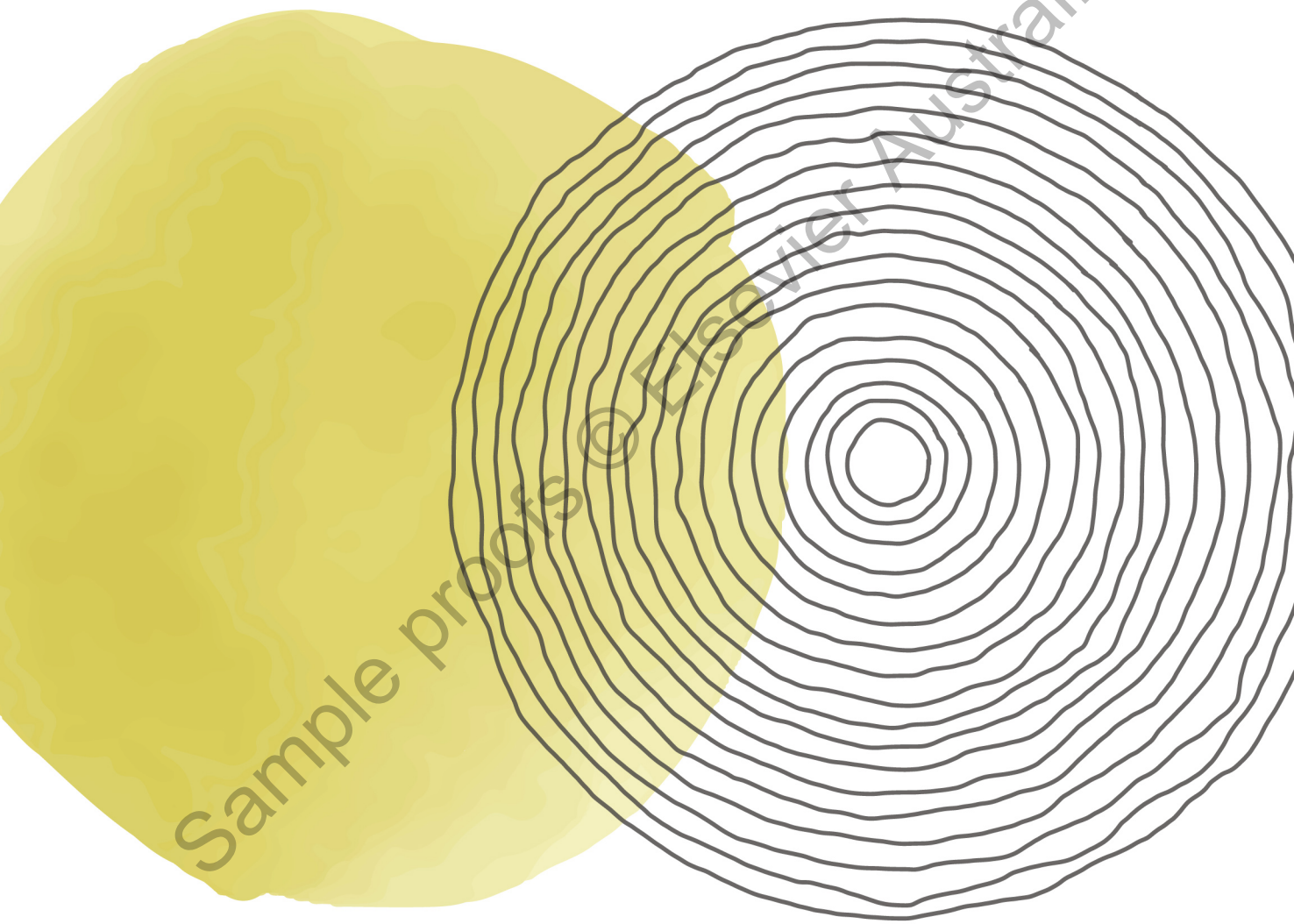
MENTAL HEALTH IN EMERGENCY CARE



PETA MARKS

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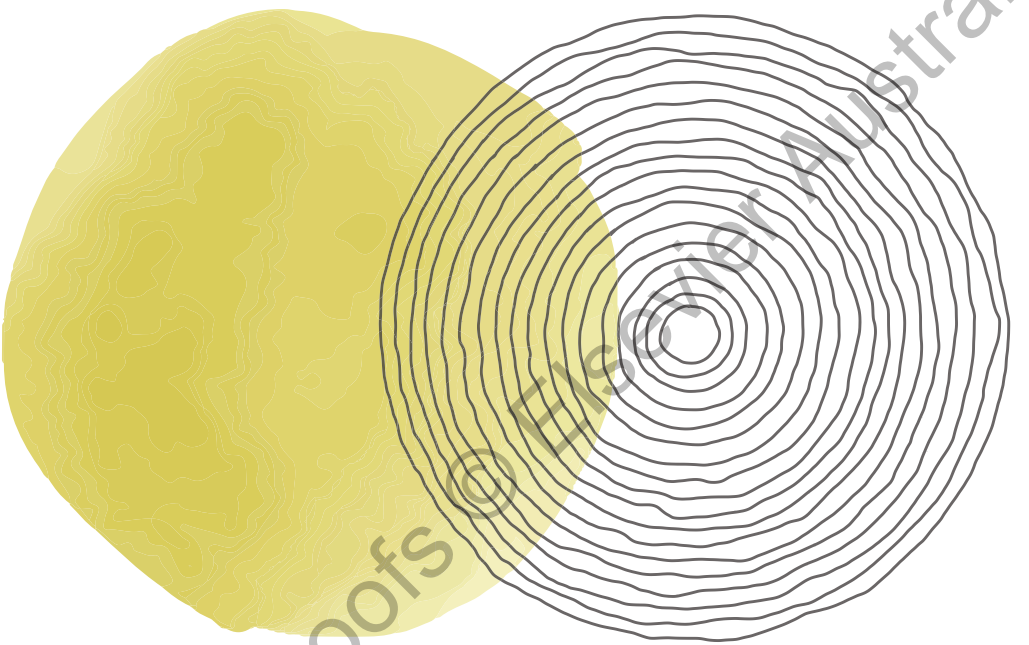

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Contents

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Foreword

As many countries, including Australia, weigh up the costs of the unprecedented disruptions and dislocations caused by the COVID-19 pandemic and concurrently occurring natural disasters, such as bushfires and floods, it has become evident that these events have had serious impacts on people's mental health. We are already seeing significant increases in the rates of mental health conditions, and this is likely to continue well into the future. At the same time, the number of people with newly presenting, as well as pre-existing mental health conditions, has threatened to overwhelm already stretched and stressed health services.

These events have raised serious questions regarding how best to promote and protect mental health and how to respond to the needs of the increasing number of people living with mental health conditions. There is a clear need for transformative action to significantly improve all aspects of mental health care, and to do so through collaborative approaches that acknowledge and value of human rights and lived experience, and are free of stigma and discrimination. As stated in the World Health Organization's (WHO) *World Mental Health Report 2022,* 'Business as usual for mental health care simply will not do'.

Mental health in emergency care is a critically important area of consideration, if mental health systems are to be transformed in the ways envisaged by the WHO. There are increasing numbers of people experiencing mental health conditions presenting for emergency care. To sensitively, effectively and respectfully respond to the mental health needs of these individuals, emergency care practitioners need to have a strong grounding in mental health knowledge and skills; in short, emergency care practitioners need to build mental health 'know-how'. The chapters of this timely and informative text on mental health in emergency care provide exactly the kind of knowledge and skill base required by practitioners working in emergency care settings. The editor, Peta Marks, has assembled an impressive group of authors, who cover important topics within the mental health emergency care context. These include a range of clinical conditions and service types and locations – working with Aboriginal and Torres Strait Islander peoples presenting with mental health concerns, providing care for refugees and asylum seekers, mental health care provided in dedicated emergency departments, first responder work in disaster settings, paramedic intervention prior to transportation to hospital, and emergency care in remote locations; these are some of the areas addressed.

Especially noteworthy throughout the chapters of this impressive text is a focus on systems transformation, the social ecology of mental health, recovery-oriented and trauma-informed approaches to care, and, in most chapters, the inclusion of a lived experience commentary that provides poignant, insightful lessons on what it is like to live with a mental health condition and to interact with healthcare services and practitioners; to confront challenges and hurdles; to find hope, compassion and strength, despite adversity.

In Australia, as in other countries, there is a need for urgent action to reform mental health care. Such a transformation will necessarily involve careful consideration of how mental health care is provided in emergency situations, whether this be in an emergency department or in a community setting. The chapters in this impressive text have an authority and authenticity that accord well with the knowledge required by the practitioners who provide mental health care in emergency settings. The voice of lived experience that adds value to the theoretical and technical detail provided by the authors in each chapter is undoubtedly a key feature of the text. It is to be hoped that the production of professional texts in the mental health field has now reached a stage of development in which the inclusion of a substantive lived experience commentary is considered best practice and it will no longer be acceptable for such works to be undertaken without the inclusion of the voice of lived experience.

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August 2022

Preface

At a conference I heard a keynote speech by an incredibly inspiring and eloquent woman who was sharing her gender transition experience – the ups, the downs, her greatest fears and her biggest challenges. But the thing that touched me the most was her tender, heartfelt description of the impact of one particular nurse who had cared for her when she was in hospital during some of her darkest days, and who, according to the speaker, had saved her life – not physically, but in a spiritual and emotional sense, through their caring, acceptance and empathy. Don't all health professionals want to be *that* kind of clinician?

For nearly 30 years I have specialised in working with people who have eating disorders and their families. Over this time I have heard many clinicians from a range of disciplines say that they don't 'do' eating disorders. In the same way, I have heard mental health clinicians say they don't 'do' physical health, and generalist colleagues say that they don't 'do' mental health. This siloed way of thinking about the human experience is perplexing. People become nurses because they want to help other people … how can we claim to do that, or be 'holistic' practitioners without considering what is happening (or has happened) to the person as a whole? If someone experiences a physical illness or injury, shouldn't we consider the impact of that experience on their emotional wellbeing too? If someone develops a mental illness, shouldn't we make sure that their physical health is not adversely impacted, or is making things worse for them? If someone is presenting with symptoms which can be explained by or traced back to trauma, or disadvantage, or racism, or stigma, shouldn't we be cognisant of that and ensure our practice is informed by and responsive to that knowledge? To my mind, the best way to be *that* clinician, in any clinical situation or setting, regardless of discipline or area of specialisation, is to consider and connect with the human experience of the person in front of us – with all elements of their being – their unique identity, as well as their physical, emotional, psychological and social experiences. And to do that, we need to purposefully develop the required knowledge and skills in order to inform our practice; this text has been developed to help with that process.

There is nothing quite like the voice of lived experience – it is powerful, it is important and it helps to remind us why we do what we do as healthcare professionals. I've learnt so much from people's stories, and my practice as a mental health nurse and as a project manager has been enriched by listening to people speak about their healthcare journey or the healthcare journey of their loved one; about what has helped and what they have found lacking.

I feel very honoured that Bundjalung Elder Associate Professor Boe Rambaldini has shared his story in this text and that Helena Roennfeldt has so generously offered such insightful comment around each and every scenario chapter, informed by her lived experience and her knowledge of the lived experience of others with mental health concerns. I would

also like to acknowledge Enara Larcombe and Paul McNamara, who used a true co-design approach to the development of their scenario chapter. I also feel incredibly appreciative that the nurses and other clinicians who have contributed to this text agreed to share their clinical knowledge, insights and experiences – their clinical expertise, demonstrated through their writing and what they have chosen to include here, adds a richness to the knowledge that can be gained from text books and journal articles.

The 2022 National Study of Mental Health and Wellbeing identified that nearly 44% of Australians have experienced a mental disorder at some point in their life – over 20% of people and nearly 40% of 16–24-year-olds in the previous 12 months. It is clear that now, more than ever, the mental health and social and emotional wellbeing of every patient seen in every clinical context must be considered, regardless of the person's presenting circumstances. While not every clinician needs to specialise in mental health, if we are to improve the mental health of Australians in general, First Nations people and young people in particular, all health professionals need to enhance mental health communication and observation skills, employ empathy and work in a culturally competent, collaborative and recovery-focused way.

In a post-COVID world, working in any healthcare setting is challenging. Clinical work can be exciting, interesting, exhausting, uplifting, upsetting, frustrating, humbling and hilarious – sometimes all in one day. It is my hope that the information and clinical scenarios shared in this text will support nurses and other health professionals to develop their mental health knowledge and skills, and more than anything, to connect (or re-connect) with the desire to be *'that'* clinician – to approach each patient as a person, and each person as unique, and not allow time pressures or staffing shortages, or the business of 'the system', to divert us from the need to be holistic, or to devalue the importance of the human-to-human interactions that make a difference to a person's wellbeing and their healthcare journey.

Peta Marks

August 2022

CHAPTER 3.1

Supporting the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples presenting with mental health concerns

Candace Angelo and Madeline Ford

KEY POINTS

- The consequences of and traumas associated with colonisation have an ongoing impact on the health, mental health and wellbeing of Aboriginal and Torres Strait Islander peoples.
- Culturally safe and appropriate health services and the integration of social and emotional wellbeing (SEWB) concepts into care, enhances recovery for Aboriginal and Torres Strait Islander peoples.
- Access to appropriate mental health services is challenging in rural/regional/remote emergency settings, particularly for Aboriginal and Torres Strait Islander peoples.
- Nurses in rural/regional/remote areas are often the primary providers of holistic health care.
- Mental health assessment and promotion, including social and emotional wellbeing concepts, play an important role for practitioners in emergency settings.

LEARNING OUTCOMES

This chapter will assist you to:

- understand cultural safety when providing care for Aboriginal and Torres Strait Islander peoples presenting with mental and/or physical health concerns
- increase awareness of general mental health key concepts, assessment and mental health care approaches relevant to the rural geographical location and the emergency care setting
- appreciate the co-existence of multiple health issues and how these might be exacerbated by mental illness or mental distress and the intergenerational impacts of the traumas associated with colonisation
- apply holistic nursing care approaches, involving family, community members and kinship networks, wherever possible
- consider the impact of language and that the word ‘mental’ holds significant shame, stigma and fear for some people.

Lived experience comment

by Boe Rambaldini, Bundjalung Elder

MY WALK FROM THE TRAUMA OF THE PAST THROUGH THE TRAUMA OF TODAY TO THE OPTIMISM OF THE FUTURE

History has played some very devastating events to Aboriginal people, and my family and I were not excluded from the trauma of the past. Every state and territory government passed laws that allowed them to have complete control of our lives. With these laws, the authorities could do and did what ever they wanted to us, they also had full custody of Aboriginal children.

Having a brother removed simply for being Aboriginal caused some great painful emotions for our whole family, particularly my mother who, as a single parent, carried the hurt, pain, loss and guilt for not protecting her son. When my brother returned as an adult after many years separation it was clear that he had missed the kinship, love and cultural upbring that we were provided. My mother smothered him with love when he came home – she was so entrenched with guilt for not protecting him and did all she could to make up for the trauma of all those lost years of not knowing where he was or how he was.

On a personal level, I was deprived of a relationship with my brother and it was something that I could not comprehend. The kinship I had with my other siblings was so culturally rewarding and instilled the importance of cultural integrity with our strong values. I was provided with an understanding of our culture, customs, history and social positioning that laid the foundations of my being that allowed me to interact with others in a respectful way, valuing the interactions I have with Aboriginal and non-Aboriginal people.

During my early years my education suffered, and I was penalised from not having a proper education just because of being Aboriginal. Although I had a strong work ethic, the best opportunities were not offered to me and I was the subject of numerous floggings from the police. These traumatic events in my life led to difficult emotional feelings and questions, as well as struggles with my mental health and that of my wider family and friends. I still at times relive and suffer from the traumatic events in my past and there are many times when anxiety sets in, and I feel culturally unsafe. This and the racism I am constantly subjected to, impacts on my health. The trauma of the past has a huge impact on me and my family today and only truth-telling and allowing inclusion will work towards true reconciliation.

INTRODUCTION

As a consequence of the historical and ongoing intergenerational impacts of colonisation and its associated traumas, including racism embedded in our social systems and structures, there are vast disparities between the health and wellbeing outcomes of Aboriginal and Torres Strait Islanders and non-Indigenous people in Australia. Aboriginal and Torres Strait Islander people experience poorer physical and mental health and markedly higher levels of psychological distress, mental illness and comorbid mental disorder than the general population (Hepworth et al 2015; Priest et al 2011; Wilson & Waqanaviti 2021). As Sherwood (2021) identifies, 'First Nations health today is a story informed by history, policies, warfare, Western medicine and press bias' (p. 17). Simultaneously though, as the longest enduring culture in the world, Aboriginal and Torres Strait Islander peoples have also 'demonstrated

an innate capacity to thrive despite such adverse conditions' (Wilson & Waqanaviti 2021, p. 282). Where nurses and other health professionals working in emergency care settings recognise and draw upon these strengths and align their practice with a social-ecological perspective, aimed at enhancing social and emotional wellbeing outcomes (for both the individual and their community), better outcomes can be achieved.

ABORIGINAL AND TORRES STRAIT ISLANDER SOCIAL AND EMOTIONAL WELLBEING

Aboriginal and Torres Strait Islander health and wellbeing does not just relate to a person's physical and mental health; it is viewed in a holistic context, which includes and is underpinned by the interconnection between the health and wellness of families, communities and the land, as well as cultural, psychological, spiritual, physical and emotional wellbeing. This perspective, described as social and emotional wellbeing (SEWB) (see Fig. 3.1.1), also acknowledges the relevant historical, political and social determinants – such as dispossession and the impacts of colonisation, collective and intergenerational trauma – and recognises the intimate connections between mental health and a person's background, culture, beliefs and experiences.

For First Nations people, 'SEWB is an expression of cultural and spiritual being and doing . . . it is experienced as an internalised sensation that is felt within the core of a person's humanity and is outwardly expressed through relationships between culture and lore in a continuous cycle of life and death' (Wilson & Waqanaviti 2021, p. 282).

Culture, self-determination and empowerment are powerful protective factors in providing a buffer to psychological distress for many Aboriginal and Torres Strait Islander peoples. Factors that have been identified as enhancing SEWB include connection to country, spirituality, ancestry and kinship networks, as well as strong community governance and cultural continuity (Zubrick et al 2014). Meaningful connections to people (kinship and

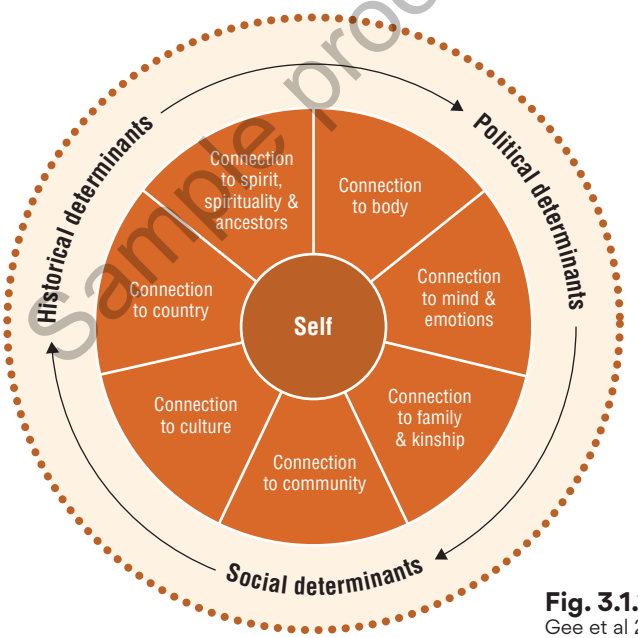

Fig. 3.1.1 Social and emotional wellbeing (SEWB). Gee et al 2013.

Mental health in rural and remote areas

People living in regional, remote and very remote Australia experience similar prevalence of mental disorders to people living in metropolitan areas (AIHW 2019), but are at a higher risk of premature death and death by suicide (Roberts et al 2018; van Spijker et al 2019), and are less likely to seek mental health treatment (Commonwealth of Australia 2018). For Aboriginal and Torres Strait Islander peoples, the rate of suicide is almost double that of non-Indigenous people (Rouen et al 2019) and reported self-harm is also more prevalent and increases with remoteness. Physical family violence and sexual assault in remote settings is double the rate for urban areas (Smith 2016). Almost half (47%) of rural emergency presentations in Aboriginal and Torres Strait Islander communities include an interpersonal violence context, adding another level of complexity to consider in the provision of care. A higher prevalence of depression, trauma grief and loss contribute to illicit drug use, alcoholism and volatile substance use, which further exacerbate mental health issues. Violence experienced by Aboriginal and Torres Strait Islander women in remote settings is 45 times higher than for their non-Indigenous counterparts in urban settings (Lim et al 2020).

HEALTH AND MENTAL HEALTH SERVICE ACCESS IN RURAL AND REMOTE AREAS

In general, people living in regional and remote areas experience a variety of health disadvantages – poorer access to primary and acute care, poorer chronic disease management, social and geographic isolation, lack of consistent access to skilled healthcare providers, as well as long distances/travel times and costs associated with accessing services, poor service coordination and funding. Access to robust stepped care mental health services, mental health providers (such as psychiatrists, mental health nurses and psychologists) and effective models of care for both short and longer-term mental health issues/presentations, are also ongoing challenges (Beks et al 2018; van Spijker et al 2019). Lack of mental health services means early identification and intervention opportunities are missed. Mental health care models commonly service remote regions via an outreach approach from tertiary services in metropolitan areas, in the form of telehealth or a visiting individual in a fly-in fly-out model (Burke et al 2015). This approach often disrupts continuity of care, with designated staff changing frequently, shifting accountability and lack of opportunity to establish rapport, resulting in the person's healthcare journey being fractured (Byrne et al 2017).

It is widely accepted that emergency departments are not the ideal environment for treating people with mental health issues (Judkins et al 2019). However, lack of access to acute mental health care or after-hours mental health services in rural and remote areas means that people in mental health crisis *need* to present to ED settings as there is nowhere else to go (Sutarsa 2021). While people commonly present with several concerns, all requiring timely assessment and intervention (Smith 2016), rural and remote EDs often don't offer the resources needed to accommodate a holistic approach to complex physical and/or mental health concerns, so the primary focus will be on the acute presenting issue – which is often physical. For example, Haswell, Wargent and Hunter (2018) found examples of incomplete documentation and noted that some aspects of mental health care were often not addressed for Aboriginal and Torres Strait Islander people in rural and remote areas. This was

attributed to a lack of mental health knowledge and skills of staff, and the focus on acute and physical health issues.

Physical health and mental health

It is important to remember that mental health disturbances could be manifesting and are sometimes the cause of an acute physical health presentation. For example, we know mental illness has a demonstrated reciprocal relationship between both intentional and non-intentional injury. Emergency presentations involving accidental injury are not uncommon in Australia; in fact, they account for 6% of all hospitalisations (a significantly higher number do not require hospitalisation) (Vallmuur & Pollard 2017). For many reasons, people in rural and remote areas face a higher probability of injury (e.g. higher risk-taking behaviour and less use of safety equipment) and a mental health crisis is known to further increase the likelihood of experiencing injury (Inder et al 2017). In the instance of an injury presentation where a person has a background of mental health issues, the acute physical injury perspective may be well managed, while the mental health issues are often poorly addressed or completely overlooked. It is essential for nurses to assess for and consider potential underlying mental health issues in all patients presenting to emergency care settings when assessing and treating any physical illness or injury.

The need for culturally safe and appropriate services

The problems outlined above impact on the health of all people in rural and remote communities. Aboriginal and Torres Strait Islander peoples living in rural and remote areas are therefore doubly jeopardised (Gynther et al 2019). For First Nations people across *all* geographic locations, any health service access issues are compounded by a range of barriers, including a lack of access to culturally appropriate health and mental health services (see Box 3.1.1) (Commonwealth of Australia 2018; Innes 2014; Wakerman & Humphreys 2019). Mainstream health services do not adequately address the complexity of many Aboriginal and Torres Strait Islander people's SEWB needs, are not culturally appropriate, culturally sensitive or culturally safe, and do not adequately address specific health problems that

Box 3.1.1 Barriers to mental health care for Aboriginal and Torres Strait Islander peoples

Barriers include:

- systemic and institutional factors – social exclusion, cultural dislocation, rapid urbanisation, socio-political disempowerment, disadvantage and marginalisation due to displacement, discrimination, forced removal and racism
- direct barriers, such as treatment costs
- indirect barriers, such as lack of transport
- opportunity costs, including lost wages and time away from family
- world view, conceptions of mental health, stigma
- lack of cultural training of healthcare staff
- lack of culturally appropriate assessment tools and treatments.

Page et al 2022.

require attention. For example, there is evidence to suggest Aboriginal and Torres Strait Islander people are more negatively affected by alcohol consumption and illicit drug use than non-Indigenous persons; however, it has also been reported they are less likely to access services for these issues than their non-Indigenous counterparts due to a lack of culturally appropriate programs (Berry & Crowe 2009).

CULTURALLY SAFE CARE

Unsafe cultural practice is 'any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual' (Clear in Parker & Millroy 2014, p. 114). It leads to poor engagement and alienation from health services and health providers, misdiagnosis and poor health outcomes. Culturally safe practice is about providing care that takes people's unique needs into account – by challenging the status quo, by addressing the inequalities and power imbalances that are rooted in historical and structural violence and discrimination, through a continual process of learning and self-reflection, as well as empathy, shared respect, knowledge and experience. Cultural safety is essential to achieving equity and better health outcomes for Aboriginal and Torres Strait Islander peoples (McGough et al 2022).

To be able to provide culturally safe care, health professionals need to understand and acknowledge the impacts of colonisation and the intergenerational trauma that it has caused. Historically, discriminatory policies and practices (such as the forced removal of children from their families and country), as well as structural racism, have contributed significantly to the power imbalances that are embedded in institutions and systems, and contribute to fear and/or mistrust in government-run services – including healthcare services.

'Culturally valid understandings must shape the provision of services and guide assessment, care and management of Aboriginal and Torres Strait Islander people's health problems generally, and mental health problems in particular' (Commonwealth of Australia 2018, p. 3). While the statement that services should be shaped by culturally valid understandings is true, the terms 'mental health problems' and 'mental illness' have negative connotations for Aboriginal and Torres Strait Islander peoples – arising from shame, stigma and negative experiences with health and welfare services (Ward 2021). They imply a deficit approach and do not reflect all the factors that make up and influence SEWB. The concept of SEWB aligns with a more holistic and strengths-based approach – where the person's assortment of strengths (including their own, their loved ones and their community's) are identified and they are supported to recognise and draw from these strengths in their recovery (Wilson & Waqanaviti 2021). Similarly, trauma-informed care, where distress is seen as a symptom of underlying trauma(s), enables a standpoint from which a person is able to talk freely about their experiences, which might be sensitive, complex and difficult to speak about, without shame or embarrassment. In this way, trauma-informed care centres the person and their experience in an authentic relationship with the nurse and creates an environment where SEWB can be promoted (Wilson & Waqanaviti 2021). (See Chapter 1 for more information about a trauma-informed, strengths-based approach.)

Developing culturally safe practice is an essential journey which all nurses are responsible for undertaking. Box 3.1.2 outlines its key elements.

Box 3.1.2 The journey to cultural safety

Cultural awareness: Move towards understanding difference. Reflect on your own cultural background: what cultures and ethnicities do you identify with? How? Why? How does this shape your own identity, beliefs, values and attitudes?

Cultural sensitivity: Recognise the differences between yourself and Aboriginal and Torres Strait Islander people you work with. Seek out knowledge and better understand the ongoing impacts of colonial history. Acknowledge the profession of nursing has 'power' and 'whiteness' and that racism is inherent within the healthcare system, and that these impact on Aboriginal and Torres Strait Islander people.

Cultural safety: Cultural safety is achieved as the outcome of cultural awareness and cultural sensitivity, when an Aboriginal and Torres Strait Islander person experiences cultural safety in your care and in your service. When you value Aboriginal and Torres Strait Islander peoples and cultures and difference, commit to self-determination and build respectful partnerships.

Best 2021

Reflection

There are so many historic and contemporary threats to the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples.

1. How can you contribute through your nursing practice to improving the situation?
2. What do you need to learn?
3. What do you need to do?
4. How do you intend to be part of the solution and part of the change that is required?
5. How can you promote social and emotional wellbeing for all Aboriginal and Torres Strait Islander people you work with, including patients, their loved ones and your colleagues?

The two scenarios below explore the provision of culturally safe and competent care to Aboriginal and Torres Strait Islander consumers in urban and regional/remote emergency care settings. Example scenarios outline key details and information required to determine the appropriate nursing care approaches. Cultural considerations are examined to ensure that the needs of Aboriginal and Torres Strait Islander consumers are addressed, including specific gender business protocols, and the consideration of kinship and family roles.

SCENARIO 3.1.1

Matty

Matty is a 19-year-old Aboriginal man who presents to the emergency department clinic of a remote area hospital with a penetrating lower limb injury. Matty is accompanied by his aunty and several cousins, who carry him into the department. Matty says that he fell out of a large tree he climbed that morning.

On arrival, Matty's aunty says she thinks that he is 'buntha' (crazy) and says he is always injuring himself. She says that over the years he has had many occasions where he didn't 'seem himself', but his family weren't sure if he was 'gammin' (joking) or not. Most recently,

he has been staying awake all night and talking quickly. His aunty says she asked Matty if he wanted her to take him to the city to see a doctor, but Matty expressed that he already felt shame that his brothers were calling him 'buntha' and didn't want the stigma.

On assessment

Matty reports he was followed and chased up a tree by 'warra wirrin' (bad spirits) and he lost his footing causing him to fall onto a fence below. Matty reports that he landed on his legs and there was no head strike. He had no cervical spine tenderness, his pupils were equal and reactive to light, he was alert and orientated to time, place and person. Matty is breathing independently with respirations 22 breaths per minute, his airway was patent and while talking rapidly, his blood pressure was 148/89. Matty was tachycardic with a regular heart rate of 130 beats per minute and afebrile 36.4 degrees. His lower left leg wound (14 cm × 3 cm) had defined wound edges, moderate swelling, was red and had localised pain. Matty's pain was 6/10 and described as 'throbbing'.

RED FLAGS

- Altered perceptions.
- Risk-taking behaviour resulting in physical harm.
- Reduced sleep.
- Painful physical injury to leg (will require medical intervention).
- Altered vital signs, e.g. tachycardia and hypertension.

PROTECTIVE FACTORS

- Family and kinship networks are reportedly strong.
- Matty has demonstrated awareness regarding his current situation, as he stated, 'Something isn't right'.
- Presented to hospital with his aunty, this can demonstrate his willingness to receive intervention.
- Currently not suicidal or engaging in self-harm.
- Orientated and Glasgow Coma Scale of 15.

KNOWLEDGE

- Many Aboriginal and Torres Strait Islander people have been impacted by discrimination and racism. There may be distrust in government-run organisations such as healthcare due to the impact and subsequent trauma of the Stolen Generations. This knowledge/understanding is foundational for culturally competent practice.
- Healthcare professionals have a tendency to assess Aboriginal and Torres Strait Islander people with non-Indigenous criteria and/or expose them to culturally insensitive environments. Consider your workplace; what adjustments for culturally appropriate care are required?
- Symptoms of a mental health crisis may be mistaken for spiritual or cultural traits, particularly where concepts of 'health' and 'illness' are integrated with culture and lore. For example, belief that illness is the result of individual punishment for a wrongdoing rather than poor adherence to treatment, or that delusions actually relate to 'spirits' (Hinton et al 2014).
- Involving family members and other kinship is a key factor in supporting the individual to remain connected to community. Health education and psychoeducation are as important for families as for the client (Sayers et al 2016).

- A genuine inquiry about connection to culture and land can help establish the therapeutic relationship. Determining the connection to land and kinship helps to establish a personal connection. Do this by asking the person's last name and if they are local to the area. If you recognise the last name from another client, then that may be used to form a connection (keeping confidentiality of course) (Ranzijn et al 2009).
- The impact of the social determinants of health on wellbeing outcomes, self-determination and empowerment can be powerful and should be considered by nurses and other health professionals when assessing and planning care.
- Access to definitive mental health care provision may require relocation to urban/tertiary facilities, i.e. taking people away from family, culture and other supportive factors. This should always be an approach of last resort.

ATTITUDES

- 'Reflective practice is a critical aspect of providing culturally safe care' (Cox & Taua quoted in Ward 2021, p. 158). Are you aware of your own biases? Do you subscribe to any stereotyping of Aboriginal and Torres Strait islander people in your life or work? Are your interactions culturally safe? Remember, racism can be subtle or intentional. How can you put practices in place so that you are not experienced as a 'racist nurse'? And what should you do if you discover cultural biases, assumptions or stereotypes in the care you provide? (Cox & Taua 2013).
- If you are a non-Indigenous person and you haven't done so already, undertaking cultural awareness training is an essential element of competent nursing practice.
- Reflect also on your own perceptions around mental health and illness to ensure these are not impacting on your practice in a negative way (reflective practice).
- Be open, respectful, empathetic, compassionate and transparent in your approach.

MENTAL HEALTH SKILLS

- Engage with the individual and their family or support network to develop a therapeutic rapport. Use culturally appropriate communication strategies. Direct eye contact can be seen as confrontational and rude, so should be kept to a minimum.
- Mental health care planning (short term and long term) should incorporate appropriate family and cultural supports into a mental health action plan. For example, asking Matty's aunty whether she thinks it is likely his agitated behaviour will escalate and how best to support him is important. Refer to medical records of previous presentations to identify any history of aggression or self-harm. Note previous interventions used to prevent escalation and replicate these as required, i.e. reduce stimuli, facilitate space and privacy, accommodate meals and personal hygiene.

CULTURAL SAFETY CONSIDERATIONS

- Provide access to cultural support (e.g. an Aboriginal and/or Torres Strait Islander mental health worker), family, Elder, community members; but try to avoid using family members as health interpreters, as the health issue may be viewed as 'shame' (Westerman 2004).
- Encourage the patient to maintain connection to country, spirituality and kinship networks.
- Remember that English may be the person's second, fourth or fifth language – ensure you speak in a clear, jargon-free way and remember Aboriginal and Torres Strait Islander people may speak in a circular way (Ramsay 2021).
- Cultural roles and understanding of women's vs men's business dynamics are important. Consider gender when providing care – it is culturally inappropriate to for men to discuss personal issues or 'men's business' with women, or for women to discuss 'women's business' with men. Facilitate another member of staff to attend if required.

- Ensure the assessment environment is a calm, inviting and culturally sensitive space; offer a comfortable place to sit and enough space for family and supports.
- Privilege Aboriginal and Torres Strait Islander culture and knowledge systems. This means listening to and respecting cultural knowledge, customs, values, feelings, religion/spirituality.

NURSING ACTIONS AND INTERVENTIONS

- Introduce yourself and explain what the assessment entails and its purpose.
- Consult with Matty and his kinship network – identify if he would feel more comfortable if an appropriate male Elder and/or male staff member were allocated and facilitate if requested.
- Gain consent from Matty and explain all procedures prior to performing them, maintaining privacy and dignity at all times. Validate and acknowledge any distress, and gently redirect the discussion to maintain safety as required.
- Assess current mental state and baseline mental state – include collateral information from Matty's aunty. What is Matty usually like? What has changed? See Box 3.1.3 for Matty's mental state assessment.
- Maintain awareness of cultural issues that may be relevant – if you aren't sure, ask.
- Note subjective and objective behaviours/experiences observed and voiced by Matty. Consider these in the context of cultural norms.
- Head-to-toe health assessment (primary survey) to determine other potential injuries from recent fall from tree – including, but not limited to, airway-breathing-circulation-disability, vital signs, pain score, neurovascular observations of affected limb and other investigations as indicated.
- Physical screen to rule out organic factor for behavioural disturbance, i.e. pathology, infection screening, imaging, therapeutic level testing. Once diagnostic screening is completed to eliminate any biological influences, refer to mental health or psychiatry team according to local policy.
- Promote independence and self-care wherever possible.
- Document findings, including interventions and outcomes.
- Liaise with medical officer for medical intervention, where appropriate.
- Invite a second staff member to assist/support with the assessment-taking if indicated. Remain conscious about personal safety, but avoid overcrowding. Note and ensure an exit strategy at all times during the assessment.
- Use opportunity for relevant education and health promotion – with Matty and his aunty.
- Collaborative care planning with extended teams as indicated, e.g. mental health community service, rehabilitation services, Aboriginal and Torres Strait Islander community controlled health services.

RELEVANT TREATMENT MODALITIES AND CONSIDERATIONS

Physical injury presentation of a penetrating leg injury

- A–G assessment/primary survey (systematic assessment approach to ensure a full physical assessment).
- Analgesia for pain relief.
- Check tetanus and immunisation status.
- Wound care and ongoing dressing management.
- Imaging and x-ray for unknown fracture status.

Mental health

- Provide access to treatment and care that is appropriate to, and consistent with, Aboriginal and Torres Strait Islander cultural and spiritual beliefs and practices.

BOX 3.1.3 Matty's mental state assessment

Appearance
- Age 19 years, alert, Aboriginal male of thin athletic build, with rigid posture. Avoids eye contact (culturally appropriate). Distinguishing features included multiple scars to torso and lower limbs, no tattoos, tobacco-stained fingers.
- Clothing choice was inappropriate for current conditions – wearing only footy shorts, no footwear or shirt.
- Manner was suspicious; appeared distracted.
- Prominent physical irregularity: profuse sweating
- Emotional facial expression: stressed, tense, screaming, furrowed brow

Motor/Behaviour
- Agitated, unable to lie still, excessive movement

Speech
- Rate rapid, pressured, hyper-talkative
- Volume appropriate and articulation clear

Mood/Affect
- Stable
- Intensity: exaggerated
- Affect: euphoric, pleasant

Thought Content
- No suicidal or homicidal ideations
- Expressed paranoid and magical ideation related to being chased by spirits
- Delusions: reports he is being followed

Thought Process
- Stream: flight of ideas

Perception
- Illusions (misinterpretation of actual external stimuli) frequently reports seeing 'warra wirrin' (bad spirits), but family say that it is just wild dogs.

Cognition
- Orientated to time, place and person
- Capacity to read and write, completed year 10 at high school
- Level of consciousness: alert and orientated Glasgow Coma Scale of 15

Insight/Judgement
- Awareness of illness – has insight that there is something 'not right', but fearful of bringing shame to his family.

- Assess and treat specific mental health symptoms.
- Therapeutic management.
- Use de-escalation strategies if required.
- Psychosocial interventions with individuals and families, i.e. holistic and social factors that contribute to ongoing care.

SCENARIO 3.1.2

Tahnee

Tahnee is a 21-year-old female who presents to the emergency department by ambulance with a police escort, called by Tahnee's sister Jess. Jess reported that Tahnee had moved from a regional town several hours away, to stay with her 18 months ago to look for employment. Jess said that about 2 weeks ago she noticed that Tahnee was talking 'rubbish' and she couldn't make sense of her, but she was in a rush to get to the train station for work and thought that Tahnee was just waking up and wasn't quite alert yet. She also reported that Tahnee has been increasingly disorganised, forgetting to pay her board, attend job interviews or social gatherings with her friends. Over the past week Jess noticed Tahnee has been talking increasingly about religion, which she has never previously done. Jess reported that when she returned home from work today, Tahnee had 'trashed' the house, she had smashed several photo frames and crockery, upturned furniture and was trying to light a book on fire. Jess said that Tahnee was screaming in 'some other language' and lunged at her when she tried to stop her from setting fire to the house. Tahnee identified herself as Aboriginal on the intake form.

RED FLAGS

- Altered perceptions.
- Relatively rapid deterioration in mental health.
- Destruction of property.
- Unpredictable behaviour and potential for aggression.
- Possible sense of disconnection from country.

PROTECTIVE FACTORS

- Strong family, friends and kinship networks in existence.
- Tahnee has presented to hospital with her sister in attendance and is accepting of being in the ED setting.
- Not suicidal or self-harming.

KNOWLEDGE

- For many Aboriginal and Torres Strait Islander people, connection to country, to the natural world, to culture and cultural practices, are intrinsic to SEWB. While many urban-dwelling First Nations people have a very strong connection to land and community, loss of connection to country (including living 'off-country' or relocating to an urban area where there is limited access to shared cultural practice) may cause cultural/spiritual trauma, compromising a person's resilience and impacting SEWB.
- Kinship carers, particularly siblings, are often not recognised, yet their role in supporting a loved one through a crisis is vital and their involvement during mental health assessment is part of culturally safe practice (Parker & Millroy 2014). A meaningful partnership between health services/providers and family and kinship networks will strike the balance between them being overlooked and under-utilised, and being exploited and abandoned to care for their loved one without support (Wright 2014).
- The experience of psychosis is a significant issue for Aboriginal and Torres Strait Islander people (Parker & Millroy 2014). While research is limited (another outcome of systemic racism), Australian findings indicate an extremely high prevalence of psychosis among Aboriginal people (five times higher for men and three times higher for women) in the

Northern Territory – higher than for Torres Strait Islander populations and for mood disorders, which are similar to the general population – and increasing over time (Gynther et al 2019).
- Vitamin B_{12} deficiency is a known cause of psychosis. HIV and systemic lupus erythematosus (SLE) can present like psychosis and there are considerably higher rates of both in Aboriginal and Torres Strait Islanders, along with higher rates of diabetes, anaemia and kidney disease than non-Indigenous Australians (Dorney & Murphy 2020).
- While Aboriginal and Torres Strait Islander people are more likely to present to EDs than non-Indigenous people (Chapman et al 2014), many people are not asked their Aboriginal status and do not reveal it to health services. They fear experiencing stigma or discrimination, fear not being believed (particularly if they don't 'look Indigenous' (Chapman et al 2014)), fear adverse consequences like having their children removed, fear not being taken seriously, and/or fear health professionals attributing health or mental health issues to the use of alcohol and other drugs.

CULTURAL SAFETY CONSIDERATIONS

- Recognising the influence of culture and working in collaboration with Aboriginal mental health workers is vital for those presenting with psychosis. This helps to create a shared meaning. For example, Parker and Millroy (2014) identify that it is common for First Nations people to hear their relatives' voices, and that where relevant cultural issues are not considered, this may be misinterpreted as a hallucination. They cite various authors who describe a range of meanings that relate to the words 'schizophrenia' and 'psychosis' – including Pintubi words relating to living in a 'world of their own' and having 'closed ears', and other explanations that relate psychosis to emotional stress, and relating delusions to sorcery against the person.
- The inclusion of identifiable cultural features, such as Aboriginal flags, artwork and symbols, as well as health promotion and illness prevention information available in waiting rooms and other areas, supports feelings of acceptance and welcome (Chapman et al 2014).
- Appreciating DSM-V criteria that guide diagnosis, while also recognising that signs and symptoms need to be considered through a patient-centred lens, which is inclusive of Aboriginal and Torres Strait Islander context. Always consider culture-bound syndromes when assessing patients.

ATTITUDES

- Reflecting on the beliefs, values and attitudes that we have formed about Aboriginal and Torres Strait Islander peoples – through our upbringing (family, socioeconomic status), our ethnicity, our education and the media (including social media), where Aboriginal people are often stereotyped, excluded or shown in a negative light – is an important part of practising in a culturally safe way (Best 2021).
- The clinical approach to mental health assessment is embedded in the Western biomedical model – the same place from which concepts of mental health and illness emanate. This approach generates expectations and ways of understanding symptoms, experiences, diagnoses and treatments. It is important for all nurses to understand and acknowledge the impact of this position on practice, and to challenge any pre-existing assumptions about Aboriginal and Torres Strait Islander people relating to assessment, diagnosis, experience and treatment of illness.
- Nursing as a profession is also entrenched within the biomedical model, which has typically excluded Aboriginal and Torres Strait Islander health knowledge. The goal of providing holistic care requires that we reflect on this and consider how to expand and facilitate our knowledge about Aboriginal and Torres Strait Islander approaches and practices in order to improve our cultural awareness and facilitate a more collaborative and culturally safe approach to recovery.

aspect of care when providing support for Aboriginal and Torres Strait Islander consumers, with particular emphasis on family and community involvement. The nursing actions and interventions demonstrate the integrated healthcare and community approach required within the rural context.

Reflection

Cultural awareness prompt

All individuals have varying world views depending on their experiences, culture, community input and family influence; this is known as your social schema. A crucial skill as a health practitioner is to practise cultural awareness when working with clients who come from different cultural backgrounds to your own. Reflect on your viewpoints, attitudes and belief system.

1. Where do they come from?
2. How are they different from other individuals, and what influences have made them different?
3. How might this influence your practice?
4. What additional training or learning do you need to ensure you provide culturally safe and competent practice to your community?

Mental health prompt

1. Would your attitude and approach differ if it was a member of your family or close friend who presented to the ED experiencing a mental health crisis?
2. Reflecting on your role as a health practitioner, how might you adjust your current practice with this in mind?

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I would like to acknowledge my Elders who have come before me and have provided me a path and guidance to continue in my journey. I acknowledge the Bigambul people who are my traditional ancestors from the Goondawindii area and I would like to acknowledge and give my appreciation to Kalkadoon country, Mount Isa where I grew up and which has pathed my future today.—Madeline Ford.

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Useful websites

Australian Indigenous Health Infonet https://healthinfonet.ecu.edu.au/

The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention. Best practice screening and assessment: https://cbpatsisp.com.au/clearing-house/best-practice-screening-assessment/

WellMob healing our way: Social, emotional and cultural wellbeing online resources for Aboriginal and Torres Strait Islander People, https://Wellmob.org.au

Yarnsafe headspace resources https://headspace.org.au/yarn-safe/

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CHAPTER 3.6

Assessing and responding to someone who presents following intentional self-harm

Enara Larcombe and Paul McNamara

KEY POINTS

- Borderline personality disorder is often misunderstood and many people who have been given this diagnosis feel that it has stigmatised their care in the hospital and health system.
- Intentional self-harm is a complex phenomenon; it does not always indicate a wish to die.
- Nurses and other emergency care professionals are well placed to provide both physical and mental health care to the person who presents following intentional self-harm.

LEARNING OUTCOMES

This chapter will assist you to:

- improve your understanding of the diagnosis of borderline personality disorder and what this means for the person
- articulate the differences and similarities between a suicide attempt and non-suicidal self-harm
- describe examples of stigma that the person who self-harms experiences and consider how this might impact on practice
- identify nursing interventions and practices that are helpful to the person who self-harms
- describe the communication and interpersonal skills that can be deployed to support the person who intentionally self-harms/who has been diagnosed with borderline personality disorder.

Lived experience comment
by Helena Roennfeldt

STIGMA

Stigma is highly prevalent for people diagnosed with borderline personality disorder (BPD). This scenario chapter highlights the judgemental comments and attitudes that people with BPD may experience. The impact of this discriminatory treatment can leave people feeling shame and consequently may impact any future help-seeking. The voice of lived experience woven through the chapter offers powerful personal testimony of the experience of someone with BPD, including some of the reasons for self-injury. The reasons for self-injury are varied, reinforcing the importance of gently asking questions and not making assumptions. Similarly, the high prevalence of trauma enhances the need for trauma-informed approaches when providing care. This chapter also highlights the potential positive impact of kind and compassionate responses, which may be particularly impactful given the predominance of these negative experiences.

Autoethnography, with its origins in the post-structuralist paradigm, was first used as a research term by Hayano in 1979 to describe studies in which the researcher is a member of the group being studied (Luggins et al 2013). In this scenario chapter, the otherwise unreferenced sections in *italics* are informed by the lead author's lived experience of hospitalisation following intentional self-harm.

INTRODUCTION

From July 2008 to June 2019 there were an average of over 28 000 hospitalisations per year in Australia secondary to intentional self-harm (National Hospital Morbidity Database 2019). The true statistics around self-harm are unknown due to poor reporting systems and individual factors – including whether a person reports self-harm or just the resulting injury (Sveticic et al 2020). *This represents a significant onus on emergency services and departments as the first points of contact for those patients presenting with self-harm. This initial interaction can be a polarising experience for these individuals and be highly influential in terms of future help-seeking behaviours. Subsequently, there is a need for healthcare practitioners to have a thorough understanding of the needs of the consumer, both in terms of physiological and mental health, and to respond to self-harm presentations with safe and appropriate knowledge, professionalism and empathy.*

Intentional self-harm occurs with or without suicidal intent (Edmondson et al 2016; Hooley et al 2020). *The lived experience is that there is rarely any correlation between the objective lethality of injury and the intent. Clinicians should be wary of projecting their estimation of the objective of self-harm onto the people in their care – I have been close to death when aiming only to release intense emotions and have been sutured in ED and sent home when I wanted to die.* To further complicate matters, there is little consensus as to the definitions of self-harm and/or suicide, with terms such as 'intentional self-harm', 'deliberate self-harm', 'non-suicidal self-injury (NSSI)', 'suicide', 'completed suicide' and 'suicide attempt' being used in different contexts (American Psychiatric Association 2013). However, there is some consensus around the lived experience of self-harm; Box 3.6.1 identifies a range of 'truths' around self-harm for people who experience it.

Complex trauma and the diagnosis of borderline personality disorder (BPD) often coincide (Jowett et al 2020). People with a diagnosis of BPD are known to have experienced

Box 3.6.1 Self-harm truths from the lived experience perspective

A seminal study found that – from a lived experience point of view – the following statements can be true.

Self-harm:

- *is a form of communication*
- *provides a way of staying in control*
- *provides distraction from thinking*
- *can create feelings of euphoria*
- *is a release for anger*
- *expresses emotional pain*
- *can be a response to sexual abuse*
- *is a coping strategy*
- *helps a person maintain a sense of identity*
- *provides an escape from depression*
- *helps to deal with problems.*

Warm et al 2003, p. 76.

a significantly higher rate of childhood abuse than the general population, including sexual abuse, neglect and emotional abuse; they are up to 13 times more likely to report historical childhood abuse (Porter et al 2020). People who have experienced complex trauma are more likely than the general population to self-harm as a way to ventilate or regulate emotions (Bradley et al 2019). Emotional regulation or a desire to avoid emotions entirely has also been cited as a major factor in self-harm (Brereton & McGlinchey 2020). Alexithymia (i.e. difficulty identifying and communicating emotions) has been shown to be prevalent among people diagnosed with BPD and is also thought to play a considerable role in why some people self-harm (Sleuwaegen et al 2017). Dissociation of moderate–severe intensity is commonly experienced among people diagnosed with BPD (Jaeger et al 2017) and influences both the risk of engaging in self-harm behaviours and the severity of physical injuries as a result of the self-harm act (Dorahy et al 2019). *Dissociation is a separation of mental processes, a feeling of detachment from the world, like you aren't really present. Time, places, people and actions have very little significance – it's like you're floating and your senses have all been altered. Sometimes it feels like your mind is trying to protect you, but it can be a dangerous thing as you can easily act impulsively and perilously, with little knowledge of or regard for the consequences of your actions.*

People with the diagnosis of BPD access the emergency department (ED) for all sorts of reasons, including safety (Vandyk et al 2019). Research has found that there can be empathy failure from nurses towards people who present to the ED after intentional self-harm (Baker et al 2021; Rayner et al 2019). A recurrent theme in the literature is that people diagnosed with BPD experience stigma from health professionals (Vandyk et al 2019); some studies contend that nurses are the health professionals who have the poorest attitude towards this cohort (Dickens et al 2019). Consumers who present to the ED after repeated self-harm are sensitive to this empathy failure, and identify where improvements can be made (Meehan et al 2021). *My presentations to hospital have been varied. On some occasions I have walked into the emergency department with relatively serious injuries and little shame, then barely a week later reappeared with intense*

shame and higher distress, but with smaller wounds. Occasionally, I present not with injuries, but for my own safety, when I (or my treating team) feel that I cannot cope safely at home with the distress I am experiencing.

Healthcare practitioners commonly misunderstand the intentions behind presentations for self-harm behaviour, believing it to be purely 'attention-seeking' or 'manipulative' (Day et al 2018). Language historically associated with self-harm and people with a diagnosis of BPD includes words such as 'difficult, manipulative, attention-seeking and self-destructive' (Vandyk et al 2019, p. 758). Unsympathetic judgements or remarks, even when said without malicious intent, can result in a reluctance to seek help or engage in continued support for self-injurious behaviour (Owens et al 2016).

Statements like 'Try harder next time', 'What a waste of time and resources', 'There are real emergencies', 'You did this to yourself', etc. are not only unhelpful, but are seriously damaging to a person's perception of the practitioner, the health industry and themselves. These words and phrases are hurtful and only serve to further stigmatise. In fact, they can perpetuate further self-harm and result in an increased risk of suicidal behaviour.

Diagnosis of borderline personality disorder carries stigma, but can also be a useful adjunct to insight and understanding for the individual, and facilitate more informed and evidence-based treatment for practitioners (Campbell et al 2020). Diagnosis of BPD need not be a barrier to therapeutic consumer–nurse relationships, and there are strategies that have been shown to help enhance the therapeutic rapport (Romeu-Labayen et al 2020). Responding with empathy, understanding or a sincere effort to understand, is much more conducive to a therapeutic relationship. Communicating harm minimisation strategies or suggesting alternatives to self-injurious behaviour may be helpful substitutes (Pengelly et al 2008).

Neutral statements, or where possible, positive and empowering words and phrases such as 'courageous for seeking help,' 'resilient' and 'self-aware', should be used instead.

Many people who self-harm recognise when their emotions, ideation or actions have reached crisis point and other resources have been exhausted (Vandyk et al 2019).

Personal experiences have shown serious physical and emotional consequences to occur as a result of these people in crisis not being seen as a matter of urgency. As a practitioner, it is imperative to fully engage with these individuals to prevent further harm. Asking individuals to rate their current level of distress provides a good indication as to how treatment needs to be prioritised.

Where possible, it is helpful for the person's individual needs to be accommodated (e.g. avoiding certain beds/bays or minimising waiting room times), as they may have the potential to provoke or escalate maladaptive coping mechanisms (Stanley et al 2019). Additionally, the association between impulsivity and self-harm should be considered (Lockwood et al 2017). It is a balancing act: constant supervision (nurse specials and security) and removal of personal belongings is associated with higher levels of resentment and dissatisfaction, and an increased risk of violence towards both self and others (Pengelly et al 2008).

People who present to ED after self-harm commonly experience guilt, shame, feelings of isolation, unworthiness, fear and failure (Owens et al 2016). Medical trauma from previous presentations (e.g. having self-inflicted lacerations repaired without local or parental analgesia) can significantly impact on the person's willingness to seek and accept external assistance (Hall 2017) and their ability to regulate emotions during this process. In certain circumstances and for some individuals, exposure to negative attitudes and unhelpful interactions from health practitioners can have such a significant impact as to induce or

exacerbate violence, either towards the self or others, and can result in a person subsequently being unwilling or refusing to seek or accept help (Shaikh et al 2017).

People who self-harm should be invited and encouraged to actively participate in their own care and be empowered to make decisions regarding their ongoing needs (Ntshingila 2020).

While this can sometimes be difficult in an emergency environment, it is imperative to keep people updated on their care, on timelines, on procedures and referrals. Even the simple action of reassuring the person that their needs are still being considered can be effective in helping them regulate their emotions and adjust expectations.

Patients who experience positive interactions with health practitioners report higher levels of trust, an increase in help-seeking and greater participation in treatment; in contrast, patients with more negative interactions reported isolation, resistance to treatment and a reluctance to engage with services (Cully et al 2020). Early, positive intervention and support for patients presenting with self-harm have been found to reduce future self-harm presentations, and a decreased risk of suicide ideation and attempts (Cripps et al 2020).

Reflection

A helpful question for practitioners to ask themselves is: 'What is the person trying to communicate or regulate?' Gently asking this question may be appropriate in some circumstances. Be sure to reassure the person that they did the right thing by presenting to hospital/calling an ambulance, and that their needs are valid and they are deserving of care and treatment. Recognise and verbalise that the hospital or prehospital environment may be a trigger or a distressing environment for them.

The following scenario illustrates possible challenges for the person presenting to hospital after self-harm, and some considerations for the nurses providing care. The example is based on an amalgamation of actual events. Put yourself into the shoes of the nurse and reflect on how you would respond under similar circumstances. Following the scenario, key aspects related to assessment, management and the provision of person-centred care will be highlighted.

SCENARIO 3.6.1

Taylor

Taylor is a 20-year-old woman diagnosed with borderline personality disorder (BPD), who has presented to the emergency department via triage at 2300 hours. She presents alone with significant new lacerations to her left forearm, which she has covered with a clean towel. There are seven lacerations made with a razor blade, they range in depth from 5 mm to over 15 mm. Taylor explains that she has had a series of stressors over the past few days and has cut herself tonight to help 'release' these emotions. She was recorded as being calm and cooperative in her interactions with the triage nurse.

You have just come on shift and are receiving a bedside handover from your colleague on the earlier shift. In contrast to her earlier calm demeanor, during this handover Taylor is visibly distressed, wringing her hands, crying and refusing to make any eye contact. Your co-worker states, 'She's only here because she's cut herself up.' He does not offer any clinical information beyond Taylor's name and age, her mechanism of injury and the location of the injuries. No basic observations have been taken.

RED FLAGS

- Taylor was calm and cooperative when she presented at triage, now she is distressed and not engaging. Consider what has changed for Taylor since she has been in hospital.
- Taylor is distressed. Consider whether she is at risk of further self-harm while in hospital, or of leaving the department against medical advice. Consider what steps can you take to decrease Taylor's risk.
- A colleague displays a negative attitude towards Taylor's presentation. Consider whether the negative counter-transference from your co-worker is contributing to Taylor's distress.

PROTECTIVE FACTORS

- Self-initiated, voluntary presentation – Taylor has demonstrated that she can identify when to seek help.
- At triage Taylor was able to verbalise emotions and identify stressors/triggers for self-harm.
- To date Taylor has been playing her part in harm minimisation by keeping the wounds clean and covered, and staying in hospital for wound review.

KNOWLEDGE

- Vital signs and vascular observations of the affected limb are required. The physical care of the person who self-harms should be no different to the care of someone who sustained the same sort of injuries in an accident.
- Assessment and ongoing monitoring of Taylor's mental state in the ED is important – especially to monitor and document changes. Any increase in distress should be considered a sign that extra support may be required.
- An awareness of and willingness to practise trauma-informed care (TIC) is required. As described by (Isobel et al 2021), elements of TIC include:
  - being aware of trauma
  - collaborating in care
  - building trust
  - creating safety
  - offering a diversity of treatment options, with a decreased focus on medications
  - staff practising with consistency and continuity.
- Taylor presented to hospital of her own volition. However, under some circumstances, people presenting with self-harm may need to be treated under the Mental Health Act, e.g. if the person remains actively suicidal, is showing signs of mental health problems, lacks capacity for decision-making, and is refusing to remain in hospital as a voluntary patient. An awareness of the legal requirements of providing treatment under the Act relevant to the jurisdiction, as well as knowledge of local policies and procedures is essential. Regardless, the person should be treated in a non-threatening, non-judgemental way, where decisions around treatment are discussed in an open and honest manner.
- How and when to refer to the mental health team/consultation liaison psychiatry service. This should be routine part of practice when a person presents with intentional self-harm. Knowledge of local policies and practices is essential.

ATTITUDES

- Empathy not sympathy: Unlike sympathy, which can be disempowering and minimising of a person's suffering, empathy is a compassionate recognition and validation of suffering. In her landmark paper, Wiseman describes empathy as 'a skill which is crucial to the helping relationship' (1996, p 1164). An empathetic approach enables a person-to-person connection, and can include acknowledging that, while you don't fully understand self-harm, you would like to know more and gain insight into the person's experience, so as to assist if you can.
- Professional curiosity: *There is literally no other way to explain this. Clinicians always have something to learn from patients and particularly so from people who engage in self-harm behaviours. It gives clinicians the opportunity to reflect on their own knowledge of why people self-harm, of emotion regulation, and the ability for people with BPD to define and describe their own emotions. People with BPD may also have the experience of being deemed a 'frequent flyer', and while this often has negative connotations, it also means that they are in a unique position to be able to offer a new perspective on the continuity of mental health care and attitudes within the health service.*
- Reflective practice. Take time to consider the person's lived experience and be informed by the principles of trauma-informed care (as above). Be mindful that some people who have experienced trauma are very sensitive to feelings of neglect or rejection. Your communication skills, collaborative approach and warmth are the best antidotes to this.
- Whether they are self-inflicted or not, wounds need to be repaired. Most nurses will attempt to live-up to nursing's reputation of providing kind and compassionate care. See Box 3.6.2 for tips from someone with lived experience of both BPD and intentional self-harm to assist you to do so.

MENTAL HEALTH SKILLS

- Use active listening. To ensure that you are accurately understanding the content of the person's narrative, check occasionally by rephrasing or asking follow-up questions, e.g. 'When you say "I just want it to end", are you talking about wanting the intrusive negative thoughts to end, or are you saying you want your life to end?'
- The personal competencies of self-awareness and self-management, and the social competencies of social awareness and relationship management are known as emotional intelligence (Hurley & Linsley 2012). These skills are helpful in all nursing settings, especially when working with people who have been diagnosed with BPD. Reflecting on your practice with a trusted colleague (aka clinical supervision) may assist in developing confidence with emotional intelligence.
- 'Therapeutic use of self' is an essential mental health nursing skill used to assist the people in our care towards recovery (Wyder et al 2017). This is the opportunity to use your communication skills, your empathy, your warmth, your clinical skills, your communication skills and your personality in the service of someone in need. Mental health nurses working in this way are humble enough to know that we cannot impose change onto someone else, but we are confident in our ability to create a space where the person can make changes when they are ready.
- Recognise and manage transference (the patient's unconscious bias about the clinician) and counter-transference (the clinician's unconscious bias about the patient). This emotionally intelligent approach to care is important; without it there is a risk of empathy failure and/or escalation of harmful behaviours.
- Attend to the changing needs and nuances of establishing and maintaining a therapeutic relationship. As articulated in trauma-informed care, this will include building trust, collaborative care planning, and consistent practice.

Box 3.6.2 Tips for care of person with borderline personality disorder and intentional self-harm

Instead of telling me that I am a 'waste of time and resources,'

Try: 'I am so proud of you for seeking help.'

Instead of saying, 'You did this to yourself,'

Try: 'You appear to be in so much pain.'

Instead of telling me to 'try harder next time,'

Try: 'How can we help you?'

Instead of calling me 'attention-seeking,'

Try: 'I recognise that you are coping in the best way you know how.'

Instead of guilt-tripping me by saying 'there are real emergencies,'

Try: 'Your feelings and your injuries are real and valid.'

Instead of saying 'you are ruining your body,'

Try: 'You are resilient.'

Instead of asking me, 'Why are you doing this?'

Try: 'I don't understand why you hurt yourself, but I'd like to know why you are in distress, and I want to help you.'

Instead of telling me I am 'not worth the time' (of mental health services),

Try: 'Would it be useful to involve the crisis team? Would you like me to ask them to see you now?'

Please treat me with respect, care and be honest with me. Positive interactions with clinicians influence my help-seeking actions in the future, and significantly affect my future self-injurious behaviours. If you can't maintain a positive attitude towards me, please try to remain neutral. I am placing a lot of trust in you by asking you for help.

- Basic skills in mental state assessment, i.e. looking, listening and asking. Looking at the person's behaviours, listening to the content and meaning of the person's speech, and asking about their concerns and needs.
- Understanding the uses and limitations of the Mental Health Act as a means to decrease risks. The Mental Health Act may be useful as a short-term tool to prevent discharge against medical advice in someone who meets criteria (i.e. has a mental illness, is at risk to self/others, lacks decision-making capacity, and unreasonably refuses treatment). However, the Mental Health Act is not a long-term solution to addressing underlying problems or preventing future self-harm.

NURSING ACTIONS AND INTERVENTIONS

- Introduce yourself, ideally using your first name. *Likewise, use my name. We are both humans. If you like my tattoos, tell me. Ask me what music I'm listening to. Forming a rapport without volunteering too much information about yourself is relatively easy if you can show interest in me beyond my wounds or diagnosis.*
- Maintain the person's dignity and privacy at all times. *If you afford this to every other patient, I deserve it too.*

- Undertake a risk assessment – including risk of further harm to self or to others. *You'll need to ask me; I'll need to trust you with the answer.*
- Evaluate the safety of the person in a busy environment. *Consider the risk of me leaving if I am placed in a 'busy' waiting room with any number of triggers. This doesn't mean I expect to be seen straight away, but offering a quiet space to wait can help me.*
- Provide adequate information about treatment and procedures and gain consent. *Don't assume anything, including the extent of the treatment I am seeking. Just because I have presented to hospital does not mean I want stitches, etc. Sometimes I have presented just for my own safety. Keep me informed about my care. Please acknowledge tedious processes and long waits.*
- Remain positive and recovery-oriented. *Recognise positives without being condescending. Saying, 'I'm really glad you presented tonight' is a lot more helpful than 'You've done a good job this time'.*
- Encourage people with BPD to identify triggers and maladaptive behaviours and enable choices that lead to the mitigation of these. *Give options (does the person want to sit on the bed or on a chair?) If possible, allow them to make a choice in which area to be seen and where they feel safest (this can help minimise trauma).*
- While still following local policy and procedure, consider the necessity of security specials and other actions that may be viewed negatively by the person or by others. *Unless the person is an acute risk to themselves or they are under the Mental Health Act, do not remove belongings, do not request they turn their phone off, do not use a scanning wand – it's embarrassing and feels like a violation. It also elicits trauma responses and can disrupt emotion regulation and distraction techniques currently being used.*
- Offer a standard of care equivalent to that of any other patient. *Treatment as usual please. If it's a wound that would normally be sutured, please suture my wound too. Please don't punish me for causing the wound – I will notice it. I will be offended by it.*
- Patient advocacy should remain a priority for nurses working with people who have self-harmed. *Nurses are often the strongest advocate for patients regarding the provision of adequate analgesia. There was an occasion when I cut into a tendon and was refused paracetamol, let alone offered anything stronger. It REALLY hurt! Please don't let the fact that I caused the wound cloud your common sense or change your usual practice – of course I don't want long-lasting pain. Would you offer me analgesia if my wound was caused by an accident? If the answer is 'yes', you should offer me analgesia for self-harm too.*
- Local procedures may necessitate the use of mental health outcome measures, which should be undertaken in a safe and efficient manner. *I understand that you will need to assess my mental state, risk and safety, but I would be grateful if you could do so without reading off a formal checklist (even if you must document using one). It's much more helpful to me if you integrate your questions into a conversation. You will probably realise that I will catch onto you quickly and volunteer the information anyway.*
- Be aware of your language and the content of your conversations with colleagues, during handover. *Language is powerful. Use facts, communicate my needs and desires to the treating team and address my need to be included in clinical decisions where appropriate.*
- Be conscious of your language and judgement in your documentation. *It is relatively easy for me to access my own medical information (especially with MyHealthRecord) and it can cause me significant emotional distress should you use language that portrays me negatively, including making assumptions about me or my history.*
- Maintain a clinical focus and be alert to any other concurrent mental or physical health issues that may be occurring, and the risk of serious complications. *Be aware of my other potential health concerns, including further self-harm that I may not be disclosing.*

- Consider the potential for deterioration both mentally and physically, and encourage the person to communicate any concerns. *Take my observations. Sit with me. Reassure me. Trust me, I've probably been in this position before and if I tell you that I'm not okay, then I'm definitely not okay.*

RELEVANT TREATMENT MODALITIES AND CONSIDERATIONS

- Be kind.
- A person-centered and holistic approach to all physical and mental health treatments is required.
- Engage the mental health team as early as is practical, not just to refer the person for assessment or admission, but for support and to advise the clinical team as well. The mental health team may be able to facilitate access to evidence-based outpatient treatment specific to the person's needs, e.g.:
  - Dialectic behaviour therapy (DBT) was developed specifically to treat people who experience BPD. Therapy can be delivered individually or in a group program. It includes strategies relating to acceptance and change, mindfulness, distress tolerance, emotional regulation and enhancing interpersonal effectiveness.
  - Cognitive behaviour therapy (CBT) is a psychological therapy which focuses on recognising and addressing thoughts and behaviours that are unhelpful and ineffective at managing the symptoms which are impacting on their life.
  - Eye movement desensitisation and reprocessing (EMDR) is a psychotherapy which targets traumatic memories and distressing life experiences, helping to alleviate the person's distress and develop insights into the impact of trauma on their life experiences.
  - Acceptance and commitment therapy (ACT) uses experiential exercises to help people change their relationship with painful thoughts and feelings, and to take actions that are guided by their own personal values in order to create a life that is meaningful to them.

SUMMARY

There are many instances where the health system has failed to provide compassionate, effective care to people diagnosed with borderline personality disorder who present to hospital following intentional self-harm. This empathy failure is evident in the literature and reflected in the voices of lived experience. The focus for all health professionals should not be on what mistakes have been made in the past, but on how we can 'do better' in future.

The person who presents to hospital following self-harm is not necessarily suicidal. They may be suicidal, but we know that self-harm can serve a number of purposes: it may provide relief, release, distraction, a form of communication, and may prevent distress from escalating. People present to hospital for safety because their needs are not being adequately met at home/in the community. The hospital becomes – temporarily – the safest place for the person to receive support.

The clinical skills honed by emergency clinicians caring for accident survivors can be equally useful to the person who has self-harmed. Wounds need evaluation, cleaning, care, repair and maintenance, no matter the aetiology. Similarly, clinicians can be therapeutic by using the communication and interpersonal skills they have already developed and used with other patients in the emergency setting. When these skills are deployed with patience, persistence and intent to assist a person who is experiencing distress, positive outcomes can be generated.

A trauma-informed approach provides a framework for clinicians to contextualise their understanding and work in partnership with the person who has presented with self-harm.

Being understanding of, and respectful about, the person's experience of trauma, positioned not as 'What is wrong with you?', but as 'What has happened to you?', enables reflection on the clinical approach that will be most helpful. Collaborating with the person about the plan and delivery of care moves hospital clinicians from a paternal 'doing to' approach, to an interpersonal 'working with' model of care. This is likely to be much more satisfactory for the consumer and the clinician.

General hospital clinicians can borrow the mental health meaning of recovery when working with people diagnosed with BPD who self-harm. That is, 'recovery' can be considered a direction in which a person is travelling, rather than as a point at which they have arrived. In this context, a person who self-harms less frequently this year than they did last year can be considered to be working towards (or being in) recovery – depending on the person's own definition of what recovery means to them. We should be encouraged and encouraging about that sort of progress; sometimes the person experiencing distress relies on others to hold hope for them on their behalf.

Caring for people who experience BPD and intentional self-harm is an aspect of nursing that enables and encourages us to stretch our skill set. Yes, it can be challenging at times, but when we draw on principles and practices that enable and support the person who is in distress, it can also be a very rewarding aspect of our work. In this chapter, we have used examples from the lead author's lived experience to add clarity and nuance to the academic content. It is our hope that this approach has provided clinicians with a deeper understanding of the issues, that it has highlighted the power and importance of your words, attitudes and actions, and provided the opportunity to reflect on how to help.

To succinctly summarise, the best first step for anyone providing care for a person diagnosed with borderline personality disorder who self-harms, is this: be kind.

Reflection

1. In the text above, there are 11 reasons for self-harm identified by people who have self-harmed. Reflecting on that list, how many myths about self-harm that you have been told/heard can you identify?
2. What interpersonal skills and personality traits do you have that allow 'therapeutic use of self' when providing care to the person diagnosed with borderline personality disorder who intentionally self-harms?

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