it was a more serious attempt, and [ED staff] hadn't met the person before".

Participants noted that people who present to the ED with self-harm for the first time (as opposed to representations) tend to receive more time and attention from staff. Nurses are typically more alert and engaged with these individuals due to not knowing what to expect:

> When it's their first episode of self-harm, our empathy and everything in our engagement seems to be so much higher. I guess everything slips away the more we've seen someone or the more they present. […] Everything steps down, the empathy wanes a little bit, it kind of slows.
>
> (P3)

ED staff get to know the patterns of behaviour of people who frequently present, which sometimes means they do not "necessarily [see these individuals] as particularly high risk" (P7) and are not as engaged in their care as they would be with others. Participants expressed feelings of hopelessness and compassion fatigue towards people who frequently present with self-harm:

> It feels like no matter what you do or say or provide the kind of supports in the community, this patient is just going to continue to bounce back. Perhaps it's a protective mechanism that people stop being invested in that person and stop being hopeful for that person […] getting better, recovering.
>
> (P10)

Although participants acknowledged that negative attitudes towards self-harm are not shared by all staff, they said that some staff "think that it's attention-seeking" or "don't want to understand it" (P13). People presenting with self-harm are dismissed as being low priority, and thus may be "given even less time" or "treated very abruptly" (P4) by staff. Participants also noted that these

individuals may receive less frequent observations than those presenting for non-mental health reasons.

One participant witnessed an instance where a person presenting with self-harm was not offered pain relief during suturing of wounds. P5 explained that this person expressed not wanting pain relief, "but that doesn't mean it's right [for staff] not to give her pain relief or even offer it to her". P5 added: "if anyone had come in with a wound of that nature [that was not self-inflicted], they would have just been given pain relief straight away".

Participants stated that although staff have varying views on self-harm, they do not necessarily let these views affect how individuals are treated. When working with people who present for the first time with superficial self-harm, P2 said: "I still take it seriously because that has then the potential to escalate into something really dire".

Staff suggestions for improving self-harm management in the ED

Participants provided suggestions for how barriers to optimal self-harm care could be addressed. These centred around the provision of specialised education and training and improving ED settings.

Provision of tailored education and training about self-harm care

Participants identified the need for tailored education and training for self-harm management in ED and offered examples relating to the content and delivery of this training. An emphasis was on training staff to understand the person's mental state and possible reasons for self-harm:

> Maybe just giving people a picture of what it's actually like to be inside the headspace of someone that's having those thoughts of self-harm, just so they can understand the headspace that someone's in.
>
> (P10)

In terms of clinical skills, participants reported wanting specialist training on communication about self-harm, which covers not only *what* to ask, but *how* to ask certain questions during an assessment. P10 highlighted the role of "trauma-informed practice" in informing a person's assessment:

> Instead of going "What's wrong with you?", it's asking the patient "What's happened to you? What's happened in your life that's led you to this moment that you want to end your life or significantly hurt yourself?"

As for the most optimal and acceptable way of delivering training to ED staff, participants highlighted the value of real-life examples, such as videos of a clinician talking to a person with self-harm. P1 explained that practical skills cannot be learned just from reading a textbook: "A protocol can be good because it can give you the foundation but it's yeah, how it's done and your tone of voice which you don't really get from reading".

Organisational and logistical recommendations

Participants provided recommendations regarding how EDs could be set up to offer a better experience. One suggestion was to have a separate department within ED for mental health presentations specifically. This would be a quiet, low-stimulus environment offering respite to those presenting for mental health reasons.

> I would love it if we had a separate department that was just for patients that were presenting to emergency that were suicidal and - or just had some self-harm and that as per our mental health clinicians, were deemed low risk and could be managed in the community. I think it would be nice if we had a separate section where they could stay overnight and just have that comfort of a bed, a roof over their head.
>
> (P10)

Participants suggested that EDs should have guidelines on treating self-harm available for a quick "on-the-spot" reference. Most were unaware that such guidelines already exist (Department of Health and Human Services, 2010). However, participants who were aware found them inaccessible: "It wasn't there, accessible, in the Emergency Department to have a read about all the different presentations of self-harm and […] good ways to approach each one" (P1).

Participants expressed that investing in more specialist mental health staff would be valuable. One participating hospital recently introduced a new role, Mental Health Nurse Educator, whose job is providing on-the-floor mentoring to ED nurses regarding mental health presentations. Participants mentioned that Emergency Mental Health Workers can be a helpful resource, but they are often too busy with their own patient load. A Mental Health Nurse Educator who is situated in the general ED area would address this gap by being able to provide mental health-related guidance on the spot:

> I think the holes we had in educating and processes and policies because we didn't have that level of knowledge, has now been filled by her. I think she will be a wonderful buffer between the nursing and medical staff

and the mental health world, and she'll help bring it together.

(P8)

DISCUSSION

Key findings and implications

The present study provides an in-depth account of ED staff perceptions regarding barriers to providing optimal self-harm care in the context of Victoria, Australia. The findings add to the existing evidence and offer insights into how service delivery could be improved.

Our study findings highlight how the ED setting can be challenging for those with self-harm. Noise and brightness levels (Byrne et al., 2021), long wait times (Quinlivan et al., 2021), and lack of privacy (Liddicoat, 2019) have been previously identified as exacerbating a person's psychological distress. Present study participants suggested addressing this by introducing a separate area in ED that offers respite in the form of a quiet, comfortable, and low-stimulus space. Research shows that provision of a private and secure waiting area for mental health presentations that is visible from the main ED triage area is helpful to both staff and patients (Broadbent et al., 2014). Some EDs in Victoria already have separate mental health areas, which is a positive step forward and should be adopted more widely. Additionally, therapeutic spaces where people experiencing mental ill-health can go as an alternative to ED, such as Safe Haven Café, can be beneficial and reduce the number of mental health presentations to ED (Safer Care Victoria, 2020).

Delivery of self-harm care could be improved by having a mental health professional such as the Mental Health Nurse Educator to provide specialised guidance and support to staff on the spot. A recent study evaluated a mental health liaison nursing (MHLN) team embedded in an ED in New South Wales (Wand et al., 2020). This team works alongside ED nurses to provide specialist mental health support to those requiring it. The service was found to be beneficial to people who present for mental ill-health, ED staff, and the overall service provision. The MHLN team contributed to making people's ED experience more time-efficient and therapeutic, improved ED capacity, and increased confidence in ED clinicians. Such teams could be a valuable addition to EDs in Victoria.

In line with previous research (Rayner et al., 2019), our study showed that negative attitudes, including dismissiveness and lack of compassion, towards self-harm affect therapeutic engagement and clinical practice. A study of young people's experiences of presenting to ED for self-harm (Byrne et al., 2021) showed that young people feel they have to escalate their self-harming behaviour to be taken seriously by ED staff. This, in turn, increases pressure on staff which makes young people feel like a burden, leading to a "vicious cycle" that both parties found problematic (Byrne et al., 2021). Similarly in the present study, participants identified compassion fatigue as a challenge when working with people presenting frequently for self-harm. As such, meeting a person with compassion and ensuring that their needs are adequately met during their first ED presentation is crucial for reducing re-presentations, thereby improving experiences of service provision for both patients and staff.

Improving attitudes towards self-harm is a complex process, but one way to do it is through the provision of up-to-date, evidence-based training offering a holistic understanding and assessment of self-harm (Michail & Tait, 2016). Consistent with previous research (Ngune et al., 2021), staff in the present study reported that training and education on self-harm are currently insufficient. Our findings describe several elements that could be incorporated into such training. Participants emphasised the importance of understanding *how* to ask questions sensitively during assessment and learning "soft skills" like empathy and active listening, which are integral to therapeutic engagement and patient satisfaction (Beattie et al., 2012; Hunter et al., 2018). Participants also highlighted the relevance of trauma-informed approaches. A recent systematic review showed preliminary evidence that trauma-informed suicide prevention approaches are associated with reductions in suicidal thoughts and behaviours (Procter et al., 2023). Furthermore, in a qualitative study with caregivers of young people with co-occurring traumatic stress and suicidal thoughts and behaviours, caregivers emphasised the importance of clinician education on how trauma impacts suicide risk (Inscoe et al., 2022). Irrespective of the training content, upskilling ED staff on self-harm must be regular, evidence-based, and delivered either as a standalone program or incorporated into existing training packages used by EDs (Richards et al., 2023).

Our study findings also raise implications for better implementation of existing guidelines for the management of self-harm in ED (Department of Health and Human Services, 2010). This can be guided by specific frameworks for implementation of clinical guidelines into practice, such as those by Sarkies et al. (2022), which involve assessing barriers and enablers of implementation, tailoring implementation strategies, and monitoring, evaluating, and sustaining implementation. More broadly, our findings suggest that despite the existence of resources like the guidelines to provide staff with self-harm-related knowledge they may otherwise lack, staff continue to identify the lack of knowledge and resources as a barrier. Future studies could examine what is preventing staff from utilising these existing resources to the fullest extent.

Many of the barriers to effective self-harm care described in the present study are not unique to the ED and apply across other healthcare settings. General practitioners in the UK and Australia have reported

experiencing lack of self-harm-related knowledge and skills, as well as challenges with doctor–patient communication, which affect the quality of care provided (Bellairs-Walsh et al., 2021; Michail & Tait, 2016). Recommendations from these studies included training general practitioners on specialised self-harm knowledge and general communication skills, introducing self-harm assessment tools into standard practice, and highlighting the need for better service integration to streamline referral pathways. There is potential to extend these recommendations to EDs as part of the movement to reform mental health care by the Royal Commission into Victoria's Mental Health System (State of Victoria, 2021). This is timely given that the rates of self-harm presentations to Australian EDs have increased since the COVID-19 pandemic (Sara et al., 2023), placing more pressure on the already under-resourced healthcare system. Several initiatives to optimise mental health care have already been implemented, such as the Hospital Outreach Post-suicidal Engagement (HOPE) program (Victoria Department of Health, 2022) and respite facilities for mental health and suicidal crises ("safe spaces") (State of Victoria, 2021). While these initiatives have the potential to improve self-harm care on a larger scale, to do so they must be well-resourced, compassionate and not further burden or fragment the existing services.

Strengths and limitations

The study was presented in line with COREQ (Tong et al., 2007), ensuring the comprehensive and transparent reporting of all study elements. Formulation of themes was performed by three researchers of varying backgrounds and levels of qualitative research experience, meaning that a range of perspectives and interpretations contributed to the final result. Another strength was that the sample comprised staff from different geographical areas (metropolitan, regional) who had various roles, levels of experience working in ED, and demographic characteristics. This allowed us to capture a breadth of perspectives.

Despite the richness of the data collected, pragmatic limitations such as staff workload and time constraints may have influenced the depth of discussion and interaction with the participants on such a complex issue as their experience of working with people who self-harm. Another limitation is that ED staff self-selected to participate. This may mean that the sample predominantly consists of staff with a particular interest in self-harm. Although this may be the case, participants presented a variety of views and were able to reflect on practices upheld by themselves and colleagues. Future research could investigate barriers to self-harm care in EDs from other more varied geographical locations and use different sampling methods to recruit staff members of different roles, backgrounds, and education levels.

It is also worth noting that both participating EDs have specific mental health-related facilities or features that other EDs in Victoria may not have. As such, these two EDs may be better equipped to treat self-harm compared to other EDs across the state. Given that the participating EDs experienced multiple barriers to optimal self-harm care, other EDs that have less mental health resources may be facing different or more prominent barriers.

CONCLUSION

This study explored staff-identified barriers to treating self-harm in EDs in Victoria, Australia. The barriers centred around the de-prioritisation of self-harm presentations due to shortages of hospital resources, insufficient education and training about self-harm care for staff, challenges relating to ED as a physical environment, the nature of a person's circumstances or presentation, and negative staff attitudes towards self-harm. Staff recommendations for addressing these barriers included integrating mental health-specific staff and respite areas into ED, and better implementation of guidelines for treating self-harm. Given that self-harm presentations to ED are associated with elevated rates of suicide-related mortality (Goldman-Mellor et al., 2019), it is essential that people who harm themselves receive high-quality, efficient, and comprehensive care as early as possible.

Relevance for clinical practice

This study highlights the need for improved education and training for ED clinicians working with people who present with self-harm. The content should cover specialised self-harm knowledge and general communication skills, with an emphasis on using appropriate words and tone of voice. Employing Mental Health Nurse Educators is another effective way to provide on-the-floor mentoring to ED staff in relation to self-harm care. Additionally, given that EDs are not ideal environments for comprehensive and long-term support for those who self-harm, investment and implementation efforts could be directed into alternative treatment pathways, such as mental health cafés and "safe spaces".

AUTHOR CONTRIBUTIONS

JR and KW conceived the study idea and acquired funding. ML and KW supported participant recruitment and study administration. ML, HR, and CB collected the data. MV, MM, and HR analysed the data. MV drafted the manuscript, and all authors contributed to the edit of the manuscript. All authors listed meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors and are in agreement with the manuscript.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

The study received ethical approval from the Melbourne Health Human Research Ethics Committee (2017.342).

PATIENT CONSENT FOR PUBLICATION STATEMENT

All participants provided full informed written consent for their data to be used in this study.

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APPENDIX A

TOPIC GUIDE

1. If you see a patient who has self-harmed, what are your next steps?
2. What (if any) are some of the challenges you experience when working with people who present with self-harm?
   - Probe: Are there any additional challenges when working with young people specifically?
3. How is self-harm viewed by staff in the emergency department (ED)? Do you think this influences how self-harm patients are treated?
   - Probe: Does the hospital culture influence the way you work with these patients?
4. Are you aware of protocols or resources for working with people who present to ED with self-harm?
   - Probe: What do you think of these protocols? What are the challenges you face following these protocols? Are there additional resources that would support your work with this population?
5. What are your views about clinical recommendations for working with this population? Does this apply to the recommendations that all patients with self-harm should be: assessed; seen quickly (within 10 minutes); treated with respect and empathy; referred to follow-up care?
   - Probe: How often do you follow these recommendations? Why might you/might not follow the recommendations?