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How do emergency ambulance paramedics view the care they provide to people who self harm?: Ways and means

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ABSTRACT

The UK has one of the highest rates of self harm (SH) in Europe, and almost four times more people die by suicide than in road traffic collisions. Emergency ambulance paramedics are often the first health professionals involved in the care of people who have self-harmed, yet little is known about the care provided or issues raised in these encounters. The aim of this study is to explore paramedics' perceptions and experiences of caring for people who SH, to inform education and policy. Semi structured interviews were conducted with paramedics, and themes generated by constant comparison coding. This paper reports two emerging themes: Firstly, *professional, legal, clinical and ethical tensions*, linked to limited decision support, referral options and education. The second theme of *relationships with police*, revealed practices and surreptitious strategies related to care and detention, aimed at overcoming complexities of care. In the absence of tailored education, guidance or support for self-harm care, '*ways and means*' have evolved which may negatively influence care and challenge ethical and legal frameworks. There is an urgent need to include evidence from this study in revised guidance and educational materials for paramedics working with people who self-harm in the prehospital emergency setting.

1. Introduction

Since gaining professional status in 2001 paramedics are increasingly contributing to early joined-up care across a range of specialities, including stroke, cardiac and primary care. Traditionally, paramedic education and skills have focussed on life threatening emergencies, trauma and resuscitation. However, up to four times as many people die by suicide than in road traffic collisions (ONS, 2014a, 2014b), and suicide is the third largest contributor to premature mortality (World Health Organisation, 2000). Self-harm (SH) is not always an attempt at suicide (Swales, 2005), although it carries a raised risk of completed suicide at one year. Hawton, Zahl, and Weatherall (2003) reported that of 11,583 patients who attended hospital for SH between 1978 and 1997, 0.7% had died by suicide within a year (66 fold increase over the general population risk), and 3% within 15 years. The UK also has one of the highest rates of SH in Europe at 400 per 100,000 of population (Horrocks, 2002) and is one of the five top causes of acute hospital admissions (RCP, 2010). Paramedics are often the first health professional contact following SH and completed suicide, yet this may not be reflected in their skills or education.

SH often occurs without need for medical intervention (MIND, 2004), population based studies indicate only 10%–20% present to hospital (Pages, Arvers, Hassler, & Choquet, 2004; Ystgaard, Reinholdt, Husby, & Mehlum, 2003). Many avoid emergency carers because of the unsympathetic responses and hostile reactions they expect (McAllister, Creedy, Moyle, & Farrugia, 2002; Mental Health Foundation, 2006; MIND, 2004; Warm, Murray, & Fox, 2002). In a survey of people who SH, 43% said that they had avoided emergency services for these reasons, and also for fear of being detained under the Mental Health Act, as the person's actions may bring them to the attention of the police and conveyance to a place of safety (NCCMH, 2004). How patients fare in this first contact is vital, and may determine the quality and continuity of care they receive from then on (RCP, 2010).

There is an increasing recognition of the role paramedics play in SH care with moves towards shared decision making, and reduced reliance on law enforcement practices (NICE, 2004; RCP, 2006). Extension of emergency provision in Australia authorises paramedics to fulfil a role in mental health care previously restricted to police officers or other approved persons (Parsons, O'Brien, & O'Meara, 2011). The England and Wales Mental Health Concordat (2014) commits a range of agencies

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to work together to improve the system of care and support for people in mental health crisis, and acknowledges the role paramedics play in providing initial assessment and care.

Calls have been made for research focusing on nurses, and allied health professional including paramedics (NICE, 2004; RCP, 2010; Warm et al., 2002), and qualitative research, in particular, in order to better understand staff attitudes to self harm and their psychological and social origins (NICE, 2004). A systematic review by Rees, Rapport, Thomas, John, and Snooks (2014) identified a gap in the SH literature; no studies explored paramedic SH care, and despite guidelines indicating need for education and policies (JRCALC, 2006; NICE, 2004), there was limited evidence of real change in practice. A metasynthesis by Rees, Rapport, and Snooks (2015) exploring a wider range of qualitative literature on paramedic care for people who SH revealed themes including *frustration, futility and legitimacy of care*, and of particular significance, *decision making, detaining patients and balancing legislation, risk and patient autonomy*.

This paper forms part of a study using Evolved Grounded Theory Methodology (EGTM), to explore paramedics' perceptions and experiences of caring for people who SH in order to inform education and policy. In this paper, the emerging themes of *professional, legal and ethical tensions* and *relationships with police* are explored and their influence discussed.

2. Methods

2.1. Methodological approach

Strauss and Corbin's (1990) EGTM was used as a methodological framework for the study, which explicitly acknowledges that people construct the realities in which they participate. It follows a constructivist perspective, where the researcher is a "*passionate participant as facilitator of multi-voice reconstruction*" (Lincoln & Guba, 2000, p. 196), and therefore co-constructs data with participants (Charmaz, 2006). In this case, the researcher (NR) has been a paramedic for over twenty five years; such insight and awareness of practice and subtleties in data adds to the ability to bring meaning to findings. However, care must be taken with such insider research that preconceived ideas do not unduly influence data. Trustworthiness of data construction was maintained by awareness of this. Through reflexivity and memo-writing, pre-conceived ideas were monitored and bracketed out in analyses, with a second researcher independently reviewing coding. A study is considered credible when it presents faithful interpretations that people having the experience would recognise as their own (Guba & Lincoln, 1989); member checking was therefore conducted, where themes were presented back to participants for their consideration. Themes were further influenced and amended to reflect participants' comments.

2.2. Data collection, sampling and analysis

A systematic review (Rees et al., 2014) and metasynthesis (Rees et al., 2015) previously carried out by the research team were used to incorporate existing evidence in the development of the interview guide. Participants were paramedic volunteers; a sampling framework was applied to purposively recruit a range of ages, practice areas—rural versus urban, gender, educational level, vocational training and experience. Semi-structured interviews of approximately 1 h were conducted using the interview guide. The concept-indicator model of Strauss (1987) was used throughout the three levels of open, axial, and selective coding of Strauss and Corbin (1990). Interviews were undertaken following Guba and Lincoln's (1989) recommended method of recruitment to the point of redundancy where no new information is forthcoming, in order to maximise information; having reached a state of saturation (Munhall, 2001). Anonymity of the informants was protected throughout the study as they were drawn from a sample known only to the researcher. Interviews were not conducted in health or ambulance trust venues; neutral locations were mutually agreed by the interviewee and researcher. All interviews were recorded and transcribed, anonymised and kept in password protected files and locked cabinets.

Research ethics approval was not required as participants were NHS staff recruited by virtue of their professional role, however NHS permissions were granted.

3. Results

Eleven paramedics were interviewed, sampled purposively from a pool of 52 volunteers. Four interviewees were female and seven male. Four worked primarily in urban areas, three in rural areas and four had worked in both settings. Five had undergone higher education, six were vocationally trained, and three had undertaken mental health specific training. Years of experience ranged from 2 to 40 years as a front line crew member.

Two themes: 1) *Professionalism, legal and ethical tensions* and 2) *relationships with police and coercion* emerged from analysis of interviews and are presented in this paper as early findings related to the understanding and application of legal and ethical matters in caring for people who SH. These concerns are of importance to the consideration of the development of the paramedic role in this field.

3.1. Professional, legal and ethical tensions

A range of factors influenced decision making, which included concerns that actions may be followed by the patients killing themselves; they felt isolated and unsupported in their professional role:

> "*you can't get hold of mental health practitioners to be able to help you, the lack of advice and support. The lack of referral facilities. Shouldn't there be a facility that we can refer directly to a mental health crisis team unit, and be able to go directly there instead of A&E*?" (para 4).

They also felt that ambulance services had limited capacity to support them in their decision making with people who SH:

> "*You can speak to a clinical support desk, you can speak to a doctor at a hospital, or you can speak to an on call GP. And ultimately they'll virtually say the same thing, you know, you're the clinician on the scene, you have to make that decision*" (para 2).

And when questioned:

> "*And how do you feel about that?*"

The answer was:

> "*Lonely*"

This led to an uncomfortable position for paramedics wherein they have to stand by their decision made that was often made in isolation:

> "*You judge a person, do they have capacity? You can only judge it at that time... and they are adamant that they are refusing treatment or transportation, I know fully that it's going to be down to me when I sign them off. No matter what, no matter who I speak to, I'm the professional on the ground, I'm there.*" (para 6).

Such isolation and confusion over decision making was also found in the international literature by Rees et al. (2015). There was, however, a feeling that standards of care had improved alongside recent professionalisation:

> "*Everybody needs to be treated with dignity and respect. I think perhaps that wasn't there in the past, that people were often dealt with contempt, and very little understanding. And it can only be a more professional thing for our standing.*" (para11).

Paramedics pointed to sanctions that could be imposed on them: being held accountable in law, such as in coroners' hearings and