

Running Head: AN INQUIRY INTO DSH

**An Inquiry into the organisation of care for deliberate self-harm patients in a South African hospital**

by  
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*Thesis presented in fulfilment of the requirements for the degree of Master of Arts and Social Sciences (Psychology) at Stellenbosch University*



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March 2016

### **Declaration**

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### **Abstract**

Deliberate Self-Harm (DSH) is a significant problem in South Africa. Individuals engaging in DSH have an elevated risk for a subsequent presentation of DSH and for completed suicide. DSH patients also place a burden on the health care system and have shorter life expectancies than the general population. Research suggests that hospital Emergency Departments (EDs) are a site of potential intervention for DSH patients.

This study sought to investigate how an ED of a SA urban hospital responded to DSH patients. An ethnographic inquiry was employed to examine the policies, practices, attitudes and knowledge that generated the response by health care professionals. Specifically, the organisational structure of the ED was studied, both in relation to the hospital as well as in relation to the broader health care system.

Three different data method collection techniques were used; observations, semi-structured interviews and document analysis (pertaining hospital policies). Data was collected over a period of eight months (May – December 2014). Semi-structured interviews were conducted with 28 health care professionals. This sample included medical officers, a medical registrar, medical interns, medical students, nurses, a student nurse, psychiatry registrars, psychologists and social workers. Thematic analysis was implemented to group findings into meaningful themes.

This study found that health care professionals are doing their best, under difficult circumstances, to respond to the needs of DSH patients. Nonetheless a number of barriers and opportunities to the provision of care were identified. Significant barriers included the lack of resources, a discontinuity of care, the impossibility of a relationship with the DSH patient, as well as negative attitudes and emotional responses of health care professionals, such as stigmatisation, and negative perceptions. Opportunities to the provision of care included health care professionals' positive attitudes, such as empathy and a willingness to provide quality care to DSH patients.

This research has found that an under-resourced system and negative attitudes of health care professionals prevent the ED from being optimally utilised as a space for intervening with the DSH population. The implementation of existing resources in the ED may be re-examined as to use them optimally.

Key words: deliberate self-harm, emergency department, intervention, ethnography, barriers, opportunities

## Opsomming

Doelbewuste selfbeskadiging (DSB) is 'n gewigtige probleem in Suid-Afrika. Individue wat DSB beoefen loop 'n groter risiko vir 'n daaropvolgende DSB-episode, asook vir selfdood. DSB-pasiënte plaas ook druk op die gesondheidstelsel en het 'n korter lewensverwagting in vergelyking met die algemene bevolking. Navorsing stel voor 'n hospitaal se ongevalle-eenheid kan dien as 'n spasie van moontlike ingryping wat DSB-pasiënte betref.

Hierdie studie het ondersoek hoe 'n ongevalle-eenheid van 'n stedelike Suid-Afrikaanse hospitaal optree teenoor DSB-pasiënte. 'n Etnografiese ondersoek is geloods om die beleide, gewoontes, houdings en kennis wat tot die optrede van gesondheidspersoneel gelei het te ondersoek. Die organisatoriese struktuur van die ongevalle-eenheid, met betrekking tot die hospitaal, sowel as die groter gesondheidsstelsel, is spesifiek bestudeer.

Drie verskillende data-insamelingstegnieke is gebruik: waarnemings, semi-gestruktureerde onderhoude en dokument-analise (met betrekking tot hospitaalbeleide). Data is oor 'n tydperk van agt maande (Mei – Desember 2014) ingesamel. Semi-gestruktureerde onderhoude is gevoer met 28 gesondheidswerkers. Hierdie steekproef het die volgende mense ingesluit: mediese beamptes, 'n mediese kliniese assistent, mediese interns, mediese studente, verpleegsters, 'n studenteverpleegster, psigiatriese kliniese assistente, sielkundiges en maatskaplike werkers. Daar is van tematiese analise gebruik gemaak om die resultate te groepeer volgens betekenisvolle temas.

Hierdie studie het gevind dat gesondheidswerkers onder moeilike omstandighede hulle bes doen om op die behoeftes van die DSB-pasiënte te reageer. 'n Aantal hindernisse tot en geleenthede vir die voorsiening van sorg vir DSB-pasiënte is geïdentifiseer. Betekenisvolle hindernisse sluit in: 'n tekort aan hulpbronne, 'n onderbreking in sorg, die onmoontlikheid van 'n verhouding met die DSB-pasiënt, negatiewe houdings en emosionele reaksies van gesondheidswerkers, byvoorbeeld stigmatisering en negatiewe opvattinge. 'n Geleentheid vir die voorsiening van sorg is gesondheidswerkers se positiewe houdings, byvoorbeeld empatie en 'n bereidwilligheid om gehaltesorg aan die DSB-pasiënt te voorsien.

Hierdie navorsing het gevind 'n stelsel met 'n tekort aan hulpbronne in kombinasie met die negatiewe houdings van gesondheidswerkers verhoed dat die ongevalle-eenheid optimaal benut word as 'n ruimte van ingryping by die DSB-bevolking. Die implementering

van bestaande hulpbronne behoort herevalueer te word in 'n poging om hierdie hulpbronne optimaal te benut.

Sleutelwoorde: doelbewuste selfbeskadiging, ongevalle-eenheid, ingryping, etnografie, hindernisse, geleenthede

### Acknowledgements

Firstly, I would like to thank the Lord for providing me not only with this opportunity, but also for giving me strength and guidance. Without Him none of this would have been possible.

Secondly, I would like to thank everyone at the hospital where I collected my data. Thank you for allowing me to take away from your time, and for being willing to talk to me about such an important yet sensitive topic. I could not have done this research project without your help and kindness.

Thirdly, I would like to thank my supervisor, Dr. Jason Bantjes, for constantly believing in the importance of this research, especially when I was discouraged. Thank you for being with me every step of the way, for always listening to me and for patiently answering all my questions. What I have learnt from you is invaluable. Thank you for giving me the opportunity to work in a hospital – I have always wanted to.

Fourthly, I would like to thank my family and friends. My parents – thank you for your unwavering support and for your interest in my work. Thank you for being so encouraging and for reminding me to always follow my dreams. I could not have done this without you. My grandmother – thank you for your encouragement and your patience. Nicola – thank you for “suffering” with me, for your support and for making the lonely road of doing a Masters thesis less lonely. Sulien – thank you for your motivation and for your genuine interest in my work.

Finally, I would like to thank the NRF for their financial assistance. I would not have been able to undertake this degree or this research project without their support. *The financial assistance of the National Research Foundation (NRF) towards this research is hereby acknowledged. Opinions expressed and conclusions arrived at are those of the author and are not necessarily to be attributed to the NRF.*

I would like to dedicate this to all Deliberate Self-Harm patients and health care professionals who both fight their own battle everyday in the hospitals of this country – may you find strength and purpose.

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## Chapter 1: Introduction

Deliberate Self-Harm (DSH) is a significant public health concern (Arensman, Corcoran, & Fitzgerald, 2011; Hegerl et al., 2009; Schlebusch, 2005; Sinclair, Gray, & Hawton, 2006). Individuals who engage in DSH need special consideration because they are at high risk of repeating DSH and eventually completing suicide (Owens, Horrocks, & House, 2002; Silverman, 2011; Zahl & Hawton, 2004). The effects of DSH have far-reaching consequences, and are severely burdensome to the healthcare system (Jacobs & Brewer, 2004; Suominen, Suokas & Lönnqvist, 2007). Värnik et al. (2008) assert that the development of efficient interventions for patients who engage in suicidal behaviour, including the DSH population, is a crucial part of the work of those conducting research and of those working in public health. Research specifically proposes that the Emergency Department (ED) has great potential to serve as a site for intervention for this demographic (Larkin & Beautrais, 2010). However, research also suggests that the development and implementation of suicide intervention measures can be challenging (Schlebusch, 2005). Therefore, this study aims to investigate and to understand how the ED responds to DSH patients.

### 1.1 DSH: A Definition

DSH is considered a form of suicidal behaviour, specifically non-fatal suicidal behaviour (De Leo, Burgis, Bertolote, Kerkhof, & Bille-Brahe, 2006). For the purpose of this research, DSH can be defined as follows:

A potentially self-injurious behaviour with a nonfatal outcome, for which there is evidence (either explicit or implicit) that the person intended at some (nonzero) level to kill himself/herself (O'Carroll et al., 1996, p. 247).

In their definition of non-fatal suicidal behaviour, De Leo et al. (2006) add to this the important aspect of DSH being a non-habitual act. There is no single definition for DSH. Other descriptions commonly used in the same capacity as DSH includes terms such as a *suicide attempt*, *parasuicide* and *intentional self-harm* (Silverman, 2011). This leads to a significant amount of controversy surrounding the use of the term DSH in research, clinical practice and with regard to public health record keeping (De Leo et al., 2006). In chapter two the concepts of DSH and suicidal behaviour, the controversy surrounding the definition of these concept, as well as the different classifications of subtypes relating to suicidal behaviour will be revisited. In addition to this, issues surrounding intent and lethality will



also be discussed. For the purpose of this research, we will only use the term *DSH* unless quoted directly from a source.

## **1.2 Statement of the Problem: DSH as a Public Health Concern**

Section 1.2.1 examines the problem of the DSH patient who presents repetitively, whilst in section 1.2.2, the increased risk of a patient who engages in DSH to ultimately commit suicide will be discussed. In section 1.2.3 the burden placed on the health care system by the patient who engages in DSH will be examined. Finally, the focus of 1.2.4 will be an overview of the issue relating patients who engage in DSH, and who are at a significantly increased risk for losing their lives prematurely.

**1.2.1 The DSH patient at risk of repetition.** Research suggests that a history of non-fatal suicidal behaviour is highly indicative of potential repetitive acts of DSH (Arensman et al., 2011; Carroll, Metcalfe, & Gunnell, 2014). After conducting a systematic review by looking at the statistics of the repetition of non-fatal self-harm, Owens et al., (2002) found an average repetition rate of 16% within one year, and an even higher 23% repetition rate over the course of four years. A follow-up study reviewing 150 patients after engaging in DSH and presenting to hospital as a result, found that more than half of these DSH patients (57.4%) had presented with one or more acts of DSH during the 6-year period (Sinclair, Hawton, and Gray, 2010).

Arensman et al. (2011) also found that within the first three months after patients presented with DSH, approximately 50% of all repeat self-harm acts took place. Despite the fact that patients who present with DSH are carefully and sufficiently evaluated psychosocially once they are medically stable, they may still be at risk of entering the system again after they have been discharged (Larkin, Smith, & Beautrais, 2008).

**1.2.2 The DSH patient at risk of completing suicide.** Gairin, House and Owens (2003) suggest a strong link between non-fatal suicidal behaviour and completed suicide. In addition to this, the strong link between DSH and completed suicide is also emphasised in suggesting that DSH is one of the single, strongest predictors of completed suicide (Crawford, Turnbull, & Wessely, 1998; Freedenthal, 2008). Arensman et al. (2011) support this by asserting that a patient with a history of DSH, carries an increased risk to ultimately completing suicide. Bickley et al. (2013) found this risk to be as much as 20 times higher for a patient with a history of DSH, than their counterpart in the general population. Furthermore,

Foster, Gillespie, & McClelland (1997) suggest that 25 % of people who completed suicide have, within the last year of life, visited the ED as a result of DSH.

Hawton et al. (1998) also supports the strong predictive quality of an incidence of DSH for completed suicide, and suggests that this is especially the case for men. White (2011, p.139) puts forward an interesting point in saying that someone with a history of suicidal behaviour is especially at high risk when the suicide attempt was serious: "...a person who has made a serious suicide attempt has shown he is willing to cross that line that most others won't".

**1.2.3 The burden of DSH on the health care system.** Not only does South Africa (SA) have high rates of the population experiencing some form of psychological problems, but the country also suffers from insufficient mental health care services and resources (Herman et al., 2009). It can be argued that DSH patients presenting in the ED pose a burden on the healthcare system of SA in the following two ways: firstly, in terms of utilising financial resources; and secondly, by exerting additional pressure on a system that already has an insufficient number of staff members.

Research proposes DSH to place a burden on the health care system in terms of financial expenditures (Giordano & Stichler, 2009; Sinclair et al., 2006; Suominen et al., 2007). In the SA context, mental health services are under immense pressure. It is estimated that a mere 4.5% of SA's national health budget is allocated to the mental health sector (Fokazi, 2015). Schlebusch (2005) argues that while the costs of health care in SA are already high as it currently stands, suicidal behaviour inevitably leads to an increase in hospital expenses and an added burden on the health care system.

In addition, Schlebusch (2005) emphasises the issue of DSH patients, especially those who engage in DSH repetitively, exerting additional pressure on the health care staff owing to a shortage in numbers of staff: "There are not enough mental health specialists to cope with the magnitude of problems associated with suicidal behaviour and its social, economic and other consequences, which have a spiralling effect throughout the community" (Schlebusch (2005, p. 151). In this assertion the interdependence between financial restraints and the lack of adequate numbers of health care professionals is emphasised. The available financial resources are largely insufficient. Additionally, as a result of the fact that there are a total of only 36 psychiatric wards (located within a general hospital) throughout the whole of SA (Tromp, Dolley, Laganparsad, & Govender, 2014), there is also undoubtedly an

inadequate number of mental health professionals in the field. It is estimated that in 2014 the ratio between psychiatrists and SA citizens were 0.39:100 000 (Fokazi, 2015).

There is also the reality of mental health professionals working privately, instead of occupying government positions. According to the head of non-communicable diseases at the Department of Health, Dr Melvyn Freeman, 85% of all psychologists in SA work in private practice, providing services to a mere 14% of the SA population (Tromp et al., 2014). Moreover, the operations director at the South African Depression and Anxiety Group, Cassey Chambers, highlights the worrisome lack in adequate numbers of mental health care professionals such as psychiatrists and psychologists working in government institutions. In an interview, Chambers also discusses how it negatively impacts the care that these DSH patients receive: “There aren’t enough psychiatrists or psychologists available in government hospitals or clinics, which makes it difficult for patients to access treatment and get well” (Fokazi, 2015, p. 1). Consequently, it can be argued that the constant and substantial pressure on the mental health care system is already of great concern, as it is, without the additional pressure of patients presenting with DSH at the ED.

**1.2.4 The DSH patient at risk of a lower life expectancy.** Research conducted by Bergen et al. (2012) in EDs throughout the UK found that for the period of 2000 – 2007, patients who presented with DSH experienced an increased risk of premature death in comparison to their counterparts who have not self-harmed. Even research conducted as early as the 1980s introduced the notion that patients presenting with DSH are at greater risk to die prematurely (Neeleman, 2001). Sinclair et al. (2006) also emphasise the negative impact DSH has on the individual’s years of life lost.

The risk of premature death due to accidental causes proved to be seven times higher in the DSH population than in the general population, whilst the risk of premature death due to natural causes was increased two times in comparison to the general population (Neeleman, 2001). Subsequently, it is important to take note that these premature deaths are not exclusively as a result of risk factors commonly associated with the DSH population, such as a higher risk for completed suicide, but are also as a result of natural causes (Bergen et al., 2012).

A follow-up study examining mortality rates following a medically serious incident of DSH found that over the course of five years, approximately 10% of the 302 people who were reviewed had died. Of this 10%, 59.2% died by completing suicide (Beautrais, 2003).

The author continued to emphasise that this follow-up study proposes that in comparison to a gender- and age-matched sample in the general population, mortality rates of this DSH sample are more than five times higher (Beautrais, 2003). Furthermore, Beautrais (2003, p. 598) emphasises the added risk to loss of life that accompanies the DSH population: "...those making suicide attempts are an at-risk population for excess mortality, from both suicide and other causes...". Beautrais (2003) adds that only second to completed suicide, motor vehicle accidents are the cause of the majority of deaths of the DSH population.

Interestingly, Bergen et al., (2012) also draw a correlation between a low SES (socio-economic status) and the detrimental effect on physical health. These authors argue that DSH patients who reside in poor and underprivileged areas, are commonly faced with obstacles such as having difficulty in accessing health care services, they have inadequate sanitary conditions and insufficient space for relaxation. Subsequently, another possible explanation for this early loss of life could be that not enough attention is paid to consulting and maintaining the physical well-being of patients presenting with DSH (Bergen et al., 2012).

### **1.3 Research Rationale: The ED as a Potential Intervention Site**

The ED that served as the field site for this research includes the Casualty Department (Casualty), which consists of two units namely the Medical unit and the Trauma unit, as well as the Emergency Psychiatry Unit (EPU).

**1.3.1 The response of the ED to DSH: A lack in research.** Little is known about how health care professionals make decisions regarding the management and treatment of DSH patients in the ED and the quality of care that is provided to DSH patients (Bantjes & Kagee, 2013). Authors conducting research in the international context also emphasise that while there exists some evidence of what is helpful and effective when managing and treating DSH patients, there are still a lack in knowledge regarding routine guidelines and policies that are implemented: "...several aspects of the routine management of patients who self-harm lack a clear evidence base" (Carroll et al., 2014, p. 477).

In addition to this, it is important to note that SA has no existing national prevention program for suicide, which renders the problem much more critical (Schlebusch, 2012). Subsequently, we can infer that the response of health care workers in the ED towards DSH patients is also fuelled by other factors. These factors include elements such as their core beliefs, perceptions and attitudes, as well as training they have received and the knowledge

they have acquired. In addition, there is also a lack in research in this regard: “Clinicians’ emotional responses to suicidal patients have not been the subject of many research studies” (Yaseen et al., 2013, p. 2).

As a result, we can divide the responses of the medical staff into two categories namely *practical responses* (practices) and *emotional responses* (attitudes). There still exists a great gap in our understanding of exactly how the SA health care system responds to these patients. A literature review of relevant practices and attitudes will be discussed in depth in chapter two.

**1.3.2 The ED as a potential site for intervention for DSH patients.** The ED has significant potential to serve as a space for intervention in the DSH population. This potential can be realised in two ways – specifically, it is possible for it to intervene in DSH cases, and in its ability to prevent suicidal behaviour or suicide:

“A visit to the emergency department presents an opportunity for suicide prevention if the nursing and medical staffs accurately assess the risk and make the appropriate intervention to mitigate the risk or provide the appropriate level of care necessary for the patient” (Giordano & Stichler, 2009, p.22).

In addition, Owens, Dennis, Jones, Dove, and Dave (1991) argue that while health care workers, clinicians in particular, may be frustrated with the idea of admitting these DSH patients, arguing that they take up valuable resources, evidence seems to indicate that the admission of such DSH patients, however fleeting it may be, is still more beneficial in terms of a reduced risk of recurrence, than not admitting them at all.

Central to the argument of the ED potentially serving as an important point of intervention with the DSH population, is the fact that all DSH patients presenting at the hospital will move through the ED (Schlebusch, 2005). When looking at the EPU specifically, research showed that an estimated 65% of patients referred to emergency psychiatric services in a general hospital were assessed to be at risk of self-harm or suicide (Hatfield, Spurrell, and Perry, 2000). Therefore, it is evident that DSH patients account for a substantial proportion of emergency psychiatric referrals. Larkin and Beautrais (2010) also continue to predict an even greater increase in these numbers in the future. Subsequently, we can agree with Larkin and Beautrais (2010, p.1) when they discuss the significance of the ED as a space to treat these DSH patients: “Emergency departments (EDs) are the most important

site, epidemiologically speaking, for treating those who make suicide attempts". Therefore, the ED of a hospital potentially has a vital role to play in serving as a point of intervention for the DSH population (Arensman et al., 2011; Mackay & Barrowclough, 2005).

Although there is a lack of literature regarding statistics of admissions, referrals and discharges of DSH patients in a general hospital in SA, we can refer to similar research conducted in the UK in support of our argument. A study focusing on DSH cases presented at EDs of hospitals in Manchester (The Manchester project), during the period from January 2010 to December 2011, found that only 49% (2010) and 44% (2011) of the DSH patients presenting at EDs were admitted to the hospital to a medical ward (Bickley et al., 2013). Furthermore, the research also found that a mere 4% (2010) and 6% (2011) of DSH patients ultimately received a psychiatric admission while 34 % (2010 – 2011) were referred by mental health care professionals to other mental health services including outpatient care and day hospitals (Bickley et al., 2013). Approximately 17% of DSH patients presenting at the ED were discharged directly from the ED (including self-discharged) without any referral (Bickley et al., 2013). Additionally, De Leo et al. (2006) suggest that the majority of DSH patients presenting at the ED are discharged straight from the ED, once they are medically and surgically cleared. Consequently, a large number of DSH patients never move beyond the ED and therefore make the ED space an undeniable point of intervention.

In the quote below, Larkin and Beautrais (2010, p. 2) emphasise the large number of DSH patients utilising the ED as their only point of contact with a health care professional, but also highlight the missed opportunity for the ED to intervene with a large number of this population:

Suicide prevention work to date has not taken advantage of ED volumes, "teachable moments," or ED opportunities for care linkage, relying instead on traditional models of outpatient mental healthcare delivery, with attendant attrition, lack of engagement, and broken links in the chain of care.

Several reasons that could be ascribed to a high volume of DSH patients presenting at the ED will be discussed in the following section.

**1.3.2.1 Easy accessibility to the ED.** Fields et al. (2001) suggest that, in many countries, the ED may serve as the only point of contact with health care professionals that is open to the public 24/7. Babiker and Arnold (1997) describe this permanent availability of

health care as a potential lifeline to those at risk of harming themselves, especially in light of the fact that patients presenting at Casualty with DSH can find instant assistance, and can seek treatment without being referred from another medical facility. Clarke, Brown, & Giles-Smith (2008) take this further by stating that the availability of the ED for DSH patients is not only vital for prevention of completed suicide, but also serves as an important connecting point for the DSH population to mental health care services. Larkin and Beautrais (2010) put forward a significant point in viewing the ED as the default or *de facto* choice in the event that suicidal patients are in critical need for contact with the health care system when they are experiencing a crisis period. Miller and Taylor (2005) suggest that the ED might be the suicidal patient's only available option when seeking help.

**1.3.2.2 Lack of inpatient psychiatric services.** Another factor contributing to the great volume of patients presenting at the ED for treatment after engaging in DSH, is the termination of inpatient psychiatric services and an overall decrease in availability of inpatient beds (Baraff, Janowicz, & Asarnow, 2006; Larkin & Beautrais, 2010). This is the case in South Africa, where we have seen a shift towards outpatient care within the community of the patient: "In post-apartheid South Africa, the government's efforts have moved away from institutionalization towards outpatient care" (Tromp et al., 2014, p. 4). Quirk and Lelliot (2001) take this notion further by discussing the decrease in numbers of beds, especially the lack of beds available for long-stay patients, as well as the shift in focus to community-based care, as contributing factors to the number of patients presenting at Casualty.

This shortage in beds does not only result in increased rates of admissions of patients into EPU, but also results in a subsequent increase in readmissions (Quirk & Lelliott, 2001). It is arguable that this is owed to the, sometimes, untimely discharges of patients. This lack of beds can also be referred to as *bed pressure*; a term commonly used which refers to a situation where there is added pressure on the health care system owing to a lack of beds to accommodate all patients. Throughout this thesis I will make use of the term, *bed pressure*. Conlon and O'Tuathail (2012) also emphasise the problem of having a high demand for beds, but having an inadequate supply of resources. The implication is the decrease in availability of beds for all psychiatric patients, including DSH patients. In addition to this, the authors also named these factors as answerable for an increased threshold when it comes to admitting patients, (Quirk & Lelliot, 2001) subsequently supporting our argument of the majority of patients not travelling past Casualty.



**1.3.2.3 Inadequate community-based health care.** The previous section discusses a lack of beds owing to a shift in focus from inpatient health care to community-based health care, but the mental health care available in communities is often insufficient and inadequate. Cassey Chambers from the South African Depression and Anxiety Group explains this problematic situation: “If a patient does get to a hospital or clinic, it doesn’t mean that there is a psychiatric ward, or a psychiatrist or trained psychiatric nurse, psychologist or psychiatric medication available to treat the patient (Chambers as cited in Fokazi, 2015, p. 1).

In addition to the insufficient availability of community care, research suggests that follow-up treatment, for example psychotherapy, is poorly attended in South Africa: “Patients may keep their first out-patient appointment, but not subsequent ones” (Schlebusch, 2005, p. 123). This combination of poor availability and poor attendance also results in more DSH patients presenting and, more importantly, representing at Casualty.

**1.3.2.4 The inaccessibility of primary health care.** Another reason contributing to the high volumes of DSH patients visiting Casualty may be a lack of accessibility to primary health care. Visiting a General Practitioner (GP) is considered an unfeasible option for many DSH patients. This could be a result of the high costs associated with an appointment with a GP (Larkin & Beautrais, 2010), as well as the fact that many of these patients may not have access to such a primary care provider who could identify and treat mental health issues (Folse, Eich, Hall, & Ruppman, 2006).

**1.3.3 The significance of utilising the ED as a site for intervention.** Not only does the ED have great potential to play a role in intervention with DSH patients, but there is also great significance in optimally utilising this space. Individuals may only seek treatment once they harm themselves, to the extent of their injury resulting in physical symptoms (Folse et al., 2006; Suominen et al., 2007). Consequently, for many individuals presenting with DSH, a visit to the ED may be their first time in contact with any health care professional and it may also be the first time where any type of health intervention is possible (Clarke et al., 2008; Giordano & Stichler, 2009; Mackay & Barrowclough, 2005).

By intervening with these patients in the ED following an act of DSH, an effort will not only be made to prevent patients from becoming *repetitive* patients, but the intention is also to reduce mortality rates (Hegerl et al., 2009). Giordano and Stichler (2009) emphasise the likelihood of intervening with DSH patients to promote the prevention of completed suicides. Effectively utilising the ED as a point of intervention with DSH patients is also



likely to decrease rates of premature deaths, a closely linked risk factor of individuals who deliberately self-harm (Bergen et al., 2012).

Additional evidence estimates that 39% of people who eventually complete suicide actually visited the ED as a result of deliberate self-harm, or another mental health problem in the past year (Gairin et al., 2003). These authors do not only highlight the link between DSH and completed suicide, but also emphasise the lost opportunity having assessed and treated those individuals prior to their suicide. It seems uncontested that the ED of a hospital has a significant and underutilised role to play when it comes to suicide intervention and the subsequent prevention of future incidences (Giordano & Stichler, 2009).

Larkin and Beautrais (2010, p. 4) take this notion further by proposing that “ED-based interventions” will not only decrease the representation of patients with DSH to the ED, but these interventions are also likely to serve as a very significant effort to reduce costs of healthcare as discussed in section 1.2.3. Similarly, Schlebusch (2005) emphasises the need to prevent suicidal behaviour in order to attempt to decrease the number of incidences, and also to address the urgent financial burden that accompanies suicidal behaviour. Hegerl et al. (2009, p. 432) also adds to this by explaining their own attempt to promote suicide prevention programs in Europe:

Our hypothesis is that the intervention will lead to reductions in the numbers of completed suicides and non-fatal suicidal acts; this in turn will be associated with an overall reduction in the use of resources, such as health care and emergency services.

In conclusion, Larkin and Beautrais (2010, p. 4) accurately summarise the significance that lies in optimally utilising the ED as a space to intervene in several ways with the DSH population: “...the ED is an untapped setting for developing cost-effective approaches to screening, establishing suicide registers, developing brief interventions, promoting referrals, enhancing engagement, and ensuring follow-up”. It is on this basis that the following research questions were developed and addressed by way of this research project.

#### **1.4 Research Questions**

This ethnographic study seeks to answer the following research questions:

1. What are the policies and practices in place at *the hospital* to respond to patients who present for treatment following acts of DSH?
2. To what extent are these policies and practices adhered to, and what mechanisms are in place for ensuring that health care professionals are aware of these policies?
3. What is the knowledge of suicidal behaviour, as well as the implicit attitudes towards suicidal behaviour?

### **1.5 Estimated Significance of Research**

While Bantjes and Kagee (2013) suggest that further research in these areas will provide us with more information regarding suicidal behaviour, Pope (2005) emphasises its importance both in terms of future medical and social research, and what it has to offer health care professionals. This information will then assist with the development and implementation of programmes. It will ensure that these programmes take into account the great variety of cultural needs we find in the South African context. However, it will also support the development and implementation of training and educational programmes, so as to increase the ability of health care professionals in identifying suicidal individuals and consequently responding to them appropriately.

The theoretical importance of the study is not only a development of new themes in illuminating the knowledge, attitudes and practices of medical staff working in an ED and who are treating deliberate self-harm individuals. Based on these new themes, quantitative studies may be conducted in order to generalise findings. In terms of the practical importance of the study, the findings could suggest training programmes that could be incorporated into graduate programmes. It could also advise educational training for medical staff working in an ED, to better equip them to triage patients and conduct psychosocial assessments. The findings of the study may also advocate changes to the policies and practices in the hospital to improve quality of care.

### **1.6 The Scope and Limitations of the Research**

**1.6.1 The scope of the thesis.** It is important to note that although suicidal behaviour constitutes a broad spectrum of suicide-related behaviour such as completed suicide, suicide ideation and self-injury, this thesis will focus only on DSH, with and without intent. As mentioned in section 1.2, several reasons are provided regarding the reason why DSH should

be seen as a public health problem. However, all sub-groups of suicidal behaviour can be viewed as a public health problem, especially suicide (Hegerl et al, 2009). The reason why the scope of the thesis only includes DSH, is because of the heightened risk that accompanies this group and the subsequent strain this population places on the health care system, as discussed in section 1.2.

The scope of the thesis also includes a view of all mental health professionals who came into contact with suicidal individuals, instead of focusing on a specific subgroup of staff working in the ED. The thesis focuses on the *system* of individuals within the hospital that manages and treats the suicidal individual, rather than specific individuals. These mental health professionals include nurses, clinicians, psychologists, psychiatrists, psychiatric registrars, social workers, and medical students. Consequently, the focus will not fall on the patients' experiences themselves but on the response of the above-mentioned health care workers.

**1.6.2 The limitations of the thesis.** Several limitations were identified prior to conducting the research. With regards to the complexity and sensitivity of the research questions, the time spent researching this topic, was limited. Data was collected over a period of eight months. However, as the research was conducted in fulfilment of a Master's degree, the time allocation could therefore be considered as sufficient for its purpose. Furthermore, it has to be taken into account that this research endeavour seeks to add to our understanding of DSH, and not to offer a solution to - or an explanation for - the phenomena. Another aspect of time that translated into a limitation was the specific time the data was collected. It is arguable that data collected at a different period in time, for example the summer months, may have elicited different data.

Another limitation of the research is the fact that it only focuses on one general hospital, mainly due to resource constraints and ethical considerations. It can be argued that data collected in a different setting, especially in a private hospital as opposed to this government hospital, may produce different findings. Limitations in relation to the specific methodology that was implemented as well as limitations based on the research's findings will be discussed in chapter seven.

### **1.7 Overview of the Thesis**

Chapter two focuses on DSH, its relation to the concept of suicidal behaviour as well as an in-depth discussion of suicidal intent and lethality. The chapter subsequently consists of a review of the literature. The literature focuses on the practices of the assessment, management and treatment of DSH patients. The literature review also reviews the knowledge, training and attitudes of medical staff towards DSH patients presenting at an ED.

Chapter three discusses the methodology of the research. The aims of the study are stated followed by the research questions. Qualitative research is discussed in depth, before an evaluation of ethnography as a research method. The rationale behind implementing ethnographic research in a health care setting is also provided. The research design, including the data collection, sampling strategy and data analysis is then presented. The criteria for the trustworthiness of the data are then stated, followed by a discussion of what steps have been taken in order to address these criteria. The chapter concludes with a thorough discussion of the ethical considerations relevant to this study.

Chapters four and five consist of the findings of the study. Chapter four looks at how the DSH patient physically moves through the field site, as well as the assessment; management; and treatment practices involved. Chapter five focuses on presenting barriers and potential regarding the provision of care to the DSH patient in the ED.

Chapter six takes the form of an in-depth discussion of the data as presented in Chapters four and five. In this chapter the results are explained, critically assessed and are compared to previous literature of a similar interest, as presented in the literature review. New, relevant literature is also introduced in support of the discussion.

Chapter seven consists of concluding comments and recommendations based on the findings of the research, as well as a reflective section of my personal experience of conducting the research.

## Chapter 2: Literature Review

This chapter starts with a definition of the concept of suicidal behaviour, a discussion of its relationship with DSH and other forms of non-fatal suicidal behaviour. I continue to discuss the concepts of suicidal intent and lethality as well as the incidences of DSH in the context of developed and developing countries, including the SA context. This is followed by a discussion of the best practice guidelines in comparison to how health care professionals actually respond to DSH patients. These practices include the assessment, management and treatment of DSH. The chapter concludes with a discussion of the knowledge and training of health care professionals as well as their attitudes towards DSH patients.

### 2.1 DSH as a Form of Suicidal Behaviour

**2.1.1 The broad spectrum of suicidal behaviour.** The term *suicidal behaviour* is a wide, encompassing and complex term that includes a broad range of suicide-related thoughts and behaviour, including DSH (Sveticic & De Leo, 2012). It is suggested that suicidal behaviour generally occurs on a continuum or a spectrum (Schlebusch, 2005; Sveticic & De Leo, 2012). Apart from DSH, this spectrum includes *suicidal ideation* which refers to any thoughts of potentially taking part in suicidal behaviour (O'Carroll et al., 1996); as well as having a *suicide plan*, which involves the actual planning or construction of a stepwise method through which to harm oneself (Nock, Borges, Bromet, Cha, Kessler, & Lee, 2008b). At the end of the continuum we can categorise *suicide (completed suicide)*, which refers to a person harming him or herself, with definite intent to end his or her life, to the extent that the act results in death (O'Carroll et al., 1996). Furthermore, *self-injury* is on this continuum of suicidal behaviour. It is important that self-injury should not be confused with DSH. Section 2.1.3.1 defines the concept of *self-injury* and discusses the distinction between the two terms in greater detail. It is argued that owing to the lack of suicidal intent associated with self-injury, it does not form part of the spectrum of suicidal behaviour. However, it is discussed on the continuum of suicidal behaviour as it is still considered to be a self-inflicted act, and in an attempt to emphasise the difference between DSH and self-injury.

Mann (2002) proposes that suicidal behaviour consists of two facets, namely *intent* and *lethality*. Suicidal intent refers to the premeditated quality of the act and the wish to die, whilst lethality refers to the medical outcome or injuries that resulted from the suicidal behaviour (Mann, 2002). Consequently, we can argue that these two concepts serve a divisionary purpose between different types of suicidal behaviour. This is especially the case

when suicidal behaviour results in death. It is argued that where the intent to die exists, the death is considered a completed suicide and in cases where there was no intent to die, the death is considered accidental (De Leo et al., 2006).

While it is evident that all the different types of suicidal behaviour overlap to the degree that they are grouped and discussed together, they are still distinct populations within themselves, which can be distinguished by means of their unique risk factors and etiology (Silverman, 2011). A discussion of these respective risk factors, however, falls beyond the scope of this thesis.

**2.1.2 Defining suicidal behaviour.** A great deal of controversy is associated with defining the concept of suicidal behaviour. There is a lack in uniform terminology related to suicidal behaviour, and there is a subsequent inconsistency when applying the variants of terminology and classifications in different settings (De Leo et al., 2006; Silverman, 2011). Silverman (2011, p. 11) provides a warning regarding the potential implications of this problem: “Such variability in terminology not only contributes to imprecise communication, but also limits comparison of epidemiological prevalence rates nationally and internationally, and hampers clinical and preventive interventions”.

De Leo et al., (2006) also emphasise how this inconsistent use of suicidal behaviour nomenclature negatively impacts research relating to suicide, and subsequently the development of suicide preventative measures. Larkin and Beautrais (2010) add that it is exactly this lack of uniform terminology when it comes to understanding and referring to types of suicidal behaviour that can negatively impact the development and implementation of interventions for the DSH population.

In addition to this, research suggests that this lack of universally acceptable terminology also negatively impacts the way health care professionals respond to patients presenting with suicidal behaviour. Medical staff members treating DSH patients differ in their understanding of suicidal behaviour, especially when distinguishing between attempted suicides and self-injury (Simpson, 2006). Arguably, this discrepancy could result in problems when it comes to the care these patients receive.

In an attempt to simplify and to create a uniform system, which could be used in research globally, the complete spectrum of suicidal behaviours was divided into three categories. These three categories consist of *fatal suicidal behaviour*, *non-fatal suicidal*

*behaviour with injuries and non-fatal suicidal behaviour without injuries* (De Leo et al., 2006). However, it is important to note that this distinction is drawn based on the outcome of the act, and not the suicidal intent of the person. I will return to this issue in a subsequent section. For the purpose of this research we will be focusing on non-fatal suicidal behaviour and DSH, more specifically.

### **2.1.3 Distinguishing between DSH and other non-fatal suicidal behaviour.**

**2.1.3.1 DSH and self-injury.** Although DSH and self-injury are two overlapping phenotypes of suicidal behaviour, as in both cases the individual deliberately harms him- or herself, it is necessary to note that DSH and self-injury should not be confused with each other. These terms should not be used interchangeably. Babiker and Arnold (1997) continue to define *self-injury* as a type of behaviour where a person deliberately hurts and causes injury to themselves and/or cause themselves to experience some form of pain. Most importantly, self-injury presupposes that there is no suicidal intent underlying the individual's behaviour (Klonsky & Muehlenkamp, 2007). While the term *self-harm* is traditionally used in the same manner as what we currently refer to as self-injury, we can agree with Babiker and Arnold (1997) when they distinguish between *self-harm* (including suicide, parasuicide and overdosing) and *self-injury* (self-mutilation, cutting, burning, etc). While both DSH and self-injury are self-inflicted behaviours, self-injury is a habitual type of behaviour with a complete lack of suicidal intent. "Intent to die or stop living is a characteristic that distinguishes suicide from habitual and manipulative behaviors, and should be considered for inclusion in a definition of suicidal behavior" (De Leo et al., 2006, p. 10).

More recently, *self-injury* is commonly referred to as *non-suicidal self-injury* (NSSI) (Silverman, 2011). The term NSSI was formally introduced into section three of the new DSM-5 (Diagnostic and Statistical Manual of Mental Disorders (Brunner et al., 2014) The term NSSI refers to damage that is intentionally inflicted to the self with a lack of conscious suicidal intent (American Psychiatric Association, 2013).

**2.1.3.2 DSH, parasuicide and attempted suicide.** The terms *parasuicide* and *attempted suicide* are often used in relation to DSH. However, different authors use these two terms in different capacities. The term *parasuicide*, used with its original meaning, can be viewed as the equivalent of DSH. Silverman (2011) argues that the term DSH developed from the term *parasuicide*, originally coined by Kreitman in 1977. If we look at Kreitman's description of parasuicide, it is similar to the definition of DSH that we use in this research.



The author describes parasuicide as all injuries that was inflicted by the self, including self-poisoning, that was treated in the hospital and considered to be non-accidental, irrespective of the intent of the suicidal behaviour (Kreitman, 1977). However, the current usage of the term *parasuicide* indicates low levels of suicidal intent (Bille-Brahe et al., 1994). On the contrary, a suicide attempt is defined as “self-injurious behaviour with evidence of suicidal intent” (O’Connor, Platt & Gordon, 2011, p. 2). De Leo et al. (2006) even go as far as to say that one could only refer to it being a “true” suicide attempt when the person has tried to take their own life, but failed to die.

Bille-Brahe et al. (1994) distinguish between attempted suicide and parasuicide in terms of intention, with attempted suicide often used to describe cases of suicidal behaviour where there was a clear indication of suicidal intent. A suicide attempt can therefore be viewed in a similar manner to DSH with intent to die, whilst a parasuicide act can be viewed as being similar to DSH where intent was low or zero, in agreement with Bille-Brahe et al. (1994).

We can therefore argue that the question of suicidal intent is central to the discussion of distinguishing DSH from other types of suicidal behaviour. Thus, we can continue to distinguish between *DSH with intent to die* and *DSH without intent to die* (De Leo et al., 2006). Both sub-population groups, which resulted in injury serious enough to be treated in an emergency department, formed part of our study sample. It is necessary to include both patients engaging in DSH with and without intent in our study. This is owed to the fact that a significant part of the study will focus on how health care professionals determine the intent underlying the act of DSH of patients presenting at the ED. I will return to this issue in the section 2.2.

**2.1.4 DSH in an urban SA hospital: creating an operational definition.** Similar to the issues surrounding the concept of *suicidal behaviour*, as discussed in the previous section, defining DSH is not without controversy and challenges. Authors in different settings make use of their own terminology in an attempt to describe DSH. While the term *DSH* gained much popularity in Europe, the same cannot be said for the United States of America where the term *non-suicidal self-harm* is used instead (Silverman, 2011). Europe has since removed the word *deliberate* from the term due to the argument that it carries derogatory connotations, and only the term *self-harm* (with or without intent) is used (Bickley et al., 2013; Silverman, 2011).



Europe and the United Kingdom, however, are not alone in questioning the use of the word *deliberate*, although the rationale behind the questioning may differ. McDougall, Armstrong, & Trainor (2010) also oppose the use of the word *deliberate* and advocate the use of the term *self-harm*. They argue that the act of harming oneself is usually done in a context of impulsivity, irrationality and without thinking it through; therefore, in essence, the decision to self-harm may not have been truthfully deliberate (McDougall et al., 2010).

For the purpose of this thesis, *DSH* can be viewed as a non-habitual, non-fatal act of harm inflicted to the self, which results in a medical injury serious enough to require admission to hospital. Furthermore, unless otherwise specified with regards to intent, I will use the term DSH only.

## 2.2 Suicidal Intent

The intent underlying an individual's act of DSH is of great significance because the concept of intent is such a complex phenomenon and is, therefore, difficult to infer (McDougall et al., 2010). The first step in attempting to understand the concept of determining intent is to define the concept.

For the purpose of this research, intent can be defined as “the purpose a person has in using a particular means (e.g., suicide) to affect a result” (Andriessen, 2006, p. 535) and; “Intent refers to the individual's desire to die and expectation that death will result from action” (Moscicki, 2001, p. 314).

However, it is not only the intent or the lethality of the patient's self-inflicted harm that is of significance to us, but also the manner in which the health care system responds to these aspects of the presentation. We are thus interested in how these patients are responded to, and what quality of care they receive as a result of this decision. Following this, the way in which health care professionals determine a suicidal individual's level of intent, and how they interpret the lethality of the patient's act, is central to the assessment and identification of suicide risk and the prevention of suicide.

**2.2.1 Suicidal intent versus lethality of the act.** We cannot discuss suicidal intent without referencing the concept of lethality. Some research suggests that people engaging in DSH using a lethal method have high suicidal intent. Conversely, it is argued that people who use non-lethal methods have low or no suicidal intent (Freedenthal, 2007; Harriss, Hawton, & Zahl, 2005). However, this is not always the case, and the explanation is not as simple. It is

arguable that the intent of a suicidal act and the outcome of a suicidal act (lethality) are not necessarily positively correlated. (De Leo et al., 2006; Freedenthal, 2007). While someone may have intent to take their own life, they may not be seriously hurt. In other words, the outcome of their act might not reflect their true suicidal intent (Wagner, Wong, and Jobes, 2002). What can be argued is the fact that someone may suffer non-fatal or minor injuries, hereby creating the impression that their intention was not to die or to hurt themselves badly. Yet, truthfully, they wanted to take their own life and had intent to die. Consequently, health care professionals may underestimate the patient's intent and could potentially mismanage these patients (Wagner et al., 2002). Someone might also engage in an act of DSH that results in a medically serious injury without having had intent to die. It is possible that the person used a method to self-harm, and they were unaware of the potential consequences (Wagner, et al., 2002). In addition, Brown, Henriques, Sosdjan and Beck (2004) suggest that an individual's lack of knowledge and perception regarding the consequences of using the method in reality may play an important role. Thus we can argue that the lethality of someone's DSH act may potentially provide a misleading indication of the person's suicidal intent.

It is on this basis that Brown et al. (2004) argue that it is the perception of the outcome, or the expectation of the consequences following the DSH, rather than the actual outcome that should be indicative of the person's intent. In addition, McDougall et al. (2010, p.9) emphasise this focus on the DSH patient's expectation of the outcome when they argue: "Rather than the professional's opinion, it is the young person's perception of, or belief in, potential lethality that matters". Brown et al. (2004) also mention that in an attempt to determine an individual's true level of suicidal intent, the desire to die may carry more weight in the assessment of the severity of the act of DSH than the lethality of the method. Ultimately, it is argued that the responsibility rests with the health care professional to determine the severity of the individual's suicidal behaviour, both in terms of their intent and the lethality of their behaviour, as well as their risk: "Professionals must weigh information on intent and lethality, and combine the information to construct a sense of the seriousness of the behavior" (Wagner et al., 2002, p.3).

**2.2.2 Suicidal intent and the role of the patient.** When a person reports a high level of intent and it matches the lethality of the method they used to engage in DSH, Freedenthal (2007) suggests one can easily infer their true intent. However, the author continues to say that in many cases, determining an individual's intent is not that explicit (Freedenthal, 2007),

as is discussed in the previous section. Sayers (2003, p.236) continues to emphasise the challenge posed by the task of trying to determine a patient's true suicidal intent: "Yet how are they to know which one of these patients reasonably intends suicide, which one is too disturbed to sustain rational intentions, and which intends simply to attract sympathy or attention?".

Although some research suggests that the patient who actually engages in DSH is likely to be the most accurate source regarding their suicidal intent, Wagner et al. (2002) suggests that this is not always the case. People engaging in DSH may not always indicate or even acknowledge their intent to die. Some patients may choose to downplay or even deny the seriousness of their intent in an attempt to avoid being admitted to hospital or to avoid other negative consequences such as stigma (Freedenthal, 2008). It may also be the case that some people might not be able to recall the truth regarding their suicidal intent. This can be attributed to several reasons such as intoxication during the act of DSH, memory problems, impulsivity, associated mental illness and a general sense of confusion (Freedenthal, 2007). Therefore, people may sometimes engage in suicidal behaviour while in an irrational state of mind, thus not making the decision to take their own life whilst being fully consciousness (Freedenthal, 2007).

On the contrary, some patients who have no real intent of taking their own life may only pretend to have suicidal intentions for reasons such as attention-seeking (Freedenthal, 2007). People may also appear ambivalent or inconsistent when asked about their intention following suicidal behaviour, because they may not be sure of the level of suicidal intent they are truly experiencing. Due to the fact that the concept of suicide risk is a fluctuating phenomenon, it is important to realise that suicidal individuals often move back and forth between acts with intent and no intent: "Intent can change from moment to moment" (Freedenthal, 2007, p.61). It is on the basis of this ambivalence and confusion often experienced by DSH patients, that Wagner et al. (2002, p.2) disputes the trustworthiness of patients self-reporting their suicidal intent: "Thus, the validity of self-reported suicidal intent is often highly questionable".

In contradiction, Freedenthal (2007) argues that patients' self-reporting their intent may seem more feasible since it may be too challenging for a second party to truly understand another person's state of mind. Also Overpeck and McLoughlin (1999) emphasise this seemingly impossible task of really knowing what a DSH patient is thinking in terms of

suicidal intent, whilst at the same time highlighting the ambivalence that patients may be experiencing: “It is sometimes hard to know our own intentions when we act – much less those of someone else” (Overpeck & McLoughlin, 1999, p.11). Freedenthal (2007) ultimately asks the question of whether or not patients who present with DSH should be trusted when they report their suicidal intent, or if clinicians should rely on the circumstances pertaining to the DSH presentation.

**2.2.3 The significance of suicidal intent.** Apart from our interest in the health care professionals’ response to DSH patients and the quality of care they provide to these patients, there are also other reasons for the importance of accurately determining a DSH patient’s suicidal intent. Failing to accurately determine a DSH patient’s suicidal intent and risk of future suicidal behaviour may potentially result in loss of life: “Believing suicide attempters who disingenuously deny suicidal intent could result in death. Believing those who falsely profess intent could result in the misuse of scarce mental health resources and in negative therapeutic effects for those who are hospitalized unnecessarily” (Freedenthal, 2007, p. 58). Although we argued in section 2.2.1 that lethality is not always very reliable in indicating intent, we can argue that intent is a good predictor of high risk. Consequently, it is arguable that determining intent can play a major role in suicide prevention.

Loss of life due to suicide is tragic. However, when taking into account section 1.2.3, one is also reluctant to dismiss the potentially negative impact on the already burdened health care system as a result of admitting patients who were incorrectly determined to be at risk. Gutheil and Schetky (1998) also emphasise the challenge of determining whether a DSH patient requires admission, or whether they have ulterior motives. The authors subsequently refer to this situation in which people threaten suicide merely to secure the shelter and food of a psychiatric hospital as “the tricky terrain of suicidal intent as blackmail or coercion” (Gutheil and Schetky, 1998. p. 1502).

In addition to this, assessing suicidal intent is paramount for research purposes (Freedenthal, 2007). Bronisch (1992) adds to this by stressing the importance of distinguishing between DSH with and without intent. This is significant as it is common among researchers to group all non-fatal suicidal behaviour under DSH without properly assessing the presence or absence of intent. As a result, the group of patients who only engage in self-injury (without intent) may appear to be much smaller than in reality (Linehan, 1986).

The same is true for injuries appearing to be the result of an accident but, in truth, may have underlying suicide intent. Lester (1992) emphasises this issue by suggesting that the suicidal intent of people's injuries may commonly be misinterpreted and in fact underestimated, for example in the case of a single vehicle car crash. While these authors place the emphasis on suicide morbidity, De Leo et al. (2006) continues to argue that the same issue is also valid when looking at suicide mortality rates in comparison to accidental deaths. De Leo et al. (2006) suggest that suicidal intent ultimately distinguishes between what is classified as accidental deaths, and which deaths are labelled as completed suicides (De Leo et al., 2006).

### **2.3 Incidence of DSH**

Although completed suicide is a public health problem that is of great concern, completed suicide only constitutes a small part of suicidal behaviour (Joe, Stein, Seedat, Herman and Williams, 2008). On a global level, DSH is considered to be an immense public health problem (Arensman et al., 2011). For every person who completes suicide on a global scale, it is estimated that between 10 and 40 people engage in non-fatal suicidal behaviour (Schlebusch, 2005). Furthermore, Hegerl et al. (2009) suggests an estimated ratio of 1:10 between completed suicide and non-fatal suicidal behaviour.

Although research suggests incidences of DSH to be quite high, there are variations of DSH statistics not only between different countries but also between different regions of the same country (Schlebusch, 2005). It is suggested that only a small number of countries' statistics regarding DSH is in fact reliable (Arensman, Corcoran et al., 2011). The incidence of DSH in developed countries and developing countries and, more specifically, DSH in the South African context will now be discussed.

**2.3.1 DSH in developed countries.** While rates of DSH are found to be fairly low in Scandinavian countries, in countries such as Belgium and the UK, DSH rates are comparatively higher (Arensman et al., 2011). Extensive research about DSH was conducted in the UK in EDs between the period of 1 January 2010 and 31 December 2011. Data relating to incidences of DSH elicited during this period showed an increase in DSH rates since 2009 by approximately 14% (Bickley et al., 2013). Additionally, during these two years the ED's saw 7334 incidences of DSH, while only 5141 individuals presented with DSH (Bickley et al., 2013), hereby indicating a high incidence of repetition. From 2003 to 2008, Ireland conducted a detailed documentation of all patients that presented at Emergency Departments

as a result of DSH, by means of the National Registry of Deliberate Self-Harm (NRDSH) (Arensman et al., 2011). Over this 6-year period, a total of 63 154 visits were made to the ED after an incident of DSH. However, these presentations constituted only 41 205 individuals, clearly indicating a strong sense of repetition of DSH amongst some patients (Arensman et al., 2011).

An article about the economic crisis and recession in Europe, which started developing in 2008 suggests a significant increase in suicide in most of European countries (Stuckler, Basu, Suhrcke, Coutts, & McKee, 2011). In conclusion, there is also a significant lack of research providing us with epidemiological information of DSH in the USA (Owens et al., 2002; Vastag, 2001).

**2.3.2 DSH in developing countries.** Nock et al. (2008a) suggests that the majority of research regarding DSH is focused in the context of high-income countries. Developing countries, such as India, have a great lack of research regarding incidence of DSH (Avasthi et al., 2008). With regards to Africa, research suggests a general lack of formal, trustworthy records of suicidal behaviour throughout the continent (Schlebusch, 2005). Osafo (2012) argues that this lack of reliable data may be due to the stigma that is attached to suicidal behaviour and consequently may result in people avoiding reporting any incidences. It is important to note that in some countries such as Ghana, suicidal behaviour is against the law and is an act punishable by jail time for up to 3 years (Osafo, 2012). While Osafo (2012) suggests that there exists a strong positive correlation between younger males with lower incomes and an elevated risk for suicidal behaviour, there is still an evident lack in actual statistics of incidences of DSH in Ghana. Therefore, we can arguably infer that there is a relationship between suicidal behaviour being considered a crime, and the underreporting of accurate epidemiological data of suicidal behaviour.

**2.3.3 DSH in the SA context.** Although there is a considerable body of work regarding suicide and suicidal behaviour on a global level, this is not the case for SA. Even though there is some research providing us with epidemiological information of completed suicide, there is a great deficiency of epidemiological information for non-fatal suicidal behaviour in the SA context (Joe et al., 2008). Bantjes and Kagee (2013) also argue that there is a lack of reliable statistics regarding incidences of DSH in SA. Schlebusch (2005, p. 50) adds to this by saying: “Accurate statistics are not available regarding the real occurrence

of non-fatal suicidal behaviour as there has been no systematic data collection in this domain in South Africa”. However, I will now provide a short overview of existing research.

Non-fatal suicidal behaviour has shown an increase in South Africa in recent years (Schlebusch, 2005). Existing research has indicated that for every person who completes suicide in SA, there are approximately twenty incidences of non-fatal suicidal behaviour (Schlebusch, 2000). After studying DSH in a SA general hospital, Mhlongo and Peltzer (1999) reported that, in comparison to incidences of completed suicide, it is the incidence number of cases of DSH that has shown an increase, with the majority of these people being younger than 25 years of age.

A study conducted at Groote Schuur Hospital (GSH) in Cape Town investigated the primary diagnosis of patients admitted to the Emergency Psychiatric Unit of GSH (Wilson, Flisher, & Welman, 2005). The study was conducted over two months in 1988 and repeated in 1998. The researchers used the term *suicide attempt* which, for the purpose of the study, included all forms of suicidal behaviour “that involved a self-inflicted, injurious, sub-lethal suicide act” (Wilson et al., 2005, p.81). In 1988, 10.7% of the total number of patients received a primary diagnosis of a suicide attempt. In 1998, the Emergency Psychiatry Unit saw an increase, with 18.8% of patients presenting with a suicide attempt with only mood disorders (29.7%) having a higher percentage (Wilson et al., 2005).

#### **2.4. Health Care Professionals’ Response to DSH Patients in the ED**

Skegg (2005) suggests that only a small proportion of people who engage in DSH present to the ED of a hospital. This can be viewed as a result of the fact that only those DSH patients that are seriously injured, to the extent of warranting medical or surgical attention, are the people who ultimately present at the ED (De Leo et al., 2006).

Much work has been done to try to develop best practice clinical guidelines in response to these DSH patients, and in an attempt to intervene with this at-risk population. Examples of clinical guidelines for the best practices include the *National Institute for Health and Clinical Excellence guidelines* (NICE Guidelines) (2004; 2011) as used in England and Wales; and *The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviour* (APA Guidelines) (2003). These guidelines are relevant to the assessment, management and treatment of DSH patients and will be referred to throughout the remaining sections of the literature review.



In the sections below I summarise the literature relating to the best practices in the health care professionals' response to DSH patients, as well as what health care professionals do in actual practice. In addition to this, some of the complexities, issues and challenges that clinicians face in providing care to these DSH patients will be discussed. The health care professionals' responses are divided into different sections: triage, assessment, management and treatment. However, it is important to note that this divide is an artificial one as these practices commonly overlap. I will return to the issue of providing management and assessment to patients serving the purpose of treatment in chapter six.

**2.4.1 Assessment of the DSH patient in the ED.** Assessing the DSH patient in the ED is not only one of the first steps in the triage process, but is arguably one of the most important steps of the process. When assessing a DSH patient, the health care professional attempts to discern the risk that the patient will engage in DSH in the future. They then seek to determine what needs to be done to reduce this risk (Bantjes & van Ommen, 2008). An efficient assessment of a DSH patient presenting in the ED has the potential to serve as an intervention for targeting this vulnerable population, and is likely to improve the prevention of suicide (Barr, Leitner, & Thomas, 2004; Gould, Greenberg, Velting, & Shaffer, 2003). However, an assessment does not always guarantee an accurate prediction of the person's future risk of engaging in DSH (McDougall et al., 2010). Therefore, we can argue that assessing suicide risk is neither an easy task nor is it a straightforward task. Bantjes and van Ommen (2008, p. 391) emphasise the challenge of assessing a DSH patient:

When clinicians assess suicide risk they attempt to predict the likelihood that an individual will engage in suicidal behaviour. Speaking of suicide assessment in this way seems to imply that suicide risk is an objective, stable, and quantifiable phenomena.

In an attempt to determine future risk, health care professionals commonly turn to psychometric scales that are used to measure the DSH patient's level of intent (Sisask, Kõlves & Värnik, 2009). I provide an overview of some of these psychometric scales in the following section.

**2.4.1.1 Assessment scales: an overview.** Range and Knott (1997) propose two types of scales commonly used to assess DSH patients in the ED: *Self-report scales* and *clinician scales*. Clinician scales or *clinician assessment instruments*, as they are often referred to, are scales where the clinician conducts the assessment by posing questions to the DSH patient



and the clinician completes the assessment accordingly (Range & Knott, 1997). An example of a clinician scale is the *Pierce Suicide Intent Scale* (PSIS) (Pierce, 1977).

*Self-report scales* or *self-assessment instruments* are scales, which are completed by the DSH patients themselves (Range & Knott, 1997). This would be a typical paper-and-pencil psychometric instrument (Range & Knott, 1997). An examples of a self-report scale is the *Beck Depression Inventory* (BDI) (Packman, Marlitt, Bongar, & O'Connor Pennuto, 2004). Both clinician scales and self-report scales have advantages and disadvantages. However, the focus is on the value of the psychometric scales, as a whole, in their ability to improve the accurate prediction of suicide intent and risk in comparison to non-psychometric scales.

Some research favours the psychometric instruments in the assessment of a DSH patient. Sisask, Värnik, Kõlves, Konstabel, & Wasserman (2008), for example, argue that using psychometric-type scales are very effective in ensuring a sense of objectivity when assessing the severity of an act of DSH by a patient. In addition to this, although the research suggests that the psychosocial assessment is the best assessment *tool* for assessing DSH patients, some literature also argues that a brief assessment scale is necessary due to the pressure of time in the ED setting (Horowitz et al., 2001).

The majority of research seems to be critical of the use of psychometric assessment instruments. Overall, the research cautions against relying too heavily on psychometric assessment tools to predict suicide risk (Hawton, 2013; Pompili, Girardi, Ruberto, Kotzalidis, & Tatarelli, 2005). The use of quantitative measures to assess DSH patients are particularly faulted because they fail to allow for the consideration of the unique traits of the specific individual being assessed (White, 2011). Hjelmeland et al. (1998, p. 221) also adds to this by suggesting the importance of focusing on the DSH patient's account, rather than what the psychometric assessment elicits: "Maybe more attention should be given to what the patients themselves actually say, rather than administering questionnaires or structured interviews" (Hjelmeland et al., 1998, p. 221).

Range and Knott (1997) highlight the importance of ensuring the suicide risk assessment is age- and population-relevant. These authors argue that important factors such as the validity and the reliability of the assessment instrument are also of great importance (Range & Knott, 1997). Additionally, Fox and Hawton (2004) argue that the majority of risk assessment tools available for use were developed in the United States of America. We can

agree with Bantjes and van Ommen (2008) in their questioning the value of the use of internationally developed psychometric assessment scales by health care professionals in the South African context. This is especially relevant when it comes to the reliability and validity of these unadapted scales when used in this setting.

**2.4.1.2 The significance of the psychosocial assessment.** In addition to the critique psychometric assessments have received, research commonly suggests that one of the most effective and important assessments to employ in the ED setting, when assessing DSH patients, is a psychosocial assessment (Cooper et al., 2006; Hawton, 2013; Kapur et al., 2013). In a summary of the APA Guidelines, it is suggested that a psychosocial intervention has great value in the reduction of suicide risk (Jacobs & Brewer, 2004).

Research conducted in the UK suggests that a simple psychosocial assessment conducted in the ED with a DSH patient, may contribute to a reduction in subsequent DSH incidences and presentations at the ED by as much as 40% (Bickley et al., 2013; Kapur et al., 2013). Although the significance of the use of a psychosocial assessment is emphasised, research does not specify that these psychosocial assessments should be conducted by a mental health professional specifically (Cooper et al., 2006). Therefore, regardless of who conducts the psychosocial assessment, the important thing is that every patient who presents at the ED after an act of DSH should receive a psychosocial assessment. The NICE Guidelines (2011) suggest a psychosocial assessment (Table 2.1.) that is a comprehensive and integrated evaluation of both the DSH patient's risks and needs.

Similar to a psychosocial assessment, the APA Guidelines (2003) propose an integrated psychiatric assessment of DSH patients where different aspects of the patient are evaluated. These aspects include the current presentation of suicidality, any comorbid psychiatric illness, a history of suicidal behaviour, the psychosocial situation, as well as the coping skills of the DSH patient (Jacobs & Brewer, 2004).

Furthermore, Barr, Leitner, and Thomas (2005, p. 131) explain how the psychosocial assessment is different from other assessments: "Unlike routine clinical assessments, psychosocial assessment involves a specific focus on mental state, personal relationships and social situation".

Table 2.1

*Proposed psychosocial assessment for DSH patients*

<b>Assessment of needs</b>	<b>Assessment of risks</b>
Skills, strengths and assets.	Methods and frequency of current and past self-harm.
Coping strategies.	Current and past suicidal intent.
Mental health problems or disorders.	Depressive symptoms and their relationship to self-harm.
Physical health problems or disorders.	Any psychiatric illness and its relationship to self-harm.
Social circumstances and problems.	The personal and social context and any other specific factors preceding self-harm, such as specific unpleasant affective states or emotions and changes in relationships.
Psychosocial and occupational functioning, and vulnerabilities.	Specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm.
Recent and current life difficulties, including personal and financial problems.	Coping strategies that the person has used to either successfully limit or avert self-harm; or to contain the impact of personal, social or other factors preceding episodes of self-harm
The need for psychological intervention, social care and support, occupational rehabilitation, and also drug treatment for any associated conditions.	Significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk.

The needs of any dependent children.	Immediate and longer-term risks.
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*Note.* Adapted from NICE Guidelines, 2011, pp. 7 – 8.

The NICE Guidelines (2004) also warn against relying on risk assessments alone, without considering the psychosocial situation of the DSH patient. Firstly, these guidelines advise health care professionals not to rely solely on risk assessment tools and scales for a prediction of future repetition of DSH or suicide. Secondly, these guidelines argue that risk assessment tools and scales should not serve as the determining factor relating to which DSH patients are offered treatment, and which DSH patients are discharged instead (NICE Guidelines, 2011).

Finally, assessing the DSH patient is not merely dependent on following guidelines or conducting a psychometric assessment scale. The clinical judgements of the health care professionals, as well as possibilities regarding the management and treatment of the DSH patient at the given time, also influence the final decision: “The final judgment regarding assessment and treatment rests with the psychiatrist, based on the clinical information provided by the patient and the treatment options available” (Jacobs & Brewer, 2004, p. 373 – 374). This concept of opportunities and barriers to the provision of care to the DSH patient forms the basis of my findings. I return to this discussion in chapters four and five. Barriers and opportunities to the provision of care to DSH patients.

**2.4.1.3 Failure to assess.** The reality is that many DSH patients will ultimately leave the ED without receiving any kind of assessment (Giordano & Stichler, 2009). Additionally, many DSH patients will go without being psychosocially assessed (Bickley et al., 2013). Research conducted for the Manchester project as discussed section 1.3.2, found that only 52% (2010) and 59% (2011) of patients who presented with episodes of self-harm, received a psychosocial assessment (Bickley et al., 2013). In addition, Research conducted in the EDs of four teaching hospitals in Britain over a 4-week period found that a psychosocial assessment was given only to an estimated 53% of patients. This is barely more than half of the patients who presented after deliberately harming themselves (Kapur et al., 1999). Moreover, Nakin, Joubert, Pretorius, & van Vuuren (2007) who reviewed cases of attempted suicide in hospitals in Kwazulu-Natal in South Africa, found that psychiatric assessments were not part of the routine examination process of patients admitted to the ED after a suicide attempt.

Several reasons could account for DSH patients not receiving any form of assessment while in the ED. The ED of a general hospital is one of the busiest and most intense workspaces (Clarke et al., 2008). Research suggests that health care professionals often struggle to find enough time to provide patients with a mental health assessment. As a result, mental health issues are often not identified or addressed (Houry, 2004). Horowitz et al. (2001) also continue to suggest that instruments commonly used to screen for suicide risk, are too lengthy and take up too much time, which may result in the risk for suicide going undetected in many cases. Clarke, Brown, Hughes, & Motluk (2006) also found that often the real reason for mental health patients, including DSH patients, spending an extended period of time in the ED (before discharged or referred) is due to the time-consuming assessments conducted by mental health care professionals. In addition to this, nurses who formed part of a study in Australia regarding attitudes toward DSH patients reported that they were not always able to conduct assessments and referrals of these patients owing to the size of the hospital and the subsequent workload (McAllister, Creedy, Moyle, & Farrugia, 2002). In addition to the lack of sufficient time, Kapur et al. (1999, p. 601) also suggest the costs of assessments to play a role in the failure to assess patients: “Economic considerations may also be playing a part. It is expensive to provide psychosocial assessments and even more so to admit overdose patients to medical beds”.

Another reason for the lack of assessments is the fact that many DSH patients are discharged straight from the ED. Research also suggests that DSH patients who are discharged prematurely, especially those discharged straight from the ED, have a lower probability of receiving a psychosocial assessment than their counterparts who were admitted as inpatients (Barr et al., 2004).

Lastly, another reason for DSH patients not receiving a psychosocial assessment may be owed to the negative attitudes of health care professionals (Barr et al., 2005; Crawford et al., 1998). The authors argue that staff members may feel that these patients are unlikely to benefit from a psychosocial assessment (Barr et al., 2005). I return to the discussion of the attitudes of health care professionals later in this chapter.

The literature discussed thus far suggests that assessments are not always conducted where necessary. In the event that they are conducted, they may not be completed or conducted in a correct manner. Crawford and Wessely (1998) argue that patients whose risk

assessments are not completed by a health care professional are considered to be three times more likely to repeat an act of DSH.

**2.4.2 Management of DSH patients.** Research suggests that it is not only important to assess the suicidal risk of the DSH patient but it is also pertinent to “address and manage the risk” of the patient (McDougall et al., 2010, p139). Research suggests a positive correlation between failing to manage the DSH patient adequately and an increased risk of subsequent completed suicide (Nakin et al., 2007). The management practices of DSH patients including the admissions, referrals, treatment, discharge and follow-up will now be discussed.

**2.4.2.1 Hospital admissions.** When looking at the best practice guidelines regarding the admission and referral process of DSH patients, we consider both the APA Guidelines (2003) as well as the Mental Health Care Act (MHC Act) (2002). The APA Guidelines (2003) provide a set of criteria that generally warrants for the admission of DSH patients. This set of criteria include violent and premeditated acts of DSH, which resulted in a near-lethal outcome; a lack of precautions taken in order to avoid being discovered; and expressing regret over being alive, coupled with continued suicide ideation. Other risk factors include patients who are psychotic upon presentation, being male and older than 45 years of age, a lack of social support and impulsive behaviour and a poor sense of judgement (APA Guidelines, 2003). These guidelines also suggest which subgroup of DSH patients will benefit more from outpatient treatment instead of being admitted to hospital. I will return to the discussion of outpatient- and follow up care in section 2.4.2.3.

The MHC Act (2002) also serves as legislation that governs psychiatric admissions in SA. The MHC Act (2002) states that a patient suffering from mental illness can either be admitted as a voluntary-, assisted-, or involuntary patient. A voluntary patient seeks treatment on his or her own and has decision making capacity regarding their health care. They are subsequently admitted to the hospital like any other patient. An assisted patient requires a mental health care intervention and does not refuse the intervention, but lacks capacity to make an informed decision regarding their mental health. An involuntary patient, like the assisted patient, is in need of a mental health intervention and lacks capacity to make informed decisions about their mental health care but refuses the intervention (MHC Act, 2002). Patients may receive an emergency admission. In such a case, patients are admitted without their consent in an attempt to remove them from a situation, which may potentially

end in death or harm, either to themselves or others (MHC Act, 2002).

The MHC Act (2002) also proposes a 72-hour assessment period during which a decision is made about whether or not a patient qualifies for further care based on a potential or definite psychiatric diagnosis. The patient will then be moved to a psychiatric hospital where care and recovery will be continued, or be referred to outpatient services (MHC Act, 2002). Furthermore, the NICE Guidelines also suggests that patients who have to wait in the ED before receiving treatment, or while completing the 72-hour period of observation, should be able to do so in a safe space:

If a person who has self-harmed has to wait for treatment, he or she should be offered an environment that is safe, supportive and minimises any distress. For many patients, this may be a separate, quiet room with supervision and regular contact with a named member of staff to ensure safety” (NICE Guidelines, 2004, p.16).

**2.4.2.2 Treatment of DSH patients.** Similar to the assessment and admission procedures of the DSH patient, the APA best practice guidelines also propose an integrated treatment plan for DSH patients. The APA Guidelines suggest the collaborative use of somatic treatment and psychosocial interventions (Jacobs & Brewer, 2004). In addition, the APA Guidelines (2003) suggest that while somatic treatment may be more suited for acute symptom relief, therapy such as cognitive behavioural therapy (CBT) or psychotherapy may be more suited to long-term goal-orientated outcomes (Jacobs & Brewer, 2014). The significance of therapeutic input with DSH patients cannot be emphasised enough: “Clinical consensus suggests, however, that psychosocial interventions and specific psychotherapeutic approaches are beneficial in reducing risk of suicide” (Jacobs & Brewer, 2004, p. 380).

Furthermore, the NICE Guidelines propose treatment plans for patients presenting with suicidal behaviour. Similar to the APA Guidelines (2003), the NICE Guidelines (2004) also propose a psychological and social intervention with DSH patients, should it be deemed necessary. This is then combined with the necessary pharmacological interventions. The NICE Guidelines (2004) continue to propose the development of a plan of treatment that aims to reduce the risk of engaging in suicidal behaviour, and to improve the patient’s everyday functioning and quality of life. This treatment plan should be a collaborative effort, including a multidisciplinary team; a family member of the patient; and the patient themselves, with the patient being informed of treatment options. (NICE Guidelines, 2004).



Regardless of the best practices and protocols regarding how DSH patients should be responded to, there are multiple challenges that prevent health care professionals from adhering to these practices and protocols. Research commonly suggests that DSH patients presenting at the ED of a general hospital are first treated medically (De Leo et al., 2006; Schlebusch, 2005). Giordano and Stichler (2009) found that nurses working in the ED commonly give priority to the physical assessment of the DSH patient, as opposed to the psychosocial assessment.

It is suggested that clinicians are less likely to become involved in managing the DSH patient, should they only have minor or no injuries: “Doctors seem less engaged in the treatment, unless of a serious physical injury” (Pompili et al., 2005, p. 176). Hunt (1993) continues to mention that owing to their training and knowledge, nursing staff working in the ED tend to want to care for physically unwell patients as opposed to psychiatric patients. This avoidance of psychiatric patients is not necessarily a result of staff’s unwillingness, or lack of empathy for these patients. Instead, it is suggested that caring for the purely physically ill, results in nurses feeling more accomplished and fulfilled in their professional capacity (Hunt, 1993). In addition to this, McElroy and Sheppard (1999) also found that health care professionals typically did not experience it as rewarding when treating and managing DSH patients. I will return to the concepts of knowledge and training in section 2.5.

Nevertheless, research suggests that health care professionals have a greater role to play than merely providing the necessary physical care to DSH patients who are admitted after a suicide attempt. Pompili et al. (2005) emphasise the importance of treating DSH patients not only for their physical injuries, but also to extend that treatment to the mental health of the patient. Nurses working in the EPU expressed concern that the precedent was to provide patients with pharmacological treatment, rather than focusing on a more therapeutic approach (Hummelvoll, & Severinsson, 2001).

Literature suggests that the most evident reason argued for this lack of therapeutic input, in comparison to pharmacological care, is the lack of time available to health care professionals. Lelliott and Quirk (2004) discuss the challenge of conducting therapy with these patients in an emergency setting, with the burden of a lack of time due to the busy nature of the work environment. Lelliott and Quirk (2004) continue to argue that it is common for the nursing staff that manages the DSH patients in the EPU to have limited time in which to engage in a therapeutic relationship with these patients.



Following this, it is argued that owing to the nature of the ward it is expected that some psychiatric patients may exhibit dangerous behaviour. This creates a volatile environment and consequently renders it challenging for health care professionals to provide care within the environment (Lelliott & Quirk, 2004). Research suggests that these psychiatric patients do not only take away time from other patients in the ward, such as DSH patients, but they are also inherently challenging to engage with: “Psychiatric nurses find that there are intrinsic difficulties associated with adopting the role of ‘therapeutic instrument’ for acute patients” (Lelliott & Quirk, 2004, p. 299). These difficulties are seated in the fact that many acute psychiatric patients make it challenging for nursing staff by provoking them, treating them without respect and rejecting their care (Hem & Heggen, 2003). Gallop and O’Brien (2003) also argue that not only do health care professionals find it challenging to engage in a therapeutic relationship, but this is even more so with DSH patients who are often manipulative and display self-destructive behaviour.

A second obstacle affecting the nurses’ ability to spend time with the DSH patients, and which prevents them from forming relationships with the patients, is the administrative tasks to which they have to attend during work hours (Higgins, Hurst, & Wistow, 1999). Thirdly, with regards to the issue of a lack of time spent with patients, the regular rotation of nursing staff owing to shift changes, also negatively impacts the opportunity for the building of relationships with DSH patients. Lelliott and Quirk (2004, p. 299) refer to the problem of varying staff members managing and treating DSH patients as “inconsistent staff-patient contact”.

**2.4.2.3 Discharge and follow-up care.** Contrary to the process of admitting patients, there is a lack of information available regarding the best practice guidelines when it comes to discharging patients, and in terms of their follow-care. Nevertheless, the decision to discharge is a vital part of the process of managing a DSH patient. Research suggests that due to a shortage of bed space, patients often spend inadequate amount of time in hospital (Quirk and Lelliott, 2001). McDonagh, Smith and Goddard (2000) argue that acute psychiatric wards can easily become congested when patients have no housing arrangements or support within their communities. This slows down the discharge process. Hummelvoll & Severinsson (2001) argue that the challenge lies in finding the balance between *emptying beds* at a rate that does not obstruct the numbers of patients being admitted (more than currently is the case), whilst still providing the patients with sufficient care and treatment. Moreover, Rhodes (1991) emphasise the challenge of to this attempt of trying to find a balance between

providing patients with sufficient care, while still monitoring the number of beds available and maintaining a steady flow of discharged patients.

The referral of a DSH patient to outpatient health care services for a follow-up carries great significance in the continuation of care for these patients. Schlebusch (2005) argues the importance of initiating follow-up care for patients who presented with suicidal behaviour in an ED, with either a psychologist or psychiatrist. This follow-up care will potentially serve as a good preventative measure in monitoring these high-risk individuals, as a history of suicidal behaviour is positively correlated with an increased risk of completing suicide (Schlebusch, 2005). Whilst outpatient care has great value, patients are neither always adequately referred to these services by health care professionals (Bickley et al., 2013), nor do they attend their follow-up appointments (Schlebusch, 2005). DSH patients are likely to attend a first therapeutic appointment as an outpatient, but general attendance of subsequent appointments is poor (Schlebusch, 2005).

Rudd et al., (1996) estimated that approximately 50% of DSH patients, after presenting at the ED, refused to attend any kind of follow-up outpatient care, with a slightly higher 60% of DSH patients attending their follow-up appointments for less than 7 days (Jauregui, Martinez, Rubio & Santo-Domingo, 1999). In addition to this, Monti, Cedereke, and Öjehagen (2003) suggest a treatment dropout rate of between 40% and 60%, three months into the outpatient treatment. Therefore, as a result of the poor utilisation of outpatient treatment, the importance of focusing on intervention during the initial consultation of a patient in the ED is emphasised once again (Larkin & Beautrais, 2010).

## **2.5 Knowledge and Training of Health Care Professionals**

A literature review of the knowledge and training of health care professionals who respond to DSH patients in the ED elicited a great deal of significant information. Research suggests that the knowledge and the training of health care professionals regarding DSH is especially important when it comes to the assessment of these patients: “The importance of the emergency personnel recognizing an attempted suicide cannot be overemphasized, and this can contribute decisively to the prevention of a relapse” (Pajonk, Gruenberg, Moecke, & Naber, 2002, p. 69). Therefore, having sufficient knowledge about DSH could potentially contribute to reducing the number of DSH patients who present repetitively.

Additionally, Morriss, Kapur, and Byng (2013) discuss the importance of non-mental health professionals having adequate knowledge relating to the assessment of DSH patients, and the identification of suicidal risk factors. These risk factors include elements such as any record of previous mental disorders, a history of DSH, feelings of depression, or any sign of the individual experiencing emotional distress. It is therefore critical for medical staff to be familiar with - and comfortable in assessing and identifying psychosocial issues. Anderson and Jenkins (2006) take this notion further by emphasising the importance of the medical staff having adequate knowledge pertaining groups of patients that are particularly high risk, by means of screening for people at risk owing to their age groups as well as their cultural, social and ethnic background. Nevertheless, research suggests that suicide risk assessments are usually conducted by clinicians with little experience – usually the young residents who are on call in the Emergency Department (Pompili et al., 2005). Schlebusch (2005) goes on to assert that there should also be a focus on training both medical students and nursing students, as they often come into contact with these suicidal patients in a general hospital setting.

Furthermore, while literature states that nursing staff working in the ED generally provided physically injured patients with efficient and accurate assessments (Hay, Bekerman, Rosenberg, & Peled, 2001), they reportedly demonstrated a decreased level of accuracy when assessing mental health care patients (Happell, Summers, & Pinikahana, 2002). Whyte and Blewett (2001) also argue that medical staff members working in the ED, who lack training in mental health, generally conducted assessments of poor quality. It is also suggested that ED staff members who receive training in mental health care are likely to increase the quality of psychosocial assessments (Crawford et al., 1998). It is therefore clear that while some of the medical staff may be responsible for making the very important decision regarding which patients are at risk of suicide, they may not always have sufficient knowledge and training to make these management decisions.

Apart from the knowledge and the training of medical staff, literature shows that even the level of training psychologists receive regarding DSH is not always adequate. Formal training with regard to suicidal behaviour was only offered by an estimated 40% of clinical psychology graduate programs in the USA (Bongar and Harmatz, 1991). Although this research focused on psychologists, research suggests a lack of suicide-specific training throughout the spectrum of health professionals.

Researchers did not only measure the health care professionals' lack of knowledge and training, but the participants themselves also reported it. The results of a study conducted by Conlon and O'Tuathail (2012) have shown that nurses working in the ED of a general hospital reported a worrisome lack of adequate skills that would properly equip them to manage, treat and deal with self-harm cases. Giordano & Stichler (2009) also report that health care professionals working in the ED have expressed concern about not being able to assess mental health care patients adequately and competently. According to Pompili et al. (2005) clinicians working specifically in the ED reported that they did not consider themselves to be sufficiently trained when it comes to psychobehavioral disorders. In addition to this, research also found that nursing participants were not only doubtful in their professional ability to deal with DSH patients, but also expressed a need for more training specifically in providing care to DSH patients (Clarke et al., 2006; Conlon & O'Tuathail, 2012).

## **2.6 DSH and Psychiatric Illness**

The previous section discussed the importance of health care professionals in the ED having sufficient knowledge to be able to identify risk factors associated with DSH when assessing the DSH patient. Research reports a strong correlation between suicidal behaviour and psychiatric illness, in the sense that it is considered to be a risk factor for suicidal behaviour (Van der Feltz-Cornelis et al., 2011). Research continues to suggest that an estimated 90% of people who ultimately complete suicide have had a diagnosable psychiatric illness, typically a depressive disorder (Hawton, Saunders, Topiwala, & Haw, 2013). Bantjes and Kagee (2013) argue that this is especially the case in westernised and developed countries.

Research conducted in an Indian hospital recorded the incidence of DSH between 2000 – 2005. An estimated 50% of the patients who presented were reported to have had a diagnosable psychiatric illness at the time (Avasthi et al., 2008). These authors continue to indicate the differences in relationships between DSH and psychiatric illness, between developing countries, such as India, and developed countries when evaluating the psychosocial environments or situation of these countries (Avasthi et al., 2008).

## 2.7 Attitudes of Health Care Professionals towards DSH

### 2.7.1 The impact of negative attitudes on the care provided to DSH patients.

Research suggests that one of the most significant factors that influences and affects the quality of the care DSH patients receive, are the attitudes of the health care professionals (Herron, Ticehurst, Appleby, Perry, and Cordingley, 2001; Valente & Saunders, 2004). Subsequently, negative attitudes displayed by health care professionals may have a disadvantageous impact on the DSH patients whom they come into contact with.

Slaven and Kisely (2002) suggest that negative attitudes such as hostility, or expressing attitudes of rejection towards these DSH patients, may increase the likelihood of the person engaging in suicidal behaviour repetitively. Jeffery and Warm (2002) also emphasise this influence of negative attitudes when they conducted a study with DSH patients who spent time in the ED. These patients reported that their experience in the ED only strengthened the negative feelings that catalysed their suicidal behaviour in the first place (Jeffery & Warm, 2002). In addition, Pompili et al. (2005) suggest that health care professionals' attitudes could be viewed as indicative of a DSH patient's future suicidal behaviour: "Staff attitudes toward suicidal and self-harming patients have been considered as a key element influencing whether such patients will ultimately commit suicide" (Pompili et al., 2005, p. 170).

In addition, Herron et al. (2001) suggest that negative attitudes such as 'suicide prevention is not my responsibility', are likely to negatively impact on the ability of health care professionals to assess the suicide risk of patients. Herron et al. (2001) continue to suggest that health care professionals who commonly display an attitude of suicide prevention not being their responsibility, may result in them being less likely to assess the DSH patient's suicide risk or to be willing to receive training in suicide risk assessment. The author added that generally medical training of clinicians more often than not didn't focus on aspects of preventing suicide (Herron et al., 2001).

Although the detrimental influence of negative attitudes towards DSH patients is evident, it is also suggested that one should consider and address the influence of the negative attitude, as opposed to the negative attitude itself: "...negative attitudes are not necessarily incorrect, but if they influence clinical behavior they may adversely affect the management of some suicidal patients" (Herron et al., 2001, p. 346).

A literature overview highlighted several factors that contribute to health care professionals developing and displaying negative attitudes when responding to DSH patients. These factors will now be discussed.

**2.7.2 The influence of emotional responses.** Research indicates that health care professionals who display negative attitudes towards DSH patients can be viewed as a result of the interaction between DSH patients and health care professionals (Mackay & Barrowclough, 2005; Saunders, Hawton, Fortune, & Farrell, 2012). Emotions generally experienced by health care professionals include feelings of anger, impatience, hostility and anxiety, which could lead to health care staff withdrawing from- and avoiding these patients.

Moreover, DSH patients may also cause health care professionals to experience feelings of ineffectiveness in their professional capacity, which in turn may negatively influence their attitudes towards these patients (Yaseen, et al. 2013). Although I discussed the anxiety experienced by health care professionals, there should be a differentiation between anxiety experienced as a result of a lack of resources, and anxiety experienced as a result of interacting with DSH patients. In a study where the attitudes of nurses working in the ED were ‘measured’, several negative attitudes were reported. Negative attitudinal statements such as “when individuals self-harm it is often to manipulate their carers” and “people who self-harm are usually trying to get sympathy from others”, evoked the greatest positive response from participants (Conlon & O’Tuathail, 2012, p. 7).

Literature also suggests that health care professionals working in the ED are often reluctant to question patients regarding their suicidal behaviour or ideation, as staff members fear it might make them uncomfortable or that it might re-enforce their behaviour (Folse et al., 2006). Therefore, emotional responses have great significance even in its anticipation as opposed to its reality.

**2.7.3 The influence of a challenging work environment.** Firstly, the attitudes of health care professionals may be influenced by the nature of their work environment. As mentioned previously, the ED is a demanding and challenging workplace. The research suggests that this stressful environment and the challenges that come with it may have a negative impact on health care professionals’ attitudes: “It has been shown that work stress has negative effects on the attitude of ED personnel toward suicide attempters” (Pompili et al., 2005, p. 172). Research asserts that this stress may also be a result of having to work with limited resources:

Disillusionment is inevitable in a system of mental health care where an increase in professional staffing cannot completely resolve the perceived unmet need of the population (Double, 2002, p. 901).

The influence of the work environment also becomes apparent when the attitudes of health care professionals working in this environment are compared to those of health care professionals working in a different health care setting. In comparing attitudes of staff in the emergency room with those working in the intensive care unit, the former showed more negative attitudes (Pompili et al., 2005).

Apart from the influence of the work environment and the potential emotional responses brought on by DSH patients, research also suggests that the health care professional's personal experience with suicide influences their attitudes. Neimeyer (2000) argues that a clinician's personal history with suicidality is likely to play a pivotal role in the way they respond to patients at risk of suicide. While there are several factors that contribute to the health care professionals' development of negative attitudes, there are also factors that may potentially have a positive impact on staff members' attitudes.

**2.7.4 Factors that positively influence health care professionals' attitudes.** One of the factors that may potentially have a positive impact on health care professionals' attitudes toward DSH patients is adequate training and knowledge related to DSH (Herron et al., 2001). Furthermore, Herron et al. (2001) suggest that health care professionals who have had training in specifically suicide risk assessment generally respond more positively to DSH patients as a result.

Research suggests that the demonstration of empathy by health care professionals is another positive factor. Pompili et al., (2005) emphasise the advantage of the DSH patient feeling understood and listened to by the health care professional: "A sound therapeutic relationship, or working alliance (even if it is often hard to schedule follow-ups in the ED), will go a long way toward preventing repeated suicidal behaviour..." (Pompili et al., 2005, p. 171). Research measuring the attitudes of nurses, which was mentioned in the previous section, also elicited positive attitudinal statements such as "an individual has the right to self-harm" and "people should be allowed to self-harm in a safe environment" (Conlon & O'Tuathail, 2012, p. 7).

**2.7.5 Ambivalence.** The literature review shed light on ambivalent attitudes of health care professionals towards DSH patients. Pompili et al. (2005, p. 170) highlight the essence of the ambivalence that underlies the attitudes of medical staff working with suicidal individuals due to the fact that they have to provide care for these patients, even though the patient is challenging that for which the health care professional stands. Babiker and Arnold (1997) take this further by stating that health professionals may find it challenging in their attempt to try and make sense of, and accept, patients who harm themselves intentionally. Pompili et al. (2005, p. 176) also emphasise the ambivalence experienced by medical staff when dealing with DSH patients: “Doctors need to take care of an individual who wants to die and at the same moment asks to be saved. No doubt people working in the ED are the ones who most often experience this inner struggle”.

## **2.8 Conclusion**

There are a substantial amount of international studies regarding the attitudes and knowledge of nurses and, in a lesser sense, clinicians and psychiatrists. However, there exists a significant deficiency in literature regarding other medical personnel working in the ED of a general hospital. Such personnel include medical students and social workers. The next chapter will look at how the ED of this study responded to DSH patients, and specifically how the system organised itself in terms of care provided to these DSH patients as they moved through every sphere of the ED.



## Chapter 3: Methodology

### 3.1 Aims of the Research

To complete this research endeavour an ethnographic research method was used in order to investigate how DSH patients are responded to at the ED of a large public hospital in an urban South African city (hereafter referred to as *the hospital*). The word *ethnography*, a derivative from the Greek language, literally translates into “the description of a people and its way of life” (Angrosino, 2007a, p.1). I return to *ethnography* as a methodology in section 3.3.2. This study formed part of a larger study. The aim of this particular study was to:

1. Document and review how DSH patients are triaged, assessed, and managed in the emergency department of the hospital.
2. Document and review the procedures and policies that are in place to guide the assessment, management and treatment of DSH patients in the emergency department of the hospital.
3. Investigate the knowledge and attitudes of medical staff that are involved in treating cases of DSH in the emergency department of the hospital.

Ultimately, this study aimed to investigate the potential opportunities and barriers for hospital-based interventions. These opportunities and barriers will be discussed in chapter five.

### 3.2 Research Questions

This study intended to answer the following research questions:

1. What are the policies and practices in place at the hospital to respond to patients who present for treatment following acts of DSH?
2. To what extent are these policies and practices adhered to, and what mechanisms are in place for ensuring that health care professionals are aware of these policies?
3. What is the knowledge of suicidal behaviour, as well as the implicit attitudes towards suicidal behaviour?

### 3.3 Research Design: A Rationale

**3.3.1 Qualitative research methodology.** A qualitative research design was implemented in order to answer these research questions. Qualitative research adds to our understanding of how the subjects of the study make sense of their world and their experiences in it (Pratt, 2009). While the scientific and standardised approach of quantitative research allows us to answer questions such as *what*, qualitative research serves a greater purpose in seeking to answer the more complex questions such as *why* and *how* (Marshall, 1996). Qualitative research is especially helpful in providing us with insight into the phenomenon being studied, as well as the meaning that people may attach to this phenomenon or how they make sense of it (Leech & Onwuegbuzie, 2007). Flick (2007, p. viii) emphasises the potential of qualitative research to enhance our understanding of a specific environment in its natural form: “Qualitative research is intended to approach the world ‘out there’ (not in specialized research settings such as laboratories) and to understand, describe and sometimes explain social phenomena ‘from the inside’ in a number of different ways”.

**3.3.2 An ethnographic inquiry.** Ethnography is a form of qualitative research (Hammersley, 2006). As a research methodology, ethnography has its origin in anthropology (Narayan, 1999), which focuses on the study of practices and beliefs shared by smaller groups of people (Savage, 2000). Angrosino (2007a, pp. 1 – 2) explains how ethnography echoes the underlying principles of anthropology:

At that point, ethnography became associated with the new discipline of cultural anthropology – indeed, it became the foundation for that new science, concerned as it was with the comparative analysis of the peoples of the world and their cultures. In fact, the greatest insight of cultural anthropology was the concept of culture itself – the idea that people’s behaviors, beliefs, interactions, and material productions were not random, but rather formed a “complex whole” that was meaningful, logical, more or less consistent, and worthy of respect on its own terms.

Similar to anthropology, ethnography focuses on the behaviour, practices and routines of a particular group in an attempt to gain further insight into the way the group naturally functions (Angrosino, 2007b; Fossey, Harvey, McDermott, and Davidson, 2002). As a result, ethnography is also commonly referred to as a naturalistic inquiry (Savage, 2006). Angrosino (2007b) adds to this by emphasising the importance of trying to determine established,

everyday patterns deemed typical and characteristic of the people functioning in their environment, rather than focusing on single, random incidences.

Savage (2000) argues that *ethnography* is both a process and a product. For the purpose of this research, ethnography is implemented as a research methodology. With regards to ethnography as a product, the findings will not be presented in the form of an ethnography but in the form of a thematic analysis. I will return to this concept in section 3.5.

**3.3.3 Organisational ethnography.** This research implemented a specific type of ethnography, namely organisational ethnography. Organisational ethnography is also known as *institutional ethnography*. These two terms will be used interchangeably. Research suggests a history of implementing an ethnographic research methodology “to study the everyday, such as organizational life or industrial relations” (Savage, 2006, p. 386). Organisational ethnography therefore looks beyond the behaviour of the group of people being studied, to the institutions within which they function (Angrosino, 2007b). Forsythe (1999, p. 127) recommends ethnography for its ability “to illuminate real-world work processes and work settings”, also referring to the term *system evaluation*. In addition to this, Angrosino (2007b) emphasises the shift that has been made from early cultural ethnography to ethnographic research focusing on larger groups of people functioning in a system.

It is impossible to discuss institutional ethnography without drawing on the work of Canadian sociologist, Dorothy Smith. Smith is well known for her work in sociology and for the coining and development of the concept, *institutional ethnography* (Devault, 2006). Smith explains the process of institutional ethnography as follows: “Institutional ethnography begins in the local actualities of the everyday world, with the concerns and perspectives of people located distinctively in the institutional process. From this perspective, an ethnographic exploration of those institutional processes is launched” (Smith, 2005, p. 34). Therefore, although institutional ethnography focuses on the organisational structure, it is the people within the organisation that serve as a lens through which this information is learned.

Grahame (1998) continues to argue that the participants functioning within the system merely serve as a means to an end. The *end*, being an understanding of how the setting under study functions in relation to, or as a result of, the institutional order within which it is located:

Smith uses the term ethnography to emphasize the idea of exploring organization concretely by using the experience of some particular person or persons as the entry point into forms of social organization which shape local settings but originate outside of them (Grahame, 1998, p. 352).

It is important to understand what Smith means when she uses the word *institutions* within the context of institutional ethnography: “Institutions are not viewed as singular forms of social organization, but rather as functional complexes such as education, health care, and law, in which several forms of organization are interwoven” (Grahame, 1998, p.352). Therefore, institutional ethnography focuses on the organisational structure of a system or institution that exists within a broader health care system. Following this, we can view the ED as a system within the hospital, and the ED as a system in relation to psychiatric hospitals

**3.3.4 Ethnographic research in a health care setting.** Qualitative research methodologies such as ethnography are often implemented when conducting research within health care settings (Pope, 2005; Savage, 2006; Van der Geest & Finkler, 2004). Research suggests that qualitative research plays an important role in augmenting our understanding of complicated health care issues (Fossey et al., 2002). Furthermore, qualitative research methodologies are likely to add to our understanding of the how the health sector functions or, more specifically, how it explores the process of having to make decisions in a medical setting (Bradley, Curry, & Devers, 2007).

Morse and Field (1996) specifically discuss the contribution of qualitative research methodologies to our understanding of the organisation of health care, as discussed in the previous section. In a study similar to this one, the ethnographic research approach allowed the researcher to explore the process of how staff members made clinical decisions and, subsequently, the service they provided to patients by attending staff meetings and keeping a record of how patients moved through the clinic (Ware, Lachicotte, Kirschner, Cortes, & Good, 2000).

Furthermore, it is argued that qualitative methodologies are valuable to health care research, as they have the ability to examine complicated issues influencing the care that is provided to patients (Morse, 2005). Savage (2006, p. 391) adds to this by saying: “Within the paradigm of qualitative inquiry, ethnography, with its multi-method approach and attention to context, is particularly well suited to tackling such complexity”. Dixon-Woods (2003) also

assert that ethnography possesses great value when examining the quality of health care provided to patients. It is even more valuable when factors that negatively impact the quality of health care are imbedded in the organisational structure under study. Savage (2006, p.385) also suggests the potential of ethnographic research in attempting to understand the organisational structure of an institution such as a health care setting:

It is arguably the way in which ethnography makes links between the micro and macro, between everyday action or interaction and wider cultural formations through its emphasis on *context*, that most clearly distinguishes ethnography from other approaches (and makes it particularly valuable for researching healthcare issues).

Finally, the literature also asserts that ethnographic research is useful in development and improvement of health care interventions. Bradley et al. (2007, p. 1768) continues to argue that qualitative research methodologies have the potential to examine a health care system, come to understand how it functions and as a result, identify limitations as well as possible interventions. Savage (2000) takes this notion further by stating that ethnographic research, specifically in comparison to other research methodologies, may contribute to addressing challenges the health care system may be facing: “As a detailed way of witnessing human events in the context in which they occur, ethnography can help healthcare professionals to solve problems beyond the reach of many research approaches, particularly in the understanding of patients’ and clinicians’ worlds” (Savage, 2000, p. 1402).

**3.3.5 A lack of ethnographic research in a health care setting.** There is a significant lack of organisational ethnographic research in low- and middle- countries, including South Africa. Some of the few existing examples include work by Swartz (1991) and his observation of psychiatric ward rounds in a South African hospital; Beck’s work on pain management of cancer patients in a South African hospital (Beck, 2000); and ethnographic research conducted in Botswana with oncology patients (Livingston, 2012). Examples of ethnographic research within health care settings, conducted in developed countries, include the studying of nurses’ responses towards DSH individuals in the ED (Hopkins, 2002), as well as the work of Rhodes (1991) in an Emergency Psychiatric Unit in the USA.

Van der Geest and Finkler (2004) suggest two important reasons for the lack of research in a hospital setting. Firstly, they argue that the environment of a hospital may seem

familiar and somewhat universal in their organisational structure and portrayal of staff members. As a result, the false conception of this setting not needing to be examined is created. Secondly, these authors suggest that hospital authorities may also have contributed to the lack of ethnographies in hospital settings, because they were both cautious and reluctant to have researchers observe them in their workplace (Van der Geest & Finkler, 2004).

**3.3.6 Ethnography and the lack of a theoretical framework.** This study did not make use of a theoretical framework as an ethnographic research methodology was implemented. Research argues that it is a commonly accepted practice for research methodologies within the social sciences not to implement a theoretical framework: “It is commonplace in the social sciences now to allow and to value the presentation of qualitative research as narrative, virtually unadorned with the theoretical and conceptual trappings of the scientist” (Whaley, 1993, p.39).

When examining the institutional ethnography that was implemented in this study, Smith refers to this process of research as an exploration taking place “ethnographically rather than theoretically” (Smith, 2005, p.38). Angrosino (2007b) also emphasises the complete lack of any preconceived hypothesis or theory when utilising ethnography as a research methodology; rather, the researcher starts with the system they want to study as opposed to with a hypothesis or theoretical framework.

**3.3.7 Ethnography: A contested methodology.** Ethnography is a contested research methodology (Savage, 2000). There is an on-going debate regarding whether or not ethnography can be viewed as a research method with scientific value, or if it should be viewed merely as a fictional narrative of people in their everyday life. Not only is the scientific value of ethnography in question, but the question of how, if at all, ethnography can be distinguished from fiction, still remains. This is especially problematic due to the issue of the overlapping of the genres of *ethnography* and *fiction* (Narayan, 1999). Behar (1999) adds to this by suggesting that genres are *blurred*, and that there are many grey areas between the *truth* and *fiction*. However, regardless of the overlapping of genres, and its questionable scientific value, ethnography can (and should) be viewed as a valid research method in its own right.

We can argue this on the basis of three arguments. Firstly, ethnography can be distinguished from pure fiction by the underlying principles and process of writing. Though the presentation of some ethnographies may echo the format of a narrative, one should keep

in mind the *micro-practices* that are involved in the systematic writing process (Narayan, 1999). Secondly, ethnographic research operates on the assumption that the data elicited by the research methodology is indeed trustworthy. Literature suggests the importance of ensuring that the data has the same validity and reliability as their scientific counterparts: “Social science is not fiction. Certain distinctions must be preserved in order to mark that fact. Such constructs as reliability and validity, which have traditionally given rigor and legitimacy to this kind of research, are values that can be tinkered with, even replaced, so long as what replaces them somehow imparts to the project an acceptable scientific eidolon” (Whaley, 1993, p. 40). Thirdly, Narayan (1999) suggests that in comparison to fictional writing, where the audience approaches the work with the assumption that they will encounter information that was fabricated, ethnography operates on the basis that the information it generates is perceived as factual and truthful.

### 3.4 Data Collection

**3.4.1 Introduction.** Ethnography is not a method of data collection in itself, but it is a research methodology that may consist of more than one data collection technique (Angrosino, 2007a). Ethnographic research is typically conducted using two or more different techniques of data collection such as observations, interviews and consulting relevant documents (Angrosino, 2007b). Using multiple data collection techniques is useful in providing a thick description of the research setting: “The richest histories will emerge from multiple methods, with intertextual analysis, participant accounts, and observation of activity working together to produce a fuller portrait of the process” (Prior, 2004, p. 197). Furthermore, Lillis (2008) suggests that using multiple methods of data collection plays an important role in attempting to address limitations that accompany single method of data collection, such as a lack of sufficient context.

Using multiple data collection methods also allows for methodological triangulation of the data. We are people with contradictions, which implicates that we often do something and say something else in different contexts. Angrosino (2007b, p. xv) explains it as follows: “Data collection relies on a variety of techniques; indeed, it is desirable to approach the collection of data from as many different perspectives as possible, the better to confirm that things really are as they seem”. I will return to the concept of triangulation in section 3.6.



Although ethnographic research focuses on studying people as a group, rather than focusing on the individual, a big part of the data collection process consists of interviewing individuals that form part of the group. Angrosino (2007b, p.42) offers an explanation for this contradiction:

The ethnographer ultimately comes to a point of recognizing or inferring meaningful patterns in observed behaviours. But the inevitable next question is: what, exactly, *do* those behaviours mean? At that point, it is necessary to start asking questions of knowledgeable people in the community or group under study. Interviewing thus grows logically out of observation

On the contrary, Mulhall (2003, p. 308) argues that it is also possible for observation to stem from the interview process: “Interviews with individuals provide the pieces of the jigsaw and these pieces are then fitted into the ‘picture on the box’ which is gained through observation”. Even though an integral part of this ethnographic method of research is the interviewing of individuals, it is ultimately the collective beliefs and practices that are of importance. We do not merely value ethnography for its ability to explore participants’ patterns of practices in their workplace and their patterns of thought, but rather because of the relationships between these two aspects (Forsythe, 1999).

**3.4.2 Data collection methods.** Qualitative data was collected from the following three sources:

**3.4.2.1 Observations of the practices in the hospital.** The observation process involved the surveillance of practices regarding the assessment, management and treatment of DSH patients in the ED (Casualty and EPU). Observations of practices in the ED took place over an eight-month period from May to December 2014. During this time I attended an average of three EPU ward rounds and one Liaison Psychiatry ward round per week. During the Liaison Psychiatry ward rounds I also observed discussions of patients between health care professionals.

The process of observation is especially important owing to its ability to provide insight into the full context in which the staff members interact and make decisions (Mulhall, 2003). Hammersley and Atkinson (1983, p. 2) explain the observation process as follows:



The ethnographer participates, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions; in fact collecting whatever data are available to throw light on the issues with which he or she is concerned.

The observations took place in the research setting, also referred to in ethnographic research as the *field site*. From this point onward, I will refer to the observation setting as the field site. The field site was preselected in line with the research rationale and subsequent research questions. The studying of subjects within their natural setting, the field site, is commonly referred to as *doing fieldwork* (Angrosino, 2007a; Narayan, 1999). Fieldwork is generally labour-intensive and time-consuming, with the researcher spending extended periods of time in the field site (Pope, 2005). It is suggested that the process of observation commonly starts off broadly where the setting is the focus. After this point, the focus falls more on individuals that serve as potential participants for the research (Angrosino, 2007a).

Similar to the manner in which I approached the observation process of my own study, Angrosino (2007b) suggests that one should attempt to observe the field site so as to gain a sense of the environment prior to conducting any analysis. However, some research suggests that there will always be interpretation on some level on the part of the researcher. I will return to this issue in section 3.5.

Throughout the observation period I, the observer, made detailed field notes. Field notes may take on different forms. They range from *description field notes* (a descriptive account of the field site and the people in it) to *dialogue field notes* (an account of conversations as part of a group of participants and conversations between participants). This research endeavour focused largely on dialogue field notes and, to a lesser extent, it generated descriptive field notes (Mulhall, 2003).

In ethnographic research, field notes serve as texts for analytical purposes: "A major part of qualitative research is based on text and writing – from field notes and transcripts to descriptions and interpretations and finally to the presentation of the findings and of the research as a whole" (Flick, 2007, p. ix). Consequently, we can view everything observed as a text, and we can operate on the assumption that everything observed potentially has meaning. Behar (1999, p.477) also emphasises the importance of interactions and relationships in the conducting of ethnographic research, and how these interactions translate into texts:

The bottom line about ethnography is that it is about forming relationships; it is about the search for connection within and across borders. The text is a record of a particular set of interactions between a particular observer and her/his particular subjects.

For the purpose of this study, I moved between the researcher roles of Participant-as-observer and Observer-as-participant. More often than not, I found myself in the role of Observer- as- participant. Participant observation is a role taken on by the researcher and is not an inherent data collection technique (Angrosino, 2007b). The author continues to describe the role of the latter as follows: “The researcher is known and recognized, but relates to the ‘subjects’ of study solely *as* a researcher” (Angrosino, 2007b, p. 54). Ultimately, I can identify with Angrosino (2007b, p. 32) when he reflects on his experience of working in a field site: “As such, I could come and go in a natural fashion, since I had a recognized role to play; but at the same time I was not officially ‘staff’, so the clients felt relatively comfortable sharing their private feelings with me”. I will return to my reflexivity of conducting this research in the concluding chapter of this thesis.

**3.4.2.2 Hospital documents (policies and protocols).** All documents relevant to how the health care professionals responded to patients who presented for medical attention at the ED, following an act of DSH were sourced. When sourcing these documents, I searched for protocols, policies, and procedures that directly related to the assessment, management, and treatment of deliberate self-harm and suicide. These hospital documents did not include patient files, or any information about patients. My supervisor, Dr J. Bantjes, and I reviewed all documents collected for this study.

Document analysis, in addition to observations and interviewing, also played a vital role in the triangulation of data. Therefore, documents may prove to be valuable in the verification of information gained from other sources (Bowen, 2009).

**3.4.2.3 Semi-structured interviews.** Health care professionals in the ED who came into contact with DSH patients and who were willing to participate in this study were interviewed by conducting semi-structured interviews (see Appendix A). Semi-structured interviews are commonly used in healthcare research (Gill, Stewart, Treasure, & Chadwick, 2008). Sorrell and Redmond (1995) discuss the value of an interview in augmenting our knowledge and understanding of the experiences of people regarding a particular issue. In relation to the discussion in section 3.4.1, Forsythe (1999, p. 132) argues the importance of

interviewing individuals within the system being studied, as opposed to merely observing the system: “In system evaluation, for example, it is advisable to observe people using the system as well as to elicit their opinions about it”.

The interviewing process is considered to be both a unique and intimate experience between the interviewer and the participant. It is argued that valuable information is more likely to be disclosed during an interview in comparison to completing a questionnaire (Sorrell and Redmond, 1995). In addition to this, Angrosino (2007b, p. 43) captures the essence of an ethnographic interview by arguing, “...it is not merely an oral version of a shotgun survey questionnaire”. Instead, it is an in depth conversation in an attempt to illicit the underlying, complex meaning and opinion of the interviewee (Angrosino, 2007b). Furthermore, semi-structured interviews provide the perfect balance between guiding the subject by asking certain key questions, whilst still allowing for some flexibility. This is significant as participants can elaborate or add information the researcher may not have deemed relevant (Gill et al., 2008).

Participants for interviews were recruited via purposeful sampling. Purposeful sampling is generally viewed as one of the most common techniques of sampling (Marshall, 1996). Marshall (1996, p. 523) describes purposeful sampling as selecting “the most productive sample to answer the research question”. In other words, those people who will provide us with a thick description of their experiences and beliefs are selected. Therefore, health care workers were invited to participate in a semi-structure interview if they were observed to come into contact with DSH patients on a regular basis and would therefore be able to provide us with a thick description of their experience. Barbour (2001) emphasises the value of making use of purposeful sampling as it allows the researcher to have more control over the inclusion or exclusion of participants based on the potential value they will add to the research.

The interviews were conducted after the field site had been observed for some time. This chronology of data collection allowed us to truthfully employ the principle of purposeful sampling, by placing ourselves in a better-informed position to purposefully select potential participants to interview. Mulhall’s (2003) suggestion that observations may also follow from the interviewing process, was echoed in the research process. Some interviews naturally resulted in me returning to the field site, and observing specific aspects of the system.

Semi-structured interviews were conducted with 28 participants. This sample (see table 3.1) included medical officers, a medical registrar, medical interns, medical students (4<sup>th</sup> year and 6<sup>th</sup> year), nurses (Casualty and EPU), a student nurse, psychiatry registrars, psychologists and social workers. This thesis focuses on how the DSH patients move through the system of the ED, as opposed to how they come to present at the ED. In addition to this, research suggests that when studying a group of people that is very diverse, it is also important to have a heterogenic sample to be representative of the diversity of the group (Angrosino, 2007b). The terms *Casualty* or *EPU* used in brackets next to each participant indicate the section within the ED where they were based at the time of their interview.

Table 3.1

*Study sample*

<b>Health care profession</b>	<b>Female</b>	<b>Male</b>	<b>TOTAL</b>
Medical Officer (Casualty)	1	2	3
Medical Registrar (Casualty)		1	1
Medical intern (Casualty)	1	2	3
Medical student (6 <sup>th</sup> year) (EPU)	3		3
Medical student (4 <sup>th</sup> year) (EPU)	2		2
Nurse (EPU)	5		5
Nurse (Casualty)	1		1
Student nurse (EPU)	1		1
Psychiatry registrar (EPU)	2	3	5
Psychologist (EPU)	2		2
Social worker (EPU)	1	1	2
<b>TOTAL</b>	<b>19</b>	<b>9</b>	<b>28</b>

### 3.5 Data Analysis

Although the process of data analysis has received insufficient critical discussion, especially in comparison to the process of data collection (Bradley et al., 2007; Thorne,

2000), data analysis is arguably one of the most intricate phases of qualitative research (Thorne, 2000). Data analysis should be a purposeful process to which the qualitative researcher adheres, in an attempt “to generate findings that transform raw data into new knowledge (Thorne, 2000, p. 68). Cohen and Crabtree (2008) also emphasise this transformation of data into newfound understanding, by arguing the purpose of data analysis is “to organize individual statements into themes that produce new, high-order insights” (p. 335).

Data analysis is considered as a step in the research process that follows the data collection. However, it is arguable that the process of analysis already begins during the data collection period, and it takes place continuously throughout the research process (Bradley et al, 2007). Although the observational period should initially solely seek to observe without interpretation, this may occur on a subconscious level. It is arguable that the researcher already forms an idea of potential themes while collecting the data. Ryan and Bernard (2003) suggest that during the process of writing field notes the researcher can be considered as a *theme filter*, as he or she may find themselves leaving out certain information whilst focusing on other significant facts. While this process of “information selection” arguably occurs on a subconscious level, it may still add to investigator bias. Investigator bias exists when the subjectivity of the researcher may potentially influence the research (Barbour, 2001). I will return to the issue of investigator bias in section 3.6.1.

There are several qualitative data analysis strategies or approaches such as Constant Comparative Analysis, Phenomenological approaches, Narrative Analysis and Discourse Analysis (Thorne, 2000). This study implemented a Thematic Analysis approach. The three data sets (field notes, interview transcripts and documents) were therefore analysed using thematic analysis.

Thematic analysis is one of the most commonly used methods of data analysis for qualitative research, and it is widely regarded as the “foundational method for qualitative analysis” (Braun & Clarke, 2006, p. 78). Thematic analysis consists of a step-by-step process to ensure data is optimally analysed and reported (Braun & Clarke, 2006). This approach to analysis is a particularly good pairing with qualitative research, as provides a method which enables us to make sense of rich narratives. Moreover, it provides a platform where this data can be presented in an organised, understandable and enlightening manner (Braun and Clarke, 2006).

After the interviews had been conducted, they were transcribed by a transcription company. Field notes also served as “transcriptions”. The same method of analysis was employed when analysing the notes made whilst observing medical staff. Applicable documents were also used as data and were therefore analysed as part of the thematic analysis. Thematic analysis was implemented to identify the main themes in the data, which were coded and organised by me, the researcher.

**3.5.1 Coding.** The first step of the process was to get acquainted with all the data (Braun & Clarke, 2006). As I conducted all of the interviews myself, I had some knowledge of the data upon approaching the analytic process. However, I still had to familiarise myself even more with the data. Braun and Clarke (2006) refer to this important part of the process, in which the researcher becomes actively involved with the data, as “repeated reading” (p. 87). This step in the process of analysis was also important, so as to ensure that the context underlying the important and interesting points of interest does not get lost or altered (Bradley et al., 2007). After the transcriptions were returned to me, I checked the accuracy of the transcriptions by listening to the audio interviews and re-reading the transcription simultaneously.

Once I was more familiar with the data, I organised it into initial codes based on the parts of the data that appeared interesting, useful, insightful (Muhr, 1991) and relevant to my research questions. I began my initial coding by using the different colours to highlight different codes in each transcription using Microsoft word. After the initial coding process, a more detailed coding process followed involving the careful scrutiny of each line (Bradley et al., 2007). In addition to this, I summarised each participant’s transcription separately, based on my initial coding. This also helped me with organising and making sense of my big data set. Being able to review participants’ summaries also allowed me to check for accuracy of the findings.

During the process of coding, it was also important to make notes regarding how ideas and concepts linked together (Bradley et al., 2007; Fossey et al., 2002). This was done so as to keep the context of the data relevant and understandable. Although coding is important in order to organise the data and to make it more accessible to the researcher, it should under no circumstances become a replacement for the original data: “...if the codes are not conceptually rich and are oversimplified in their separation from the context of their occurrence, the insights from the inquiry will be limited” (Bradley et al., 2007, p. 1765). In

order to make complete sense of the data during the process of analysis, it is important to realise that data analysis is more complicated than merely organising it into codes, regardless the significance of coding: “...developing an understanding of qualitative data requires conceptual level processes of exploring the meanings, patterns or connections among data that involve the researcher’s own thought, reflection and intuition” (Fossey et al., 2002, p. 729).

In conclusion, Miles and Huberman (1994) also highlight the fact that the quality of the analysis is very much dependent on the quality of the coding. A code structure that is coherent, logical and developed with effort and thorough detail will enhance the quality and value of the thematic analysis.

**3.5.2 Development of themes.** After identifying the codes, I organised the codes in groups to form themes and subthemes (Braun & Clarke, 2006) in the form of mind maps. Themes are patterns of information within the data regarding the subject being studied (Bradley et al., 2007). Several pieces of information throughout transcriptions were indicative of new themes, such as a change between different issues or content, as well as fluctuations regarding the interviewee’s tone of voice or pauses in speech (Ryan & Bernard, 2003). Some themes were not considered to be solid themes, whilst other themes were found to overlap or be repetitive of each other (Braun & Clarke, 2006). However, even though I deemed some themes insignificant and discarded them as a result, it is more desirable initially to identify all possible themes in order to allow for a thorough, secondary analysis to occur where themes were reviewed and edited (Ryan & Bernard, 2003).

Although the development of themes is at the centre of the data analysis process, it is important to guard against writing a summary of the data. It is suggested that for data to be optimally represented, one should guard against simply describing the data: “The data must be challenged, extended, supported, and linked in order to reveal their full value” (Bazeley, 2009, p. 8). The author also cautions against relying too heavily on selected extracts and single quotes, as opposed to taking into account the whole data set, in an attempt to generate themes (Bazeley, 2009). While a relevant quote at the right time can serve as very powerful evidence and support of an argument, the researcher should guard against relying on quotes alone to tell the story of the data. “Clearly, participants’ words must lie at the basis of the conclusions you reach, but rarely will a participant make the argument for you in a few words” (Bazeley, 2009, p.19). Moreover, the literature asserts that when the researcher is able

to present the words of the participants (quotes) in contrast to the researcher's own interpretation and conclusions, it provides the reader with the opportunity to assess the credibility and overall trustworthiness of the data (Fossey et al., 2002). The idea of trustworthiness will be discussed in more detail in the following section of this chapter. A summary of the main themes and subthemes of the findings is provided in tables 3.2 and 3.3 respectively.

Table 3.2

*Barriers to the provision of care to DSH patients*

<b>Barriers</b>	
A lack of resources	The problem of bed pressure
	Insufficient numbers of staff
	Lack of psychological services
	Poor management of existing resources
	Consequences of resource constraints
Impossibility of a relationship	The problem of a lack of sufficient time
	Lack of confidentiality
	The DSH patient not being truthful
	Discontinuity of care
Health care professionals' experiences and perceptions of DSH	Emotional responses
	Stigma attached to DSH
	Negative attitudes toward DSH patients
	Perceptions regarding the prevention of suicidal behaviour
A lack of training and knowledge regarding DSH	



Table 3.3

*Opportunities to the provision of care to DSH patients*

<b>Opportunities</b>
Health care professionals' attitudes of empathy and non-judgment
Health care professionals' ability to understand and relate to DSH behaviour
Personal experience of suicide positively impacting levels of empathy
Positive attitudes despite resource constraints

Once the themes were finalised, I named the themes based on the essential meaning of each theme (Braun & Clarke, 2006). Ultimately, the name of a theme should have the ability to communicate its essence to the reader without having it explained to them (Bazeley, 2009). Bazeley (2009) warns against the oversimplification of themes, as it is important to keep the themes relevant to the context and not to omit important information in an attempt to present concise themes. The data was then scrutinised to make explicit the knowledge and attitudes about DSH, which underlie the practices of these health care professionals. Finally, the data was analysed against the backdrop of relevant research so as to show the extent to which the procedures are supported by evidence based practice and theory.

### **3.6 Trustworthiness of Findings**

It is vital for qualitative research to be conducted in a systematic and rigorous manner (Fossey et al., 2002). Rigour, also commonly referred to as accuracy, thoroughness and precision, is fundamental to any study (Barbour, 2001). Ensuring that a study is conducted in a rigorous manner allows the reader to trust the outcome, and to perceive the results of the study to be true and trustworthy.

Angrosino (2007b, p. 59) emphasises the importance of the data having to be trustworthy in stating the following: "...if there is no basis for trusting the observation, then the research is meaningless". Barbour (2001) continues to argue that ensuring the rigour of a study is especially important when conducting qualitative research in a medical setting: "In medical research the question is no longer whether qualitative methods are valuable but how rigour can be ensured or enhanced" (Barbour, 2001, p. 1115).

It is therefore necessary that qualitative research should be open to examination and critique in order for the findings of the study to be considered applicable at all (Long &

Johnson, 2000). Mays and Pope (2000) also emphasise the importance of having certain procedures in place that allow us to measure and evaluate the quality of qualitative research. It is often the case that the trustworthiness of qualitative studies is questioned, and not that of quantitative studies. Owing to this, even more attention should be awarded to addressing this aspect of the research (Shenton, 2004).

Lincoln & Guba (1985) suggest a set of four criteria, which should be addressed to add to the trustworthiness of qualitative research. It is important to note that both quantitative and qualitative research make use of different terms for the same concept (Cohen & Crabtree, 2008). The set of four criteria and the provisions that were made to address these criteria are summarised in table 3.4.

**3.6.1 Confirmability.** Confirmability rests upon the assumption that the findings of the research are not based on the subjective opinions and experiences of the researcher, but rather that it is a result of participants' lived experiences and beliefs (Shenton, 2004). Confirmability can be viewed as the equivalent of objectivity in quantitative research (Guba, 1981). The confirmability of the research was improved in the following ways:

***Investigator triangulation.*** Triangulation may assume several different forms, but generally includes the use of several data sources; techniques of data collection and research investigators (Farmer, Robinson, Elliot, & Eyles, 2006; Long & Johnson, 2000). Triangulation is implemented to add to the validity of the research (Farmer et al., 2006), and to decrease the shortcomings that accompany the use of a single method or only one researcher. Investigator triangulation consists of a second person or investigator taking part in the data analysis process, with researchers comparing their respective results to improve the confirmability of the results (Tuckett, 2005). This method of triangulation was specifically employed in this study in relation to the observation process. My supervisor and I spent a great deal of time observing the field site, and we compared and discussed field notes on a regular basis. We analysed and discussed relevant documents collaboratively, and had regular in-depth discussions regarding the thematic analysis of all of the transcriptions.

***Reflexivity.*** Maintaining a sense of reflexivity is an important role in attempting to improve the confirmability of the findings (Guba, 1981). Hall and Stevens (1991) describe the concept of reflexivity as acknowledging the need of the researcher to take into consideration the effect that their own subjective beliefs, feelings and interest in the research,

have on the findings. In addition to this, Mays and Pope (2000) refer to the idea of reflexivity as maintaining a sense of sensitivity to the manner in which the researcher and the research process have impacted the data collection process.

The interviewing process indeed relies solely on the interaction between the researcher and participant. However, it is suggested that the processes of observation and the document sourcing are more objective because one can observe, and review documents without interaction with participants (Angrosino, 2007b).

Table 3.4

*Criteria for trustworthiness and addressing these criteria*

<b>Quality criterion</b>	<b>Quantitative term</b>	<b>Provision made to improve trustworthiness</b>
Confirmability	Objectivity	<i>Investigator triangulation, reflexivity.</i>
Credibility	Internal validity	<i>Triangulation of methods, peer evaluation of research, debriefing with my supervisor, extended engagement with the field site, experience level of researcher, recordkeeping of data.</i>
Dependability	Reliability	<i>Systematic recording and analysis of data, in-depth description of research design.</i>
Transferability	External validity/Generalisability	<i>Thick description of participants.</i>

*Note.* Adapted from Shenton, 2004.

One of the unique aspects of ethnography is the important role the researcher plays in this research method. Even though our intentions may be for our observations to be objective, we cannot help but observe things through a filter of personal experience and beliefs as discussed in section 3.5. Forsythe (1999) asserts that all the factors that influence the researcher (such as training, theory and personal experience) serve to calibrate the research instrument. Pope (2005) also emphasises the fact that the foundation of ethnographic research lies in the researcher acting as the main research instrument. Therefore, who you are as a person, your personal beliefs and opinions, undeniably moulds the outcome of the findings.

The author, however, emphasises the importance of remaining conscious of-, and reflecting on, these *filters* or preconceived opinions rather than trying to guarantee a complete sense of objectivity (Angrosino, 2007b). Before embarking on the research task, it was essential to acknowledge my personal opinion and views about suicidal behaviour, the individuals that engage in this behaviour, as well as the medical staff treating them. It was also important to work through these opinions by myself in order to position my views so that I was consciously aware of them. This was to ensure that they did not influence the results of my study. Regular meetings and discussions with my supervisor allowed him to recognise any biases of which I may have been unaware (Shenton, 2004).

**3.6.2 Credibility.** Credibility refers to the truthfulness of the findings (Krefting, 1991) and, specifically, to how the reality of the participants is accurately reflected in the findings of the research (Merriam, 1995). Credibility is equivalent to the concept internal validity used in quantitative research (Guba, 1981). The credibility of the research was improved in the following ways:

***Methodological triangulation.*** In order to improve the credibility of the findings, this study implemented the triangulation of methods (methodological triangulation) (Barbour, 2001; Farmer et al., 2006). Tuckett (2005) defines methodological triangulation as using multiple methods of data collection to study the same phenomenon. The data from all three data collection methods of this study was triangulated.

Richardson (1991) suggests that rather than merely comparing data from different sources, the emphasis should be placed on allowing the different sources to complement each other in an attempt to create a coherent picture of the sample being studied. Farmer et al. (2006) assert the importance of using triangulation owing to its ability to illuminate the way we understand and make sense of complex issues within health care.

***Peer evaluation of research.*** Evaluation of the research by colleagues and other academics is likely to have improved the credibility of this research. The feedback following these evaluations was incorporated into the research (Shenton, 2004). Shenton (2004) adds to this by saying that peers who are detached from the project are likely to add a sense of objectivity and perspective to the research.

Two colleagues from the Department of Psychology at Stellenbosch University reviewed the research proposal for this study. The suggested changes were implemented prior to data collection. Furthermore, I presented preliminary findings to a group of academics involved in similar qualitative research. Their opinions and discussions served as guidelines throughout the remainder of the research process. In a second presentation, I discussed the challenges that I experienced in relation to my research methodology. Thereafter, the feedback that I received was incorporated as the research process continued.

***Debriefing with my supervisor.*** Throughout the research process, I had regular meetings with my supervisor. During these meetings, he fulfilled the role of providing feedback with regards to the development of my ideas and perceptions. Throughout the research process, these debriefing sessions served as a platform where I could reflect on my experiences and opinions in a collaborative manner. Regular discussions aimed to highlight possible errors in my thought process and the execution of the different phases of research, which could have potentially negatively impacted my study (Shenton, 2004).

***Extended engagement with the field site.*** Long and Johnson (2000, p.34) assert that spending extensive time engaging with the field site under study is likely to improve the credibility of the research:

It is a means to enhance validity, then, if the researcher can spend a significant length of time in contact with respondents individually and with the topic generally. This allows time for emerging concepts to develop and for potential implications to be recognized.

Mays and Pope (1995) also discuss the importance of spending time in the field site in order to establish relationships with potential participants, and to get acquainted with the context surrounding these participants. This time will also allow the people being observed and interviewed to become comfortable with the researcher's presence and their purpose for

being there. This allows the researcher to make informed decisions and conclusions when analysing the data.

To this end, I spent eight months immersed in the field site. Prior to conducting interviews and observations, I spent several weeks orientating myself with the field site and becoming acquainted with the people working within the field site. My intention was to build rapport with potential participants. Throughout this process, I also had the opportunity to identify any potential challenges to my research process.

***Experience level of researcher.*** It is suggested that the researcher's level of skill regarding conducting research can pose advantages or disadvantages to the credibility of the research results (Angen, 2000). However, I commenced the research process having only some experience with interviewing. In my Honours year I attended lectures on interviewing techniques, and I also practiced interviewing techniques with my supervisor and other Master's students. I also spent a significant amount of time over the course of the data collection period observing my supervisor, and conducting semi-structured qualitative interviews for a different study in a similar context. In addition to this, it is important to note that I conducted the observations of this study in collaboration with my supervisor, who had extensive experience in ethnographic research, and from whom I learnt a great deal.

Having had no previous experience with the ethnographic process of observation myself, I did a significant amount of research regarding the observation process and observation techniques prior to data collection. Throughout my study, with regard to interviewing and observing, I adjusted my approach based on trial and error. This forced me to adapt and to improve my research approach, which strengthened the credibility of the researcher as a result. Having limited experience in qualitative research and no experience in ethnographic research also has its advantages. Some research suggests that not being an expert at your craft should not necessarily be considered a disadvantage. The premise of this statement is that researchers with little experience are less likely to run the risk of becoming too comfortable in their ways, and inattentive during the research process (Holloway and Todres, 2007).

***Record-keeping of data.*** Keeping a thorough record of all collected data, as well as the data analysis process, to which one can refer for reviewing purposes, also contributed to the credibility and the dependability of the research (Mays & Pope, 1995; Tuckett, 2005). I

will return to the issue of dependability in the next section. These records included all voice recordings of interviews, field notes, transcriptions, codes and the thematic analysis.

**3.6.3 Dependability.** Dependability refers to the level of consistency of the findings, should the research be replicated in another study (Krefting, 1991). Dependability is viewed as the equivalent of reliability, as used in quantitative research (Guba, 1981).

With qualitative research, and specifically ethnographic research, the potential dependability of the research comes into question. Angrosino (2007b) argues that the environment and the conditions pertaining to the research may be incredibly difficult to replicate in future research. Angrosino (2007b, p.36) continues to emphasise that in ethnographic research, maintaining consistency of findings across a spectrum of similar research projects is challenging at the very least: “The ‘reality’ we perceive as ethnographers is thus always conditional; we cannot take it for granted that another ethnographer, looking at the same set of ‘facts’ at a different time, will come to exactly the same conclusions”. In addition, Behar (1999, p.477) also suggests that reproducing ethnographic research is highly unrealistic: “Those interactions can never be exactly reproduced again. Ethnography is reinvented with every journey”.

Therefore, we can infer that ensuring the dependability of the research is especially challenging owing to the significant role the researcher plays as an instrument when conducting research (Pope, 2005). However, research suggests that there are ways in which the dependability of the study can be improved. The dependability of this research was improved in the following ways:

***Systematic recording and analysis of data.*** In order to improve the dependability of the research, Long and Johnson (2000) propose that the data should be collected or recorded in a systematic and consistent manner. This will decrease any variation in the outcome of the data. As discussed in section 3.3.7, ethnography is often perceived as an unscientific research method, with no rules or framework in place when collecting the data. However, Forsythe (1999) argues that quality ethnography is dependent on a systematic method of conducting research.

I collected my data both in a systematic and consistent manner. This systematic recording of data was especially applicable to the observation process. Angrosino (2007b) suggests that as opposed to everyday observations, observation as part of the ethnographic

research process takes on a more formal format and systematic approach. The observation process starts with observing and making notes about the workplace in general. This is followed by more detailed observations regarding individuals within the workplace (Borman, Puccia, Fox McNulty, & Goddard, 2007). In addition to this, I followed a similar observation routine every day. More specifically, I tried to write field notes soon after the observation had taken place, as well as in a similar format.

Apart from the systematic recording of data, the systematic analysis of data is also vital to improving the dependability of the research (Krefting, 1991). This is not only important for the researcher, but also for those aiming to conduct a similar study so that they can understand and implement the same research principles: “Understanding these processes is therefore an important aspect not only of doing qualitative research, but also of reading, understanding, and interpreting it” (Thorne, 2000, p. 68).

***In-depth description of research design.*** It is important to provide an in-depth description of the research design that was implemented for this study (Krefting, 1991) in order to improve the dependability of the research. Shenton (2004, p. 71) refers to it as an account of “the research design and its implementation, describing what was planned and executed on a strategic level”. In sections 3.4 and 3.5 I provided a detailed account of how data was both collected and analysed.

**3.6.4 Transferability.** Transferability refers to the extent to which the findings of the research are applicable to a different context, using different participants. In other words, it refers to the generalisability of the findings to larger populations (Krefting, 1991). Transferability is viewed as the equivalent of the concept of external validity used in quantitative research (Guba, 1981).

Krefting (1991, p.220) highlights the challenge that qualitative researchers face when considering the transferability of their research: “...the difficulty with qualitative research is situational uniqueness; the particular group studied may not relate to others and hence conclusions may not be transferable”. In addition to the criticism that qualitative research has received regarding its inability to produce generalisable findings (Savage, 2000), some research has dismissed the generalisability of findings as an insignificant and unnecessary quality of qualitative research. For example, Marshall (1996) suggests that when studying certain psychosocial phenomena, the added understanding of the issue is privileged over the potential generalisability (transferability) of the results.



Even though some research may not view transferability as crucial when it comes to qualitative research, there are still certain things that can be done to improve it. The transferability of this research was improved in the following ways:

***Implementing a heterogenic sample.*** In an attempt to improve the transferability of a study, it is suggested that the emphasis should be placed on the level of representativeness assigned to participants in relation to the broader group to which they belong: “A key factor in the transferability of the data, then, is the representativeness of the informants for that particular group” (Krefting, 1991, p. 220). In this study, I made use of a heterogenic sample. I used participants from each discipline that forms part of the health care staff who come into contact with DSH patients in the ED.

***Thick description of participants.*** Research suggests that providing a thick description of the research setting and participants is likely to improve the transferability of the research (Krefting, 1991; Tuckett, 2005). Thick descriptions may include information regarding the setting, biographical information of participants, and anything else of added relevance which will add to an improved understanding of their documented experiences (Tuckett, 2005).

My study includes a detailed description of the field site as well as the basic biographical details of participants, such as their gender and their professional discipline. In the case of this study, the biographical details of participants may be less important owing to the ethnographic nature of the research, and the focus on the system of individuals. However, even though a thick description of the field site was provided, it is arguably only applicable to the context of the specific setting, and to the specific researcher who conducted the research. Therefore, it is the unique role of the field site and the influence of field worker (the researcher) that renders the replication of this research challenging.

### **3.7 Ethical Considerations**

Ethical clearance to conduct this research study was granted by Stellenbosch University (N13/05/074) and the University of Cape Town (HREC/REF: 645/2013) (see Appendices B & C). In addition to this, institutional permission was obtained from the Department of Health as well as the Superintendent at the hospital (see Appendix D).

Ethnographic research is accompanied by a fair degree of controversy with regard to ethics. Pope (2005, p. 1182) specifically mentions the ethical challenges within a healthcare

setting: “Ethical issues are often magnified in medical environments, not least the issue of ‘informed consent’”. Mulhall (2003) takes this assertion further by saying that the problem of adequately informing participants, and subsequently obtaining consent, is especially difficult in a busy setting such as an ED of a hospital. This was especially problematic when it came to the data collection method of observation. It can be argued that the unobtrusive nature of observing people not only reduces the opportunity for harm could be caused to participants, but it also promotes the validity of the actions and responses of participants. However, it is the very nature of this unobtrusiveness that raises the issue of the participants’ privacy and the issue of informed consent (Borman et al., 2007). Therefore, we can ask the same question as Mulhall (2003, p. 309): “How informed can participants really be?”.

Pope (2005) offers different suggestions regarding how to deal with this issue of informed consent effectively. This included the idea of having a meeting where the research is explained to staff members, and making a point of writing field notes openly so as to ‘remind’ participants that they are being observed (Pope, 2005). Similar to these suggestions, my supervisor and I introduced ourselves to the health care professionals at the start of the data collection period. We also explained the purpose and the extent of the study. Additionally, I made field notes during my observations, as opposed to compiling notes once I had left the field site.

Health care professionals, whom I actively observed while having informal conversations, were informed of the research and asked for verbal consent. In the event where I observed health care professionals responding to DSH patients, those patients were informed of the study and were asked for verbal consent to being observed. There were several occasions when I observed the interaction between healthcare professionals and DSH patients in a group setting with other health care professionals during ward rounds. I presented as a staff member and informed consent was not obtained. It is suggested that ethical considerations of a study should continuously be addressed and adapted as the study evolves and progresses (Mulhall, 2003). Pope (2005, p. 1182) also emphasises that “ethnography and, by extension, consent are not single events but involve a negotiated process”. It is important to note that because this study implemented an ethnographic research design, the ED within the hospital served as our unit of analysis and not the individual *per se*. This means that I observed and reported on the way in which the ED functions as a unit in response to the DSH patient, and not on specific individual medical staff or DSH patients within the ED.

The influence of the researcher on the researched was also brought into question. However, Mulhall (2003, p. 308) asserts an interesting point regarding the potential effect the researcher may have on the subjects: "Once the initial stages of entering the field are past, most professionals are too busy to maintain behaviour that is radically different from normal". One can thus argue that while the researcher may have some effect, it is not to the extent where that this effect will influence the findings of the research.

With regard to the interviewing process, participants were invited to participate in the study based on their availability while working in the ED. This was done so as not to interfere with the care they provide to patients. Participation in the study was voluntary, and informed consent was obtained from each participant (see Appendix E). Those participants invited to partake were informed of their right to decline participating in the study without providing any reason for their decision. Participants also had the right to stop participating in the study at any given time during the interview. In such a case, their information and answers would not be used in this study. As far as possible, interviews were conducted in a private space, which included consultation rooms in the ED, on-call rooms or staff rooms, depending on availability. Interviews were recorded to allow for the data to be transcribed. Only the participant and I were present during an interview in order to ensure privacy and confidentiality.

With regard to the interviews and observations, anonymity and confidentiality were protected by not recording participants' names and by removing all details that could lead to the identification of individuals. Data was also stored electronically on a password-protected computer. My supervisor and I were responsible for anonymising and storing the data.

As the interviewer, I also monitored the level of distress of individuals who were interviewed. This was necessary in order to terminate the interview should it have become clear that the participants were distressed by the questions. In the event that participants in this study experienced psychological and emotional distress as a result of participating in this study, a referral would have been made to the Liaison Psychiatry Services Unit within the Department of Psychiatry and Mental Health at University of Cape Town. This is so that the participant could receive psychological support. It is important to note that during the research period, there were no cases warranting such a referral. Limitations of the methodology, especially regarding the observation process and ethics will be discussed in the Conclusion chapter.

## Chapter 4: Organisation of Care within the Field Site

### 4.1 Setting the Scene

It was an ongoing piazza, the emergency department. Flamboyant, but also grave. A continuous chaos, each moment seeming as if it had just erupted – a fusion of doctors, nurses, students, visitors, security guards and porters. Every now and then a couple of paramedics would deliver a couple more patients, and disappear again almost as rapidly as they had arrived. The place never slept. To me, it was the Times Square of medicine and held in itself a sense of magic; an immeasurable energy.

In Casualty the discussion of patients was reduced to merely discussing them as cases: easy cases, difficult cases, interesting cases, DSH cases. Patients' histories were presented like a news bulletin, and the curtains were drawn more as a courtesy than a practicality. They were paper thin, anyway. I remember the face of the young man who attempted suicide by overdosing on medication. He lay there, quietly, while being discussed. Not ashamed, not guilty, not sick, not anxious. Just quiet. Despondent. I remember him so well. That day I felt guilty for being on the *other side*. But this was a teaching hospital and he was the lesson. Maybe he learnt his own lesson. Maybe he will be back soon.

Some days the smell in the casualty was better than others, or in fact, more bearable. I always regretted going there during lunchtime. Somehow the patients' most valued moments – when they got a hot meal – turned out to be my worst olfactory nightmare. The smell of food, in collaboration with the smell of excretion, sanitiser and cleaning product, managed to force me all the way out of the ward to the emergency entrance, desperate for fresh air.

Walking into the holding area and the overflow area, right next to casualty, I often had to remind myself that people came to this place to get better. One of the staff members once told me this is where all the mental patients wait so they can keep an eye on them. Patients waited here if the beds in casualty were filled up. Overflow. Superfluous? In this small room, adjacent to the TB seclusion room, patients' stretchers were separated by less than a meter, if it was that much. Some patients lay on their beds, seemingly trying to hide under the thin linen. Others sat upright, rocking themselves, or moaning. Non-medical patients converged here, waiting to be discharged or taken to the Emergency Psychiatry Unit. I often wondered which option was worse. Here security was a strong presence. It was not called the holding area for nothing.

Just around the corner, patients on stretchers were scattered along the wall in the corridor. Charts lying by their feet and their fate waiting indefinitely. I often wondered why they were waiting, and for how long, as they stared blankly at the ceiling, rarely making eye contact. Perhaps they could not, they were too ill. Perhaps they did not want to. I always tried to walk past them as fast I could.

The Emergency Psychiatry Unit, conveniently located just out of earshot of this crazy world, seemed to be, ironically, less crazy – a safe haven. Tranquil, clean(er) and hopeful. A place I could regroup, recollect and breathe. A place where proceedings seemed more calculated and more controlled. But every now and then the face of a patient peeking through the upper glass part of the psychiatry ward door, dressed in their blue hospital gown, would remind me of the world behind the doors. The truth, lurking just beside the psychiatrists' office, tea room and meeting room, would force its way through that glass and all the way to under my skin: my safe haven someone's last hope, my tranquility their white noise, and my escape their reality – at least for now.

And between all the medicine, all the trauma and all the crazy, were the patients who tried to take their own lives; those who should not be named. The depressed. The psychotic. The borderline. The overwhelmed. The odd one out, who looks out of place in the very ED they have come to for help. Those converging with the diabetics, the cardiac patients and the gunshot victims – and appearing to be just another nameless patient in a frail gown. The dichotomy between those frantically fighting to live, and those badly wanting to die. Until you look closely. What do they allow you to see? Or witness?

To me, it was the Times Square of medicine and held in it a sense of magic; an immeasurable energy. Perceived energy perhaps. Or rather a desperate sense of trying to hold everything together. A great sense of responsibility but also a great lack of control. The heroes, the educated and the willing. Fallen heroes, perhaps – unable to 'save the world' yet expected to.

It was easy to feel sorry for the patients. But what about the health care workers? Who felt sorry for them?

## **4.2 Introduction**

This chapter discusses the field site for this study and describes how DSH patients move through the hospital, as well as how care is organised to respond to the DSH patient at

each point of interaction between the DSH patient and the health care professional. This chapter describes the policies and practices within the hospital as well as my observations and extracts from interviews with hospital staff. A few participants experienced the *system* to be efficient, with a participant suggesting: “The system actually surprisingly works quite well”. However, the majority of interviews with health care workers, as well as detailed observations, suggested that there may be inherent problems with the organisation of care and opportunities to improve patient care. There were multiple ways how the patients could move through the hospital. These pathways through the system also constitute the study site of this research:

1. Presented at Casualty. Discharged without being referred.
2. Presented to Casualty. Referred to social work. Discharged.
3. Presented to Casualty. Referred to psychiatry. Discharged.
4. Presented at Casualty. Referred to psychiatry. Referred to EPU. Possible referral to psychology or social work.
5. Presented at Casualty. Transferred to another medical or surgical ward. Referred to Liason Psychiatry. Possible referral to psychology or social work.

These processes will be elucidated in the ensuing discussion.

### **4.3 Triage and Treatment of DSH Patients in Casualty**

DSH patients who are considered for treatment at the hospital are first assessed in Casualty, which consists of a trauma unit and a medical unit as previously mentioned. The functions of Casualty are to: (1) prevent death by ensuring that patients are medically stable; (2) treat those whose injuries are not serious enough to warrant admission; (3) assess and refer patients who require inpatient care. There are a large number of patients who arrive for treatment at Casualty, making this a busy and stressful environment.

The data collection period took place over an eight-month period from May to December 2014. In addition, a detailed analysis was conducted of 200 consecutive cases of DSH from 16 June 2014 to 15 February 2015 as part of the broader research project, which focuses on DSH in the SA context. During this time there were 220 presentations of DSH at Casualty of which 20 consecutive cases were excluded due to different reasons. Statistics that were generated through this analysis will be referred to throughout this chapter and subsequent chapters.

As a result of the large number of patients presenting at Casualty a triage system has been put in place to assist patients as efficiently as possible and to ensure that those most urgently in need of medical care are attended to first. In terms of this triage system when patients arrive at Casualty they are assigned to one of four colour categories (i.e. red, orange, yellow and green) on the basis of their vital signs (see table 4.1 below). Patients' names are also recorded in a triage book in Casualty indicating the time of admission, a brief description of the nature of the physical complaints and a sticker showing the colour of the category to which the patient has been assigned. Typically, DSH patients are identified in the triage book by means of labels such as *overdose*, *suicide attempt*, or *suicidal*. The potential underlying psychiatric illness, which is believed to have caused the suicidal behaviour may also be used. Such examples also included *psychotic* or *depressed*, even though the reason for the hospital presentation was an act of DSH.

Table 4.1

*Expected waiting times for treatment based on triage colour*

<b>Triage colour</b>	<b>Level of emergency</b>	<b>Expected waiting time</b>
Red	Emergency	Less than 1 hour
Orange	Very Urgent	1 to 2 hours
Yellow	Urgent	4 – 6 hours
Green	Routine	More than 6 hours

As is evident in the table above, patients are sometimes required to spend long periods of time waiting to receive medical care in Casualty, particularly if their injuries are minor. Consequently, some DSH patients with non-serious medical injuries wait for more than 6 hours to receive care even though they might be experiencing high levels of psychological distress. A medical officer and a medical registrar explained the medical focus of the triage system in the following quotes:

Dis eers absoluut, die fokus op medies en of dit *trauma* is of 'n oordosis of iets anders wat sistemies. So dit is *emergency care* eerste. [Firstly, the focus is absolutely on the medical...and whether it is a trauma or an overdose or something systemic. So it is always emergency care first].

So they all get treated exactly the same initially, and once they've woken up you assess each one as appropriate.

Another medical officer articulated the ED's focus on physical health by saying:

We don't really care about the reason why you took the attempt, if you're still suicidal [...] thereafter once you're a bit more stable then we start talking, are you still currently suicidal.

Although doctors are required to treat the most medically serious patients first, they may select which of the patients in each category they prefer to see. This is not a hospital policy but rather a personal preference and arrangement among health care staff. Whilst some doctors avoid DSH patients, others report that they choose to take these cases, as is evident in the quote below provided by a medical officer who had experience working in Casualty:

So daar is so houding, daar is mense wat meer natuurlik gemoedelik is as hulle *suicidal* pasiënte sien, en ek dink dis ook okei. Daar is mense wat ook die resus moet run en dis *nice* as daar 'n gebalanseerde span is en daar is altyd een iemand in die span, daar is gewoonlik ten minste een iemand wat daai rol aanneem. [So there is this attitude, there are people who are naturally more accepting if they see suicidal patients, and I think that is also okay. There are also people who have to do the resuscitation and so it's nice if there is a balanced team and there is always someone in the team, there is always at least one person who assumes that role].

Thus, this flexibility of the system has advantages in that doctors are free to engage in the work they find most interesting, or with patients towards whom they feel empathy. Whilst being able to avoid certain patients, like DSH patients, may make medical professionals more comfortable, this may also be beneficial to DSH patients themselves due to the fact that they are then often treated by health care professionals who want to treat them.

Participants reported that it was sometimes a challenge to keep DSH patients safe during the period of time that they were waiting in the ED, and to prevent them from trying to harm themselves in hospital. Some participants expressed concerns regarding the safety of DSH patients who had to wait in Casualty for extended periods. One nurse said:

Ek weet net nie hoe goed word hulle dopgehou wanneer die *casualty* regtig besig raak nie. [I don't know how well they are watched when casualty starts to get really busy].



This participant was not certain that staff members were always able to watch over these patients once Casualty became occupied, as monitoring them is a rather demanding task. Several participants said that they have not seen specific protocols in practice with regard to the safety of DSH patients while in Casualty. Nonetheless, when a patient is brought in with suicidal ideation, the patient will be monitored constantly. One participant reported that security guards working in Casualty are also responsible to monitor DSH patients. While I have observed this to be the case, there were, however, not always enough security guards on duty to monitor entrances and exits as well as to monitor DSH patients.

#### **4.4 Assessment and Referral of DSH Patients in Casualty**

**4.4.1 The PSIS and subsequent referrals.** The Pierce Suicide Intent Scale (PSIS) is a psychometric instrument used by clinicians in Casualty to assess the intent of the patient after engaging in DSH (see Appendix F). Due to the high volume of DSH cases, not all of these patients can be referred to psychiatry for an assessment. The hospital has thus instituted a procedure utilising the PSIS, which is a clinician scale, to regulate the referral of DSH patients.

In terms of hospital policy all DSH patients, including suicide ideation patients, are supposed to be assessed using the PSIS. As per the PSIS document, the assessment tool operates on a point-basis, with each question ranging from zero to two points (only on one question a DSH patient could score a total of three points); the higher the total score, the higher the suicidal intent of the patient. In addition, the PSIS consist of three categories of scores (low, medium, and high) that were respectively indicative of whether the DSH patient should be referred beyond Casualty or whether the DSH patient should be discharged home from Casualty.

The *low intent* category commonly suggested a referral to a social worker while the *high intent* category indicated referral to psychiatry. However, participants significantly differed in their knowledge of the meaning of each score and what score indicated which referral. Although using the PSIS to assess DSH patients in the ED is hospital policy, I have observed that this policy is not always adhered to. Through statistical analysis we've found that of the 200 presentations of DSH, the PSIS was only done for 139 (69.5%) of the patients. I recall one time during a ward round in Casualty when a senior staff member reminding clinicians during a ward round that they should "get back into the habit of doing the Pierce",

while reviewing a DSH patient who had received no PSIS. In addition, one of the psychiatry registrars also reflected on the Casualty staff members not always using the PSIS:

It really differs from person to person whether they use it or not.

Some clinicians reported that they administered the PSIS because they knew this was required but they were uncertain how to interpret the score. Other clinicians reported that they did not trust the PSIS score and instead used their clinical judgment to interpret the score. Clinicians stated that the PSIS score could, at best, be used as a guideline for making clinical decisions. As one of the medical officers and a medical intern suggested:

You sometimes have to sort of think outside of the box for the appropriate score.

I think it is on a personal basis that you need to decide on how the patient reacts, the reason for them doing it, yes, I think on an individual basis you need to make that decision yourself.

In addition, some clinicians commented that they thought the *threshold* for a referral is significantly subjective. They suggested that the PSIS score should always be assessed, but that clinicians need to consider the person and the context very carefully before simply basing a treatment decision on the PSIS scores. In this context some clinicians said that they preferred to be cautious and refer DSH patients with low PSIS scores to psychiatry just to “keep their side clear”. As a medical registrar explained:

You don't want to send an unsafe person out there.

Other clinicians said they preferred to refer DSH patients to psychiatry and to consult telephonically with psychiatry registrars when they were uncertain. As a medical officer explained:

But to cover ourselves, we just, we phone the psychiatrist, tell them the story and then they can choose to come and see them or they'll say discharge to the day hospital psychiatrist, or whatever.

This medical officer said that even if the psychiatry registrar said the patient with a history of DSH could be discharged he was unrelenting in his insistence that the psychiatrist make a note to this effect in the patients' file so that it was documented that this decision had been made by psychiatry in order to avoid medico-legal consequences.

In addition, another medical officer expressed his insistence that the psychiatry registrars should always review the DSH patient if there is a history of suicidal behaviour, regardless of their PSIS score. Therefore, some doctors asserted they were more inclined to be cautious about interpreting PSIS scores when assessing patients with a history of DSH. Conversely, not all staff members expressed the same need for all DSH patients to be reviewed by psychiatry prior to being discharged. During my observations of practices in Casualty during a night shift, I observed that two DSH patients were discharged from Casualty without receiving a PSIS assessment. The psychiatry registrar who was on-call at the time, explained this decision by the medical officer in charge:

You could see he was high risk, having had two previous attempts in this month. So it is not necessary to do the Pierce.

In addition, some psychiatry registrars suggested that there was a need for staff members in Casualty to be more cautious about which DSH patients were referred to a psychiatry registrar. Psychiatry registrars suggested that these, sometimes arguably unwarranted referrals of DSH patients could be a result of fear or inexperience of medical staff in Casualty. These psychiatry registrars commented on the fact that they were under considerable pressure, and that receiving “inappropriate” referrals only exacerbated the difficulties they already had balancing large caseloads. In this context they noted that receiving too many referrals prevented them from making thorough assessments and thus compromised the care for patients who are in need of psychiatric attention. Participants expressed fear that if too many DSH patients were referred to psychiatry because ED staff was too sensitive or the threshold for referral was too low then the “system would break” and psychiatry would be unable to function.

Many of the psychiatrists mentioned that they could choose when to see certain patients depending on the priorities of their other cases. As a result, DSH patients often had to wait in Casualty for long periods of time before they were reviewed by a psychiatry registrar. However, clinicians working in the ED reported that they experienced this as a “lack of appropriate response”. A medical officer explained:

I normally do phone them, and the outcomes are either of two ways: they come out, very nice of them and the second time, they say if you know the person is fine, just make sure they don't do it again; they'll see them in the morning. Which should not happen.

I observed that DSH patients had to wait for protracted periods of time to be assessed especially after-hours and on weekends, owing to a reduced number of staff members. After-hours there were two medical officers working per shift in Casualty and only one psychiatry registrar on call. There were also no social workers, psychologists, or medical students during these times, which added further pressure on staff members. Not only was there a lack in staff members after hours but there were also many discrepancies in the knowledge of referral practices during this time. A medical registrar explained the process as follows:

So if the patient requires a social worker over the weekend, they stay the weekend. If they've got a family member who is safe and they are going to be able to be looked after, and they're very low-risk, then they might go home to come back on the Monday.

Another participant argued that it is rare that someone will stay at the hospital for the whole weekend. As there is no social worker over the weekend, this participant said that they would rather be honest with the patients, if it is a longstanding social issue and inform them their case will not be resolved until the week begins. The participant suggested that the patient should be sent home, with the instruction to return to the hospital should they feel at risk once more. Furthermore, this participant added that the majority of patients chose to go home rather than wait for the social worker on Monday. Participants mentioned that the patient could lie and wait in the ED if they are deemed *low risk* and if Casualty staff or security can watch them until the Monday when they can be further assessed by the social worker. However, some participants argued that DSH patients who present over a weekend are often assessed by the psychiatry registrar on duty, therefore putting extra pressure on psychiatry:

But on weekends the social worker's not available, so we tend to see all of the attempts regardless of the severity of them.

In addition, during my observations in Casualty a medical officer mentioned that according to her knowledge, DSH patients who had a *medium level of intent* (4-10 PSIS score) were referred to a social worker during the day, but to a psychiatrist after hours. However, as mentioned previously, this was observed to not always be the case.

**4.4.2 Health care professionals' experience of using the PSIS.** Medical staff members reported that they found it helpful to make use of the PSIS to guide the

management of DSH patients. They said that they did not always feel confident to assess these patients and needed some formalised protocol to assist them. A medical officer articulated this sentiment in the following way:

Okay from the medical point, sure yes, I can easily sort that out. As it goes higher up - that's why we have the Pierce score. Because we are all not psychiatry trained. We are more internal medicine trained and acute emergency trained. Psychiatry, the form is there. And that just breaks it down into big, nice easy big groups, social worker or psychiatrist and then once we get the score you just phone the psychiatrist.

Most of the clinicians who used the PSIS reported that they found the instrument to be useful and user-friendly, but others reported some difficulties. Some doctors indicated their concern that the PSIS is being used in an impersonal and mechanistic way by simply asking the patient a list of questions, rather than spending time with the patient and trying to understand their behaviour. Some doctors expressed the concern that this might lead to superficial assessments and inadequate exploration of the context, in which the behaviour occurred, as well as the accompanying cognitions and emotions.

Other clinicians articulated the apprehension regarding the fact that the PSIS is a self-report form that relies on patients' answers. It therefore allows for patients to misreport, and subsequently over- or under-state their suicidal intent purposefully and (as clinicians experienced it) in a manipulative way. Clinicians also indicated that they worry that patients may not fully understand the questions, especially because the instrument is only available in English. These concerns were articulated by a social worker who ultimately spent more time exploring the DSH patient's context than the doctor doing the assessment:

Some of them, the pierce score will be three and then the person who says, but I still want to die I didn't understand the question on the pierce. If you were to ask him why do you really say that you want to die then you find out that at home the father doesn't like -- or this person was sexually abused at home but nobody believed her.

Certain doctors said that they believed the PSIS had poor inter-rater reliability and expressed a perception that the scored yielded on the instrument was influenced by the professional who administered it. One medical officer emphasised this issue by asserting that while she uses the instrument, she does not like to use it because it is far too subjective, and

allows the health care professional to manipulate it to reflect a specific finding. One of the psychiatry registrars expressed this by saying:

Well, often the referral has used the Pierce scale but I don't generally use it. It's based more on, you know, my little questions that I ask myself... because the pierce scale often doesn't mean very much depending on who has taken the pierce scale.

One of the psychiatry registrars also questioned the validity of the PSIS when trying to assess the DSH patients:

I am not really sure what the validity is of the tools they use for scoring, what the sensitivity on that is.

Other clinicians also expressed a perception that the PSIS was unreliable and did not accurately predict risk of future self-harm or death by suicide. One participant reported that he found it cumbersome and time-consuming to administer the PSIS. He expressed a desire to make use of a simpler instrument, such as the SAD persons' scale, which he believed was easier to administer, as he had it studied during his training. Clinicians' perceptions of the limited utility of the PSIS, and their experiences of the problems implicit in its use, may be among the reasons for the inconsistent use of the instrument and non-compliance with the hospital policy.

#### **4.5 Discharges from Casualty**

DSH patients are treated in Casualty and then discharged if they are judged to be at low risk of suicide and if their injuries do not warrant medical admission. Protocol dictates that these patients are to be referred to a social worker for an assessment prior to discharge. In addition, participants reported that they had to document any decisions made regarding the discharge of a DSH patient from Casualty, as well as the motivation for the decision. One participant specifically reported that when they discharge DSH patients straight from Casualty after scoring very low on the PSIS, they had to document in the patient's file that they were discharged based on the low score. The medical officer explained:

Yes, and you've got in black and white you've documented the score is less than one.

Patients who are discharged are sometimes given a referral letter and instructed to follow-up at their local community clinic. However, no record is kept of follow-ups and no attempt is made to contact these patients to encourage them to comply with the referral.

#### 4.6 Admission of DSH Patients to Medical or Surgical Wards

DSH patients are admitted to the hospital only if their injuries require inpatient medical or surgical treatment or if they are assessed as being at high risk of suicide. Protocol dictates that DSH patients treated in medical or surgical wards should be referred to Liaison Psychiatry for an assessment once they are medically stable. While this protocol was not documented anywhere, health care professionals consistently responded in this manner and reported this practice to be protocol among staff members. Liaison Psychiatry is the psychiatry team in charge of reviewing and assessing patients outside of the EPU. One of the medical officers explained the importance of providing the DSH patient with psychiatric input after they have been medically stabilised:

They're going to be unconscious and they're going to die, so you need to actually do something quickly before that. And once they're fine and they're stable and you kind of got to go on to prevent that person from doing anything bad the second time.

During observations, however, I observed two problems with this referral process. It often happened that medical staff members only referred DSH patients to psychiatry just before they are discharged, arguably as a formality. Furthermore, sometimes there also seemed to be a delay between the time the patient is referred to psychiatry and the time when someone from Liaison Psychiatry is available to go to the ward to assess them, in which case they were often discharged without an assessment.

In turn, Liaison Psychiatry is also responsible for referring these patients to psychology if necessary, which is also usually a delayed process. As one of the psychologists explained:

One of the challenges I find with the consultant liaison is that often patients are referred and within those few days before you actually have a chance to see them, or when you go to see them, they have been discharged already.

This lack of, or delayed referral process was especially problematic due to the fact that arguably, DSH patients who have engaged in serious acts of DSH resulting in a near-lethal outcome, are in need of comprehensive psychiatric and/or psychological input. However, they might not be receiving the level of input their DSH presentation has warranted. In addition, the psychologist identified possible reasons for this delayed referral

and suggested that it could be as a result of a lack of awareness of non-medical factors of the presentation:

Maybe sometimes there is a lack of awareness, I am sure possibly. I think again it is a variety of reasons; sometimes there is big pressure about seeing the next patient that has a medical condition. It is like a conveyor belt. And then sometimes I think it is a lack of awareness and perhaps sometimes a neglect of thinking about the psychiatric or the psychological conditions. I suppose it really just depends.

#### **4.7 Non-psychometric Assessment of the DSH Patient**

Although clinicians working in Casualty use the PSIS to assess DSH patients, clinicians are also likely to implement non-psychometric assessments when assessing DSH patients. In addition, other health care professionals, such as psychiatrists, psychologists and social workers, also conduct non-psychometric assessments to assess DSH patients as they move through the rest of the hospital system.

**4.7.1 Assessing intent.** When asked about the assessing DSH patients, participants all agreed that it was important to assess the patient's intent. Participants reported several motives for DSH: some DSH patients intended to die; while others hurt themselves accidentally in order to communicate distress, to regulate their own feelings or to regulate the behaviour of others. Ultimately, participants said it was important to determine whether or not the patients had really intended to die.

In the context of assessing intent, some psychiatry registrars said they inferred whether or not the patient had intended to die from the lethality of the method they used to harm themselves. They also reviewed indicators such as whether the person was alone or near people who could potentially help them, substance use at the time, as well as if the person had left a letter. Registrars said that they also took into consideration the patient's reaction to finding out that they didn't die. These psychiatry registrars assessed that a patient's anger as a result of an unsuccessful attempt to end their lives was usually indicative of having had intent to die. It was also put forward that in some cases what the person believed would happen, rather than what actually happened, was more important. As one of the social workers reported:

For me, it's more important what they believed would happen than what happened. Because I've had a young girl say to me: "I've only taken 20 Panado's", and 20



Panado's could have killed her. And then I've heard somebody say, "But I took 100 of the vitamins and why am I still alive?" So it's more important to know what people think would happen; if they believe it would kill them, then that's a serious attempt.

One of the participants suggested that not all cases of DSH are accurately identified since patients sometimes claim that their injuries were accidental, rather than self-inflicted. Participants believed these patients to also carry a risk of seriously harming themselves or even completing suicide. One of the nurses explained:

Maar dan kry 'n mens ook gene wat hulle is op medikasie, hulle het vergeet om die oggend dosis te drink, die namiddag het dit te lank geword en dan dink hulle hulle kan die aand, die oggend en die middag in een *go* vat, 'n mens kry daardie ongelukke ook so nie altyd is dit 'n selfmoord poging nie maar hulle kan ook in die hospitaal of in die *ICU* beland. [But then you also get those who are on medication, but they forgot to take their morning dosage, the afternoon, then it is too late, and then they think they can take the whole day's medication in one *go*...you also get those accidents, so it's not always a suicide attempt, but they may still end up in hospital or the ICU].

Ultimately, most participants acknowledged that determining intent is difficult and that the concept of *intent* is problematic. Participants added that determining intent was especially difficult when assessing DSH patients who repetively present at Casualty after engaging in DSH, owing to the fact that what they do and what they report, are not correlated. These perceptions are evident in the following experience recounted by a psychologist:

Then the other one was sort of overdosing on benzodiazepan, but the person was dependant, you know substance dependant, benzo- dependant, and so there was an overdose there, but I think it was sort of unclear whether it was a suicide attempt or not.

#### **4.7.2 Different aspects of assessing the DSH patient.**

**4.7.2.1 Adherence to a risk factor model of suicide.** Many participants reported that they worked within a risk factor model, paying careful attention to risk factors when assessing DSH patients. One of the social workers explained:

I do obviously take a history, and from the history I identify what I consider to be the risk factors.

This participant suggested this focus on risk factors when assessing DSH patients was the result of a lack of standardised assessment tool in the hospital. I will return to this discussion in section 4.7.3.1.

There was, however, a lack of consensus among registrars about which factors signal risk. The following were most commonly perceived risk factors for engaging in future fatal and non-fatal self-harm: male gender; older age; comorbid physical condition; history of mental illnesses; no plans for the future and a general sense of hopelessness. Symptoms of depression and a history of suicidal behaviour were also considered to be significant risk factors. As a medical registrar suggested:

Things like previous attempts, a depressed patient does make one worry because eventually one does worry that they're going to get it right.

While the majority of the psychiatry registrars said that they considered a history of previous DSH incidences to indicate a high risk of death by suicide, others expressed a perception that individuals who frequently engaged in DSH were not serious about wanting to die and consequently were at lower risk. One of the psychiatry registrars suggested:

You are more likely to not think of this as high-risk suicide.

Risk factors less commonly reported by participants included a family history of suicide, issues regarding an individual's sexual orientation and a lack of community support. The consensus seems to be that when a large number of risk factors are present, patients should be admitted to hospital. Also one of the social workers, who did not directly admit patients to the EPU, pointed out the importance of rather admitting a patient not, when in doubt:

If there are too many risk factors then, of course, let's admit and get some hope. And that's the safest for us, is to, when in doubt, admit.

Only a few participants reported that they considered protective factors such as support structure at home, if the person has children and employment.

**4.7.2.2 Beliefs about the role of mental illness in the etiology of suicide.** Participants also said it was important to routinely screen DSH patients for mental illness, such as depressive disorders and bipolar mood disorders. Few registrars noted the importance of assessing for psychotic symptoms such as command hallucinations. Little, if anything, was said about the role of substance use disorder or post-traumatic stress in the etiology of suicide.

**4.7.2.3 Beliefs about the importance of context and the need for collateral information.** Psychiatry registrars said they believed it was important to consider context and gather as much information as possible about the circumstances surrounding the DSH. One of the psychologists suggested:

Maak seker jy verstaan die storie, jy het soveel van die *pieces* wil ek amper sê van die *bigger picture* as wat jy kan kry. [Make sure you understand the story, that you have as many pieces possible of the bigger picture].

Psychiatry registrars indicated that they experience a significant challenge when assessing DSH patients, especially when they were meeting the person for the first time, having had no relationship with them, and not knowing anything about their day-to-day functioning and ways of coping. Psychiatry registrars asserted that collateral information from family and friends was thus invaluable, particularly if they expressed concern that the patient was at high risk for completing suicide or engaging in suicidal behaviour. Subsequently, the registrars noted the importance of obtaining collateral information. One of the medical interns also reported the significant role of collateral information when assessing the DSH patient:

It depends on the history that you get from the patient but also on family and friends, usually they are accompanied by someone and I think also based on that.

Many psychiatry registrars acknowledged the family dynamics could contribute to suicide risk, particularly factors such as interpersonal conflict and lack of support. Consequently, they expressed the perception that it is important to enquire about the patient's home circumstances and to assess family functioning, usually in the form of a meeting with the family.

**4.7.2.4 Perception of the importance of building rapport.** A handful of participants commented on how the quality of the relationship established with the DSH patient, the way in which questions were asked and the respect shown for the patient influenced the information patients shared with doctors. One of the psychiatry registrars noted that because of the focus on gathering information as quickly as possible during an assessment, there was a danger that DSH patients might experience the consultation as an interrogation. In this context, another participant said that they believed it would be beneficial to focus on improving health care workers' skills in establish rapport with DSH patients, with specific attention paid to how to go about asking questions in order to elicit meaningful and accurate information. As one of the medical officers suggested:

Ek dink 'n mens leer om sensitief te wees teenoor die pasiënt, jy leer onderhouds *skills*, hoe om sonder 'n *rapport* te werk en dan in te gaan en die moeilike onderwerp te los as die pasiënt nie daarvoor wil praat nie ensovoorts. Om die beste geskiedenis uit die pasiënt uit te kry en die pasiënt te respekteer en hulle rapport te wen. [I think one also learn to be sensitive towards the patient, you learn interview techniques, how to work without having a rapport with the patient, and then to be able to leave the difficult subject if the patient doesn't want to talk about it... - to get the best history from the patient possible but to still respect the patient and to win their rapport].

One participant specifically emphasised the importance of not forcing the questions, but rather letting the patient lead the conversation. Should the patient be too guarded to answer the assessment questions, the health care worker should find a new way to ask questions more appropriately, or let certain questions go. Participants then argued that clinicians learn these skills through the experience of working with DSH patients, and that it is not only the knowledge or the training that they have received that is important.

Several participants also mentioned the significance of informal discussions with patients, as opposed to asking direct and formulated questions as part of an interview. It was also asserted that some patients would be open to answering questions, whilst others are more guarded. One participant said that especially when a patient presents with a second attempt, it subjectively changes the way you think about that person. As a result of this, you may treat that patient with more caution, as one of the medical officers explained:

Your approach with this person is not usually straight up. It's a bit more taken aback; you're a bit more sensitive. You're going to look out for that guarding approach.

**4.7.3 Factors influencing the assessment of the DSH patient.** There is an array of factors that influence the assessment of DSH patients and the practices adopted by health care professionals. These factors influencing the psychiatric assessment of DSH patients in the hospital are discussed below.

**4.7.3.1 Lack of standardised assessment procedures.** Non-medical health care professionals, such as psychologists and social workers, commonly reported that there was no standardised assessment procedure or protocol pertaining directly to how DSH patients should be assessed or managed, other than normal standards of care for assessing all psychiatric patients. These participants also reported that they did not make use of any psychometric instruments, checklists or interview schedules in the course of their assessment of DSH patients. One of the psychologists and one of the social workers suggested respectively:

Ek moet vir jou erken ek *rely* nie baie sterk op skale nie, ek *rely* baie sterk op *sitting with the person, talking through all the factors*. [I have to admit, I don't rely too heavily on scales, I rely very heavily on sitting with the person, talking through all the factors].

As a result of this lack of standardised assessment scales, participants reported a considerable variability in how they conducted assessments and made treatment decisions. As a social worker and a psychiatry registrar explained respectively:

I do know about the Hamilton Risk Assessment Scale, but even then with assessment scales patients can decide what they tell you. I still think spending time with somebody is probably the best way to assess them [...] I listen for risk factors and past attempts, and also what did they do after. Did they phone a friend? Did they lock the door?

I think a lot of people have devised a lot of scales on how to decide how high the person is on the suicide risk. We don't tend to use that. Well, I don't use it, even though there is another scale called a SAD persons' scale, which we were taught in medical school. But we don't use it dogmatically, it is more like something that you

just have at the back of your mind, and you sort of pick it out of your mind and apply it to the situation, and try and make the best decision possible.

In addition, a couple of psychiatry registrars reported that they consulted the PSIS score before starting their psychiatric assessment, while others said they preferred to conduct their assessment without being influenced by previous assessments. All psychiatry registrars agreed that their assessment never relied too heavily on the PSIS score. As two psychiatry registrars explained respectively:

A new interview, a new impression.

I don't make my assessment based on what score they rate. I actually sit and talk to them, interview them and then I make my assessment based on that.

**4.7.3.2 *The role of experience and training.*** Participants generally reported that the quality of the assessment was heavily dependent on the level of experience of the health care professional conducting the assessment. For example, several psychiatry registrars acknowledged that their ability to assess DSH patients and their confidence to do so was deeply influenced by their clinical experience and training.

Some participants suggested that when beginning their career and having little experience, they were not always able to pick up on the warning signs or danger signs of the DSH patient at risk, but added that this was part of the process of gaining experience. One of the psychiatry registrars explained:

I think that as one becomes more experienced, one is more able to assess suicidality better.

One participant argued that the more experience the health care professional had in psychiatry, the better their perspective of the case would be and subsequently the greater their understanding of possible underlying issues. This will allow the health care professional to explore these issues to a deeper extent, and will lead to a more efficient referral of the patient.

It was also reported that health care professionals who were more experienced are better able to rely on the feeling that they get from the patient, for example the patient's mood, just from having a conversation with the DSH patient as opposed to asking structured questions. Participants expressed a perception that as one gained more experience, one was

able to rely more heavily on your intuition or as one participant referred to it as your *gut feel*. As one of the psychiatry registrars suggested:

One has to make a true assessment on how much you are intuitively concerned about the person and put that together with collateral information.

Some of the medically trained professionals emphasised the influence of a lack in mental health experience when it came to assessing DSH patients. One of the participants specifically expressed concern that they, as medically trained professionals, did not always have the opportunity to spend an adequate amount of time with DSH patients. As a result, this prevented them from gaining experience and getting better at treating and managing these DSH patients:

I don't think we spend enough time and see enough of them compared to the other patients, to get as good at it.

One of the 6<sup>th</sup> year medical students mentioned the idea of training, and subsequently argued that experience has greater value than training:

I always get a feeling that a lot of psychiatry is not in the books, a lot of it is just people giving you life experience, like how you dealt with patients.

Another participant also drew an important connection between experience and training in saying that for her, training to work with suicidal patients happened in the form of actual experience of working with them. One of the nurses in Casualty echoed this sentiment in the following quote:

Die opleiding wat ek gekry het, was hier. Ons het nie *expose* -- Ja, met die tipe van *patients* toe ek my kursus gedoen het nie. [The training I have, I received here. We didn't get exposure...with these types of patients when I was busy studying].

In conclusion, one of the psychiatry registrars stated that while experience is very helpful and valuable, it will never fully prepare you for every DSH patient you may meet:

Experience definitely helps, but it is definitely a case-to-case thing.

## 4.8 Admission to the EPU

**4.8.1 Assessing suicidal cognitions and behaviour.** Psychiatry registrars believed it is important to do a thorough mental status examination (MSE) when assessing DSH patients. These assessments focused on evaluating the patient's outward appearance, behaviour, affect and mood, their thought process and speech, their thought content, their perceptions, cognitions, insight and judgement.

In addition, psychiatry registrars asserted the belief that a detailed history of suicidal cognitions and behaviour was important. They indicated that they asked questions to determine the duration and intensity of suicidal thoughts. In addition to this, they also found it essential to obtain the details of the most recent act of DSH in order to determine: (a) whether or not the incident was planned and how much thought went into the act; (b) how lethal the plan was; (c) the cognitions and emotions at the time of executing the plan; (d) whether or not the patient left a note; and (e) how close the person was to help. One of the psychiatry registrars mentioned that it is not only important to listen to the story of what happened and how the person deliberately harmed themselves, but it is also vitally important to learn about what they did after the incident and what their mood was like at that point. They also said it was important to assess current suicidal thoughts. Most psychiatry registrars said that their decision to admit or to discharge a DSH patient was strongly influenced by whether or not the DSH patient still felt suicidal.

**4.8.2 The process of admission.** DSH patients who are medically stable and assessed as being at high risk of suicide are admitted to the EPU of the hospital. The statistical analysis of the 200 presentations of DSH found that slightly less than half of the patients (42%) required admission to the EPU once their physical injuries had been treated.

I have observed that many DSH patients were admitted involuntarily under the MHC Act. As discussed in the literature review, this MHC Act allows for psychiatric patients to be contained involuntarily until they are no longer actively suicidal, or until they can be transferred to a specialist psychiatric hospital for inpatient care.

As per the reference to the MHC Act (2002) in the literature review, participants also commonly reported that they were aware of this law prescribing a 72-hour observation period. I also observed health care professionals to routinely comply with this law where patients were assessed and subsequently either discharged, kept in the EPU for longer or



referred to a psychiatric hospital. However, it was reported by participants that often this 72-hour period started with patients still waiting in Casualty for a bed in the EPU. As one of the medical officers explained:

So you have someone that started their 72- hour assessment, but not in the psychiatric ward.

This participant continued to say that as a result, these patients often do not receive adequate psychiatric assessment because they aren't in the EPU. In addition, the participant argued the fact that these patients having to spend extended amounts of in Casualty waiting for a bed in the EPU, is unfair towards other patients who need the bed in Casualty as well as to the health care professionals and ultimately, the DSH patient. I have also observed that the referral process from Casualty to the EPU is a lengthy process with health care professionals having to fill out multiple forms before a DSH patient may be admitted to the EPU. Psychiatry registrars as well as Casualty staff members who were responsible for facilitating these referrals spent a lot of time on this administrative process.

**4.8.3 Practices and procedures within EPU.** The psychiatry registrars continued to conduct daily MSEs with the DSH patients in the EPU. Based on these assessments, DSH and other psychiatric patients' treatment plan was adjusted. It was also based on the MSE that patients were discharged from the EPU or not. I will return to this issue in section 4.11.

Apart from the psychiatry registrars, the nursing staff also played a big role in the EPU. One of the nurses once again reiterated the fact that while ultimately all patients is treated the same medically; the suicidal patient is more fragile and subsequently treated with more caution:

Ons neem net baie meer en groter sorg met 'n patient met selfmoord neigings. [We just take more and greater care with a patient who has suicidal ideation].

Nurses working in the EPU said that they considered every person coming into the ED as being *high risk*, implying that they had to remain vigilant to avoid suicides on the ward. They said that patients who were actively suicidal were put on *suicide watch* in the ward and that this was a policy they adhered to. *Suicide watch* entails keeping a close eye on a patient who is at extremely high risk of acting on their suicidal ideation while in the ward. Participants working as nurses in the EPU indicated that there is a nursing care plan in place that they follow. This care plan involves observation in high-risk cases as well as the standard

removal of all potentially dangerous objects that could be used in DSH. Two nurses continued to say that there is always staff observing patients in the EPU at all times of the day:

You have to observe them very closely because you think that patient is fine, but you don't know what is happening.

Ons werk met baie, baie highly suicidal patients en ons moet -- dit lyk nie asof ons dingese is nie, die pasiënte monitor. Dit lyk nie asof ons kyk wat aangaan nie, maar dit is soos ons werk, soos ons doen, ons is altyd alert aan die pasiente. Altyd alert. As jy in jou bed lê, gaan ek 'n draai maak. Hallo mevrou, wat maak u. Kom lê hierso. Wil u nie opstaan nie. Ons is bewus daarvan. Hulle lê daar, hulle kan enige iets dink. Hulle dink mos heeltyd wat hulle gaan doen. Staan hulle op en oral waar hulle gaan moet ons gaan. So dis'n high risk suicidal saal, regtig. [We work with many highly suicidal patients and we have to...it may look like we aren't monitoring the patients. It looks like we don't know what's going on, but that is just the way we work...we are always alert when it comes to the patients. Always alert. If the patient lies in their bed, I always drop by; 'Hi madam, what are you busy with, come lie down. Don't you want to walk around a bit?' We are aware. They lie there, they can be thinking anything. They are always thinking what they are going to do. When they stand up and go somewhere, we follow them. So that's a high suicidal risk ward].

One of the nurses explained that should a patient be actively psychotic or actively suicidal and should they attempt to hurt themselves in the ward, they will be put in a side ward where they were monitored:

Iemand wat erger is wat nou sommer goedjies probeer in die saal, dan sal ons gewoonlik vir hulle in die side ward sit, nie seclusion nie. Maar waar ons hulle deur daai venstertjies kan dophou. In 'n erger geval dan sal ons one-on-one nursing, dan sal jy iemand allokeer wat daar by die pasiënt sit en met die pasiënt gesels en die pasiënt meer dophou. [Someone who is a bit more at risk, who will try to harm themselves in the ward, we will usually put in a side ward, not in seclusion, but where we can monitor them through the windows. Where there is greater risk, there will be one-on-one nursing, where you would allocate someone who sits and chats with the patient and who monitors them more closely].

All the nurses reported that they did not use a specific instrument to assess DSH patients in the EPU. They relied on conversations with patients, spending time with them and observing them. One of the nurses explained:

Kyk daar is -- ek weet nie of hier in hierdie saal of hulle 'n vrae lys het nie maar daar is sekere ruglynne wat ons as verpleegsters volg in die algemeen, ons kyk na die mood, ons kyk na waarheen gaan die pasiënt as die pasiënt ontslaan word, lewe die persoon alleen, is daar enige substances. [Look, there is...I don't know about this ward, if they have a questionnaire, but there are certain guidelines that we as nurses follow in general, we look at the mood, we look at where the patient will be discharged to, if the patient lives alone, if there are any substances].

Nursing staff assessed DSH patients on a regular basis throughout their admission. These continuous assessments involve the nurses observing the DSH patients, and subsequently abiding by a policy, which dictates the recording of all of their observations in a book. These documented observations included a patient's level of suicide ideation, suicide intent and notes about their general behaviour and physical condition. I have observed that these records were generally consulted at each ward round. Nurses commonly referred to these observations as *inskrywings*.

Although nurses are described as playing a crucial role when it comes to managing DSH patients, it is also suggested by a few participants that nursing staff are not necessarily consulted often enough for their valuable input, even though they spend the most time with these patients. Participants suggested that because of the time nurses spend with the patients, they could provide a picture of everyday functioning as well as emotional and mental status over a continuous period of time. It is also commonly reported that nurses generally helped these DSH patients by having everyday conversations with them and by helping them to deal with their emotions and stressors in their life. Several nurses mentioned the idea of walking a road with the patient, as well as the importance of building a relationship and subsequently gaining their trust.

Although the EPU is intended as an emergency short-stay unit, I have observed some patients to spend multiple weeks in the ward while waiting for placement in a psychiatric hospital, other care facility or for issues to be resolved at home. I will return to this issue of extended admissions due to a lack of placement in the next chapter.

#### **4.9 Referral to Psychology and Social Work from EPU**

The responsibility to refer DSH patients to social work or psychology from the EPU rested with the psychiatry registrar. However, EPU staff members reported and I have observed that not all DSH patients were referred to psychology or social work, and those who had more than one session with a social worker and especially a psychologist, were in the minority.

The statistical analysis of the 200 DSH presentations found the total number of patients who received input from a psychologist was 18 (9%). Patients can only be referred to psychology via psychiatry (they do not receive referrals directly from medical staff) and psychology only assesses DSH patients who are admitted to hospital; they do not consult with patients in Casualty. As a result, staff members commonly reported a lack of a well-established link between psychology and Casualty. This theme will also be addressed in the subsequent chapter.

One of the psychiatry registrars reported that DSH patients would be referred to social work if their presentation of DSH were related to social issues such as unemployment, family problems or inter-personal conflict. However, in addition to the significant psychological input with DSH patients in the EPU, there was also a lack in input from a social worker. The statistical analysis found that the total number of patients who have received input from a social worker was 60 (30%). In addition, I have observed that the social worker in the EPU was more often than not involved when there were issues relating to placement of the patient on discharge, particularly with homeless and geriatric patients.

#### **4.10 Discharging DSH Patients from the EPU**

Participants reported that there were no policies to help guide their decisions about when to discharge DSH patients from EPU, and that they discharged patients based on several criteria. The majority of participants agreed that a DSH patient who no longer felt actively suicidal, was apsychotic and stable and who had no suicide ideation or intent could be discharged. In addition, those DSH patients who have significantly improved since admission and who expressed to the health care professionals that they wanted to go home also warranted a discharge. Many participants also said that DSH patients who regretted what they have done, and who had insight into the consequences of their DSH behaviour, were likely to be discharged. As one of the 6<sup>th</sup> year medical students working in the EPU reported,

discharging DSH patients was very much a decision made by the health care professional to their own discretion:

Personally I would be happy to discharge a patient if they show remorse, if they regret what they did, if they don't have any other suicidal ideation.

While this participant might recommend the patient being discharged based on her own clinical judgement, the final decision to discharge a DSH patient from the EPU still rested with the team of health care professionals, with the consultant psychiatrist often making the final decision during ward rounds to discharge or not. Nurses also reported that they felt confident to speak up, should they feel that a patient is not yet ready to be discharged. Psychiatry registrars echoed this assertion. A few participants mentioned that if you are not a hundred per cent sure that you are making the right decision; the general rule is to keep the DSH patient at the hospital for a longer period of time. Participants added that even if only one person on the team feels that the patient is not ready to go home and is still at risk, the patient is very likely to remain at the hospital to receive further treatment.

Documenting decisions made with regards to discharges was especially crucial when the DSH patient was discharged due to bed pressure. I will return to the influence of *bed pressure* on the discharge of patients in section 5.1.5.

Participants reported that factors such as severe life stressors, especially those that haven't been resolved, and mental illness, usually resulted in a longer admission for DSH patients. In addition, factors warranting a shorter admission included temporary stressors, such as a university exam or conflict with a family member or friend. In addition, DSH patients who overdosed on their prescription medication may also only be admitted for a short while. In such cases they would usually be discharged into the care of someone at home that would be willing to take the responsibility of administering their medication upon discharge. Participants also reported that it was commonly patients with a personality element and who presented repetitively who are usually discharged after a shorter period. Some participants mentioned the potential issue of these patients *abusing* the system as part of their personality pathology. It was also reported that usually the consultant was aware of these types of patients, and that they would subsequently discharge these patients more easily. As one of the psychiatry registrars explained:

Maar daar is 'n laer *threshold* met daardie pasiënte om hulle uit te stuur want ons wil nie daai proses, daai siklus van *suicidal ideation*, kry my by die hospital... Daai patroon wil ons nie versterk nie en elke keer net voldoen aan al die klagtes. Dit is veral die borderline pasiënte wat moeilike pasiënte is om te sien, en hulle *latch* baie keer aan tot die sisteem. [But there is a lower threshold with those patients, to discharge them because we don't want that process, that cycle of having suicidal ideation, then being admitted to the hospital... we don't want to reinforce that cycle by always giving in their complaints... It is especially the borderline patients who are challenging patients to see, they often latch on to the system].

I have observed and participants also reported that no DSH patient was discharged without some management plan for follow up in outpatient care, or in some cases a referral to a psychiatric hospital. Participants were in agreement that patients were much more likely to be discharged when there was good family support at home. Families were often seen by the social worker, together with the patient, to observe the dynamics and potential level of risk. Some participants reported and I have also observed that there would always be a family-meeting before a DSH patient is discharged, if the family was willing and able. If further concerns arise, or should the family feel that the patient is still at risk, the patient is likely to stay longer. A few participants indicated the importance of adhering to the policy of having to discharge someone into the care of a family member, as the hospital does not allow a patient to leave on their own. They insisted that this was important to cover the hospital in the case of a discharged DSH patient who might complete suicide.

#### **4.11 Awareness of Management and Treatment Policies and Protocols**

While policies and protocols regarding the assessment, management and treatment of DSH patients are touched on throughout this chapter, this section specifically discusses the awareness of health care professionals of these policies and protocols. Approximately half of the medical staff interviewed was unaware of, or at least unsure about hospital policies and protocols relating to DSH. Many participants said that as far as they were aware, there were no existing policies. Reports included statements like the following: "I don't think there's a laid out protocol that I'm aware of"; and "Based on my observation I am not sure about the protocol".

Some participants acknowledged that there might be existing policies but that they were not sure exactly what these entailed. For example, participants' reports included

statements like “There is a policy but I am not sure”; “I am not sure if the other psychiatry registrars know what the protocol is, but I can’t say if there is a protocol”; and “I’m not aware of any specific suicide protocol. I could be in error”.

One such example is the policies pertaining to the assessment of the DSH patient. There seem to be many factors that contribute to the lack of adherence to the hospital policy regarding administration of the PSIS. The majority of medical staff told me they were aware of the PSIS while others said they knew there was some standard procedure but they did not know the details of it. As one of the medical officers said:

I’ve heard there’s a checklist in casualty and over a certain amount, the patient gets admitted.

Other participants were ill-informed about the protocols, as evident in the words of a social worker:

I used to think that it’s policy that all suicide attempts have to be seen by Psychiatry, but I don’t necessarily think... I can’t say that I’ve read the policy, and I don’t know why I believe that policy, but I don’t actually think that it does happen. I think sometimes patients are not referred to Psychiatry when they come in.

Some participants suggested that senior staff were in charge of informing and orientating new staff members on relevant policies and protocols they must follow, while others participants reported it to be a “learn as you go” environment where you need to orientate yourself and ask if you are not aware of particular practices.

A medical intern mentioned that while she wasn’t aware of any written policies, there were however, some guidelines in place:

Not that I know of that are written but I mean there are certain steps that you will know that you will follow, like getting a social worker involved, getting the psychiatrist involved so there are certain things that you do.

#### **4.12 Perceptions of Current Policies and Practices**

Participants expressed contradictory views about whether or not they thought there were adequate policies and protocols about how to manage the DSH patient, or if they experienced a lack in policies and protocols. Some of the positive comments relating to

having adequate policies and protocols in place included comments by a participant, one of the psychiatry registrars, who felt that as a result of potentially having adequate policies in place, DSH patients would receive treatment faster as a result. However, it was commonly reported by the majority of participants that the hospital guidelines were not very effective and that these guidelines needed to be reassessed and possibly modified. In addition, participants felt that the policies that were in place also served more as guidelines than as strict rules which must be adhered to. As one of the medical interns explained:

I do think that the policies in the hospital are there as a guideline.

More than one participant reported that having policies in place to follow when you are in doubt about a DSH patient was always helpful. As this social worker and psychologist suggested respectively:

I think it's always helpful to have policy; when in doubt you can just follow the policy.

I think it might be a good idea to maybe think of maybe implementing something like that.

Another participant specifically stated that policies are needed for those “grey areas” where you do not know whether you are making the right decision. This is especially significant in the case of whether or not to discharge a patient. Apart from those grey areas, it was suggested by a few participants that inexperienced junior staff, who find themselves in a new setting and having to respond to DSH patients, would benefit from having these policies in place. As one of the psychiatry registrars argued:

Protocols help most people to actually make fairly good decisions.

Participants reiterated that while these policies may help those who are inexperienced, more experienced staff tended to rely less on protocols. As one of the psychiatry registrars suggested:

I think when those people become more experienced and more mature they do tend to refer to the protocol but like I said they tend to make their own clinical judgement, much more than somebody who is new, who doesn't have that experience so yes.



With regards to policies pertaining the assessment of DSH patients, some participants argued that having scales would be helpful. However, others mentioned the ambivalence between wanting a scale but still realising the importance of viewing the patient as an individual, and not simply reducing the patient's case to a score. As one of the 4<sup>th</sup> year medical students suggested:

I think it would be nice to have something that is uniform because then we agree on one basis but then again, I think it is good to look at people individually and be like, okay let us just, not just come in there and start... how did you do it, why did you do it, and follow this like a robot but to look at each patient individually.

Participants said that they needed assistance with confidently determining a DSH patient's risk of future DSH or even completed suicide. A psychiatry registrar suggested that such instruments might be used to help make decisions about when to admit, and when to discharge, patients. Another suggested that such instruments were invaluable for inexperienced clinicians, medical interns and medical students. Participants also articulated a wish for an instrument that would help them to differentiate *real suicide attempts* from what they called *parasuicides* and *suicidal gestures*.

Some psychiatry registrars also said that they would feel more confident with a formalised system and more objective assessment methods. In this context they said that although the current procedures evoked anxiety, they acknowledge that it would be difficult to have a rigid assessment procedure. One psychiatry registrar articulated this by saying:

I think every case is different, so I think to have a standard box is quite difficult, and I think it is working as it is at the moment.

In addition, one of the 6<sup>th</sup> year medical students stated that implementing exact and specific rules wouldn't really be helpful to health care professionals. This participant elaborated by saying that these rules would not change whom they admit to hospital and how they manage these patients, and that the outcome would stay the same.

I think it could help, but I don't think it would change anything. I don't think it would change who we admit or how we manage them. I think it would come out the same.

#### **4.13 Conclusion**

This chapter provided an in-depth look at the way the health care system responds to DSH patients at the different points of interaction between the DSH patient and the health care professional in the ED. The next chapter will discuss the barriers and opportunities to the provision of care to DSH patients in the ED.

## Chapter 5: Barriers and Opportunities to the provision of care to DSH patients

This chapter serves as a presentation of the findings of this research. The findings are presented as barriers and opportunities to the provision of care to DSH patients. Sections 5.1-5.4 report on the barriers and section 5.5 reports on the opportunities.

### 5.1 A Lack of Resources

Most participants spontaneously reported that a lack of resources was a serious impediment to the provision of care to DSH patients. Resource limitations identified by the participants included a lack of physical space; a high demand for beds; long admission times; insufficient numbers of staff; a lack of psychological services; poor management of existing resources as well as the consequences of resources constraints.

#### 5.1.1 The problem of bed pressure.

**5.1.1.1 The lack of physical bed space.** Of all of the limitations listed, participants particularly struggled to cope with bed pressure. One participant indicated that they do not have the capacity to admit everyone, owing to the insufficient number of beds at the hospital. One of the nurses emphasised the gravity of this situation:

Ek sê die *system* wat ons ook het, is so dat ons kan oor al die goed praat maar daar's baie *limitations*. Want wat ek sê die, soos ons saal, ons kan net 16 pasiënte vat en dan outpatients kan net soveel pasiënte vat... En die een kan net soveel pasiënte vat, en daai een kan net soveel pasiënte vat, want ons het nie die mediese dokters en verpleegsters om dit te kan doen nie. [I would say that the system that we have allows us to talk about things, but there are many limitations. For example, our ward can only take in 16 patients and then the outpatient facility can also only take only a few...and that ward can only take so many patients, and the other ward can also only take so many patients etc, because we don't have enough medical doctors and nurses to do it].

Over the course of my observation period, there were only a few occasions when the ward was not congested and only had 16, or fewer, patients at a time. On one occasion additional beds were temporarily moved into the ward to meet the excess demand. A single participant came to the defence of the system in saying that while bed pressure was an issue and at times the ward was full and people were left waiting, this was not the case all the time.

**5.1.1.2 A High demand for beds.** All participants reported that a high demand for bed space significantly contributed to the problem of bed pressure. Participants expressed a perception that this high demand of beds was as a result of many DSH patients seeking treatment in the ED as oppose to making use of community-based social services. A medical registrar emphasised how detrimental the lack of adequate community-based social services is to the DSH patients:

People don't want to sit for 8 hours at a day hospital to see a psychiatrist or the psychiatrist's sister. So they sit at home until things are pretty bad, and then to get them out there. It's difficult.

This participant continued to emphasise how the lack of resources in the community has a knock-on effect, which translates into further pressure exerted on existing resources in the ED of the hospital under study. The participant also stated that these problems could be solved, but only with more resources, both in the community as well as in this hospital.

In addition to the lack of community-based care, DSH patients were also according to participants reluctant to access the existing outpatient community-based facilities. Some participants said that DSH and mental health issues in general were stigmatised in many SA communities. Some participants argued that the reason for this stigma could be owed to the belief system of some cultures that would regard a person engaging in DSH as weak or as a failure. This stigma prevented DSH patients from accessing help at a community level and makes follow-ups unlikely. As the one of the nurses explained:

En daar is mense in die daghospitale, daar is susters, daar is mense, daar is counsellors... maar mense is skaam om gesien te word...om te gaan. Want as jy nou na die psigiatriese suster toe gaan dan dink hulle oe, sy's alweer mentally. Hulle dink nie sy kan gaan vir iets anders nie. As jy na die psychologist toe gaan, watse probleem het sy [...] In die community, mense reik nie uit nie, want hulle is skaam. Ander mense gaan hulle sien. Hulle voel mense gaan hulle 'n stigma, dan voel hulle daai.[...] Dit is hoekom mense, hulle sit, hulle sit, hulle sit totdat hulle nie meer kan nie. As hulle hier kom is dit breekpunt en alles begin daar op primary level. maar die, daar's 'n groot probleem daar, primary level. Mense wil nie uitreik nie. En tog word hulle aangemoedig. Ek het self daar gewerk. Hulle word aangemoedig. [And then there are people in the day hospitals, there are nurses, there are people, there are counselors...but patients are embarrassed to be seen, to go. Because if you go to the

psychiatric nurse then they think, 'oh, she's mental again'. They don't think there might be another possible reason. If you go to the psychologist, people think 'what problem does she have' [...] In the community, people don't really reach out because they are embarrassed. Other people will see them. They feel that other people will stigmatise them, then they feel that...[...] That is why people, they sit, they sit, they sit until they can't anymore. And when they come here they are at breaking point and everything starts at the primary level. But that's the big problem, primary level. People don't want to reach out. And yet they are encouraged. I worked there. They are encouraged].

This participant not only points out the problem of DSH patients not utilising the mental health care facilities available to them, but also the subsequent importance of needing to place more focus on primary health care. I will return to the importance of primary health care in section 5.3.4.4.

Another participant contended that patients being discharged from hospital, and who are asked to follow up on their community, may not be ready to face the very problems within their community that precipitated their admissions. Participants argued that DSH patients, who do not follow up and who receive no subsequent contact with mental health care services, are likely to pass through the system unnoticed. Such patients are more likely to repeat DSH and therefore represent at the hospital, like the following nurse explained:

Die pasiënt is nog miskien nie gereed om te *face* wat hy moet *face* nie want, soos ek sê, hy wil nie gesien wees, in sy *community*, so hy gaan nie. So ons verloor hom. Ons verloor daai pasiënt en daai pasiënt verval weer terug in waar hy gewees het. [The patient may not be ready to face what they have to face because, like I said, they don't want to be seen, in their community, so they don't go. So we loose that patient. We loose that patient and that patient falls back into the same cycle].

A psychiatry registrar drew attention to the huge gap that exists between what happens while the patient is admitted, and what happens when they are discharged back to their family and they have returned home. This participant argued that this gap was the very reason for the large number of recurrent DSH patients:

When people get discharged from hospital, they are probably 50-60% ok. There is still a lot of work that needs to be done in terms of integrating them back into their

communities, and repairing damaged relationships or whatever it might be, and we just tend to send them home.

In addition to this, the participant proposed the idea of a halfway house as an ideal place for patients who have been discharged. It would be used as a passage way for patients who may be medically cleared and mentally stable, but who may need time to deal with social issues they have to face at home. Another participant, one of the nurses, added that some patients had not had the opportunity to spend adequate time with their health care professional, so as to form a relationship. However, they were discharged, as room had to be made for other patients in the form of ‘clearing the beds’. As she explained:

*Die problem is die system van die hospitale, jy weet mos, dis beddens. Dit gaan oor beddens, beddens, beddens. [The problem is the hospital system, you know, the beds. It’s about the beds, beds, beds].*

This participant continued to express concern as, at times, “bed pressure” forced them to discharge patients who should have been admitted for a lengthier period of time:

*Maar ons discharge die pasiënte met ’n gevoel van “Ai, gaan ons haar weer sien, gaan ons hom weer sien?” Ons is maar emergency. Dis emergency. [But we discharge the patients with a feeling of “are we going to see him again, are we going to see her again”, but we are emergency. It’s emergency].*

However, other participants suggested that even though health care workers are sometimes pressured to discharge patients as a result of bed pressure, it did not necessarily imply that patients are being discharged recklessly. As one of the psychiatry registrars expressed:

I don’t think that we are discharging patients that we feel are still at risk.

I will return to the issue of how this lack of resources potentially negatively impacts the management of DSH patients and the care that is provided to them in section 5.1.5.

**5.1.1.3 Long admission times.** I have observed that discharges were often delayed because it was difficult to find placements for some patients, or to send them home to the care of their families. The term placement refers to any form of housing where the patient may be referred to after discharge from an inpatient bed in the EPU and may include shelters, old age homes or a person’s family home. Participants suggested similar reasons as to why

the process of discharging DSH patients was frequently delayed. One reason cited by participants and explained by a medical registrar in the following quote, was that psychiatric symptoms were slow to resolve in comparison with patients who have purely physical injuries:

Things change very slowly in psychiatry. A person doesn't go from psychotic to okay in a week, it's usually five, six, seven, eight weeks.

Furthermore, I have observed that it takes time for psychoactive medications to be effective, and that time is needed to adjust patients' medication as well as to find the appropriate therapeutic combination of medications.

Moreover, patients have to be medically stable before they may be referred to certain psychiatric hospitals. However, several participants expressed a concern that this contributes to beds being used by patients who are waiting for smaller medical issues to be resolved, whilst DSH patients are forced to wait for admission.

Participants reported that long waiting lists for the transfer to inpatient psychiatric hospitals results in longer admission times. I frequently observed that DSH patients may be physically and mentally cleared for discharge, but then remain in hospital owing to a lack of placement. One of the nurses echoed this finding, namely that the delayed placement of DSH patients once they have been discharged from the EPU results in congestion in the ED:

Maar die *institute* se beddens het hulle minder gemaak, so daar is nêrens waar ons die pasiënt heen kan stuur nie. Die wat nie kan huis toe gaan nie moet hier hou. Dit *block* die beddens en die wat in kom by *casualty* moet op *stretchers* lê tussen ander pasiënte met - wat mediese sorg nodig het. [But the amount of beds in the institutions were decreased, so there is nowhere to send the patient to. Those who can't go home we have to keep here. This causes blockages to the system and those who come into casualty have to lie on stretchers among other patients who need medical care].

During my observation period it became clear that there was a great lack of beds in psychiatric hospitals. DSH patients often found themselves on waiting lists for these hospitals, which means that they would have to wait in the EPU for up to several weeks. One participant simply stated that the entire psychiatric system (including tertiary hospitals) could not cope with the demand placed on their services, owing to insufficient resources.

Furthermore, moving a patient from the EPU to a tertiary psychiatric hospital is challenging. As one of the medical officers explained:

There is always a blockage here or there - you can't move a patient efficiently.

One participant suggested that these “blockages” often started in the ED and impacted the whole system. One of the nurses expressed frustration with the extra pressure that is put on the ED as a result of the reduced psychiatric inpatient bed space:

As ek my opinie daar uitspreek, gaan jy nie hou daarvan nie. Maar toe hulle die helfde van die psigiatriese hospitaal toegemaak het, toe het onse bed *problem* begin. [If I have to voice my opinion, you are not going to like it. But our problems started when they closed half of the psychiatric hospitals].

Furthermore, some participants mentioned that DSH patients with a co-morbid drug or alcohol problem, who await placement in a substance clinic, may present the same challenges in terms of extended waiting periods prior to being placed. Additionally, participants also discussed the lengthy durations of the programmes running in these psychiatric hospitals. An inpatient program in the therapeutic unit of a psychiatric hospital, as well as the therapeutic unit within this hospital, lasted from 4 to 8 weeks. Limited number of spaces available for these inpatient programmes resulted in a limited number of DSH patients being referred to these psychiatric hospitals or the inpatient program within the hospital. Subsequently, referring DSH patients to these respective therapeutic programs was not always viewed as a feasible option both because of the actual lack of enough bed space and because it slowed down the process of discharging patients from the EPU.

Apart from the psychiatric hospitals, I have also observed that health care professionals experienced challenges when looking for placement for geriatric patients. Old age homes have often reached their capacity, or are reluctant to take in someone with a history of DSH and who may still be at risk of engaging in suicidal behaviour. Similarly, placing homeless patients was also difficult. Not only does there appear to be a lack of shelters, but there is also a form of selection that takes place before someone can be placed or reinstated at a shelter. Some patients, especially adolescents and patients with personality elements, were often disadvantaged by this system of selection. One participant expressed concern regarding the challenges of living in a shelter and that, as a result of this patients may be going from one shelter to the next and ultimately may be homeless again. The participant



also highlighted the fact that this also adds to the “bed pressure”, as a homeless people are likely to be admitted to hospital unnecessarily because they have nowhere else to go. Consequently, valuable bed spaces are allocated to patients who, in fact, could have been discharged.

Finally, it was often the case that DSH patients who are cleared for discharge have a complete lack of support at home. Owing to the fact that the patient is often very vulnerable at the time of discharge, the patient may often remain in hospital for an extended period of time (i.e. longer than needed) until support can be arranged or secured.

**5.1.2 Insufficient numbers of staff.** Participants commented on the lack of medical staff and the problems this has created for providing care for DSH patients. Participants expressed a perception that psychiatry registrars were especially under pressure. They often seem overworked and cannot always keep up with the constant flow of DSH patients who need psychiatric input and assessments. One participant expressed frustration in that it was only possible for them to treat a certain number of DSH patients, and added that more staff members were needed to address this issue. As one of the nurses explained:

Twee pasiënte per persoon. Dan kan ons meer tyd maak vir so ‘n pasiënt. Ja, twee...per suster. Daai sal ideaal wees. Maar ons is nie. Ons is nie soveel nie. [Two patients per person. Then we can spend more time with such a patient. Yes, two...per nurse. That would be ideal. But we are not... we are not that many].

A psychiatry registrar expressed frustration that because of the limited health care professionals, they are not able to meet the demand of the number of patients presenting at the ED. This participant continued to say that more funds allocated to the mental health care sector may make a difference to their current situation:

If there are a huge number of patients and a few numbers of doctors then you know, unless the government decides to allocate more money to psychiatry, that’s the way it is.

During my interview with one of the nurses, I suggested a therapy program in the EPU. She responded with frustration because of the lack of resources and its influence on the care being provided to DSH patients:

Dit sal help maar dan ons is *understaffed*. Hier's nie *staff* om dit te doen nie....

Hulle kan miskien meer beddens oopmaak, dit sal goed gewerk het maar die staat het nie daai geld nie. Die staat sal ook, hulle sal ook nie oopmaak nie. Dit wil sê dis meer beddens, meer geld, meer *staff*, meer geld. Hulle sien net geld. [It would help, but we are understaffed. There is not enough staff to do it...perhaps they can make more beds available, it will work well, but the government doesn't have that kind of money. Also, the government wouldn't make these beds available. More beds would imply more money and more staff, more money. They only see money].

Another participant also expressed concern for the similar situation of a lack of staff members in psychiatric hospitals and the subsequent influence it has on their management of DSH patients and their availability of beds. Apart from the lack of staff members in the hospital, participants reported an even greater lack of staff working after-hours and weekends, as mentioned in the previous chapter. In addition to this, it was reported that staff members tended to experience fatigue at night, which means that the psychiatry registrar might be less likely to see all DSH patients as they present throughout the night.

All participants reported challenges with managing DSH patients after hours. A medical officer clearly illustrated the added pressure of having to deal with a DSH patient amongst other medical emergencies when the ED is understaffed:

During the day it's much more easier because there's more doctors. At night things always go wrong. There's always an acute emergency and there's only two doctors on. So you've got to quickly stabilise and go in ... you get pulled by one of the nurses to go sort something else out... and then eventually you remember, yes you have to go and finish a whole Pierce score, suicidal score and they get a bit neglected at night. But during the day it's actually much better. You can spend your time with them. They'll be a bit more open.

Participants reported that this lack of staff created tension between medicine and psychiatry. A medical officer explained his experience:

It's also easier getting hold of the psychiatrist during the day. Nights they get a bit cranky and they only come see the person at 07:00 in the morning, before their rounds at 08:00. So they squeeze as much information in that time.

**5.1.3 Lack of psychological services.** Almost all participants reported that psychology had a very limited and specific role in this hospital. There were no psychological services available in Casualty. There worked only one psychologist in the EPU, and only during office hours. There was no psychologist available during weekends. As one of the medical officer explained:

Daar is nie 'n wel *established link* met *psychology* op die ED vlak nie. [There is a lack of a well established link with psychology in the Emergency Department].

Psychologists never assessed a DSH patient in the ED. DSH patients could only be referred to psychology through psychiatry. Participants commonly reported the great need for more psychological input, in addition to their concern for the lack of psychological services. As one medical officer put it:

That's a big need in this hospital. I really think that's a gap that's not filled out.

Participants expressed different views regarding the lack of psychological services as being a result either of the lack of resources, or due to a lack of awareness of the value of psychological input by medical staff. Moreover, one of the psychiatry registrars discussed a shift from working in an environment where there was a greater focus on therapy, in comparison to working in a medical setting like a hospital:

My personal interest is more toward the therapy side... and also I've been out of the medical side for a long time. So the shift for me is quite difficult.

This participant also highlights the idea that regardless of the training the health care professional has received, their personal consciousness of the role of psychology is also important. I return to this point in the discussion.

I have observed that the existing psychological services could not meet the demand of the high volume of patients, and it struggled to cope with the fast pace at which these patients moved through the system. Some participants indicated that it was common practice for DSH patients to be discharged before they had any psychological input, or perhaps with only one brief session. Several participants including this psychiatry registrar and psychologist argued that there was hardly any time for therapy:

And well, in this hospital where, I mean it's so pressured to get everyone through the system. I mean am I right if I say there's no time, a lot of time for therapy.

There isn't really space for psychological intervention due to time, and that is one of the challenges.

Several participants suggested that they valued psychological input because it provides another dimension of care to the DSH patient. Another participant who agreed psychology to be a "good idea to implement also suggested that a lot of problems don't need psychiatric input and medication but rather therapy sessions with a psychologist. A psychiatry registrar stated that it tends to be only the extreme cases that get referred to psychology, while it is in fact a service that all patients in the EPU would benefit from. This participant added that as a result of the lack of psychological services, she was reluctant to consider them as a treatment option to which DSH patients may be referred:

It would be wonderful if we could refer all these people to a psychologist but because you know that it's unlikely that they...they got so little time so you must, that little bit of time must be allocated to places where they really could help. So you sort of stop thinking of them as an option.

I have observed that one specific subtype of DSH patient, the patient with Borderline Personality Disorder (BPD) was especially a low priority when it came to receiving therapeutic input. Participants reported two reasons for this lack of psychological input: patients with BPD were not always very easy to interact with, and are therefore not considered as ideal candidates for therapy. Additionally, health care professionals are very cautious about engaging with BPD patients in a therapeutic relationship. This is owed to their perception that attending to these patients would provide positive reinforcement, and that this attention could possibly extend their admission time. One participant said that due to the heavy workload of the psychiatry registrars, psychology could play a significant role in providing help for patients with BPD. As one of the psychiatry registrars suggested:

So it would be really useful if there was a psychologist who could come in once a week and say "there's a group for borderline patients", or even if we keep a list of them and say every week on a Wednesday at nine o'clock we do this group for people who self-harm...Even outpatients could come back, have one or two sessions, and then at least we're empowering, at least we're giving them some skills. We're not just putting a bandage over the big hole that's underneath and sending them out there to come back again.

Although this psychiatry registrar emphasises the lack of psychological input, she also displays a positive attitude towards this subgroup of DSH patients and the potential role health care professionals may play in intervening with these patients. I will return to a discussion of the opportunities and possibilities for intervening with DSH patients in section 5.5.

Another participant furthered this notion by expressing concern for the lack of focus on providing therapy for borderline personality patients. As the medical officer suggested:

Borderline is still a psychiatry issue. It's a personality disorder and there is some form of management on the outpatient floor - they have cognitive behaviour therapy. So is this person [is] a candidate to be put on the list for that. They need to make that call.

One participant expressed that in the majority of cases, it is too late in the patient's life for them to see someone from psychology. More specifically, they would have benefitted from this form of treatment a lot earlier in life. This participant referenced the idea of primary intervention - a theme that will be explored later in this chapter. Another participant suggested that it would be ideal for DSH patients to receive therapy shortly before being discharged, hereby decreasing the need for people to be referred to a psychiatric hospital. This participant also added that even though a patient may no longer be suicidal, therapy not only has the potential to assist the prevention of future suicidal risk, but would also offer the health care professional some peace of mind.

**5.1.4 Poor management of existing resources.** Participants reported that available resources were not always effectively utilised. Some medical students and medical interns expressed concern and frustration that they are not optimally used in terms of their skills and time. Owing to the amount of senior staff members that medical students had to work with, they often expressed the perception that their role was unimportant and irrelevant. One of the 4<sup>th</sup> year medical students explained:

There are more people with more experience, so not so much concerned with the 4<sup>th</sup> years.

During the specific times of my observation period, there were up to five medical students stationed at the EPU. This is very significant, especially when taking into account the insufficient numbers of staff as discussed earlier. Several of them said that in comparison

to other blocks, where they had to work in the hospital, the EPU was very quiet with very little to do. One of the 6<sup>th</sup> year medical students explained:

Here, you just sit there and then you just read... and then if there's a patient you just go and interview the patient. You don't do much hands-on. You just talk. I don't like that. I like working.

Furthermore, one can deduce the attitude of a medically trained participant who views speaking with a psychiatric patient, and providing physical care, as beyond their set of duties. This is a theme to which I will return in the discussion. Although medical interns, and to a lesser extent medical students, occasionally assessed DSH patients, the patients that they assessed always had to be reviewed by a psychiatry registrar before the patient could be discharged.

**5.1.5 Consequences of resource constraints.** The issue of resource constraints had a significant influence on the care provided to DSH patients. The problem of bed pressure causes patients to move much faster through the system - often without receiving appropriate psychosocial input. One of the medical officers offered an explanation:

We have got numbers to push, and patients tend to be neglected, unfortunately.

Subsequently, medical problems seem to be the main focus, with psychiatric and psychosocial problems being demoted to secondary importance, unless the person is a danger to themselves or others. One of the psychologists working in the EPU emphasised the challenges surrounding the issue of bed pressure, and how it seemed to be beneficial to medical issues and psychiatric cases that are perceived to be a greater emergency than DSH:

Selfs binne 'n psigiatriese *ward* soos die *EPU* van die hospitaal waar ons met 'n ander oog kyk as miskien die *pure medical wards*, is dit nog steeds 'n ding van ons moet kan regtig *justify* hoekom daai persoon langer byvoorbeeld daar moet wees as daar nie 'n *medical emergency* of 'n psigose of daai tipe van ding nie. [Even in a psychiatric ward in the hospital like the EPU where we have to look at things differently than they do in the pure medical ward, there is still the issue of having to justify why a specific patient needs to be admitted for longer if there is no medical emergency or psychosis or that type of thing].

Part of this problem of patients moving through the system too fast as a result of bed pressure, is the concept of *forced discharges* of patients who may still be at risk. I have observed that in cases such as this, a note will be made in the patient's file saying *emergency discharge due to bed pressure*. This occurred several times throughout my observation period, with some of the cases being DSH patients. One of the psychiatry registrars suggested that the discharge criteria were often simply the situation of bed pressure:

We may have kept somebody but if we are pressured with more serious cases, we may opt to discharge. That is an influencing factor sometimes.

This was a practice, which this participant considered to be necessarily at times, yet not always accurate. Not only did the bed pressure impact the movement of the DSH patients through the system, but it also contributed to the health care professionals experiencing feelings of stress and anxiety. One participant mentioned that a referral from Casualty could already indicate how serious the case of DSH was, and that when dealing with a parasuicide, or not a "real" suicide, that it was definitely less provoking and stressful. This psychiatry registrar also touched on the stress and anxiety that resulted from the lack of resources:

And sometimes from the referral already one can make an assessment that this is not a real suicide attempt - then it's not that anxiety provoking. But if it is, it can be more anxiety of working to get to the suicide assessment, but not only because one's really concerned about suicidality. Sometimes it's because making the decision about whether it is true suicidality or parasuicidal, and how many beds one has available, adds to the anxiety.

The significant influence of the lack of resources, and consequently the issue of bed pressure, is also emphasised and how it places additional pressure on health care professionals when they are already experiencing significant levels of stress when working with DSH patients. This psychiatry registrar continued to explain:

So I am...anybody who says they are suicidal I feel I must take seriously and yet I can't take everybody who says they are suicidal, because of a lack of several things.

In addition, this participant noted the difference between waiting for a patient to spontaneously report suicidal thoughts and directly enquiring about them. This psychiatry registrar expressed some anxiety about acknowledging that sometimes she did not ask directly because it was better not to know the answer. She would, however, record in the

notes that the patient had not spontaneously reported that they were suicidal. As the psychiatry registrar continued to explain:

According to the textbooks, you know if you haven't screened for suicidality, that's not good practice, but yet if I do screen for suicidality, I'm stuck.

This participant implies that should she assess all patients for suicidality, the amount of patients that might potentially qualify for admission based on the assessment of risk, might be more than the system can handle at any given time. She continues to say that she experiences the feeling of being stuck as a result of her wanting to provide adequate assessments and care to DSH patients, yet not always being able to do so within the system she has to work.

These resource shortages also affected the health care professionals, and often result in staff burnouts and feelings of hopelessness. As another psychiatry registrar reported:

At 3:00 in the morning when somebody phones me and I'm half asleep, sometimes it feels like it's easier, but you don't get anything really from it, and you don't enjoy your job as much [...] there's high levels of caregiver fatigue and...when you're working in casualty for a long time it becomes very difficult to see five people who want to commit suicide every day, especially when you see the same people.

It was also evident that being understaffed and having a limited amount of time available, influenced the health care professionals' ability to provide DSH patients with quality care. One of the psychiatry registrars emphasised this frustration:

Well, again it is in comparison to where I came from, where there was enough time to do things with more thought. Here... because of the pressure, I've not always been happy that I've been able to deliver a thought through - I've not always been happy about the degree of thought that goes into my assessments [...] I think it's part of the lack of resources.

This participant continued to suggest that the only way for these issues to be resolved is for more resources to be allocated to the hospital.



## 5.2 Impossibility of a Relationship

Several factors influenced the potential for a relationship to develop between DSH patients and health care professionals. Data suggested that it was largely the lack of resources in the hospital that resulted in the impossibility to form this important bond with patients. One of the nurses reiterated this causal relationship:

Somtyds is ons eintlik veronderstel om een suster twee pasiënte te wees om 'n effektiewe benadering vir... 'n verhouding met die pasiënt, maar dit gebeur nie. Dit kan nie so gebeur nie, want daar is so baie *limitations*. [Sometimes we are actually supposed to be one nurse per 2 patients for an effective approach...to establish a relationship with the patient, but it doesn't happen. It can't happen that way, because there are so many limitations].

**5.2.1 The problem of a lack of sufficient time.** Most participants reported that they did not have adequate time to spend with DSH patients. Participants reported this lack of time to be both frustrating and a cause for concern as it prevents them to form a relationship with DSH patients.

**5.2.1.1 The value of spending time with the DSH patient.** Participants discussed the importance of spending time with DSH patients in order to develop a relationship with them. Participants expressed that this allowed them to gain the patients' trust, which will add value to assessments. Participants expressed that when the health care professional have a good relationship with the DSH patient, they are more likely to open up and tell the truth in terms of whether or not they are really still feeling suicidal. They also added that it takes patience and perseverance to build a therapeutic alliance. A few non-medical participants stated that owing to the amount of time they spent with patients, these DSH patients will often tell them things they are not telling their doctors. As one of the social workers said:

I find that patients don't necessarily always give the whole story to everybody they talk to, so it is worth it to take your own history. I think I manage to spend more time with people, and very often, then they start telling me stuff that they haven't told the doctor because the doctor is the one who's curing them. It's amazing when you spend more time with people what they will tell you.

**5.2.1.2 The work environment and lack of time.** Many participants said that they often could not spend the requisite amount of time with DSH patients due to the demanding

nature of their work environment. Participants reported that they often only had time to focus on patients' physical health, and that sometimes as a result, patients' psychological and emotional needs were not met. A medical registrar explained:

So it's obviously difficult, in a Casualty setting, especially, or in a clinic setting, out there where you've got 50 patients waiting... We don't have the two hours to sit with a patient there because then we could get backlogged.

Patients are admitted and discharged at a fast pace, which also makes it difficult to establish a type of relationship in a short period of time. One participant stated that it really depended on how long a patient stayed in the ward if they could develop rapport with these patients. One of the nurses stated, there is not always enough time to 'walk a road' with the patient. However, another nurse suggested that the time available to spend with patients was dependent on the specific day:

Jy gesels met hulle. Naweke kry ons baie kans miskien want dis stiller, maar in die week is dit net so-so. [You chat to them. Over weekends we get plenty more chances because it is more quiet, but during the week, not so much].

A nurse also stated that it was sometimes difficult to form a relationship with DSH patients in EPU when these patients were still actively psychotic:

Dit is eintlik moeilik. Baie van die pasiënte is baie psigoties, so jy kan nie eintlik, jy het nie eintlik daardie noue verhouding met die pasiënte nie. Jy doen basies maar net die nodige sorg wat hulle nodig het. Kyk dat hulle veilig is. jy doen die basiese dinge met hulle. [It is actually difficult. A lot of the patients are very psychotic, so you can't actually, you don't actually have that close relationship with the patients. You basically only provide the basic care, which they need. Check that they are safe. You do the basic things with them].

One nurse suggested that the building of a relationship with a DSH patient, and getting them to trust you takes time. According to her and several other participants, this is a very challenging task in their work environment.

**5.2.1.3 The time constraints of administrative work.** The majority of participants agreed that administrative tasks were very time-consuming. One participant specifically mentioned that due to the large load of administrative work, having more staff would be ideal

because that would allow for more time to be spent with patients. Two nurses discussed this issue of a lack of time to actually spend with patients in the EPU:

Ek dink daar moet dan meer *staff* wees want dan soos ek vroeër genoem het, daar is baie administratiewe werk. So as ons meer verpleegpersoneel het dan kan daar meer tyd gespandeer word met die pasiënte. [I think there has to be more staff, because like I mentioned earlier, there is a lot of administrative work. So if there are more nurses then more time can be spent with patients].

Vorms moet ingevul word, weggestuur word, so dit vat baie tyd van die verpleegpersoneel op, jy sal sien ons is meestal besig in die *nurses' station*. [Forms have to be completed, sent away...so it takes a lot of time from the nurses, you might've noticed, we are mostly busy at the nurses' station].

Another participant added that when a patient had to go for medical tests or scans in the hospital, they always had to be accompanied by a nurse from the EPU. Participants reported that the implication of this policy meant one less staff member to monitor and provide care to DSH patients during this time. Participants reported that the policy was also implemented when a patient was transferred or discharged from the EPU.

It was not only the nursing staff who felt pressurised by engaging in administrative tasks. A medical registrar said that filling out forms for a patient to be transferred to the EPU took up time as a result; he sometimes resented the constant flow of psychiatric patients:

And then the actual form filling in part, if they need it, is what also takes long because it has to be done properly, even though the forms keep coming back to us [...] I wish we saw less psychiatric patients, but just because of the forms.

Medical interns working in EPU also experienced that a significant portion of their time is spent completing administrative tasks. I have observed medical interns sometimes spending an entire day trying to reach families for collateral information and trying to find placement for patients as opposed to caring for them medically or psychiatrically.

**5.2.1.4 The time spent with other patients.** One participant mentioned that other non-DSH patients in Emergency Psychiatry often took away time from the DSH patients that may need more time with health care professionals than other psychiatric patients. She stated that patients who are very aggressive, for example psychotic patients, tend to take up more time

than the DSH patient. In this participant's opinion, DSH patients actually require more time and attention than other patients, especially those who are quiet and more depressed.

Participants reported that not only do geriatric patients and medically ill patients add to the problem of bed pressure, they also require a great deal of time from the nursing staff. Two nurses explained that the lack of resources, in terms of staff members and bed space, has resulted in the focus being more on providing patients with physical care as opposed to psychiatrically treating them. These two nurses explained respectively:

En as ons fisiese siek pasiënte het dan vat dit ook baie tyd. Dit is nie meer net straight forward psigiatry nie. [And if we have physically ill patients then it also takes up a lot of time. Then it is not straightforward psychiatry anymore].

En ons *problem* ook in die saal is ons het baie *geriatrics* wat *24/7 nursing care* nodig het. Ons gee somtyds in die saal gee ons seker 50 persent *nursing care* en ek praat nou van *nursing care*, ons praat van *physical*, soos jy in pasiënte moet help om te loop, pasiënte moet jy in die bed kos gee.... Is die mediese goed ook. En dit *limit* ons ook om baie tyd te gee.... Maar as dit is by 'n psigiatryse hospitaal, dan moet daai pasiënt, daar moet niks sulke goed wees nie. Hulle *focus* net op die pasiënt se *mental*. Maar hier, ons *focus* is nie net *mental* nie. [And our problem in the ward is also that we have a lot of geriatric patients who need 24/7 nursing care. Sometimes in the ward we provide about 50 percent nursing care, and I mean nursing care, like physical...like helping patients to walk, feeding patients in their beds...as well as medical care. And that limits us to be able to spend time with other patients. But when it comes to a psychiatric hospital, with those patients, then there should be nothing like that. They focus only on the patient's mental state. But here, our focus is not their mental state only].

**5.2.2 Lack of confidentiality.** Participants felt very strongly about the issue of confidentiality and expressed concern at the lack thereof when assessing and treating DSH patients. Participants reported confidentiality to be a problem owing to the physical lack of space in hospital. With beds separated by a few inches and (at most) a thin curtain, privacy was more of an illusion than a reality. A few participants even described the situation as awkward.

The following two quotes of one of the social workers and one of the psychiatry registrars respectively, highlighted both the extreme lack of confidentiality in casualty as well as in the EPU:

Confidentiality is, I think, a huge issue with the hospital, because when the doctors come and talk to you about your problems - what's medically wrong with you- there's [sic] always people there. I think ward rounds are the way it's done, the medical wards, where they go from bed to bed and talk about your medical problems. There's no confidentiality. How dare they? And sometimes it's about HIV, and -- this world is too small, there's always somebody who knows somebody. I think there are lots of areas that we can improve. And how will a patient who doesn't feel treated confidentially say something that's really sensitive - sensitive enough to want to die for it.

And neither is the EPU, for that matter. People are in and out of those offices all the time, the phone rings when you're on call. It's a nightmare, because your cell phone rings, the phone, the nurse walks in... It's very difficult. It's a deeply, deeply personal and shaming thing for lots of people, and you're sorry you were raped by your uncle, and I've got to take the phone! You don't say that, but you know what I mean?

However, participants also agreed that confidentiality is crucial and that it is a priority as far as possible, as long as resources allowed it. Some participants emphasised the fact that the patient should always be given the option of having the assessment be conducted at their bedside or not, and that you should always check with the patient that they are not uneasy with the process. Participants commonly reported that, if they could, they would take the DSH patient to the relatives' room just outside casualty, or to the EPU. However, among other participants, one psychiatry registrar suggested that the relatives' room is not always available and, on the occasion when it is available, confidentiality is not guaranteed.

There's a relative room there which I sometimes use, but it's not really for that; so then you have the security guard strolling in and then you have the family crying outside, so it's not ideal.

Apart from the available space, participants agreed that where the psychiatric assessment takes place is largely dependent on how stable and mobile the patient is.

Participants mentioned that, at times, they would use a wheelchair to move the patient to a more private space for an assessment, but patients were not always mobile or stable enough to leave their beds in casualty. The majority of participants agreed that interviewing someone in bed was only done if they had no other choice, in terms of another venue or if the patient was not mobile. The following psychiatry registrar experienced that trying to move the patient to a more private space, may be, ironically, more degrading for the patient:

And the patients then have to stroll around in their hospital gowns which don't close up in the back, and you have to put a towel, blanket around them, and then their shoes are tied up in a bag. So it becomes more of a mission to get them to the EPU with dignity and shoes, and all of that, and then sometimes it's quicker to talk to them at the bedside.

**5.2.3 The DSH patient not being truthful.** The majority of participants had experience of assessing DSH patients who were not being truthful or honest with the health care professional about their suicidal intent. This rendered decisions regarding admissions and discharges quite challenging. Participants believed that you could only really assess DSH patients when they are honest.

Participants considered one of the reasons for DSH patients not being honest when being assessed to be the lack of confidentiality. Participants argued that this lack of confidentiality results in DSH patients not being able to express their true thoughts and emotions as a reaction to how health care professionals respond to them. One of the social workers explained:

I think you can only assess when the patient is honest with you, and the patients often don't tell you, or I think they're a little embarrassed. And I think a huge problem is the nursing staff not always being empathetic, especially in a casualty where they do have to treat people who are terminally ill, and then they have to pump a stomach, and that's kind of avoidable...and you're bothering me now. There's somebody with a heart attack, I need to resuscitate, and why do I have to give you charcoal, you know? So I think sometimes it's easier to get impatient with people who present to hospitals with their own actions, and then I think it's not that easy to say what they really felt.

**5.2.3.1 The manipulative patient.** Many participants expressed frustration and anger regarding some DSH patients being manipulative when it comes to assessments. Some

participants expressed concern that these patients deceived them purposefully. One participant described the experience of trying to understand what really happened as being a “futile attempt to get behind the truth” and an emotionally draining process. In addition, one of the social worker emphasised the frustration that these patients often evoked:

Sometimes it becomes very, very difficult and it drains you because it works with your mind; especially sometimes when you feel that this person is lying to you and you see that because when the third party arrives gives you another story. The fact that I spent an hour with this person trying to deceive me, you feel bad about yourself and that person - sometimes we are human beings, sometimes you feel that “okay, I don’t think I’ll ever help this guy again”, but we are here to work.

It was commonly reported that DSH patients who formed part of the group of manipulative patients were adolescents and patients with symptoms of an underlying personality disorder, especially borderline personality disorder. Participants, like the following psychiatry registrar, found it challenging to distinguish between symptoms of underlying personality disorder and suicide intent when assessing them:

I think what particularly makes it difficult in this setting is that a number of the patients that come here - there is an element of personality or malingering. And to screen whether, as a result of that, the patient is truly suicidal and -because if one had to take every person that comes to this hospital and says that they are suicidal, if one had to admit all of those people, you know the psychiatric beds would be filled with just that and there wouldn’t be place for other pathologies. So to make that decision here, in the short amount of time that we have to see people, is a frustrating thing. So that, it’s actually upsetting for me that if patients could just be truthful, it would be so helpful.

The theme of participants experiencing the interaction with DSH patients as frustrating will be discussed in section 5.3.1.1. In addition, a few participants stated that they did not know when to believe these patients. Some participants added that it is usually this subtype of DSH patient that would claim to be suicidal when they are not. However, some participants simultaneously suggested that patients exhibiting symptoms of underlying personality disorders tend to be at chronic risk of suicide, therefore rendering it especially difficult to forecast when the risk is long-term or continuous, or acute.

When it came to adolescent DSH patients, participants thought they were often manipulative as part of their “acting out” behaviour, or it was an attempt to seek attention (usually) from a family member or friend. As with BPD patients, participants struggled to distinguish between typical teenage behaviour and pathology, as a medical registrar explained:

Okay, so the patient said she’s depressed, but she’s laughing and on her phone texting; that’s not congruent.

Another participant mentioned that it often occurred that a teenager would come in, tell a story of what happened that portrays the parents in a bad light - saying that they had an argument. This participant continued to say that when you, however, spend time with the parents to get collateral, or you spend time alone with the patient, it is not what really happened. A medical officer expressed frustration with this type of adolescent behaviour:

When they come to hospital they probably have lied. They actually didn’t take any tablets, you do a blood level, it’s zero...and then you get them alone, they tell you, they didn’t do it.

In contrast to this, one participant expressed to have made some sense of understanding the behaviour of DSH patients who were manipulative. This psychiatry registrar made sense of these DSH patients’ behaviour by viewing it as pathological. He also indicated that some cases affected him more than others:

Selfs die pasiënte wat jy dalk mag voel is besig om manipuleerend te wees, en dis nog steeds deel van ‘n siekte kompleks... So ek is redelik neutraal teenoor pasiënte, maar daar is die enkele gevalle waar jy dink “jislaaik dis erg”. [Even the patients whom you may experience to be manipulative...it is still part of the illness. So I am generally neutral towards patients, but there are single cases where you think, ‘that’s terrible’].

**5.2.3.2 The DSH patient with a psychiatric illness.** Many participants also reported that it was specifically difficult to know when psychotic patients were telling the truth (or if they were still psychotic). A participant indicated that these patients are usually incoherent and that one cannot interact with them. This resulted in participants finding it difficult to establish a relationship with this subtype of DSH patients.



One of the medical officers explained that he generally trusted his patients to an extent where the patient is coherent, otherwise he would rely on collateral information from the patient's family:

Ek is geneig om pasiënte te vertrou uit beginsel uit dat wat die pasiënt sê vertrou ek tot so mate dat vir my moontlik is om dit te volg... ek dink dit is belangrik om die pasiënt soveel as moontlik te vertrou. [I am prone to trusting patients out of principle, so I trust that what patients are telling me to such an extent that it makes sense logically...I think it is important to trust the patient as much as possible].

This section can also be viewed as an opportunity to providing DSH patients with care. Opportunities to the provision of care for DSH patients will be returned to later in this chapter.

**5.2.3.3 The ambivalence of the DSH patient.** The majority of participants reported that patients were, in general, ambivalent in their suicidality and this frequently resulted in them being untruthful when being assessed. One of the nurses articulated a view that while there were many DSH patients who presented at the hospital, there were not many people who had *real* intent to die, implying that she believed that most DSH patients were not truly suicidal. As she explained:

Baie keer dan sê hulle, hulle wil hulself doodgemaak het, maar ek voel baie keer die intensie is nie rêrig daar om dood te gaan nie. [Often they they would say that they wanted to kill themselves, but I feel that many times the intention to die is not really there].

Another participant added to this by mentioning an example of a DSH patient saying they do not have intent to die, but they have a history of multiple suicide attempts, which sends a mixed message to the health care professional doing the assessment. Another participant added that should it be a second or even a third attempt, you would take it seriously anyway, regardless of the fact that the patient is denying it. Conversely, a few participants believed that in the case of a patient who repetitively presents using the same method like multiple overdoses, it should be questioned whether there is true intent guiding their action.

One of the participants also suggested that it was important for health care professionals to have the necessary knowledge and skills to know what patients are trying to

say, and what they really mean, instead of simply believing what they are telling the health care professional. One of the medical interns described the difficulty of the situation:

You're always very suspicious, because you can have a high -- you can be very well, high- functioning [...] They turn around, look a doctor in the eye and say to you, listen, I'm not going to do it. I know better now...I've learnt my lesson kind of thing. I struggle with that a lot, personally.

Participants suggested that the ambivalence experienced by DSH patients was usually related to the concept of intent. Participants discussed the group of DSH patients who might be really suicidal, who have the intent to take their life, but without being aware of it or accepting it. While these DSH patients may not always be honest, some participants felt that it might not always be that it is on purpose. Participants continued to suggest that this may be due to the fact that patients may deceive themselves into believing that they are not really suicidal, when they may be really depressed to the extent that they have the intention to engage in DSH or to take their own life.

Participants also suggested that some DSH patients lied about their suicidality in an attempt to be discharged, so that they can engage in DSH behaviour or complete suicide. One of the psychiatry registrars explained:

If they are serious about wanting to die, maybe able to mask the intent and be able to say no, I didn't really mean to do it so that they can be discharged to do it again. So *ja*, I think it is difficult.

When it came to DSH patients who did not have true intent to take their lives, participants mentioned that sometimes DSH patients might be so overwhelmed by their life situation that they do not know how to handle it. As a result of this, they engaged in suicidal behaviour. However, participants argued that these patients may simply want a solution to their problems, rather than having true intent to take their own lives. As one of the 6<sup>th</sup> year medical students suggested:

Patients aren't very honest about things like this, it is not like they want to trick the doctors and walk away and commit suicide, they are looking for help.

Participants also discussed DSH patients who do not have any real intent to engage in DSH or take their own lives. Such patients may be informing health care professionals that

they are suicidal and claim to be at risk and therefore need to be hospitalised. One participant referred to such patients as being “trained” in what to say in order to get admitted to hospital. There may be many reasons for this type of behaviour, but it is most important to note that the participants experienced this group of patients as manipulative and frustrating.

**5.2.4 Discontinuity of care.** It was the lack of resources, and especially the lack of staff members, that resulted in a discontinuity of care. Individual DSH patients were rarely assessed and treated by the same staff member more than once. There was no allocation of patient to health care professional, indicating that DSH patients were seen based on the health care professionals’ availability. Participants reported contributing factors like the issue of staff working in shifts and the issue of employing nurses through an agency.

**5.2.4.1 The issues surrounding shift work.** The entire field site operates on a shift-work basis, which means that health care professionals work according to the hours their shift indicates and then “handover” patients to the next staff member once their shift is over. This means that health care professionals rarely see a DSH patient through the system - from admission to discharge generally resulting in a discontinuity of care. One of the medical officers explained this challenging situation:

In the ED, it’s shift work. So... doctors finish probably eight to twelve-hour shift, transferring, handing over to the next doctor, for the night or whatever. So the medical itself might take eight hours to fix and then we’ve got the brain to fix, and then now your shift has ended and you’ve handed over to the next doctor. Now they’re finally stable and now it’s a different doctor seeing that person. So they probably might not have much history. It might be a shorter interview... So a bit of the history might be lost.

In addition, participants also reported a discontinuity of care in the EPU, with DSH patients being reviewed by different psychiatry registrars on a daily basis.

**5.2.4.2 The challenge of working with agency nurses.** Not only is there a lack in numbers of staff but there is also a subsequent lack of permanent staff members, which forces the hospital to make use of nurses working for agencies. All of the permanent nursing staff members in the EPU discussed the challenges surrounding the system of having to use agency nurses. They also said that although they can put in a request to try and get the same nurses from the agency every time, there is no guarantee of this. Participants who were

permanent nursing staff expressed the importance of trying to get the same nurses from the agency each time in an attempt to establish some sort of routine and stability. One of the nurses explained the situation:

En as jy net gewoon raak aan die persoon dan raak hulle gewoon, dan is dit miskien môre weer iemand anders. So dit maak dit 'n bietjie moeilik. Maar as dit *constant* dieselfde mense is, dan maak dit baie makliker dan want ons is almal gewoon en hulle begin vasvat. Dit plaas minder druk op die permanente *staff*. [And if you just get used to the person, they get used to...then maybe tomorrow, it is someone else. So that makes it a bit difficult. But if it is constantly the same person, then it makes it a lot easier because you are used to the person and they start to get the hang of things. It relieves the pressure from the permanent staff].

### 5.3 Health Care Professionals' Experiences and Perceptions of DSH

**5.3.1 Emotional responses.** All participants reported that their interaction with DSH patients evoked strong emotional reactions among staff members. One of the psychiatry registrars expressed this by saying:

I think a lot of people roll their eyes when they hear it's another suicide attempt or an overdose or whatever.

A wide variety of emotional reactions to DSH patients were reported, including frustration, helplessness, sadness, and feeling anxious. Only one participant, a nurse, suggested the importance of addressing one's personal issues prior to working with the issues of someone else, without it affecting you, and in an attempt to minimise emotional responses:

Want die pasiënte kom met verskeie soorte uitdagings na jou toe ook. So jy moet *prepared* wees dan om - want jy is mos nou eintlik besig om vir hulle te help. Maar as jy ook nou *geload* is met baie goed, dan is dit onmoontlik om vir hulle regtig te help. Want hulle is *sickly*. Want jy sit ook mos maar met jou *baggages*... Jy moet *deal* met daai goeter want jy sit veral in toe ek *therapeutic* gedoen het, want jy sit in 'n groep en gesels met die pasiënte en skielik is daar 'n persoon wat jy kan *identify*. [Because the patients come to you with a variety of challenges. So you have to be prepared to help them. But if you have your own problems and issues, it is really impossible to truly help them, because they are sick. Because now you also sit with your own "baggage" – you have to deal with those things, especially when doing therapeutic

work. Because you sit in a group and chat to patients and suddenly there is a person you can identify with].

**5.3.1.1 Frustration and helplessness.** Participants expressed frustration when interacting with DSH patients. Firstly, several participants experienced feelings of frustration when dealing with DSH patients who are manipulative. A psychiatry registrar explained how DSH patients can evoke emotional responses by placing all the responsibility of their suicidal behaviour on the health care professional:

Suicide attempts and assessments can be a range of things. They're never entertaining, okay! They can be frustrating because there's often - the countertransference can be quite strong. Someone can be saying all the right things, but it's incongruent with the effect. The classic thing is when someone goes, "when I go out and kill myself I'm going to sue you". It's like, "I'm not actually going to kill myself, but it's making it your responsibility to worry about it".

Not only did participants report feelings of frustration, but they also discussed an added sense of anxiety and stress owing to the perceived responsibility for the DSH patient. I will return to the theme in the subsequent subsections. It was reported by several participants that dealing with DSH patients is both challenging and frustrating, as staff members often perceive these patients as neglecting their health by harming themselves deliberately. One of the psychiatry registrars offered the following explanation:

They're damaging themselves I think, and I think it's difficult for medical professionals to deal with someone who's inflicting something on themselves... So it almost doesn't make sense for medical people, because it's exactly the opposite of what they believe in.

To reinforce this notion, a few participants also mentioned the issue of adolescents' non-adherence to their medication (viewed by participants as a form of DSH) as frustrating. They also indicated that they feel helpless as a result of not being able to control that. One of the psychologists explained the frustration of the situation:

What happens is that they deliberately - they are insulin dependent so they have Type II diabetes - so anyway what happens is they deliberately don't take the insulin... So some of it is around almost a rebellion against actually having this condition, and having to live with this on a day-to-day basis just in a typical adolescent fashion.

Participants also experienced a strong sense of helplessness and hopelessness in the management and treatment of DSH patients. Apart from patients not accepting responsibility for their situation, and not cooperating with the health care professional, these feelings of helplessness also stemmed from factors such as some patients engaging in DSH due to social stressors – issues which health care professionals cannot change. One of the 4<sup>th</sup> year medical students discussed one of her experiences:

She was already planning her next attempt and it was also quite unnerving because she said “no, I know what to do, I know that I will stay here for three days and I will pretend that I regretted and that I am getting better but I am already saving up to buy paracetamol to overdose next month”. We did not really say anything, we did not know what to say, I just felt pretty hopeless about the situation because she clearly wants to die. Even looking at her home circumstances [...] so as much as you want to help, I do not know that there is that much that we can do, because even if you do treat her with anti-depressants she is just throwing them away [...] I think the big problem lies in her social circumstances and I do not know what the solution to that.

Moreover, health care professionals reported a sense of helplessness in preventing patients from engaging in suicidal behaviour. This lack of control has made these participants feel a sense of ineffectiveness because they cannot help all DSH patients they encounter. The perceptions of health care professionals regarding the prevention of suicide will be returned to in section 5.3.4.2.

In addition, participants also reported it to be difficult and frustrating to assess the DSH patient’s suicidal intent. Patients who were untruthful regarding their intent and who were experienced as being manipulative, negatively impacted the health care professional’s ability to develop a relationship with that patient, as mentioned in section 5.2.3.1. However, these types of patients, especially adolescents, also evoked emotions like frustration in health care professionals they interacted with.

Participants articulated a perception that adolescents who engaged in an act of DSH are typically doing so to seek attention, or as a result of conflict with their family because they struggle to communicate efficiently at that age. As a result, participants found it difficult to assess the true intent of this vulnerable age group, and struggled to distinguish between intent to die and reacting to a situation of conflict in a typical adolescent way. In the following quote, a psychologist emphasises this challenge of working with adolescents and

how the way their perception of engaging in DSH and the consequences may be challenging to the health care professionals having to respond to these subgroups of DSH patients:

One of the girls, she told me, she was about 16, she told me that she knew that she wasn't going to die she just took enough to land herself in hospital because she wanted to get out of the home situation. And the way she literally explained it was, she googled it... and she googled exactly how many you need to take to land in a coma but not to be fatal.

**5.3.1.2 Sadness and tragedy.** Some participants reported feelings of sadness that surface when interacting with DSH patients. One of the 4<sup>th</sup> year medical students added that dealing with medical issues proves to be a more pleasurable and rewarding experience:

I do not know how much satisfaction I would get from it, just this feeling of that you can never quite cure them, but I think it is also quite a saddening field. I do not think I would want to work like that for the rest of my life.

Something that was experienced by several participants and that challenged them emotionally was the sense of tragedy that these DSH patients evoked in staff members. One psychiatry registrar illustrated this in the following quote:

Tragic. Tremendously tragic. It evokes emotion, waste. Waste of life. Waste of... their life.

Participants expressed sadness as a result of the fact that some patients, who considered this as their only option, do not always realise that they need help and often have no insight. One of the psychiatry registrars felt that there are always avenues to access help in order to try and find a solution, and that there should always be an option other than to take your own life:

So that's the tragedy of it for me is that something could have been, could have helped make that person's life more hopeful. So if they'd only looked in the right places.

Some participants continued to say that sadly, they also experienced an attitude, amongst people in SA that taking your own life is not frowned upon. A few participants continued to say that people from their communities argued that suicide or DSH is not necessarily the worst thing that can happen to you. It is also viewed as taking the easy way

out, as opposed to struggling or working through your problems. A nurse illustrated how this “culture” has taken up residence in communities in SA:

Jy skrik elke keer as jy dit hoor. Maar persoonlik waar ek bly is self-moord ’n alledaagse ding. Weet jy dit maak dat mense sien self-moord is as hulle begin koud raak vir moord, of enige iets soos daai. Ek sien dit in my *community*. En dit is nogal iets om, is nogal - hoe kan ek sê? - hartseer om te sien, en ook dis somyds baie ’n mens kan nie glo dat die samelewing so vêr is dat moord of dood niks beteken vir mense nie. Dit is amper soos ek sal ’n bord kos voor my het en dan eet ek en dan vee ek my mond af, en dan stap ek asof niks gebeur het nie. [Everytime you hear about it you get a fright. But personally, where I live, suicide is a common occurrence. You know that it causes people who see suicide..it’s like they become obvlisious to murder, or something like that. I see it in my community. And it is rather, how can I put it...sad to see, and it’s also sometimes, you can’t believe that society is that far gone that murder or death means nothing to people. It is almost like putting a plate of food in front of me and then I eat and then I wipe my mouth and then walk away as if nothing has happened].

**5.3.1.3 Stress and anxiety.** Managing and interacting with the DSH patient was commonly experienced as stressful, because health care professionals felt that they cannot always be sure that they are making the right decision in terms of correctly assessing their intent, their risk, and in terms of deciding the treatment and management following the assessment. A few participants admitted that it scared them to assess a DSH patient because of the potential implications of missing something important during an interview, might have. As a medical intern and a social worker respectively explained:

Because it is such a high-risk, sensitive topic.

When somebody is suicidal, then there’s much more at stake, because if you do complete a suicide then there’s no turning back.

This social worker continued to tell me of a patient they had lost and as a result, how it increased their anxiety of working with DSH patients. This participant emphasised that while it was a long time ago, and she had more experience now, the risk involved still resulted in her experiencing high levels of anxiety:



So that was all very traumatic, leaving me deskilled and hard to trust patients. I wouldn't send anybody home, I admitted everybody...I'm less scared now, but there is still the risk. I do always worry. What if I miss something? Because it's an awful feeling to lose a patient.

There was also a general concern and anxiety pertaining to the safety of the DSH patients while in hospital. Participants reported feeling anxious, when assessing a DSH patient, out of fear that the patient might try to engage in DSH during the interview. During my time of observations, there were three occasions where, patients who were admitted after an act of DSH, attempted suicide again while in Casualty. In addition, several of the nurses specifically expressed concern of what might happen should a DSH patient be left alone too long in the EPU:

Selfs as hulle in die toilet is vir sewe minute dan wonder ek wat maak hulle agter daai toe deur want daar as hulle alleen, dan sal ek gaan kyk. [Even if they are in the toilet for seven minutes then I wonder what they are doing behind that closed door because they are alone... then I will go check].

This participant, who had more than 20 years of experience working in psychiatry, said that regardless of the experience, the fact that you never know what a DSH might try to do whilst in your care, still made her feel anxious and scared.

Several participants said that it was more difficult for them to work with patients who engaged in self-injurious behaviour than the DSH patient, mainly because of the personality elements involved. One participant described a specific incident where a patient who cut herself was flaunting her cuts. This 4<sup>th</sup> year medical student said that they experienced this as an unfamiliar situation, and did not know how to interact with such a patient:

It was a very strange personality; you know when you just can't manage to connect with someone.

Specifically, participants experienced high levels of stress and anxiety when assessing the suicidal intent of a DSH patient. Participants said it was important to consider the strong link between impulsive behaviour and DSH. Many participants believed that impulsive acts of DSH are less serious. However, some participants argued that just because someone has engaged in DSH impulsively, meaning that it was not a premeditated act, does not mean that

it is not as serious. The following nurse argued that the danger in this type of patient's behaviour lies in the fact that they might get it right accidentally:

Hulle maak my bang. Die wat net 'n paar drink, wat dink vier panado's sal hulle nie dood maak nie. Of want - dit bly gevaarlik, hulle kan hulle self misgis en dan kan hulle sterwe. [They scare me. Those who only drink a few...who thinks that four panados won't kill them. Or because... it is still dangerous, they can make a miscalculation en then die].

**5.3.2 Stigma attached to DSH.** Whilst some participants thought a stigma existed amongst the public, it was commonly reported that hospital staff attached a stigma to the DSH patients they managed and treated. Many participants had experienced or observed a stigma within their work setting. Participants reported that the stigma existed because of several reasons like DSH patients taking up valuable resources in the form of bed space and time from health care professionals. One of the 4<sup>th</sup> year students offered the following explanation:

I think a lot of people get angry at people who try to commit suicide, so there is a lot of stigma around that. Definitely applicable to staff. I think people are angry because they think "oh, it is a bit of a waste of...", and stuff like that so yes, definitely.

These type of beliefs were echoed by a senior staff member who I have observed expressing anger when discussing a patient who has spent 5 months in hospital following a medically serious overdose. This anger was related to the fact that the patient had cost the hospital a significant amount of money, and had used a great deal of resources as a result of her suicide attempt. In relation to this, participants suggested there seemed to be an attitude of participants feeling some patients are more "deserving" of bed space and other resources, in comparison to the DSH patient who has caused his or her own injuries. I will return to a discussion of the health care professionals' attitudes in the subsequent section.

Participants added to this by saying that the stigma as a result of a feeling of resentment towards these DSH patients was usually observed among non-psychiatric medical staff. As a psychiatry registrar explained:

Definitely from other disciplines. Probably less from the psychiatrists themselves, depending on how tired they are. But I would definitely say that there is stigma attached to it. Because doctors are in general working very hard to save lives, so if

somebody has come in wanting to take their life, they are immediately angry with that patient...it's something I've heard from doctors.

A few participants asserted that this attitude of resentment towards DSH patients may often be misplaced. This is especially in the context of the ED, where the focus is purely on the medical, and subsequently the doctors do not always care about the context of the DSH behaviour. As one of the psychiatry registrars explained:

You end up clogging up the Casualty. There's somebody choking to death on something, and you've come in with your little suicide attempt. Why are you burdening us with this problem? I'm trying to keep everyone alive. I've heard people say stuff: I'm trying to keep everyone alive, we're in Casualty. You go in here, you're healthy and now you do this to yourself. Why are you so stupid? And they don't know the story. They don't know that this 15-year-old has been raped by the uncle, or whatever.

One participant suggested that the lack of experience in dealing with these patients may result in the fear of not feeling fully equipped to manage this type of patient confidently. One participant suggested this stigmatised reaction to DSH patients to be a result of the lack in experience, the anxiety results from the interaction with a DSH patient, as discussed in section 5.3.1.3, and the hospital being under resourced. One of the psychiatry registrars explained:

The worse are the day hospitals because it's very junior people, so it's community service doctors. So the referral letters can sometimes be so derogatory: third suicide attempt, exclamation mark, exclamation mark, exclamation mark. It's ridiculous. She is manipulative. Of what?... It's burn-out, it's fear. It's frightening when somebody wants to kill themselves.

One of the nurses also suggested that the emotional responses experienced by casualty staff members also possibility contribute to them wanting to hand over the responsibility of managing the DSH to a mental health care professional, as soon as possible:

As jy ook dink aan hoe psigiatriese pasiënte behandel word in ander sale en soos hier voor in die casualty department en die medical ward, daar in trauma, in ander sale. Sodra hulle 'n psigiatriese pasiënt het, dit is amper so hulle kan nie gou genoeg ontslae raak van die pasient nie. Ek het al baie ervaar. Dis amper so hulle kan nie met

die psigiatriese pasient, die pasient moet net uit die saal uit en moet *Emergency Psychiatry* toe gaan. Hoe vinniger hulle kan uit. Maar ek weet nie of dit mense... miskien want hulle weet nie hoe om met die pasiënt te werk nie en of dit *stigma* is, of dit... partykeer dink ek ook dis hulle vrees. [And if you also think about how psychiatric patients are being treated in other wards and like in the casualty departments and the medical wards, there in trauma, in other wards. As soon as they have a psychiatric patient, it is almost like they can't get rid of that patient fast enough. I have experienced it many times. It is almost like, they can't... with the psychiatric patient, the patient has to leave the ward and needs to go to Emergency Psychiatry. As quick as possible. But I don't know if it is people... maybe they don't know how to work with that patient or maybe it is stigma, or... maybe I think it is their fear].

Participants reported a stigma that is attached to specific subtypes of DSH patients, instead of the whole spectrum. One participant interestingly suggested that a stigma existed because of minorities within the suicide spectrum, rather than the majority of DSH patients. One of the medical interns suggested that as a result, staff members were more likely to stigmatise patients with BPD who presented with parasuicide episodes, than other DSH patients:

I think also to the medical staff, because even they get really quite irritable and angry when a patient has parasuicide and they are like "oh, this is another parasuicide, they must just go back home and sort out what they need to sort out".

Participants felt these patients took up valuable resources and valuable bed space, while not really being in crisis and for attention-seeking purposes. Although it was reported that doctors were more likely to stigmatise patients than psychiatrists, one psychiatry registrar stated that when it came to this subtype of DSH patients, even psychiatrists working in the EPU stigmatised DSH patients:

But if you've worked in a place like the EPU where a lot of the patients are personality / malingering associated, the psychiatrists themselves also become, they also stigmatise patients.

Lastly, several participants reported that this stigmatisation of DSH was associated with it being a mental health problem, as opposed to it being a pure medical issue. A medical registrar explained:

Because if you think about is a Type II diabetic who's eating badly, we don't blame them for the diabetes.

While it can be argued that the diabetic patient and the DSH patient are both responsible for their own actions, and subsequently the results of these actions, the DSH patient is often judged and stigmatised as opposed to the diabetic patient.

### 5.3.3 Negative attitudes towards DSH patients

**5.3.3.1 A lack of empathy.** Several participants, like the following 4<sup>th</sup> year medical student, reported health care professionals to commonly display a lack of empathy regarding DSH and DSH patients:

I think a lot of the time suicide attempts are not treated with empathy, people are looked on as being silly or selfish.

Several participants reported this lack of empathy to be a result of having difficulty understanding why people would engage in DSH behaviour. Subsequently, they found it challenging to feel empathetic when they were unable to make intellectual sense of the DSH patients' behaviour. As a medical registrar and a 6<sup>th</sup> year medical student explained respectively:

From a personal point of view, I've never taken an overdose. And I don't know why somebody who's had an argument, say with their boyfriend or girlfriend - we've all had arguments with loved ones - and I've never felt the need to take an overdose.... So I'm not quite sure why some people have that inclination.

Like I can't quite comprehend, as a mentally well person, why anyone would want to do it.

In addition, one of the nurses also suggested that it was much easier physically treating the DSH patient than trying make sense of the reason for their behaviour:

Ek dink dis maklik om hulle te *treat but* dit is moeilik om te verstaan waar *and you try not to judge*. [I think it is easy to treat them but it is difficult to understand and you try not to judge].

Several reasons could account for this lack of understanding. However, one of the common issues participants highlighted was the fact that they attached great value to life and were therefore unable to understand why people would end their own life, as argued by this psychiatry registrar:

For me life has - is of enormous value and what we do with our lives is of eternal significance.

Ultimately, participants struggled to understand why patients would harm themselves deliberately. Even the few participants, who expressed understanding of patients who engaged in DSH, added that they were still not supportive of the behaviour and viewed DSH as an option that should not be explored. A psychiatry registrar and a social worker both explained:

I can understand how life can get to a point where it appears hopeless. But yet as a result of personal beliefs, I had to vote, no matter what happens, for me it's never hopeless.

You understand the frustration, but you don't support the decision.

I will return to the ability of health care professionals to understand and relate to DSH patients and their lack of judgement as a result, in section 5.5.2.

**5.3.3.2 Perceptions of religious beliefs regarding DSH.** The majority of participants did not voluntarily mention viewing DSH through a lens of religious judgment. Only a small number of participants discussed the relationship between religion and DSH, usually as a result of personal convictions. A few participants suggested that DSH is something that is not usually talked about owing to religious reasons. Other participants thought it played an important role because certain religions prohibit suicidal behaviour, as doing so will prevent them from going to heaven. As a 6<sup>th</sup> year medical student and one of the social workers respectively suggested:

Well certainly I know that religious people handle it differently. I know that... if you attempt suicide, or if you commit suicide, then you don't go to your respective heaven. You are looked down upon by God.

Suicide, as a Christian, I see it as a bad thing. Because even if you do suicides, it's like you are still committing a sin. You are killing someone and there's this notion that says a coward don't go to heaven. The minute you take your own life, it means that you are afraid to overcome the challenges that of God.

In contradiction, a few participants, like the following psychiatry registrar, suggested that DSH was not necessarily an unforgivable sin:

I think that the decision to live or die resides with God but I don't think it is like the unforgivable sin or... you know, I don't think that.

A medical registrar added to this by emphasising that while his religion (in principle) judges suicide, he thought that someone who suffered from mental illness and who engaged in DSH behaviour as a result, might be forgiven:

I think there is a lot of religious connotations and from a personal point of view, no, I'm not allowed to commit suicide so I'm not going to attempt it. But if you're mentally unwell...if you're severely depressed, which is an actual mental illness, then my personal opinion is one can't help it if you do it. And my religion does make some sort of – what's the word I'm looking for? – it does allow mental illness.

This participant also implied that suicidal behaviour, linked to social stressors, may not necessarily be allowed or forgiven.

Lastly, a 6<sup>th</sup> year medical student had an interesting perception of the idea of religion and suicide. This participant said that someone who takes his or her own life is brave because of the unknown the afterlife represented:

I think there should be another option other than to kill yourself. Because you just die and you don't know what's going to happen to you. So I think they are so brave that they would rather die than live what they know. Like just to die. Because when you die you don't know what's going to happen.

**5.3.3.3 Perceptions of and attitudes towards subtypes of DSH patients.** Several participants reported negative attitudes specifically towards subtypes of DSH patients. Participants expressed that it was difficult and frustrating to manage and treat these patients. These subtypes of DSH patients included the patient that presented repetitively at the ED and the BPD patient.

While participants reported to find it difficult, frustrating and stressful to work treat DSH patients in general, these feelings were reportedly amplified when dealing with a BPD patient who engaged in DSH behaviour. One of the psychiatry registrars suggested that health care professionals might often experience strong emotional responses when dealing with these patients:

So borderline can purely mean the diagnosis: borderline personality disorder, or it can mean countertransference. Most of the time when somebody's called borderline I think it's got to do with countertransference... called borderline by psychiatry, registrars... my experience is, the more junior you are, the more inclined you are to use that word.

In addition, a psychiatry registrar suggested that in comparison to other patients who are physically ill, dealing with BPD patients often evoked a sense of irritability amongst staff members:

Obviously you get a bit irritated probably with the personality disorders more than the people who are unwell.

I have also observed a psychiatry registrar argue that siding with or supporting a BPD patient was "like being the lawyer of a criminal...". This participant continued to say that it was not unexpected that these patients kept reappearing in the system, due to the lack of sufficient mental health care input they receive:

They don't really get proper help because nobody likes them.

The participant suggested that although some individuals may feel empathic towards patients with BPD, the system in the hospital generally did not do the same. In addition, participants also expressed negative attitudes towards patients who repetitively presented with DSH, like this 6<sup>th</sup> year medical student reported:



And then it is difficult because ... they just keep circulating, and you feel a bit frustrated because they are taking up resources and time that could be spent on patients who are very willing to interact with you... It is just a few silly individuals who circulate through the system again and again .

In addition, participants reported that the majority of repetitive patients were BPD patients. As mentioned in 5.3.2, Stigma attached to DSH, the general perception was that repetitive patients took away time and resources from others, and that there is less hope for these patients to reduce their risk of DSH behaviour and (ultimately) suicide.

### **5.3.4 Perceptions regarding the prevention of suicidal behaviour.**

**5.3.4.1 A perceived inability to prevent suicidal behaviour.** Participants commonly reported that suicide is not preventable, and that nothing can be done to reduce the suicide mortality rate. As a 6<sup>th</sup> year medical student and one of the psychologists explained respectively:

To be honest, if I am horribly honest with you, I don't think there is anything we can do to decrease the amount of suicides.

Op die ou einde as daar iemand is wat, ek wil amper sê regtig wil uitgaan en hulle lewe wil eindig, hulle gaan dit doen, maak nie saak hoeveel ek wil amper sê *hurdles* in die pad gooi nie. *They're going to find a way*, so ek dink dis moeilik. [In the end, if there is someone that, I almost want to say who really is out to end their life, they will do it, it doesn't matter how many hurdles there are in their way. They are going to find a way...so I think it is difficult].

Participants, like this medical officer, also expressed a view that suicide is not only not preventable, but that it is also an integral part of the society:

Dit is deel van die menswees om somtyds te sukkel en dis iets wat van die eeue af deel is van die mensdom en met ons sal bly. [It is part of being human to sometimes struggle and it is something that has been part of humanity for centuries and will stay like that in the future].

One of the medical officers suggested that suicide to be an integral part of society as a result of poverty and a lack of education, that are pertaining issues in SA:

It's like all those things. It's related to lots of things. Uneducation, poverty... so if you can treat those things, which is unfortunately the way humanity goes. So I think they'll always have that problem.

Participants suggested that the general “culture of violence” that has taken up residence in SA has made suicidal behaviour “socially acceptable”. In addition to participants experiencing this as tragic, as previously mentioned in section 5.3.1.2, this has rendered the prevention of it more challenging. This psychiatry registrar explained:

It is something that people easily talk about, even in the communities. “Oh this person committed suicide”. There isn't that sense of cringing. It has become just like people getting murdered is like news going in one ear and out of the next ear. I think those kind of things are becoming more socially acceptable because South Africa, ok society in general, is becoming more and more violent, and people are desensitised to violence. Nobody cares. On TV you see people getting stabbed, you see people getting shot, and you see all these things, so it is not a big thing to be violent towards yourself and to kill yourself. So I think it is that.

#### ***5.3.4.2 Preventing suicidal behaviour out of the health care professional's control.***

Some participants expressed the importance of having to accept their limits as health care professionals. One of the participants added that accepting these limitations might actually be beneficial to you as the health care professional. As one of the psychologists suggested:

Ek dink daar is tog waarde daarin om vir jou as ‘n *health professional* om te besluit of te besef eerder waar ons rêrige beheer ophou. Ek dink partykeer trek jy meer jou hare uit wanneer jy probeer beheer vat want ons kan nie mense beheer op daai plek nie. *They're going to do what they're going to do at the end of the day.* [I do think that there is value for you as a health care professional to decide or rather to realise where your control actually stops. I think sometimes you pull out your hair when you try to take control because you can't control people like that].

In addition, a psychiatry registrar echoed many other participants in arguing that one could only manage the DSH patient, and try to prevent future suicidal behaviour, based on the information they provide you:

It's quite difficult to do that, because you have to rely on what the person's saying and, no matter how intuitive or experienced you are, that can still let you down. So you just have to accept that there are limitations to it.

One example of such a limitation was the health care professionals' inability to control the stigmatisation of DSH in communities, as explained by one of the psychiatry registrars:

I think a lot of the time people are not going to say how they're feeling because of the stigma attached to it, and will act on it despite having a supportive family around them who is aware that there is something going on.

**5.3.4.3 A reluctance to take responsibility for suicidal behaviour.** Participants commonly reported that although it was their responsibility to provide DSH patients with the best possible care while they are in hospital, they could not prevent them from taking their own life. One of the psychiatry registrars expressed that, especially at the start of one's career, there may be the perception of feeling more responsible for DSH patients than which is possible in reality:

It's frightening, because it's a lot of responsibility to... it's perceived responsibility sometimes, because I think sometimes we - especially in the beginning, we take on a lot of the responsibility.

In addition to participants expressing the prevention of suicide to not truly be possible, participants added to say that it was also neither their role nor their responsibility to prevent suicide. A reason for this reluctance to claim responsibility was because participants felt that by the time patients reached the ED it was too late for health care professionals to intervene. One of the nurses explained this in the following quote:

Ek sal sê iets kan gedoen word, maar nie... dit lyk nie of dit moontlik is op die vlak want by die tyd wat hulle by die *hospital* kom dan het hulle klaar iets probeer. [I would say something can be done, but...it doesn't look like it's possible at this level because by the time that they are admitted to hospital then they've already tried something].

Only one participant felt that the number of DSH presentations could be reduced if the emergency services were better. They also believed that the system should take more

responsibility when it comes to repetitive DSH patients. One of the medical officers emphasised this lack of responsibility claimed by the ED as a system:

I think it's bad to have a depressed patient with repetitive suicidal attempts. I think it's really bad news. We failed this person. The system has failed the person. He came in the first time, the problem was never sorted out. So I think the system has failed. Yes, you should not get that as a repetitive patient. If it's a borderline patient, it's a different story. If it's a schizophrenic patient it's a different story. They do relapse. Not the depressed patient, with suicidal attempt. That I think is a problem. I think yes, you failed. The problem was never sorted out.

This participant also emphasised the importance of focusing on fixing the initial problem. I return to this issue in the subsequent section.

Lastly, one of the psychiatry registrars viewed his role as a health care professional as nothing more than just a job. What's not mentioned here, however, is how this participant would define the word "job" and the responsibilities it would entail:

Largely I think, *ja* I can't say I become very involved, I am quite detached, I do my job.

I return to this issue of perceptions of roles and responsibilities of health care professionals in the discussion.

**5.3.4.4 *The lack of preventative efforts on primary health care level.*** The majority of participants continued to say that they believed cases of completed suicide and DSH presentations could possibly be reduced if more emphasis was placed on trying to intervene with individuals engaging in DSH behaviour on a primary level of health care. Participants suggested that a greater focus should be placed on preventative measures, and care for those at risk of engaging in DSH behaviour. Participants seemed to be frustrated at the idea of there being a great deal of focus on available avenues for help once a person has engaged in DSH, but not so much focus on prevention on the primary level. As one of the nurses mentioned:

Ek dink nou net daar is so baie dinge wat beskikbaar is vir nasorg...as die pasiënt al reeds 'n poging aangegaan het. Maar daar is niks vir voorsorg nie. Hoe kan dinge voorkom word. *Where do we need to step in* voordat dit 'n risiko raak. [I was just thinking, there are so many things available for aftercare...for after the patient has

attempted. But there is nothing for prevention. How can things be prevented. Where do we need to step in before it becomes a risk].

Suggestions of interventions on a primary level of health care included focusing on psycho-education in schools, and focusing on life skills such as exploring different coping mechanisms, problem solving skills and ways to help regulate emotions. Participants felt that implementing these measures would create a valuable opportunity for reducing the number of DSH presentations and ultimately, preventing suicide. One of the psychiatry registrars specifically emphasised the importance of focusing on teaching individuals the value of life, as he believed that the benefits of valuing yourself would also infiltrate into other areas of your life:

I think it is good to, you know, they focus on sex education and using condoms, I think it is good to teach them and inform them, but I think it is also good to teach people about good self-esteem, valuing yourself, caring for yourself, exercise, eating right, looking after yourself, caring about your neighbour. I think it helps and I think it will even now have a knock-on effect on these other things, like, safe sexual behaviour and stuff, because when people value themselves...they are less likely to do high risk things. So I think I would advocate for it.

Subsequent to the participants suggesting that suicide prevention should be focused on the primary level of care or preventative care, participants commonly highlighted the importance of fixing the original problem when a DSH patient initially presents at the ED. As this medical intern suggested:

I think my issue would really be to try and get to the crux of what the problem is, because there is no point in trying to close the pipe when the pipe has burst open underneath the sink. Because then you have not really treated what the problem is, the room is flooding, just close the main pipe and that flooding will stop so it is just, if she is coming in for the fourth suicide attempt then you must know that it is serious. Then what is the problem? I think I would just try and investigate what's going on, just to try and help out a bit more.

Participants also reported that addressing the issues upon the DSH patient's first presentation is especially important in preventing or, at least, reducing the number of DSH patients repetitively presenting at the ED. Some participants also added to this by suggesting

the increased risk the repetitive patient carried for ultimately completing suicide. Participants also reported that addressing the problem of access to resources would reduce the risk of suicide and DSH behaviour. Several participants stated that primary prevention is especially crucial owing to the poor community follow-up system once DSH patients leave the hospital.

One of the 6<sup>th</sup> year medical students continued to argue that while preventing suicide may not always be possible, the focus should be on preventing the causative factors such as mental illness:

It seems a bit strange to say suicide is preventable but depression and the few complications that there are, are preventable.

In addition, and as previously mentioned, the stigma attached to mental illness, and especially DSH behaviour, within communities prevents people from getting help in the early phases of the development of their psychiatric or psychological difficulties. One participant also emphasised the importance of being aware of psychotic symptoms - a mental illness often associated with DSH - and that early identification of these symptoms are crucial and that families should be aware of the value of seeking help early.

#### **5.4 A Lack of Training and Knowledge Regarding DSH**

While there were some participants who reported that they have received adequate training, several other participants mentioned they had received as little as one lecture on suicide, or none at all, during their training. One of the 4<sup>th</sup> year medical students emphasised the importance of receiving training in suicide

It is a matter of life and death, and I do not think that one lecture is enough to cement it properly in your mind. So yes, like every year they could repeat it just to assess risk, but also the management.

Participants commonly reported that they felt more training was needed regarding suicide, because this would have been helpful in their approach to DSH patients, as this nurse suggested:

Ek dink hulle moet meer kursusse eintlik vir ons aanbied. [I actually think they should run more courses].

For example, one participant stated that while their training focused on underlying mental illness often associated with suicide, such as depression, the main focus was not suicide. Other suggestions for more training included learning how to distinguish more clearly between presentations of DSH and self-injury, and how to manage the suicidal patient in general.

One of the medical interns suggested that the psychiatric training they received in medical school was not always taken as seriously as when they had received training in other sub-disciplines such as surgery:

Even when you are undergoing training in medical school departments like psychiatry, people even in under-grad do not take it as seriously as they would have if they were training for surgery. That is how it is, whereas when you undergo training for clinical psychology, even just psychology as a whole, the overall topic is important to you.

In addition, a psychiatry registrar spoke about his medical school training and said that he felt equipped with the training they received when starting out to work:

I think I was adequately trained, but I always had an interest in psychiatry so I retained a lot of the training because I was interested.

Another issue regarding the knowledge of health care professionals is the issue of conceptual confusion. Conceptual confusion refers to health care professionals confusing terminology regarding DSH and suicide and as a result, implicating the way these patients are responded to by the health care system. Participants often made use of terminology that may have the connotation of the act of DSH being less serious. I have observed that health care professionals distinguished between serious acts of DSH and less serious acts of DSH. Labels commonly used to describe less serious acts of DSH include terms like *a cry for help* or *not real suicide attempts*. As one of the medical officers explained:

Ek dink in 'n sekere sin moet ek eintlik versigtig wees om die term parasuicide te gebruik, ek dink dit skep 'n wanindruk rakende die ergheids graad van die attempt. Ek dink nie omdat die persoon dalk iets non-lethal gebruik het maak die attempt nie minder of meer ernstig nie. [I think in a certain sense, one must actually be cautious in using the word *parasuicide*, I think it creates a misconception pertaining the level

of severity of the attempt. I don't think the fact that the patient used something non-lethal makes the attempt more or less severe].

## 5.5 Opportunities to the Provision of Care for DSH Patients

Although multiple barriers throughout the field site negatively impact the care health care professionals provide to DSH patients, there were also some factors that indicated possibilities and opportunities to the provision of care for DSH patients.

### 5.5.1 Health care professionals' attitudes of empathy and non-judgment.

Participants commonly reported an attitude of non-judgment toward DSH patients. These participants also stated that it was not their place to judge a patient presenting after an act of DSH due to the fact that they could not say these people were wrong to feel and act the way in which they did. People may be going through something that you are unable to relate to or that you don't know the full context of. The importance of maintaining a non-judgement was emphasised by two nurses:

What I actually learnt over these years would be that we shouldn't judge, so I just treat all the patients none judgemental as if they were normal human beings...with the suicidal patients as well. I don't want them to feel that we are nursing them or nurturing them in a different way than what we are in a normal way. If it was just affecting - where we had just a ward for suicidal patients, then I think it would have been a different approach.

So as hulle hier kom, kan jy nie nog hulle verstoot en *judgemental* wees nie, en baklei met hulle of hard wees of wat nie... Jy moet op 'n plek wees waar jy hulle sien *beyond* wat hulle gedoen het om regtig daar *empathy* pille te gee en regtig vir hulle 'n hand uit te reik na hulle toe. [So if they come here, you can't push them away and be judgemental, and fight with them or be tough with them or something... you have to be in a place where you can see them beyond what they did to really be able to show empathy and to really reach out to them].

The first quote once again emphasises the limited resources that health care professionals have to manage with. Having such a non-judgmental perspective strongly correlates with an empathic attitude towards these DSH patients. One of the psychiatry registrars illustrated the potential value of empathy:



Part of it just about getting empathy and making people feel like there is an alternative to things and there are some people that care. I'm just hopeful that sometimes kindness is enough.

It was commonly stated by participants that rather than judging DSH patients, you need to support them and guide them and try to understand the reason for their behaviour. As a student nurse explained:

Sometimes you can understand why they tried doing what they did, and they just need someone to support them and guide them. And to understand what they are going through. You don't have to judge and say "Ok, I am never going to commit suicide so why are you doing it?" You must just try to be sympathetic and try to be in the same shoes as the patient.

Participants believe that empathy and understanding are crucial, as the support from health care professionals may be a DSH patient's last hope. Several participants reported that DSH patients may have given up on life, but if there is one person, even if it is a health care professional who still cares, it may keep them alive as that patient wants to prove that person wrong. One of the nurses emphasised the importance of hope and suggested how providing a DSH patient with hope can change their suicidal intent and reduce their risk of engaging in DSH. The participant explained:

Jy moet hoop het vir hulle anders het hulle nie hoop vir hulle nie. So jy moet dit. Jy moet elke dag hoop het vir andere. Want as hulle sonder hoop gekom het, moet hulle met hoop uitgaan hierso. Dit is hulle behoudenis. [You have to have hope for them otherwise they don't have hope for themselves. So everyday you have to have hope for others. Because if they came here without hope, then they have to leave hopeful. That will be the thing that contains them].

Participants reported that non-judgement and empathy could also come in the form of simply having a sense of awareness and understanding of sensitivity and risk of dealing with DSH cases. Participants, like this medical officer, reported that as a result of the situation, they took extra care when dealing with these patients:

A bit more caution because obviously they're awake and they're alert. You don't want to make this experience a negative experience, because it might be them trying

to seek for help and is this the type of help they're going to get, then they'd rather not come to hospital which is actually detrimental to them in the end.

There were also a few participants suggesting that, especially in the case of people being physically ill and with their quality of life decreasing, it would be unprofessional of a health care professional to pass judgement. One of the 6<sup>th</sup> year medical students explained:

Professionally I would be very understanding. My chronic cancer patients, my AIDS patients, if they decide to overdose themselves on the morphine, then I think it is very wrong, whatever your personal beliefs are, to ever judge these patients. Whatever their reasons, they have reasons.

This participant added that even though, in her professional capacity, she would not judge and try to understand, in her personal capacity she believes that everything happens for a reason, and subsequently does not view suicide as a way out.

Some participants also seemed to have empathy especially with BPD patients. One participant said that often the patient with BPD who engages in DSH behaviour does not know how to manage life, and that the health care professional should not get impatient. Instead, the health care professional should be understanding and more compassionate, as illustrated by this psychiatry registrar and social worker:

I think it's very disabling to live your life feeling like that all the time.

Life broke them, they are broken.

This social worker also continued to argue that she would much rather help the borderline personality patient engaging in DSH behaviour than, for example, women who suffer from abuse and are victims of domestic violence. This participant went on to say that it was easier to work with patients who do not know where to find help, or how to access it, than those who have a choice to find help but who continue to stay in their situation, and who do not take responsibility for their situation.

A few participants also seemed to have an attitude of non-judgment as a result of medicalising the suicidal behaviour. As a psychiatry registrar and a nurse explained:

Suicide is a psychiatric illness so you can't really treat them any different.

I think it is abnormal, a normal person cannot do that, so maybe it is really psychological, you cannot control that as a person.

In conclusion, one of the psychiatry registrars suggested that empathy doesn't necessarily always have to be draining on an emotional level:

Obviously there's the burnout side-effect that goes with being empathic with everyone, but I've also learnt how to manage that. Being empathic doesn't necessarily mean taking it on. So it's going to sound weird: it's like letting these things flow through you rather than into you.

### **5.5.2 Health care professionals' ability to understand and relate to DSH**

**behaviour.** Several participants reported that they could understand why people engaged in DSH behaviour. These participants felt that they could identify with wanting a way out when things in life became too much, and said that in certain situations suicide may seem like a good option. One of the medical interns explained:

In the end, you can look at that situation and say geez, actually that pretty much looks like the only way out at that stage.

In addition, a medical registrar mentioned that stress affected people differently, and people responded in different ways, and that subsequently anyone could potentially find himself or herself in such a situation:

I'd be depressed if something like that would happen.

A psychiatry registrar added to this by suggesting that some people are exposed to such trauma that he cannot imagine them not wanting to react to their situation in the way they do:

We do these trauma screens and we ask people things, and what the world I live in is considered trauma, and the world that most people live in consider trauma, are sometimes so different. And that frightens me. And how do you not become suicidal where the neighbour's the known rapist, and nobody's been able to deal with him?

One participant, a psychiatry registrar, admitted that he is lucky to have adequate family support and could understand how people can engage in DSH behaviour when they have no support:

I personally have quite a good social support structure, so I feel ok in that regards, but if I didn't, I may be one of these patients coming in here recurrently.

Participants specifically stressed the difficult circumstances under which a large number of South Africans are living. For example, in poor SES circumstances, such as a lack of jobs, a lack of proper sanitation and a great lack of family support. As a medical registrar and one of the 6<sup>th</sup> year medical students explained:

I think part of the problem is just the on-going social issues, which we can't or are unable to address at this time.

Here it is linked to very real stuff like abuse, or substance abuse, or patients with chronic illnesses or it is mostly depression.

One participant said that people's lives are very hard, and that there are people who are alone. One of the nurses also stated that these suicidal patients really are lovely people with a lot of potential, but that their circumstances are sad and that they have given up on life. This nurse continued to say that because she can relate to their situation, and the terrible life circumstances in which they live, she has more understanding and empathy for their situation:

Ek is altyd bereid om 'n ekstra myl met iemand te stap. Want ek weet waarvandaan hulle kom. [I am always prepared to walk that extra mile with someone. Because I know where they come from].

Apart from the participant mentioning that physically ill people who engaged in DSH behaviour were more understandable, participants also suggested some other cases where DSH patients' behaviour was more understandable. Some participants said that suicidal behaviour in psychotic patients was more understandable than in depressed patients, because a depressed person can more easily seek help. Another participant said that they are especially sympathetic towards individuals who engaged in DSH behaviour as a result of social factors. Someone even argued that they would be more understanding of someone close to them engaged in suicidal behaviour, because they would know the person better and therefore understand the reason behind it. One participant suggested that they did not think there were any cases in which suicide was more understandable than other cases.

**5.5.3 Personal experience of suicide positively impacting levels of empathy.** Some participants discussed the relationship between experiencing DSH or suicide in a personal capacity and its subsequent influence on their professional capacity. The majority of participants argued that the personal experience allowed them to be more empathic towards these patients, as they could relate to the situation. One of the social workers and one of the psychiatry registrars suggested, respectively:

I think maybe it increases empathy. I think the moment something comes close it does change your understanding of it.

I think you are more empathic about it, and having had somebody in the family who's actually attempted suicide, it helps me understand what families go through. Because there's a wide range of emotions that go through a person.

In contrast to this, one of the medical interns, who had lost a close family member to suicide, said that he did not feel the experience translated into specific feelings toward DSH patients:

If you ask me about suicide, that doesn't come up in my head immediately. So it's not like a personal thing for me. I don't take my work home and I don't take my home to work... it's not an issue for me at all. That's why I say, I see these people every day and not once do I ever think about it as something that happened to me personally. So I don't use it at all. This is a very professional environment, and I try and be professional about it.

Another participant also continued to say that they do not believe that what they have experienced on a personal level had a conscious effect on them. However, they conceded that it may influence them subconsciously, though they have not really thought about it that way. This participant went on to say that they do not believe that having had personal experience with suicide has in fact made it any easier to work with suicidal patients.

**5.5.4 Positive attitudes despite resource constraints.** Participants commonly expressed positive attitudes, despite the lack of resources and the pressured system in which they have to work. They frequently mentioned that they do their best, or that they keep trying, often as an afterthought when expressing the challenges of their work environment, and working with DSH patients. Participants, like the following two nurses, illustrated a

willingness to give their best and to provide these patients with the best care possible, although it was not always possible to do so:

Maar ons probeer die beste wat ons kan met wat ons het. [But we try to do the best with what we have].

Alhoewel ons is *willing* om enige iets te doen. [Although we are willing to do anything].

However, a psychiatry registrar, also experiencing these difficulties and frustrations, has adopted a positive attitude in an attempt to cope with feelings of being unable to help all DSH patients they come into contact with:

I might not be able to help Patient Y who comes in today, but my 70-year vision is to contribute to society. So that's how I'm cognitively making myself feel better about the situation.

In several challenging situations such as the impossibility of spending extended periods of time with patients, and the issue of confidentiality due to a lack of space, participants displayed a sense of optimism. One of the nurses suggested that even though there is not always time to spend with patients, as discussed in the previous section, they always made an effort:

Ons maak tyd, ons moet tyd maak, maar soos ek sê dis *minimal*. [We make time, we have to make time, but like I said, it's minimal].

One of the medical officers working in casualty, spoke about the problem of confidentiality when talking to DSH patients, and said that the limited resources does not allow for enough space to implement greater confidentiality:

You want to take them in a private room and obviously have a proper discussion. Drawing the curtain is not really creating a private room. But limited resource, limited space, we have to improvise, so that's what we do.

One participant also argued that despite the limitations, they still give their best. However, two nurses added that they thought they could possibly do even better and improve the care they provide to DSH patients:

Daar's baie *limitations*. Daar's baie - ons probeer ons bes, maar dis seker maar nie ons beste nie, want daar's nog te veel goed wat uitgesort moet word. [There are many limitations. There are many; we try our best, but it is probably not our best, because there is still too many things that should be sorted out].

Ek probeer maar vir al die pasiënte dieselfde sorg en aandag... jy luister maar en jy probeer maar die beste vir al die pasiente doen. [I try to give all the patients the same care and attention...you listen and you try to do the best for all the patients].

## Chapter 6: Discussion

In this chapter I discuss the findings by carefully considering the barriers and opportunities to the provision of optimal care for DSH patients in the hospital. The chapter begins with a short reflection on the most significant practices in the ED. This is followed by a discussion of how these practices might be disrupted to optimally utilise the ED as a space for intervention. I conclude with a discussion of how sense might be made of the practices within the hospital.

### 6.1 Intervening with the DSH Patient in the ED

Lelliott and Quirk (2004, p. 297) discuss the vital role of the ED in caring for mental health care patients: "...no country has created a mental health care system that functions without the ability to admit people for short-term hospital care to treat their mental disorder or to prevent them from causing harm to themselves or others". Whilst I agree with the authors, I think that it is imperative to highlight that together with the importance of short-term hospital care, one must realise the importance of using this limited time optimally in order to provide interventions to DSH patients in order to reduce the likelihood of repetition and eventual death by suicide. We have found that 34% of the 200 presentations of DSH patients were treated in Casualty for injuries as a result of engaging in DSH, and were then discharged without any psychological, psychiatric or social work input. This statistic highlights the central role Casualty has to play in it being the first, and possibly the only, point of contact the DSH patient may have with any health care professional. There are multiple opportunities for intervention with the DSH population presenting at the ED.

One of the first opportunities for intervention is by means of assessing the DSH patient. The assessment tool used to assess DSH patients presenting in the ED, the PSIS, is a psychometric assessment tool. Although the PSIS may have certain positive elements, such as its timesaving quality when assessing patients in a busy environment such as Casualty, there are other issues with the use of this assessment tool.

The first issue with the PSIS is that it is only available in one language - English. What we can infer from this is that a non-English-speaking DSH patient, or a patient for which English is not their first language, may not understand all the questions and runs the risk of misinterpreting the questions. Conversely, the health care professional conducting the PSIS may also not be able to speak the home language of the patient. Therefore, in some



cases, the PSIS may lose its reliability and validity in adequately reflecting the DSH patient's need for psychiatric or psychological care.

Secondly, in contrast to the majority of other psychometric scales used to assess risk of repetition of DSH, the PSIS assesses the intent of the incident of DSH that caused the person to present at the ED (Pierce, 1977). In addition, Wagner et al., (2002) suggest that assessing the intent, as well as the lethality of the act, may provide an indication of the seriousness of the DSH patient's behaviour. However, we can question the value of having "determined" the level of seriousness or severity of a DSH patient's act, having engaged in DSH prior to their casualty presentation. Subsequently, we can argue that the PSIS score is primarily used to triage and manage DSH patients as opposed to assessing them.

Two problems arise with the concept of categorising patients by means of a score threshold. Taking into account that a high PSIS score warrants a referral to a psychiatrist and a low PSIS score warrants a referral to a social worker, the assumption is that the DSH patient with high suicidal intent is in need of a psychiatric intervention and, conversely, the low intent DSH patient has social issues that resulted in suicidal behaviour. Therefore, the underlying psychopathology may go unnoticed if the patients score low on the PSIS owing to a less serious presentation. Furthermore, one of the medical officers also suggested that a low PSIS score could be associated with BPD patients: "Two or three is more like a borderline attempt." Once again, the assumption that a low PSIS score is indicative of potential underlying Borderline Personality Disorder may result in psychopathology going unnoticed in some DSH patients.

Indeed, a higher score may be indicative of greater intent. However, McDougall et al. (2010) propose that health professionals using this scale should guard against relying on a threshold indicating low- or no risk, as any positive response by the DSH patient to any of the question should be taken seriously and should be interpreted as meaningful. It is thus evident that the PSIS should be viewed as a triage tool used to sort DSH patients presenting at Casualty in an easy and efficient manner. Therefore, it should be considered a management tool rather than a form of assessment.

Arguably, the same assertion can be applied to assessments conducted by health care professionals in the EPU. All patients in the EPU receive a MSE on a daily basis. The MSE is a practice that elicits crucial information regarding the patient's current state of mind. As a result of this, it also serves as a measurement to help psychiatrists determine who should

remain in hospital and who may be discharged. It thus seems that that the MSE also functions much like the PSIS as a means of sorting patients and making decisions about level of risk even though the MSE has not be validated for this task and its predicative ability remains unknown.

Referring patients is an integral part of a health care system, as some patients may benefit more from being reviewed by a specific type of health care professional than another. A referral, especially a referral for an outpatient follow-up appointment, was most often the only intervention that DSH patients received. However, research is in agreement with participants' reports regarding the lack of sufficient and adequate outpatient care available for DSH patients. This is both prior to admission, as a preventative health care service, and after the DSH patient is discharged from the EPU, but specifically Casualty. It was also suggested that DSH patients failed to adhere to outpatient appointments. It was commonly asserted that DSH patients failed to complete their treatment plan. As a result, these patients often reappeared in the system, placing added pressure on the ED. In turn, the ED suffers under the pressure and, once again, relies on the discharge and referral of patients to outpatient facilities.

When it comes to the treatment of DSH patients, they are generally treated medically or surgically as required on presentation at Casualty. There is a continued focus on the utilisation of pharmacological treatment for underlying psychiatric conditions or comorbid medical injuries. However, there is also a great lack of therapeutic treatment. Therefore, treatment arguably only has value in intervention with a proportion of the DSH population in the ED. One of the medical officers emphasised the need for therapeutic input:

There are a lot of problems that actually don't need a psychiatrist. They don't need medication. They actually need a psychologist who would follow them up and would continue their therapy – a good idea to implement.

The focus on pharmacological treatment instead of therapy may be as a result of different factors. The treatment of the DSH patient rarely continues beyond these necessary medical interventions. Should the DSH patient be referred for psychological input, the first assessment or review of the DSH patient by the psychologist in the EPU also serves as treatment for DSH patients. Issues such as the medicalisation of suicidal behaviour, a lack of awareness of non-medical patients and the influence of a lack of resources (such as time and bed space) contribute to the absence of therapeutic input. This issue will be readdressed in

subsequent sections of this chapter. It is evident that the focus is on a series of reviews and referrals, in an attempt to manage and navigate the DSH patient efficiently as possibly through the system.

In conclusion, one can continue to argue that should the system have implemented a psychosocial assessment in Casualty, as recommended by the best practice literature, that the assessment could have been considered a suitable intervention. Instead, the psychometric assessment tool serves as a form of management, treatment and ultimately, intervention. In addition with the lack of reliable and effective outpatient care, it is evident that the optimal utilisation of the ED as a space for intervention with these patients, is lacking.

## **6.2 Factors that Impede the Optimal Utilisation of the ED as a Space for Intervention**

We can pose the question whether or not the critique regarding the response to DSH patients is a result of health care professionals failing to optimally use the ED as a space for an intervention, or if the challenges that accompany the system's ability to respond to these patients are too difficult to overcome. Essentially, it is important to distinguish between the critique being a reflection of the "cracks in a broken system", as opposed to it being hailed as "a failure of providing quality care" by the staff members within this system, which is essentially a management issue. Several aspects of the ED system served as challenges to health care professionals in their ability to provide DSH patients with quality of care and to intervene with the population.

### **6.2.1 The nature of the setting.**

**6.2.1.1 The DSH patient in a hospital setting.** When we discuss the care that is provided to DSH patients, it is crucial to keep in mind the context in which these patients are cared for: the ED of a general hospital. As a result of this, three factors play a significant role in the care DSH patients receive: Prioritising medically injured patients over DSH patients, prioritising other EPU patients before DSH patients, and the influence of bed pressure.

The physical injury or medical condition will always be the priority of health care professionals when treating patients presenting at Casualty. This means that new patients coming into Casualty with more severe injuries will always command the attention of the health care professional attending to the needs of the DSH patient. While it can then be argued that DSH patients' physical injuries receive equal attention as their non-DSH counterparts, the same cannot be said for the amount of attention that is paid to the non-

physical once the physical has been dealt with. I will return to this discussion in a subsequent section of this chapter. Similarly, DSH patients often find themselves to be of lower priority in comparison to other psychiatric patients in the EPU who may need more “containment”. It is thus clear that DSH patients are not only deprioritised in comparison to medical patients, but also in comparison to other psychiatric patients who may be considered more in need of care.

Furthermore, an issue that was discussed avidly by the majority of participants was the concept of bed pressure. A lack of beds in Casualty meant increasing the priority of patients based on their physical injury. Therefore, patients are referred or discharged once they are medically stable because the bed space is needed. I will return to this discussion of bed pressure in the next section.

The findings also indicated that the nature of the setting has also greatly contributed to health care professionals’ negative attitudes towards DSH patients. As one of the medical officers explained:

If you have a busy emergency unit and you have someone come in with suicide behaviour, they are maybe going to be a little bit treated differently then. Nursing staff or doctors may be a little bit more irritable towards them. That is unfortunate, but you can sort of imagine it happening.

**6.2.1.2 The medicalisation of suicidal behaviour.** It is impossible to discuss the DSH patient in the hospital setting without discussing the medicalisation of suicidal behaviour. There are two parts to the medicalisation of suicidal behaviour: the underlying beliefs, and the implications of these beliefs. The medicalisation of suicidal behaviour presupposes that all who engage in DSH have done so as a result of a comorbid, or underlying psychiatric condition and ultimately disregards social issues as the sole contributing factor to suicidal behaviour. Health care professionals may medicalise suicidal behaviour for several reasons such as having to treat DSH patients in a medical setting, having a general lack of awareness and consideration for the situation and context of DSH patients, as well as a lack of training in both suicidal behaviour and its relationship to psychiatry. As a result of inadequate amount of training, clinicians are either more likely to fail to recognise psychiatric symptoms, or they explain these presenting symptoms by means of an “organic, nonpsychiatric etiology” (Pompili et al., 2005, p. 170).

The underlying beliefs of the medicalisation of suicidal behaviour and the implications of those beliefs are of great significance for how DSH patients are assessed and managed. One of the inferences that can be drawn relates to the issue of medically trained health care professionals failing to take responsibility for suicide prevention: “The medicalization of suicide has placed suicidal behaviour into the domain of psychiatry making the task of preventing suicide a problem for mental health care workers to solve” (Bantjes, 2014, p.18). In addition, Appleby (1992) also propose that all health care professionals that come into contact with DSH patients should view suicide prevention as a part of their job, and ultimately, a priority.

Moreover, an important implication of viewing DSH as a result of a psychiatric illness is how it determines the treatment that the DSH patient will receive. Owing to the fact that health care professionals perceive DSH as part of a mental illness complex, and not as a result of social issues, DSH subsequently becomes something that can be treated medically and not necessarily therapeutically.

As discussed in the literature review, the APA Guidelines (2003) suggest somatic intervention to be more suited to acute symptom relief while therapy, is more relevant when addressing long-term goals. This is significant as the hospital setting may be more conducive to treating DSH patients somatically, regardless of their needs for therapy. It is also conducive to treating patients on a short-term basis rather than focusing on long-term goals. Acute symptom relief may indeed be possible, and very likely, while long term functioning and improvement of the quality of life of DSH patients is unlikely.

**6.2.2 An under-resourced system.** Not only does the DSH patient present for care and an intervention in a primarily medical setting, but this care also has to be provided to them by a system that suffers from a lack of resources. As mentioned in the findings chapter, this lack of resources includes shortages of bed space, staff members, time and financial support. This issue is also discussed in the SA context when the causal relationship between a lack in sufficient financial resources and the care that is ultimately provided to patients is explained by Gibson (as cited in Van der Geest & Finkler, 2004, p. 1999):

The lack of economic resources leads to unequal treatment in the hospital despite the recent ideological transformations that call for equal access to health care. There is thus a continuous shifting of patients, services and staff in an attempt to provide

redress and equal health services for all. Decisions must be made regarding who should get access to beds and to maximum care owing to a lack of funds.

While these authors are not specifically focusing on DSH patients, the influence of having to provide quality care in an under-resourced system is still emphasised. In an attempt to interpret how the lack of resources influenced the level of intervention with DSH patients, I make reference to research similar to this study with specific regard to the methodology employed; the setting that was studied; and the results of the research. The work that will be referenced is an ethnographic study conducted in an Acute Psychiatry Unit (APU) in the United States of America over a period of two years, published as *Emptying Beds*, by Lorna Rhodes (1991). If this ethnographic research echoes similarities of the present study, then the title of the book, *Emptying Beds*, could be viewed as a summary of the present study. Although the work by Rhodes is set in a high-income context, some of the elements are similar in the findings, though arguably for different reasons. Rhodes (1991, p. 14) explained the situation of health care professionals having to function in a system constantly under pressure: “The staff experienced constant pressure on their beds and the constant threat of a bottleneck within the unit that would make these beds unavailable to “emerging” patients”.

It is in the context of this concept of *emptying beds* that all of the other implications, such as the lack of therapy, are better grasped. The system does not have enough bed space for the high demand of patients who are physically injured, let alone DSH patients. In addition to this, the system has a shortage of staff members, which is directly related to a scarcity of time to attend to all patients. Consequently, therapeutic input that is time-consuming and requires a longer admission period, even though the DSH patient may be physically recovered, is not feasible or sustainable in a system where the primary objective is to admit and discharge patients efficiently and adequately.

Furthermore, the lack of proper referral measures from the ED is also better understood in the context of an under-resourced system. Due to the shortage of staff members, especially after hours (no social workers worked after hours), DSH patients were not always appropriately referred to other health care professionals. Although some participants were under the impression that no DSH patient left the hospital without seeing at least a social worker, the lack of social workers after hours meant that a psychiatrist would review the DSH patient prior to discharge. The reality, however, as discussed in chapter four, this did not occur. Indeed, we are only interested in how the ED responds to the DSH

patients. However, this above-mentioned lack of an adequate response to DSH patients by the medical wards causes us to focus even more on intervening with the remaining DSH patients.

**6.2.3 The organisational structure of the system.** The medical nature of the setting and the lack of resources contribute to the insufficient utilisation of the opportunity in the ED to intervene with the DSH population. However, it is also the organisational structure of the ED system that undeniably hinders the health care professionals' ability to intervene with this population. When we review the organisational structure of the ED, we can assess it in relation to the hospital as a system; but also in relation to external psychiatric hospitals that form part of the broad health care system. This is especially significant when we address the issue of follow-up care for DSH patients.

As discussed in section 6.1, the ED system is heavily dependent on being able to refer DSH patients to a psychiatric hospital or an outpatient care facility. However, the option of referring patients to outpatient care is, first and foremost, an option within the context of deinstitutionalisation. The decrease of psychiatric hospitals and the shift of focus to the development and implementation of community care programs is an international trend. However, in SA we are following a similar trend without having adequate community care. One is consequently forced to ask the question of how applicable this reliance on outpatient care is in the context of low- and middle income countries such as SA.

While I have observed that the EPU always discharges a DSH patient with a follow-up plan in place, the same cannot be said for the DSH patient that is discharged straight from Casualty. This is especially problematic since it can be suggested that not all of the 34% of DSH patients who are discharged straight from Casualty may receive any follow-up treatment. However, there is limited information regarding the percentage of DSH patients who are discharged without any referral for outpatient care. Future research should focus on the determining the referral rates of this subgroup of DSH patients to outpatient care. Although Rhodes (1991) conducted her research in the international context, the same problem was also found in terms of follow-up care. The clinical director of the hospital explained to her: "One area that concerned him was "aftercare"; he wondered whether there was some way to persuade more patients to return for outpatient appointments after they were discharged..." (Rhodes, 1991, p.2).

Many reasons may be explored to explain why patients do not attend follow-up outpatient appointments. It could be a result of a lack of sufficient availability of outpatient



care and health care professionals working there. Furthermore, DSH patients may not attend these appointments owing to the challenges involved with getting to these appointments, having to wait too long to see a health care professional or because of other factors such as being stigmatised. However, regardless of all the possible reasons, the focus should be on the fact that the ED, together with the outpatient care system, is not optimally intervening with the DSH population. Consequently, this over-burdened system has also resulted in a repetition of DSH patients presenting in the ED. By drawing attention to the issue of DSH patients presenting multiple times, the problem at the roots of the system is also highlighted:

Over one-fourth of the patients who were admitted to the APU were returning to the unit. Some came back so many times that the staff compared them to migrating birds homing in on a favourite tree. Although the staff could produce an empty bed by moving a patient on, eventually the bed was likely to be filled again by the same patient. These repeating patients had a significant effect on the way the unit's staff felt about their work; by returning again and again they made visible, often in very idiosyncratic ways, the problematic nature of the emergency service the APU offered (Rhodes, 1991, p. 117).

Participants also highlighted this problem with one of the participants arguing that they thought the system had failed to do its job in preventing future suicide behaviour, if a DSH patient reappears at the ED. Interestingly, however, is that this participant continued to argue that he does not have the same perception of the system having failed in the event that a BPD patient presents repetitively at the ED.

In the previous quote, Rhodes references the concept relating to how the repetitive DSH patient may have an impact on the health care professional, and subsequently the care health care professionals are able to provide. This brings us to the influence of health care professionals' attitudes and perceptions on the system.

**6.2.4 Health care professionals' negative attitudes and perceptions.** The previous sections discussed the influence of the nature of the system as well as its organisational structure on the ability of health care professionals to intervene with DSH patients. Additionally, the health care professionals' attitudes and perceptions may also influence the functionality of the system, its ability to serve as a space for intervention, and ultimately the care DSH patients receive. Taking into account the absence of policies and protocols, as well as the lack



of implementation of existing policies, attitudes and perceptions are of vital importance as they serve as the driving forces behind the response to individuals presenting with DSH in the ED.

Health care professionals who have to respond to DSH patients often do so with preconceived negative attitudes towards this population. As discussed in the literature review, these negative attitudes may be detrimental to the quality of care provided to DSH patients. Significant contributors to these negative attitudes included the emotional responses that DSH patients evoked when interacting with health care professionals as well as health care professionals' perceptions of DSH patients taking up valuable resources. In addition, the findings also suggested health care professionals to display a lack in awareness for the context surrounding the DSH incident after the physical and medical injury or condition has been addressed.

Together with being in a hospital setting where physical injuries always have priority, there is also a subsequent lack of awareness of psychiatric issues, especially of DSH. This is especially the case with those health care professionals working in the ED who are primarily medically trained (including psychiatry registrars). De Leo et al. (2006) argue that medical staff treating DSH patients in the ED focus on the injury itself, instead of the context surrounding the act of the DSH. Therefore, the lack of awareness in relation to the referral of DSH patients from the ED is of great importance to us.

DSH patients were not always appropriately referred beyond the ED. The responsibility rested with the clinicians in the ED either to refer to a psychiatrist or to a social worker. It is important to note that no referral could be made from Casualty to psychology. Similarly, the responsibility rested with the psychiatrist to refer a DSH patient to social work or psychology.

Although these referrals may eventually be made, they often take place too late. This commonly resulted in DSH patients being discharged without being reviewed by a psychiatrist or a psychologist. A common explanation for this was that health care professionals only referred patients to a psychiatrist just before discharge because the DSH patient in the medical ward cannot be discharged before a psychiatric evaluation. The implication is that, once again, the psychiatrist's assessment serves a managerial purpose as opposed to a potentially therapeutic input over the course of time.

In this case the referral procedures and policies are in place but are not appropriately implemented by relevant health care professionals. As a result, it negatively impacts the opportunity to intervene with the DSH patient.

### **6.3 The Significant Potential of Positive Attitudes and Perceptions**

Apart from the obvious positive effect they have on the interaction between the health care professional and the DSH patient, positive attitudes and perceptions expressed by health care professionals may also significantly contribute to the intervention with the DSH patients. This is of great significance within the context of an over-burdened system. One such an example is the important role that empathy can play in the intervention with DSH patients. Empathy is a positive attitude that promotes psychological healing (Rogers, 1951). However, in its absence there is little room for a therapeutic relationship. Empathy is therefore important when there is a lack of time, space, and resources to develop a relationship with the DSH patient. At times, having empathy for a patient may be the only tool of intervention that the system allows and should therefore be implemented and optimised.

In addition, health care professionals seemed to be doing their best to provide quality care to DSH patients under difficult circumstances. Many participants, regardless of their perceptions of DSH patients, believed or at least hoped, that they provided the best care to their ability. While they admitted that due to the over-burdened system this was not always possible, the fact that they displayed a willingness to provide good care and an awareness of the situation should be viewed as positive influencing factors. I will return to this issue in section 6.5.2 as well as in chapter seven.

### **6.4 The System versus the Health Care Professionals**

The nature and organisational structure of the system and the health care professionals' attitudes and perceptions both influence the extent to which the ED is utilised as an intervention site for DSH patients. We can argue that, in comparison to negative attitudes of health care professionals, flaws within the system translates more directly into poor quality of care provided to DSH patients. However, it is important to note that we do not have sufficient information to determine whether the attitudes of these health care professionals are a result of the work environment and their interaction with DSH patients or whether they are preconceived attitudes and perceptions. In addition, should these attitudes and perceptions in fact be a result of these interactions with DSH patients, we can only

speculate as to how an *improved* work environment or organisational system would potentially influence these attitudes – especially attitudes that stem from emotional responses. Even though these responses may be directly related to the interaction with the DSH patient, one may argue that doing so in a system with many challenges enhances these negative experiences and attitudes.

In many cases, the findings of the study were applicable to DSH patients as well as other psychiatric patients. Two conclusions can be inferred as a result. It can be argued that the only thing that separates the care that psychiatric patients and DSH patients receive is the specific attitudes of the health care professionals towards DSH patients. Furthermore, it can be argued that the difference in the care that these DSH patients receive, and the level of intervention with each population, reflects a bigger issue of the overall management of psychiatric patients within the system.

### **6.5 No Standard of Care for DSH Patients**

We have discussed the response of the system as a result of the nature of the setting, organisational structure of the system, as well as the attitudes and perceptions of health care professionals functioning within this system. This response towards DSH patients is influenced by these different factors, and ultimately translates into an overall lack of standard care that is provided to DSH patients. The lack of standard care may manifest in a variety of ways.

We can argue that a relationship exists between the absence of standard training, and a lack of standard care provided to DSH patients. Schlebusch (2005) discusses the importance of mental health professionals and medically trained professionals receiving sufficient training with regard to managing, treating and improving the prevention of suicide. However, while health care professionals may be adequately trained, they may not be trained in the same way. There is no standard training and the training health care professionals receive is dependent on different institutions and different lecturers. It is also dependent on whether or not they were primarily medically trained, or if they are trained psychologists. This may result in discrepancies when treating DSH patients - for example with regards to conceptual confusion of suicide-related terminology used in reports and referrals.

There may be a shortfall in the standard of care due to a discontinuity of care. Issues including shift changes and a lack of taking *ownership* of patients, with the exception of a

few of participants, were cited as contributing to the discontinuity of care. From an organisational point of view, the absence of relationships seems to protect the clinician, but completely fails the patient. However, it can be argued that it may alienate the health care professional and also contribute to experiences of burnout.

In addition to the concept of the DSH patient being treated by different health care professionals, one can argue that the specific health care professional the patient encounters may also influence the care they provide to the DSH patient. Here we can make the link with the influence of a health care professional's awareness of the mental health aspect of the DSH, as well as the attitudes and perceptions they may express towards these patients. For example, one of the psychologists discussed the idea of health care professionals varying in their awareness and consideration of the mental health of the patient in addition to the physical injuries:

I am sure, as with any field, some medical doctors are more psychologically minded, psychiatrically minded and others aren't.

Furthermore, the time and day that the DSH patient presents at the ED may have an influence on the standard of care they receive. An influencing factor is the availability of beds. In other words, is it the case that the patient was easily and quickly admitted, or was it a process trying to find a bed? Similarly, the bed pressure at the given time may also influence the referral and discharge process. Importantly, the ED functions quite differently during office hours during the week in comparison to after hours and weekends. For example, on the weekend, there is a decrease in staff members, but especially mental health care professionals. As a result, the care provided to DSH patients during this time may differ from the care they receive at any other time. In this case, the difference in care provided to DSH patients after hours is especially important due to the fact that the vast majority of DSH patients presented at Casualty during this time. The statistical analysis conducted for the 200 consecutive presentations of DSH patients found that the majority of DSH patients presented after hours. Between 7am-5pm, Monday to Friday, 26.5% (53 participants) of the DSH patients presented at Casualty. On the other hand, 70.5% (141 participants) presented at Casualty after hours (weekdays 5pm-7am and weekends). The time and day of the presentation of the remaining 3% of the DSH patients was unknown.

It can also be argued that this lack of standard care is also relational to the adequate and appropriate implementation of policies, or the lack of implementing a policy may also

influence the standard of care provided to the DSH patient. In addition to the lack of implementing existing policies, section 4.11 also discussed the lack of awareness of many of the policies that are in place. As a result, it is contended that in this case health care professionals also failed to implement these policies because they were not aware of them or what they entailed.

Conversely, the DSH patient themselves may also contribute to lack of standard care they receive. The literature review also illustrated that the attitudes of health care professionals were very dependent on the specific DSH subtype of DSH patient who presented at the ED. While staff members may be more patient with those who are depressed, they may not have the same patience when interacting with a BPD patient.

**6.5.1 The possibilities for developing and ensuring a standard of care.** As a result of the lack of standard of care provided to DSH patients, the question must be asked whether or not the provision of standard care for DSH patients is possible. If so, how might it be developed and implemented? One could argue that more policies and a stricter adherence to these (existing) policies may improve the standard of care. For example, Schlebusch (2005) emphasises the importance of developing and implementing a protocol to support the process of referral after patients present in the ED after an act of DSH. McElroy and Sheppard (1999, p. 67) also emphasise the importance of developing and implementing policies and protocols when it came to managing and treating DSH patients in a setting like the ED: “Policies and protocols must be introduced and evaluated, to ensure that the self-harmer’s experience during crisis is not a catalogue of unhelpful encounters”.

Regardless of the suggested importance of these policies, the findings of this study have illustrated that even though there may be policies in place, the system does not necessarily allow for these policies to be implemented or adhered to by health care professionals. One such an example may be the lack of utilising risk assessment tools in the ED, specifically Casualty. While one of the reasons for this may be due to its’ poor predictive quality of future suicide risk (Jacobs & Brewer, 2004), the lack of assessing risk may also be as a result of not being able to handle the result of assessing DSH patients’ risk. Simply put, it is possible that the ED does not assess risk because they cannot afford to do so. Throughout the findings it was reported that if health care professionals admitted everyone they thought were at risk of suicide, they would admit everyone. In addition to this, one participant specifically stated that they would usually wait for a DSH patient to volunteer information

about their suicide intent and ideation, as opposed to asking particular questions to elicit this information. This participant said that she did this because she was afraid of what their answer may be.

It may be the case that if all existing policies are adhered to, it could potentially have a negative impact on the functioning of the system. Examples of this may include aspects of policies that would ensure adequate and more efficient care, yet they could be more time-consuming and subsequently congest the system, hereby causing it to slow down. For example, should all DSH patients start their 72-hour assessment period in the EPU (as hospital policy prescribes), as opposed to lying in Casualty, the EPU may potentially become completely congested as a result of the influx of DSH patients completing their assessment period.

Ultimately, we may then pose the question: What is the use or the value of having policies in place if they cannot be implemented? Moreover, the findings suggested that not being able to adhere to existing policies, places additional stress on health care professionals, which negatively affects their interaction with DSH patients. It also affects the quality of care they are able to provide to these patients. Consequently, it is not only critical to identify the issue of a lack of standard of care, but also to acknowledge the ambivalence that health care professionals may be experiencing as a result.

**6.5.2 The ambivalence of working in an over-burdened system.** Health care professionals wanting to provide DSH patients with quality care within a system that does not always allow it results in feelings of ambivalence. It is like walking a tightrope between providing the DSH patient with the best possible care, and maintaining the best possible attitude while still maintaining a functional system in the long run. Rhodes (1991, p. 1), in reflecting on her own ethnographic research, also discusses this challenge that health care professionals are facing:

Three aspects of the unit's work particularly captured my attention. The first was the contradictory nature of the task...the staff described themselves as having an "impossible mandate" that required that they discharge patients quickly and yet treat them adequately.

**6.5.3 The perceived roles of health care professionals.** In an attempt to address the issue of this ambivalence, it is important to address the roles that health care professionals

working in the ED are expected to fill regarding this intervention process. The first and most important role of the ED is to treat patients medically and surgically, as well as provide containment for acute psychiatric patients. However, as mentioned previously, there is much more involved with a DSH patient than merely the physical injury they present with. In addition to this, a role that both the literature and the findings suggested is that health care professionals have to provide primary care to patients, especially in the EPU. Many nursing participants expressed frustration at having to care for geriatric and physically ill patients in the EPU. This takes away time from them being able to care for DSH and other psychiatric patients. Similarly, Rhodes (1991, p. 25) found the same problem when her research participants expressed the following: “We’re just babysitters. Do you know how to change a diaper? This is what has happened to us, we have no role anymore other than catering to the patients...”.

Another role we have come to expect health care professionals to fulfil in the ED is ensuring that the patients move as fast as possible through the system in order to regulate the bed space available. As Rhodes (1991, p.60) explains:

The staff of the APU congratulated themselves on keeping beds empty. For instance, Sam often announced a “score”. He would say, “We’re down to five, we’re in good shape” or “We’ve got some leeway (before a weekend); we’re not constipated. The staff were often reminded that their role in maintaining open beds was important to the hospital.

Furthermore, Lelliot and Quirk (2004, p. 299) also suggest that the focus of the health care professionals often falls on the system and its ability to function efficiently, as opposed to focusing on the DSH patient: “Clinical staff sometimes perceive that the focus of mental health service managers in acute care is more about safety, throughput and cost than about the quality of clinical care”. Even the focus on the care of the DSH patient in terms of ensuring their safety in the ward arguably implies that as long as the DSH patient is safe, and not attempting to engage in DSH while in the ward and hereby compromising the stability of the ward as a result, the patient is receiving good quality of care.

In conclusion, it can be argued that health care professionals didn’t generally perceive the provision of therapeutic input as a role that they needed to fulfil. As one of the psychiatry registrars said to me during an informal discussion, “I’m not a therapist.” In addition, another psychiatry registrar also emphasised that due to the nature of the environment, the ED



automatically has a certain role to fulfil:

You have to remember that it is an emergency unit. We deal with aggressive patients, psychotic patients, those that are too elevated, and too depressed – for them to have a meaningful session with a psychologist, they waste their time on such a patient.

### **6.6 What Role should the ED play regarding the Intervention of DSH Patients?**

It is therefore evident that the health care professionals in the ED have multiple roles to play when responding to DSH patients. However, the question must be asked whether or not the assumption of these roles has been effective in intervening with the DSH population in the ED. We can question whether or not the role of the ED is merely to prevent death by intervening medically or surgically, or if their role is to also prevent the DSH patient from repetitively presenting at the ED? Following this, should interventions not be aimed at improving quality of life, even for those who may never truly be at risk of taking their own life, and especially those BPD patients who suffer from “chronic” suicidality? The ED may succeed in continuously keeping patients alive every time they present with DSH, but is that sufficient?

Moreover, we are forced to question the role the ED has to play in terms of DSH patients who engaged in DSH as a result of social issues. A consultant psychiatrist at a mental health care facility in the UK accurately describes the current situation we face in South Africa with regard to the relationship between mental health care and presentations of DSH: “Mental health care may function as a panacea for many different personal and social problems” (Double, 2002, p. 901). The findings of this research echo this statement by Double, with a high influx of DSH patients presenting at the ED as a result of social issues. Muijen (1999, p. 258) takes this notion further when stating the following:

A picture is emerging of an inefficient, atherapeutic and poorly coordinated service, profoundly demoralising to both patients and staff and unable to cope with the growing pressures. What can be done? First, we need to question the function of the ward as a depository for all those people community services cannot manage.

Therefore, as a result of a deficit in alternative avenues of health care, especially mental health care, one can argue that the broader health care system in which this ED is



organised has already failed these patients prior to presenting at the ED after an incident of DSH.

Furthermore, what about the DSH patients who may not be aggressive, psychotic, elevated or depressed to the extent that they need physical or pharmacological containment - should they not be “contained” as well, and if so, should we then not seek to redefine the concept of *containment*?

## **6.7 Conclusion**

An overview of the perceived roles of the ED, and especially its role in the intervention with DSH patients, prompts us to ask the following question: Is the intervention with the DSH population in the ED a lost opportunity, or is it simply an impossible task? Ultimately, we can argue that it is largely the challenges inherent to the nature of the system and its institutional organisation that results in the intervention of DSH patients in the ED being considered a missed opportunity. However, it should not be considered a lost opportunity. Even though the space is not always optimally utilised, certain measures can be put in place to improve the utilisation of the ED as an intervention space. The next chapter includes recommendations, based on the findings, to improve the utilisation of the ED as a space for intervention with the DSH population, as well as for the purpose of future research.

## Chapter 7: Conclusion

This chapter provides an overview of the limitations of the methodology, the limitations based on the findings as well as the recommendations based on the findings. This section concludes with a reflection relating to my experience of having conducted this research.

### 7.1 Limitations

The limitations discussed herein should not be confused with limitations of the research identified prior to data collection, as discussed in section 1.6.2. There were several limitations that were encountered throughout the research process. One of the limitations of the methodology was the difficulty in obtaining access to the field site. Although this study was awarded ethical clearance prior to commencing the data collection, I found that that ethics did not necessarily guarantee access. Obtaining access was not only a time consuming process, but it also relied heavily on my interaction, as a researcher, with those in charge of providing access and granting contact with potential participants (Mulhall, 2003). In response to the complexity of this process, Murphy and Dingwall (2007, p. 2225) suggest that the process of conducting ethical research is “relational and sequential”, rather than a once-off agreement:

Typically, at the start of such research, consent is both tentative and limited and the researcher’s access to sensitive aspects of the setting may be restricted. Over time, as the trust between the researcher and host develops, access may be granted to previously restricted areas or interactions.

Furthermore, in relation to the issue of access, Angrosino (2007b) distinguishes between *formal* but also *informal gatekeepers*. The author indicates that apart from seeking approval for entrance into the field site from formal (official) authorities, it is also important to gain approval from informal figures in the site of study, for example respected elders (Angrosino, 2007b). In the case of my research, examples of informal gatekeepers whose *approval* assisted me immensely throughout my research included administrative workers, doctors on call, and other staff members.

Another limitation based on the specific methodology I implemented was the challenge of attempting to observe the response to DSH patients, and the interactions between DSH patients and health care professionals in the casualty. Attempting to be there

the moment when DSH patients were admitted was rather challenging, as nobody could predict when this would occur. Additionally, I could not rely on health care professionals to alert me to any new DSH presentations in the casualty, as that would have interfered with their professional duties.

A third limitation that was identified was the nature of the research setting. There were time constraints as a result of health care professionals that were busy working. When the health care professionals were not working, attempting to speak with, and interview, them between shifts remained a challenging task. In addition to this, the field site was not always conducive to maintaining a sense of privacy between the researcher and the participant. On approximately one or two occasions, this resulted in having to conduct an interview in the corner of casualty.

The busy nature of casualty also translated into a limitation regarding the limited number of staff members in casualty I was able to interview. Although the rest of the sample was very heterogenic, and even though I interviewed 5 nurses working in the EPU, I was only able to find one Casualty nurse who was willing and able to allow me to interview her. This limitation is especially important, as it is the nursing staff that spends the majority of time with patients. Nurses play a pivotal role in providing care for DSH patients and interacting with them when they are most vulnerable.

Other limitations include a lack of data collected from the trauma unit of the ED. One reason for this was the small number of DSH patients who presented at the ED in need of surgical treatment (who were therefore triaged to trauma). The majority of DSH patients who presented after a case of an overdose were admitted to the medical unit. Another reason to account for the lack of focus on the trauma unit was their lack of adequate reporting on DSH cases. What was found was that, at times, cases were reported as simply a “gunshot wound”; when in fact the wound was self-inflicted. In many cases the patient may have also been too severely injured to be questioned about the context surrounding their injury, which would have helped to assess whether it was a case of DSH or not.

## **7.2 Recommendations Based on Findings**

Although the findings have highlighted the under-resourced system, there are also certain recommendations that could be made to make use of existing resources in the system. One example of a change that could be made is related to the assessment of the DSH patient.

Firstly, it should be a consideration that the PSIS is made available in languages other than English. Although the PSIS is an assessment tool consisting of clinicians asking the questions, patients may find it more helpful if you were able to conduct the PSIS in their own language.

In addition to this, students have reported that they are not permitted to use the PSIS to assess DSH patients in the ED. However, they are allowed to conduct an MSE in the EPU. I believe that students and interns could be better utilised in this assessment process, as they could be taught how to conduct a psychosocial assessment. Students may not be trained to conduct and to interpret a PSIS assessment. However, it is arguable that less training is needed to be able to conduct a psychosocial assessment. Students have more time to conduct these time-consuming assessments. Following this, they have the potential to contribute significantly to lightening the workload of more senior members of staff, and they are able to provide the DSH patient with better quality care.

Other recommendations include the possibility of greater psychological input in the ED; more efficient and timely referrals of DSH patients between health care professionals; as well as health care professionals focusing on treating the same DSH patient so as to improve the possibility and quality of a therapeutic relationship. The system could also focus on utilising resources more optimally after-hours, as the majority of DSH patients present during that time.

### **7.3 Recommendations for Future Research**

When making recommendations for future research one is forced to shift the focus away from the over-burdened system to those operating within the system. This is because of the barriers the health care professionals present, but also the potential they hold in optimally utilising the ED as a space of intervention for DSH patients. Aspects such as the knowledge and training of health care professionals regarding DSH, as well as their attitudes and perceptions, are of great significance because of the vital role they play in the quality of care that is provided to DSH patients: “Careful recruitment, selection, and education of ED staff and attention to staff attitudes and “burnout” could reduce patient stigmatization and ensure provision of professional and compassionate care” (Larkin & Beautrais, 2010, p. 3-4).

While we are able to make some sense of the attitudes and feelings towards suicidal individuals held by medical staff working in an emergency department, the importance of

these attitudes undeniably serve as justification for future research in this regard. “Attitudes toward death and suicide and personal suicide behaviours are areas in need of further investigation as they relate to suicide intervention skills” (Neimeyer, Fortner, & Melby, 2001, p. 72).

#### **7.4 Reflexivity**

Long and Johnson (2000) emphasise that reflection is crucial when it comes to qualitative research. When reflecting on my experience of conducting this research, I find my own experience echoing the ambivalence of the health care professionals and the DSH patients, with whom I have spent time. In retrospect, when I started with this research I was subconsciously “on the patient’s side” and convinced that I would find fault with the system and the health care professionals. As a result, I expected, and wanted to find, the mistakes and to fault the hospital. What I have found, however, is that the health care workers caring for these individuals are busy with a battle of their own. They are desperate to find ways of coping while still trying to do for the patients what is expected of them, and more. While one then empathise with the DSH patient for receiving sub-standard care, one is also inclined to empathise with the health care professionals for being “set up” by an over-burdened system to provide this care.

#### **7.5 Conclusion**

In conclusion, I have to agree with Behar (1999, p. 477) when she summarises the art of conducting ethnographic research: A type of research that asks more from the researcher than collecting data:

Do I confuse things further by saying that I think there is an art to ethnography? What I mean by this is that ethnography must be done with grace, with precision, with an eye for the telling detail, an ear for the insight that comes unexpectedly, with a tremendous respect for language, with a compassion for homesickness, and yes, with a love of beauty – especially, of beauty in places where it usually is not looked for.

Ethnography therefore has the ability to highlight the flaws, but also to celebrate the possibilities and ultimately, the beauty: beauty that seemed unlikely, if not impossible, to be found in a hospital setting. Beauty, which revealed itself in many ways: willingness, empathy, and hope.

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### **List of Appendices**

The following documentation is attached and is included in support of this research project:

- A. Semi-structured interview
- B. Ethical Clearance (Stellenbosch University)
- C. Ethical Clearance (University of Cape Town)
- D. Hospital Permission
- E. Participant information leaflet and consent form (hospital staff)
- F. Pierce Suicide Intent Scale (as used in Casualty)
- G. Turnitin Report

**Appendix A: Semi-structured interview****Interview schedule with medical staff about practices and policies for dealing with DSH  
in the Hospital**

1. Can you tell me about your experience of working in this hospital? How long have you've been in your profession? Level of experience?
2. Can you tell me about your experience of suicide?
  - take into consideration their personal experiences).
  - How frequently do you encounter DSH?
  - Have you observed any patterns?
3. Can you tell me about working with patients in this hospital who deliberately self-harms? Or attempt suicide? Is there a difference? Did you receive any education or specific training regarding the management and treatment of suicidal individuals? What additional training would you like to receive, what would be helpful?
4. Can you tell me about the policies or protocols in place to guide the assessment and management of DSH patients?
  - What are they? (Were you informed of these policies/protocols upon starting to work here, how have they changed throughout time?)
  - What has informed these?
  - Are they effective/sufficient?
  - Do you think they need to be modified/refined? How? Why?
  - Can you describe how a DSH patient who presented for treatment in the emergency department of this hospital would be assessed, managed and treated?
  - How do you determine intent? On what basis?
5. How do you understand and make sense of attempted suicide and DSH?
  - Why do people attempt suicide? What is an appropriate response in your opinion?
7. What do you think can be done to prevent suicide in SA? Do you think it is preventable? Based on your experience, do have any ideas in this regard?

**Appendix B: Ethical Clearance (Stellenbosch University)**

UNIVERSITEIT • STELLENBOSCH • UNIVERSITY  
jou kennisvennoot • your knowledge partner

**Approval Notice****Response to Modifications- (New Application)**

23-Sep-2013  
Bantjes, Jason JR

**Ethics Reference #: N13/05/074**

**Title:** An investigation of the epidemiology , physcho-social correlates , and cultural context of deliberate self harm in South Africa

Dear Doctor Jason Bantjes,

The **Response to Modifications - (New Application)** received on , was reviewed by members of **Health Research Ethics Committee 2** via Expedited review procedures on **30-Aug-2013** and was approved. Please note the following information about your approved research protocol:

Protocol Approval Period: **23-Sep-2013 -23-Sep-2014**

Please remember to use your **protocol number (N13/05/074)** on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

**After Ethical Review:**

Please note a template of the progress report is obtainable on [www.sun.ac.za/rds](http://www.sun.ac.za/rds) and should be submitted to the Committee before the year has expired.

The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance  
Number: 00001372  
Institutional Review Board  
(IRB) Number:  
IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

### Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health ([healthres@pgwc.gov.za](mailto:healthres@pgwc.gov.za) Tel: +27 21 483 9907) and Dr Helene Visser at City Health ([Helene.Visser@capetown.gov.za](mailto:Helene.Visser@capetown.gov.za) Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and documents please visit: [www.sun.ac.za/rds](http://www.sun.ac.za/rds)

If you have any questions or need further assistance, please contact the HREC office at 0219389207.

Sincerely,

Mertrude  
Davids  
HREC  
Coordinator  
Health Research Ethics Committee

## Investigator Responsibilities

### Protection of Human Research Participants

Some of the responsibilities investigators have when conducting research involving human participants are listed below:

1. Conducting the Research. You are responsible for making sure that the research is conducted according to the HREC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research.
2. Participant Enrolment. You may not recruit or enrol participants prior to the HREC approval date or after the expiration date of HREC approval. All recruitment materials for any form of media must be approved by the HREC prior to their use. If you need to recruit more participants than was noted in your HREC approval letter, you must submit an amendment requesting an increase in the number of participants.
3. Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the HREC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least fifteen (15) years.
4. Continuing Review. The HREC must review and approve all HREC-approved research protocols at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period**. Prior to the date on which the HREC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in HREC approval does not occur**. If HREC approval of your research lapses, you must stop new participant enrolment, and contact the HREC office immediately.
5. Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the HREC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written HREC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the HREC should be immediately informed of this necessity.
6. Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research-related injuries, occurring at this institution or at other performance sites must be reported to the HREC within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the HRECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Health Research Ethics Committee Standard Operating Procedures [www.sun025.sun.ac.za/portal/page/portal/Health\\_Sciences/English/Centres%20and%20Institutions/Research\\_Development\\_Support/Ethics/Application\\_package](http://www.sun025.sun.ac.za/portal/page/portal/Health_Sciences/English/Centres%20and%20Institutions/Research_Development_Support/Ethics/Application_package) All reportable events should be submitted to the HREC using the Serious Adverse Event Report Form.
7. Research Record Keeping. You must keep the following research-related records, at a minimum, in a secure location for a minimum of fifteen years: the HREC approved research protocol and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the HREC
8. Reports to the MCC and Sponsor. When you submit the required annual report to the MCC or you submit required reports to your sponsor, you must provide a copy of that report to the HREC. You may submit the report at the time of continuing HREC review.

9. Provision of Emergency Medical Care. When a physician provides emergency medical care to a participant without prior HREC review and approval, to the extent permitted by law, such activities will not be recognised as research nor will the data obtained by any such activities should it be used in support of research.

10. Final reports. When you have completed (no further participant enrolment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the HREC.

11. On-Site Evaluations, MCC Inspections, or Audits. If you are notified that your research will be reviewed or audited by the MCC, the sponsor, any other external agency or any internal group, you must inform the HREC immediately of the impending audit/evaluation.

**Appendix C: Ethical Clearance (University of Cape Town)**



**UNIVERSITY OF CAPE TOWN**  
**Faculty of Health Sciences**  
**Human Research Ethics Committee**



**Room E52-24 Old Main Building**  
**Groote Schuur Hospital**  
**Observatory 7925**  
**Telephone [021] 406 6492 • Facsimile [021] 406 6411**  
**Email: [Sumayah.ariiefdien@uct.ac.za](mailto:Sumayah.ariiefdien@uct.ac.za)**  
**Website: [www.health.uct.ac.za/research/humanethics/forms](http://www.health.uct.ac.za/research/humanethics/forms)**

**05 February 2014**

**HREC/REF: 645/2013**

**Ms L Frenkel**  
Psychiatry & Mental Health  
J-block  
GSH

**Dear Ms Frenkel**

**Project Title: AN INVESTIGATION OF THE EPIDEMIOLOGY, PSYCHO-SOCIAL CORRELATES, AND CULTURAL CONTEXT OF DELIBERATE SELF-HARM IN SOUTH AFRICA**

Thank you for your letter dated 31 January 2014, addressing the issues raised by the Human Research Ethics Committee.

It is a pleasure to inform you that the HREC has **formally approved** the above mentioned study.

**Approval is granted for one year until the 28 February 2015.**

Please submit a progress form, using the standardised Annual Report Form, if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

Please note that the on-going ethical conduct of the study remains the responsibility of the principal investigator

**Please quote the HREC REF in all your correspondence.**

Yours sincerely

A handwritten signature in black ink, appearing to read 'M Blockman'.

**PROFESSOR M BLOCKMAN**  
**CHAIRPERSON, HSF HUMAN ETHICS**

Federal Wide Assurance Number: FWA00001637.

Institutional Review Board (IRB) number: IRB00001938



This serves to confirm that the University of Cape Town Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

The Research Ethics Committee granting this approval in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

AN INQUIRY INTO DSH



**Appendix D: Hospital Permission**



**GROOTE SCHUUR  
HOSPITAL**

**Enquiries:** Dr Bhavna Patel

**E-mail :** [Bhavna.Patel@westerncape.gov.za](mailto:Bhavna.Patel@westerncape.gov.za)

To: Dr Jason Bantjes  
Psychology Department  
Stellenbosch University  
Room 2007  
Wilcocks  
Building

E-mail: [jbantjes@sun.ac.za](mailto:jbantjes@sun.ac.za)

Dear Dr Bantjes,

RESEARCH PROJECT: AN INVESTIGATION OF THE EPIDEMIOLOGY, PSYCHO-SOCIAL CORRELATES, AND CULTURAL CONTEXT OF DELIBERATE SELF-HARM IN SOUTH AFRICA.

Your recent letter to the hospital refers.

You are hereby granted permission to proceed with your research. Please note the following:

- a) Your research may not interfere with normal patient care
- b) Hospital staff may not be asked to assist with the research.
- c) No hospital consumables and stationary may be used.
- d) No patient folders may be removed from the premises or be inaccessible.
- e) Please introduce yourself to the person in charge of an area before commencing.
- f) Please discuss the study with the Head of Psychiatry, Prof D. Stein, before commencing.
- g) Please provide the research assistant/field worker with a copy of this letter as verification of approval.
- h) Confidentiality must be maintained at all times.

I would like to wish you every success with the project. Yours

sincerely

DR BHAVNA PATEL

**CHIEF EXECUTIVE OFFICER**

**Date:** 02 December 2013

G45 Management Suite, Old Main Building,  
Observatory 7925

Tel: +27 21 404 3178/9 fax: +27 21 404 3121

Private Bag X,  
Observatory, 7935

[www.capegateway.gov.za](http://www.capegateway.gov.za)

**Appendix E: Participant information leaflet and consent form (hospital staff)**

**TITLE: An Ethnographic inquiry into the organisation of care for deliberate self-harm patients in a South African hospital**

**REFERENCE NUMBER:**

**PRINCIPAL INVESTIGATOR:** Annemi Nel

**ADDRESS:** Department of Psychology; Stellenbosch University; Private Bag X1; Matieland; 7602; South Africa

**CONTACT NUMBER:** 072 440 1156

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee at Stellenbosch University (021 938 9677) and the Faculty of Health Sciences, Human Research Ethics Committee at the University of Cape Town (021 406 6338). You may contact either of these two committees if you have any questions or concerns regarding your rights or the welfare of the research participants. Furthermore the study will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

**What is this research study all about?**

*We are trying to find out more about the treatment received by patients presenting with DSH and the protocols that are in place within hospital settings. We are interested in finding out what principles guide the psychological and psychiatric treatment of these individuals as well as the attitudes and beliefs of medical staff towards this form of suicidal behaviour.*

**Why have you been invited to participate?**

*You are being asked to take part in the study because you are a member of the medical staff at the hospital and because you come into contact with patients who engage in DSH.*

**What will your responsibilities be?**

*If you agree to take part in this study you will be interviewed and asked to describe your experience of treating patients in the hospital who seek medical attention following an act of deliberate self-harm.*

**Where will the interview take place?**

*The interview will take place in the hospital at a time convenient to you. It will be conducted in a private space.*

**How long will the interview take?**

*The interview will take approximately 20-30 minutes.*

**Will you benefit from taking part in this research?**

*There is no direct benefit for taking part in this study although the study may assist to us to refine the procedures and protocols that exist in hospitals to guide the psychological and psychiatric treatment of patients who attempt suicide.*

**Are there in risks involved in your taking part in this research?**

*There are no direct risks to hospital personal associated with participating in this study.*

**What will happen in the unlikely event of some form injury occurring as a direct result of your taking part in this research study?**

*There is no danger of injury by participating in this study.*

Will you be paid to take part in this study and are there any costs involved?

*There is no financial reward for taking part in this study.*

Is there anything else that you should know or do?

- You can contact Dr Jason Bantjes (083 2345 554) or Ms Louise Frenkel (021 404 2035) if you have any further queries or encounter any problems.
- You can contact the Stellenbosch University Health Research Ethics Committee at 021-938 9207 or the Human Research Ethics Committee at the University of Cape Town at 021-406 6338 if you have any concerns or complaints that have not been adequately addressed by your study doctor.
- You will receive a copy of this information and consent form for your own records.

**Declaration by participant**

By signing below, I ..... agree to take part in a research study entitled, An Ethnographic Inquiry into the Treatment of Deliberate Self-Harm (DSH) in the Emergency Department at a South African Urban Hospital

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) ..... 2014.

.....  
Signature of participant

.....  
Signature of witness

**Declaration by investigator**

I (*name*) ..... declare that:

- I explained the information in this document to .....
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*)

Signed at (*place*) ..... on (*date*) ..... 2014.

.....  
Signature of investigator

.....  
Signature of witness

**Appendix F: Pierce Suicide Intent Scale (as used in Casualty)**

Groote Schuur Hospital Pierce Suicidal Intent Scale

Patient Name \_\_\_\_\_  
 Folder Number \_\_\_\_\_  
 Assessment date \_\_\_\_\_  
 Assessed by \_\_\_\_\_

Circumstances relating to suicidal attempt	
Isolation	0 Somebody present 1 Somebody nearby or in contact (as by phone) 2 No-one nearby or in contact
Timing	0 Timed so that intervention is probable 1 Timed so that intervention is unlikely 2 Timed so that intervention is highly unlikely
Precautions against discovery	0 No precautions 1 Passive precautions e.g. avoiding others but doing nothing to prevent their intervention (e.g. alone in room, door unlocked) 2 Active precautions (e.g. locked doors)
Acting to gain help during or after attempt	0 Notified helper regarding attempt 1 Contacted but did not specifically notify helper regarding the attempt 2 Did not contact or notify potential helper
Final acts in anticipation of death	0 None 1 Partial preparation or ideation 2 Definite plans made (e.g. changes in will, taking out insurance)
Suicide note	0 No note 1 Note written but torn up 2 Presence of note
Self report	
Patient's statement of lethality	0 Thought that what he had done would not kill him 1 Unsure whether what he had done would kill him 2 Believed that what he had done would kill him
Stated intent	0 Thought that what he had done would not kill him 1 Unsure whether what he had done would kill him 2 Believed that what he had done would kill him
Premeditation	0 Impulsive, no premeditation 1 Considered act for approx 1 hour 2 Considered act for approx 1 day 3 Considered act for more than 1 day
Reaction to act	0 Patient glad he had recovered 1 Patient uncertain whether he is glad or sorry 2 Patient sorry he has recovered
Risk	
Predictable outcome in terms of lethality of patient's act and circumstances known to him	0 Survival certain 1 Death unlikely 2 Death likely or certain
Would death have occurred without medical treatment?	0 No 1 Uncertain 2 Yes

Total score: \_\_\_\_\_

0-3 Low risk  
4-10 Medium risk  
11+ High risk

Pierce D. Suicidal intent. *Br. J. Psych.* 1977; 377-385 Dr Ian Lewis, Consultant Emergency Psychiatry, April 2010

**Appendix G: Turnitin Report**

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An ethnographic inquiry into the  
organisation of care for  
deliberate self-harm patients in  
a South African hospital  
*by Annemi Nel*


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## Turnitin Originality Report

An ethnographic inquiry into the organisation of care for deliberate self-harm patients in a South African hospital by Annemi Nel 

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