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ORIGINAL ARTICLE

Pathways and transitions for patients admitted to an emergency department after self-harming events

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Abstract

The frequency of people presented in emergency departments (EDs) after self-harming events is increasing. Previous studies have shown that the complexity of the disorders of patients admitted to the ED after self-harming events can be overwhelming for ED healthcare professionals (HCPs) to handle. The objective of this study was to observe and investigate the pathways for patients admitted to the ED after self-harming events to either transition or discharge. Participant observation and interviews were selected as the methods to generate insight into the pathways of patients admitted to the ED after self-harming events. The data were analysed using interpretative phenomenological analysis. A sample size of 20 patients was analysed, and a total of 213 h of observation took place during the data collection. Three main themes appeared: (1) patients' mental stress versus high expectations, (2) uncertainty about how to address the self-harming event and (3) a system of chaos. Patients admitted to the ED after self-harming events struggle with difficult mental stress. Despite this, they face high expectations that they will fit in and cooperate in the ED. The healthcare system is organised with unclear responsibilities and without systematic ways to care for self-harm patients and so provides chaotic patient pathways. There is a need for improved cross-sectional competencies, mutual agreements and systematic communication for discharge, transitions and follow-up care between those involved in the patient's pathway and care.

KEYWORDS
emergency department, pathways, psychiatry, qualitative research, self-harm

INTRODUCTION

The frequency of people presenting in emergency departments (EDs) after self-harming events is increasing (Borschmann & Kinner, 2019). Worldwide, 700 000 people suicide per year (WHO, 2021), and for each suicide, there are over 20 self-harming events (WHO, 2019). Injuries caused by self-harming events can lead to fatal outcomes or physical damage that require treatment in the ED (WHO, 2019). In 2018, there were 253 926 presentations in Danish EDs due to self-harming events (Denmarks_Statestics, 2018). In addition to its own personal suffering, the patient population causes a significant economic health cost due to their need for multiple resources in and out of the hospital, as well as their risk of numerous readmissions (Eriksen et al., 2016).

BACKGROUND

The reasons for undertaking self-harming actions vary, including poor mental health, loss of control and inability to manage specific situations (Stänicke, 2019). For some, self-harming actions are used as coping strategies

to achieve, to affect regulation, to exert interpersonal influence or to punish oneself (Edmondson et al., 2016); for others, self-harm is due to a sincere death wish (WHO, 2019). The triggers of self-harm require mental health support, whereas the physical damage itself requires somatic care and treatment. Presenting both needs simultaneously adds complexity to this patient population when they are admitted to the ED (Perboell et al., 2015; Rayner et al., 2019). Moreover, the ED's physical framework, crowding, waiting time and limited human resources further challenge the patients (Karman et al., 2015; Mulhearne et al., 2021).

Most ED nurses are trained in systematic approaches to acute somatic care but are not specialised or trained in mental health care (Perrone McIntosh, 2021). However, the ED is the primary source of immediate treatment, and even though it is a difficult setting for people dealing with mental stress, it is where patients needing immediate treatment are most often evaluated (Perrone McIntosh, 2021). Previous studies have shown that the complexity of patients' situations can be overwhelming for ED nurses to handle (Acres et al., 2019; Karman et al., 2015; Mulhearne et al., 2021; Perrone McIntosh, 2021). ED nurses associate feelings of powerlessness and frustration with patients presenting after a self-harming event (Karman et al., 2015; Mulhearne et al., 2021; Østervang et al., 2022). The lack of competencies to undertake mental health care, and manage emotional pain, makes ED nurses insecure and decreases their motivation to interact with self-harming patients in the ED (Mulhearne et al., 2021); this situation contributes to a significant risk of the nurses lacking empathy and having negative attitudes towards patients (Karman et al., 2015; Østervang et al., 2022; Rayner et al., 2019). To obtain improved confidence in care it is recommended to focus on the education and training of the ED nurses in therapeutic interactions with people at risk of repetitive self-harm events (Ngune et al., 2020).

Negative attitudes from ED nurses might worsen patients' mental status and intensify the urge for further self-harming behaviour (Masuku, 2019). In particular, the feeling of not being recognised as a person in need of help, like other people in the ED, can trigger a sense of inferiority, rejection and shame among self-harming patients (MacDonald et al., 2020). Patients describe experiencing mostly degrading treatment and poor communication with ED nurses (Vandyk et al., 2019). Inadequate communication and lack of interaction might lead to patients reacting with inappropriate behaviour (shouting, striking, etc.) simply because they lose control (MacDonald et al., 2020; Vandyk et al., 2019). Moreover, a lack of involvement by the patient's relatives or caregivers in the decision-making processes during the ED stay and discharge planning increases the risk of new self-harming events (Acres et al., 2019; Robinson & Bailey, 2022). A circular pattern of behaviour with repetitive self-harming events and repeated admission to the ED is likely to happen (Acres et al., 2019; Masuku, 2019; Vandyk et al., 2019).

The literature reveals that both patients and ED nurses face challenges all along the patient pathway in the ED. Training of ED nurses, psychiatric support and collaboration across sectors are suggested to make the patient's path easier (Borschmann & Kinner, 2019; Breslau et al., 2018; Clarke et al., 2015; Cranwell et al., 2017; Fernando et al., 2017; Kahan et al., 2016; Morken et al., 2019; Trondsen et al., 2018) Nevertheless, limited research has been found that describes the events in the patient's pathway from their arrival in the ED to their transition to home or a psychiatric unit. This knowledge is needed to uncover and understand barriers and possibilities for designing and improving future pathways in the ED. Therefore, the objective of this study was to observe and investigate the pathways for patients admitted to the ED after a self-harming event and to either transition or discharge.

METHODS

Design

A qualitative design was chosen due to its appropriateness to investigate and understand human experiences, experiential processes and social life (Green, 2018). The ethnographic methods of participant observation and interviews were selected to help generate insight into the pathways of patients admitted to the ED because of self-harming events. The Consolidated Criteria for Reporting Qualitative Research was used as a checklist (Tong et al., 2007).

Clinical setting

The study was conducted at a large teaching hospital in Denmark, which contains 1000 beds and covers all somatic specialities. The ED is among Denmark's largest emergency departments and receives 200 patients per day every day of the week. The ED consists of 150 nurses, 25 doctors and affiliations with doctors from other specialities. Approximately 70 000 patients are admitted each year.

The psychiatric units, including the Psychiatric Emergency Department and the Child and Adolescent Psychiatry Unit, employ 600 Health Care Professionals (HCPs). The Psychiatric Emergency Department operates every day and assesses 6000 adults, children and adolescents annually. The local Child and Adolescent Psychiatry Unit has inpatients and outpatients aged <20 years.

The psychiatric units are physically located approximately 1 km from the ED. They are not part of the teaching hospital and have separate directors.

Participants

The participants were patients aged 18–60 years admitted to the ED after self-harming events, able to understand the terms of research and able to give informed consent. We equated suicide attempts with self-harming events, as suicide is considered a form of deliberate self-harm. Patients forced to undergo treatment in the ED were not included.

We aimed to enrol participants until we derived no more themes from the analysis process. This was predicted to be reached after the consideration of 15–20 participants (Green, 2018). Otherwise, the author group agreed to continue the enrolment of new participants.

The first author had access to a patient overview programme for incoming patients and patients who had been admitted to the ED. Patients who fulfilled the inclusion criteria were approached to uncover their interest in participation. The initial approach was made by the care responsible nurse to avoid the patients feeling forced to participate. If the patient agreed, details of the study were given, and informed consent was obtained from each participant by the first author. Relatives present in the ED were enrolled to participate with acceptance from the patient. The first author was present in each patient's room in the ED, and if the patients were transferred to another ward (somatic or psychiatric), she followed the patient physically until their destination (final ward) or until discharge.

Data collection

The data collection was carried out from 16 January 2023 to 29 April 2023. Data were collected primarily between 5:00 PM and 1:00 AM and on all weekdays. The first author had no care responsibilities for any patient admitted to the ED.

All of the employees in the ED and the psychiatric units were informed about the project by e-mail and in physical meetings.

Data for every participant were merged from the participant observations and the transcribed interviews into one dataset.

Participant observation

Field observations help authors understand how interactions and activities unfold in a real-life setting (Green, 2018). Therefore, we chose this method to understand the patient's pathways. Furthermore, it provides firsthand knowledge of the pathway through the ED, the transitions and discharges. Observations can be performed using different approaches (Spradley, 1980). For this study, a non-participant approach was chosen to secure objectivity in the observations. To secure a systematic approach, an observation guide inspired by Spradley's (1980) nine domains was developed. The observations were supplemented by informal conversations during the observations. This helped to uncover potential misinterpretations and create an understanding of underlying actions that were not evident by observation alone (Green, 2018; Spradley, 1980). An example from the observation guide is, 'Who is involved in the process? When are they involved? Are the patient's network and relatives involved?'

After each observation, all field notes and quotes from the informal conversations were systematically rewritten and gathered into a single document.

Interviews

To gain an understanding of how the pathway in the ED, transition and discharge was experienced by the patient, we conducted formal interviews. Each included patient was invited to participate in a semi-structured interview 1–2 weeks after their admission to the ED. The rationale for choosing this particular time to conduct the interview was that the group of authors wanted to allow time for the patients to return to their daily lives. The interviews were based on the patients' observations and the events subsequent to their leaving the ED, regardless of whether the patient was discharged or transferred. Even though the interviews were conducted to elicit narrative as much as possible, an interview guide was developed and worked as a checklist to ensure that the focus was kept on the research aim (Kvale & Brinkmann, 2009). The interview guide was developed with inspiration from Kvale and Brinkmann (2009). One example of an interview question is, 'How did you experience the discharge?'

Eleven participants had been discharged when the follow-up interviews were conducted, and the interviews were conducted by telephone. Participants who were still admitted could choose the setting for the interview. Three of the four participants still admitted chose face-to-face interviews at the ward, and one chose a telephone interview. All interviews were recorded and transcribed. At the end of each interview, the first author summarised the interview to ensure correct interpretation. The participants were invited to read the transcript. None of the participants accepted the invitation.

Researcher reflection

The first author undertook the observations and interviews. She has 8 years of experience as a nurse and has experience in both the psychiatric units and the ED. To guard against bias caused by her preconceptions, she arranged reflective meetings with the author group during

the planning of the study, during the data collection and as part of the interpretation of data.

Analysis

All field notes, conversations and formal interviews were transcribed and transferred to NVivo12 software. Data were analysed using interpretative phenomenological analysis (IPA), a six-step phenomenological hermeneutic analysis method (Smith & Osborn, 2015). Steps 1–4 were individually read and open-coded as separate datasets (Smith et al., 2012; Smith & Osborn, 2015). This approach enabled us to analyse each observation individually and the interviews (both conversations and formal) separately. After the separate analyses and open coding in steps 1–4, the main themes that appeared most essential were selected and divided into main themes in step 5. The first author led the coding process under the supervision of the research group. Through the coding process, the first author and the research group closely discussed the codes as a strategy to limit possible bias. Investigator triangulation during the analysis helped ensure the credibility and trustworthiness of the dataset.

Ethics

In agreement with the Declaration of Helsinki and the Ethical Guidelines for Nursing Research, informed consent was obtained orally and in writing. The study is registered at the 'Record of data process of Registry of Southern Denmark' (22/54486). Data were stored in a secured SharePoint (Microsoft) and the Open Patient Data Explorative Network_1752 (OPEN, 2023). MSS was attentive to whether the patients displayed any signs of discomfort during the interview and if the situation became too overwhelming. She made it clear to all the patients that they could withdraw from their participation both during and after the interview. Several times during the interview she asked the patients if they felt themselves able to continue the interview.

RESULTS

Data were collected from 16 January 2023 to 29 April 2023. A sample size of 20 patients was analysed, and a total of 213 h of observation took place during the data collection. The range of observation time ranged from 3 to 48 h.

The characteristics of the included patients are shown in Table 1.

Fifteen patients participated in the follow-up interview 1–2 weeks after their ED admission, and two relatives participated in both the observations and the follow-up interviews.

TABLE 1 Participant characteristics.

Participants	*N* = 20
Sex	*N* (%)
Male	4 (20)
Female	16 (80)
Age	Age
Mean	26.8
Range	18–44
Self-harming action	*N* (%)
Poisoning	13 (65)
Cutting	5 (25)
Swallowed objectsSingle injuries	4 (20)17 (85)
Multiple injuries	3 (15)
Discharged or transferred to	*N* (%)
Psychiatric Emergency Department	8 (40)
Child and Adolescent Psychiatry Unit	3 (15)
General practice	4 (20)
Residence	5 (25)
Psychiatric outpatient programme	*N* (%)
Yes	13 (65)
No	7 (35)

During data collection, 47 eligible patients with self-harm injuries in the ED were identified but not included. Thirteen of them were not approached because they had been forced to undergo treatment. Notably, 6 of the 18 patients below age 18 had been forced to undergo treatment. Five adult patients were not included because of low consciousness and were not able to understand the terms of the research or give informed consent. Finally, 11 patients declined to participate. Most of these patients had been admitted to the ED with first-time self-harming events.

From the analysis of the observations and interviews, three main themes appeared: (1) patients' mental stress versus emergency department staff's high expectations, (2) uncertainty about how to address the self-harming event and (3) a system of chaos.

Mental stress versus high expectations in the emergency department

Patients admitted to the ED expressed struggles with intense thoughts about the self-harming action, loneliness, hopelessness and powerlessness. The follow-up interviews revealed that they had been unable to remain in control using coping strategies or crisis plans or to seek help within the psychiatric services before the self-harming event.

> I have a crisis plan and coping strategies, but I was not able to use them; I lost control and self-harmed.
>
> (Follow-up interview, 4 April 2023)

Patients admitted to the ED after self-harming events behaved in various ways. Some were loud, angry, insistent and splitting. Others were psychotic and/or quiet with no eye contact; some were crying and others were deflecting every question they were asked.

> She is sitting on the floor towards the back of the room. She is hiding under her jacket. Restless, upset, rocking and whimpering. No eye contact, speaking quietly, looking down at the floor. Sliding off on questions.
> (Field note, 6 March 2023)

The patients had self-harmed for different reasons. For some patients, it was a help-seeking strategy; others had a real desire to end their lives. Patients expressed feeling worse than ever before and experienced an overwhelming sense of powerlessness during their stays in the ED.

> I tried to cope with the demanding voices in my head. When I was in the ED, they were intense and wanted me to self-harm further. I felt powerless and worse than ever before.
> (Follow-up interview, 31 March 2023)

The observations and interviews revealed that the patient's mental state affected their ability to meet the high expectations and cooperate with the HCPs in the ED. They struggled to meet the HCPs' high expectations for nice, quiet cooperation during examinations and tests. The demand and expectation that the patients be willing and able to cooperate with the HCPs became too overwhelming for many patients. Some patients panicked, others appeared ambivalent about receiving treatment and some outright refused to cooperate. In all cases, the atmosphere became tense.

Patients were informed that the alternative to cooperation would be receiving care under the Mental Health Act.

> The nurse states, "You know the procedure if you do not collaborate…."
> (Field note, 18 January 2023)

The patients expressed that they perceived this as a threat, which in many cases further increased mental stress and generated uncertainty, conflict and distrust.

Uncertainty about how to address self-harming events

HCPs in the ED supported patients with their physical needs and somatic treatment, such as treatment of wounds, administration of medicine, monitoring of vitals, helping patients to the toilet, making them comfortable in bed and serving them food or drinks.

It also became evident that HCPs in the ED were comfortable providing somatic treatment and care, but they became uncomfortable when patients expressed mental stress, such as by crying. They tried to keep the patients as mentally composed as possible by avoiding addressing the patients' mental stress.

> I was alone with my thoughts and metal pain for 20 hours in the ED. I know the ED fixes the physical injury and the psychiatry the mental pain. However, I wish they could combine it.
> (Follow-up interview, 1 February 2023)

In the ED, the psychiatric assessment consisted of one question: Can you refrain from harming yourself again? When patients replied no or were avoiding answering the question, the HCPs did not explore this further and often ended the conversation.

> The doctor in the ED asks, "Can you refrain from harming yourself again?" The patient responds, "I do not want to live." The conversation ends and is not explored further.
> (Field observation, 10 April 2023)

The psychiatric assessments in the ED were recorded in the patients' medical files, and the suicide risk was often described in one line. None of the patients in the ED were assessed with a violent risk, and none were identified as psychotic; however, both were verified in the psychiatry unit or the follow-up interview.

> I remember being psychotic in the ED. I saw bugs all over the bed, in the food and the room I was staying in. No one talked to me about it or asked me about such symptoms. I did not say anything, either.
> (Follow-up interview, 3 March 2023)

In some cases, it was observed that the ED doctors and a doctor from the psychiatric unit discussed the patient's mental condition and suicide risk over the phone. It was challenging for the ED doctor to express and explain the patient's mental complexity because the HCPs in the ED lacked competencies in psychiatric assessment and treatment. Ironically, despite the lack of competencies, the assessment performed in the ED became the basis on which the patient was either transferred to the psychiatric unit or discharged directly from the ED.

When the patients arrived at the psychiatric unit, the HCPs assessed and investigated their feelings and thoughts about the self-harming event to be able to uncover the severity of the patient's mental condition.

> The atmosphere is relaxed… The nurse expresses compassion and expresses her regret for how the situation turned out.

> The patient is informed that there will be a short waiting time for the doctor; she is encouraged to take some coffee or have some fresh air.
>
> (Field note, 21 April 2023)

They were comfortable and calm during this assessment, as well as when the patients expressed mental stress.

> She had been crying nonstop for six hours in the emergency department; no one addressed it further. When she arrived at a well-known psychiatric ward, she was approached: "Ohh, darling, I see you are in mental pain. What happened?" After 10 minutes, she stopped crying and fell asleep.
>
> (Field note, 24 March 2023)

The psychiatric assessment consisted of questions about the patient's mental state. Did they feel psychotic? What were their thoughts about the self-harming event and the potential risk of further self-harming events? All patients were assessed with the Brøstet violent checklist to estimate the risk for violent behaviour. Finally, there were agreements and strategies in case of an increase in mental stress.

The observations, however, also showed that HCPs in the psychiatry unit were uncomfortable taking care of somatic treatment and care. Patients who were somatically undetermined or unstable were transferred to the ED despite their mental condition.

A system of chaos

Due to the sparse psychiatric assessment in the ED, there was no system to determine whether patients were to be transferred – and if so, to where – or if they were to be discharged with or without follow-up care.

There was two-way communication between the ED and the Child and Adolescent Psychiatry Unit over the phone before patients were transferred. There were action cards and mutual agreements for shared information before a transfer could be activated. If patients were discharged from the ED, no systematic agreement for follow-up existed.

There was two-way communication over the phone in some cases between the ED and the Psychiatric Emergency Department, but the communication mainly focused on somatic conditions. There was no system for discussing patients with psychiatric doctors.

Six patients were transferred from the ED to the psychiatric unit for assessment or admission. Two were discharged from the ED but did seek help in the Psychiatric Emergency Department themselves. After the assessment, they were both identified with severe worsening of their mental condition and were hospitalised.

One patient never attended the Psychiatric Emergency Department despite mutual agreement between the ED, the Psychiatric Emergency Department and the patient because, neither the ED nor the Psychiatric Emergency Department followed up on the case and there was no protocol in place for following up on such cases.

Three patients declined assessment and admission to the psychiatric unit and were discharged to their general practitioners (GPs) from the ED.

> I'd rather stay in the ED; here, I am treated like an adult, and I do not have to deal with what I have done.
>
> (Field note, 2 February 2023)

The HCPs had no follow-up plan for patients discharged to their GPs or residences, so the patients had to be able to take the initiative to seek help themselves if they needed it.

There was one-way communication between the ED and the GPs. ED doctors sent discharge summaries to the patients' GPs after their discharge from the ED. However, none of the four patients who were discharged for follow-up with their GPs managed to contact their GPs after discharge from the ED.

> He agreed to contact the GP the following day. Two weeks after the treatment in the ED, he has still not made contact with the GP. No one has talked to him about the self-harming event.
>
> (Follow-up interview, 7 April 2023)

Therefore, they did not receive any follow-up care after discharge from the ED. Due to the lack of a psychiatric assessment in the ED and the lack of follow-up care, these patients did not talk to anyone about the self-harming event.

There was no communication between the ED and the staffs of the patients' residences. The receiving staffs at the residences did not receive any information besides the information provided to them by the patient after discharge from the ED.

There was no communication between any psychiatric outpatient programmes and the ED, despite 13 patients being associated with outpatient programmes.

Many of the observed patients were associated with residences or outpatient programmes in psychiatry, but no contact was made with these units before the patients were discharged from the ED.

> I did not manage to reach out to the outpatient programme myself before it was too late. Without agreements before discharge,

> I struggled and got lost when I returned home.
>
> (Follow-up interview, 14 April 2023)

The patient attempted suicide again 2 days after discharge from the ED.

Identify those responsible for patients' pathways, transfers, discharges and follow-ups is unclear. Moreover, minimal or no handover between the ED and the receiving unit might have significant consequences. It became clear that many responsibilities were undefined, communication was limited and, in general, there was no protocol for offering pathways to patients at the end of the ED stay.

DISCUSSION

Navigation in chaos

In our research, the patients admitted to the ED because of self-harm injuries stated that while in the ED they felt worse than ever before. They struggled with feelings of powerlessness and mental stress, but the HCPs in the ED still expected them to be able to adapt to the ED environment.

Østervang et al. (2022) and (McGough et al., 2022) explored the perspectives of ED nurses regarding self-harm patients and found that ED nurses found it much easier to address somatic treatment, as they were trained in that direction; as a result, the patients' self-harm events were not verbally addressed. Likewise, Mulhearne et al. (2021) found that ED nurses felt insecure and nervous when dealing with patients who self-harm; however, the nurses recognised that the patients were in unsuitable environments that may have negatively impacted their treatment. The environment was found unsuitable due to risks associated with the long waiting times and the amount of stimulus was found overwhelming and able to cause further distress for the patients and conflict between them and the HCPs (Mulhearne et al., 2021). In line with these findings, our results showed that HCPs' indirect and direct expectations of patients' ability to collaborate could provoke conflicts with patients.

Our results showed that the content of the psychiatric assessment in the ED was very different from the assessment performed in the psychiatric units. Brodeur et al. (2021) explored the attitudes and experiences of ED doctors in the United States regarding the care of patients in psychiatric distress and found that the ED doctors felt they lacked the training and competencies to perform adequate psychiatric assessments and were thus restrained from performing assessments at all. As we did not include the perspectives of the HCPs, we are unable to state why the psychiatric assessments in our study, whether performed in the ED or psychiatric units, were observed to be very different. Nonetheless, the assessment had a huge impact on what the patient was offered after leaving the ED. Whether the differences in the depth of the assessments are rooted in a lack of competencies and training in line with the study by Brodeur et al. (2021), we are not able to answer. However, a lack of assessments and competencies leading to insufficient psychiatric treatment and care has been discussed in much research over the years (Boudreaux et al., 2023; Darnell et al., 2023; Doupnik et al., 2020; Ezquerra et al., 2023; Hughes et al., 2023; Im et al., 2023; Ngin et al., 2022; Ngune et al., 2021; Ross et al., 2023; Saab et al., 2022; Stewart & Lees-Deutsch, 2022).

A significant finding from our study was that transparency was lacking in the pathways. There was no system to determine whether patients were to be referred to the psychiatric unit – and if so, where – or to the outpatient programme or the GP or whether there was to be follow-up. Tacbas et al.'s (2023) qualitative study evaluated the role of discharge nurses aiming to limit the risk of patients falling through the cracks of a complex system in Canada and concluded that allocating a human resource could minimise the risk of lost or unsuccessful follow-up for patients discharged from the ED; identifying where the cracks in the system make it possible to start bridging the gaps. This was also found by Stanley et al. (2018), who found a positive association between a follow-up programme established in the ED and a reduction in suicidal events; furthermore, patients in the intervention group were more than twice as likely to attend at least one outpatient mental health appointment (Stanley et al., 2018).

Our results also showed cracks in the system. No one was given or took responsibility for systematising the pathways for the patients. The results revealed that the patients were not able to establish contact with outpatient programmes or their GPs after discharge, and there was limited or no communication among the relevant stakeholders. This led to patients being unable to navigate the system on their own and potentially promoted an increased risk of readmission to the ED. The HCPs in the ED and psychiatric units have different focuses; however, self-harming patients need both somatic treatment and mental health care when they are admitted. It seems that the patients' problems are so complex that the current organisation of the healthcare system is not able to adequately meet the needs of the patients. There is a need to investigate how the healthcare system can design and develop a shared pathway where responsibility is clearly defined and a systematic, transparent approach with clear agreements can be developed.

Limitations

This study provides knowledge of patients aged 18–44 admitted to the ED after self-harming events and who

accepted treatment in the ED. Furthermore, all included patients who had previously been admitted to the ED with self-harming injuries.

One limitation is that the firsthand observations were performed only by the first author. This is a potential source of bias; another observer could have seen the same events differently. However, the observations ensured that the data collection was reliable. An observational guide was followed to decrease bias. Moreover, the first authors' presence may have influenced the pathway and affected how patients and HCPs in the ED and psychiatric unit acted. To reduce the risk of this bias, investigator triangulation was useful in ensuring credibility. Another limitation is that the study took place in only one centre.

CONCLUSION

We observed and explored the patient pathways from arrival to the ED after self-harming events to discharge or transition and identified several issues in the pathways. Patients admitted to the ED after self-harming events struggle with difficult mental stress. Despite this, they are subject to high expectations to fit in and cooperate in the ED. The ED and the psychiatric unit require different competencies, but neither is competent to handle both somatic and psychiatric treatment. Moreover, there is limited cross-sectional communication and collaboration. The healthcare system is organised with unclear responsibilities and without systematic ways to care for self-harm patients, which creates chaotic pathways. There is a need for cross-sectional competencies, mutual agreements and systematic communication for discharge, transitions and follow-up care between all actors along the patient's pathway.

RELEVANCE FOR CLINICAL PRACTICE

The clinical management in ED settings of patients who engage in self-harming behaviour is an international priority due to the need to prevent self-harm and suicide (MacDonald et al., 2020). Efficient treatment and follow-up care can prevent readmissions and presumably reduce future healthcare costs. In the present study, we identified important weaknesses in the care pathways. These weaknesses should be considered potential items for improvement in the development of further interventions. To ensure all relevant perspectives, we recommend including all actors (patients, relatives, GPs and HCPs from the ED, psychiatry and outpatient programmes and residents) in the design and development of further interventions in an approach that involves the users.

AUTHOR CONTRIBUTIONS

All listed authors meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors, and all authors have read and approved the final version of the manuscript. Malene Sandahl, RN, MScN. Annmarie Touborg Lassen, MD, Professor Elsebeth Stenager, MD, Professor. Christina Østervang, RN, MSCN, Ph.D.

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CONFLICT OF INTEREST STATEMENT

All authors declare that they have received no financial support and have no conflict of interest.

DATA AVAILABILITY STATEMENT

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

AN ETHICS APPROVAL STATEMENT

Not relevant.

PATIENT CONSENT FOR PUBLICATION STATEMENT

Oral and written consent was obtained from the patients.

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REFERENCES

Acres, K., Loughhead, M. & Procter, N. (2019) Carer perspectives of people diagnosed with borderline personality disorder: a scoping review of emergency care responses. *Australasian Emergency Care*, 22, 34–41.

Borschmann, R. & Kinner, S.A. (2019) Responding to the rising prevalence of self-harm. *Lancet Psychiatry*, 6, 548–549.

Boudreaux, E.D., Larkin, C., Vallejo Sefair, A., Ma, Y., Li, Y.F., Ibrahim, A.F. et al. (2023) Effect of an emergency department process improvement package on suicide prevention: the ED-SAFE 2 cluster randomized clinical trial. *JAMA Psychiatry*, 80, 665–674.

Breslau, J., Leckman-Westin, E., Han, B., Pritam, R., Guarasi, D., Horvitz-Lennon, M. et al. (2018) Impact of a mental health based primary care program on emergency department visits and inpatient stays. *General Hospital Psychiatry*, 52, 8–13.

Brodeur, J., Ley, A.F. & Bonnet, M. (2021) A survey of Midwest physicians' experiences with patients in psychiatric distress in the emergency department. *Journal of Osteopathic Medicine*, 121, 773–778.

Clarke, D.E., Boyce-Gaudreau, K., Sanderson, A. & Baker, J.A. (2015) ED triage decision-making with mental health

presentations: a "think aloud" study. *Journal of Emergency Nursing*, 41, 496–502.
Cranwell, K., Polacsek, M. & McCann, T.V. (2017) Improving care planning and coordination for service users with medical co-morbidity transitioning between tertiary medical and primary care services. *Journal of Psychiatric and Mental Health Nursing*, 24, 337–347.
Darnell, D., Pierson, A., Whitney, J.D., Wolkow, C.A., Dorsey, S., Boudreaux, E.D. et al. (2023) Acute and intensive care nurses' perspectives on suicide prevention with medically hospitalized patients: exploring barriers, facilitators, interests, and training opportunities. *Journal of Advanced Nursing*, 79, 3351–3369.
Denmarks Statestics. (2018) *Acute outpatient contacts to the emergency departments in Denmark 2018; Trauma, poisoning and other violent body damage*. Available from: https://www.statistikbanken.dk/20050 [Accessed 20th september 2023].
Doupnik, S.K., Rudd, B., Schmutte, T., Worsley, D., Bowden, C.F., McCarthy, E. et al. (2020) Association of suicide prevention interventions with subsequent suicide attempts, linkage to follow-up care, and depression symptoms for acute care settings: a systematic review and meta-analysis. *JAMA Psychiatry*, 77, 1021–1030.
Edmondson, A.J., Brennan, C.A. & House, A.O. (2016) Non-suicidal reasons for self-harm: a systematic review of self-reported accounts. *Journal of Affective Disorders*, 191, 109–117.
Eriksen, L., Davidsen, M., Jensen, H., Ryd, J.T., Strøbæk, L., White, E.D. et al. (2016) *Sygdomsbyrden i Danmark—Risikofaktorer (The burden of Disease in Denmark—Risk Factors)*. Copenhagen, Denmark: Sundhedsstyrelsen.
Ezquerra, B., Alacreu-Crespo, A., Peñuelas-Calvo, I., López-Castromán, J., Porras-Segovia, A. et al. (2023) Characteristics of single vs. multiple suicide attempters among adolescents: a systematic review and meta-analysis. *European Child & Adolescent Psychiatry*.
Fernando, A., Attoe, C., Jaye, P., Cross, S., Pathan, J. & Wessely, S. (2017) Improving interprofessional approaches to physical and psychiatric comorbidities through simulation. *Clinical Simulation in Nursing*, 13, 186–193.
Green, J.T.N. (2018) *Qualitative methods for health research*. Thousand Oaks, CA: SAGE.
Hughes, J.L., Horowitz, L.M., Ackerman, J.P., Adrian, M.C., Campo, J.V. & Bridge, J.A. (2023) Suicide in young people: screening, risk assessment, and intervention. *BMJ*, 381, e070630.
Im, D.D., Scott, K.W., Venkatesh, A.K., Lobon, L.F., Kroll, D.S., Samuels, E.A. et al. (2023) A quality measurement framework for emergency department care of psychiatric emergencies. *Annals of Emergency Medicine*, 81, 592–605.
Kahan, D., Leszcz, M., O'Campo, P., Hwang, S.W., Wasylenki, D.A., Kurdyak, P. et al. (2016) Integrating care for frequent users of emergency departments: implementation evaluation of a brief multi-organizational intensive case management intervention. *BMC Health Services Research*, 16, 156.
Karman, P., Kool, N., Poslawsky, I.E. & Van Meijel, B. (2015) Nurses' attitudes towards self-harm: a literature review. *Journal of Psychiatric and Mental Health Nursing*, 22, 65–75.
Kvale, S. & Brinkmann, S. (2009) *Interview: introduktion til et håndværk*. Copenhagen, Denmark: Hans Reitzels Forlag.
MacDonald, S., Sampson, C., Turley, R., Biddle, L., Ring, N., Begley, R. et al. (2020) Patients' experiences of emergency hospital care following self-harm: systematic review and thematic synthesis of qualitative research. *Qualitative Health Research*, 30, 471–485.
Masuku, S. (2019) Self-harm presentations in emergency departments: staff attitudes and triage. *The British Journal of Nursing*, 28, 1468–1476.
McGough, S., Wynaden, D., Ngune, I., Janerka, C., Hasking, P. & Rees, C. (2022) Emergency nurses' perceptions of the health care system and how it impacts provision of care to people who self-harm. *Collegian Journal of the Royal College of Nursing Australia*, 29, 38–43.
Morken, I.S., Dahlgren, A., Lunde, I. & Toven, S. (2019) The effects of interventions preventing self-harm and suicide in children and adolescents: an overview of systematic reviews. *F1000Research*, 8, 890.
Mulhearne, P., Cotter, P., O'Shea, M. & Leahy-Warren, P. (2021) Experiences of registered general nurses who care for patients presenting with self-harm to the emergency department in Ireland. *International Emergency Nursing*, 58, 101047.
Ngin, N.L.X., Hassan, N.B. & Koh, S.L.S. (2022) Predicting suicide and suicide attempts in adults in acute hospitals: a systematic review of diagnostic accuracy evaluating risk scales. *International Journal of Nursing Studies*, 136, 104361.
Ngune, I., Hasking, P., McGough, S., Wynaden, D., Janerka, C. & Rees, C. (2021) Perceptions of knowledge, attitude and skills about non-suicidal self-injury: a survey of emergency and mental health nurses. *International Journal of Mental Health Nursing*, 30, 635–642.
Ngune, I., Wynaden, D., McGough, S., Janerka, C., Hasking, P. & Rees, C. (2020) Emergency nurses' experience of providing care to patients who self-harm. *Australasian Emergency Care*, 24(3), 179–185.
OPEN. (2023) *Open patient data explorative network*. Available from: https://open.rsyd.dk/ [Accessed: 1st August 2023].
Østervang, C., Geisler Johansen, L., Friis-Brixen, A. & Myhre Jensen, C. (2022) Experiences of nursing care for patients who self-harm and suggestions for future practices: the perspectives of emergency care nurses. *International Journal of Mental Health Nursing*, 31, 70–82.
Perboell, P.W., Hammer, N.M., Oestergaard, B. & Konradsen, H. (2015) Danish emergency nurses' attitudes towards self-harm: a cross-sectional study. *International Emergency Nursing*, 23, 144–149.
Perrone McIntosh, J.T. (2021) Emergency department nurses' care of psychiatric patients: a scoping review. *International Emergency Nursing*, 54, 100929.
Rayner, G., Blackburn, J., Edward, K.L., Stephenson, J. & Ousey, K. (2019) Emergency department nurses' attitudes towards patients who self-harm: a meta-analysis. *International Journal of Mental Health Nursing*, 28, 40–53.
Robinson, J. & Bailey, E. (2022) Experiences of care for self-harm in the emergency department: the perspectives of patients, carers and practitioners. *BJPsych Open*, 8, e66.
Ross, E., Murphy, S., O'Hagan, D., Maguire, A. & O'Reilly, D. (2023) Emergency department presentations with suicide and self-harm ideation: a missed opportunity for intervention? *Epidemiology and Psychiatric Sciences*, 32, e24.
Saab, M.M., Murphy, M., Meehan, E., Dillon, C.B., O'Connell, S., Hegarty, J. et al. (2022) Suicide and self-harm risk assessment: a systematic review of prospective research. *Archives of Suicide Research*, 26, 1645–1665.
Smith, J., Flowers, P. & Larkin, M. (2012) *Interpretative phenomenological analysis, theory, method and research*. London: Saga.
Smith, J. & Osborn, M. (2015) *Interpretative phenomenological analysis*. London: Saga.
Spradley, J. (1980) *Participant observation*. Wadsworth, OH: Waveland Press.
Stänicke, L.I. (2019) What do adolescents say about why they self-harm? *Tidsskrift for den Norske Lægeforening*, 139.
Stanley, B., Brown, G.K., Brenner, L.A., Galfalvy, H.C., Currier, G.W., Knox, K.L. et al. (2018) Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department. *JAMA Psychiatry*, 75, 894–900.
Stewart, I. & Lees-Deutsch, L. (2022) Risk assessment of self-injurious behavior and suicide presentation in the emergency department: an integrative review. *Journal of Emergency Nursing*, 48, 57–73.
Tacbas, M., McGovern, B. & Rodricks, J. (2023) Closing the gap: the role of discharge nurses in an emergency department. *Journal of Emergency Nursing*, 49, 15–21.

Tong, A., Sainsbury, P. & Craig, J. (2007) Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19, 349–357.

Trondsen, M.V., Tjora, A., Broom, A. & Scambler, G. (2018) The symbolic affordances of a video-mediated gaze in emergency psychiatry. *Social Science & Medicine*, 197, 87–94.

Vandyk, A., Bentz, A., Bissonette, S. & Cater, C. (2019) Why go to the emergency department? Perspectives from persons with borderline personality disorder. *International Journal of Mental Health Nursing*, 28, 757–765.

WHO. (2019) *Suicide and self-harm*. Geneva, Switzerland: World Health Organization.

WHO. (2021) *Suicide World Health Organisation*. Available from: https://www.who.int/news-room/fact-sheets/detail/suicide [Accessed 5th June 2023].

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