Staff experiences of managing self-harm in an inpatient unit for adolescents

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Presentation aims

- Discuss the rationale and aims of the study
- Brief outline of methods
- Results
- Discussion
- Reflections on the research process
Rationale

- Deliberate self-harm (DSH) managed with close observation in inpatient settings, both historically (Bowers, Gournay, & Duffy, 2000) and at present (Stewart & Bowers, 2012).

- Close observation poses several problems:
  1) It is costly - 20% US nursing budget using for close observation (Bowers et al., 2000).
  2) High impact on service users - DSH as a coping strategy - removing means of DSH can lead to escalation of DSH or suicidal behaviour (Holley & Horton, 2007)
  3) High impact on staff - impact on relationships, stress, burden (Curtis et al., 2013).
NICE (2011) guidance calling for a shift away from restrictive practice and close observation, but only offering gold standards and no specific guidance, particularly for inpatient services.

Few qualitative studies exploring staff experiences of managing DSH in inpatient units - even less in inpatient units for adolescents.

Few studies available report the following:

- Need for training and supervision (Wilstrand, Lindgren, Gilje, & Olofsson, 2007 - Sweden).
- High stress among staff (Thompson, Powis and Carradice, 2008 - UK)
- Feelings of frustration and helplessness (Hopkins, 2002 - UK)
Aims

- Qualitative study to explore staff experiences of managing DSH In an inpatient unit for adolescents.

- Clinical psychology department in the unit was developing a DSH strategy to be used by all staff working in the unit.

- Secondary aim: explore contagion in the unit
Methods

- Participants: 5 MDT (Multi Disciplinary Team) staff members working in an inpatient unit for adolescents with a minimum experience of 3 months.

- Design: qualitative piece of research (Thematic Analysis)

- Data collection: semi-structured interviews

- Recruitment: via email (through field supervisor)
Results

- The inevitability of DSH
- The privileged role of MDT staff
- Not knowing

Powerlessness

Taking clinical risks
Results - Theme 1: The inevitability of DSH

Powerlessness

► Participants felt powerless in relation to DSH - they felt unable to completely prevent DSH in the unit, despite the strategies put in place.

► “…young people are resourceful…” (Barbara) they “…can find ways to self-harm that we wouldn’t have thought of …” (Laura), and “…staff could put all the measures in place to prevent self-harm, occasionally it is still going to happen…” (Laura).

► One senior member of staff felt frustrated due to his inability to make sure that staff on the ward was successfully implementing the strategies put in place to keep young people safe.

► …the frustration there, is when you see the same event with the same person happening again and again, even though you’ve put in place some ways to mitigate the harm, and yet is not followed, is not implemented. And that’s frustrating…(Lucas).
Results - Theme 1: The inevitability of DSH

Taking clinical risks

- Participants recognised that ‘curing’ DSH is not within the aims of an inpatient admission, and acknowledged the function of DSH as a coping strategy for young people.

  - ...we don’t cure self-harm here, that isn’t what we do, so often the young people might still be self-harming or might still be at suicide risk at the time that they leave... (Barbara).

- However, they felt torn between wanting to take ‘therapeutic’ clinical risks, and fearing the legal consequences in case of a serious incident. Due to this fear, they often adopted a ‘safe-approach’, although this was not always beneficial for the young people on the ward.

  - ... if you go to the final worse possible outcome of any clinical decision you make, which is essentially a formal enquiry and a coroner’s, the coroner will never ever ever be sympathetic to someone who takes the approach that is taken in adult services (to take clinical risks, and allow the person to be responsible for their own safety) with someone who’s deemed to be a minor. So there is real risk aversion... (Lucas).
Results - Theme 2: the privileged role of MDT staff

- MDT staff recognised the ‘easier’ nature of their role in comparison to that of ward staff who are exposed to episodes of DSH on a regular basis, and are often unable to take time to self-care.
  - ... so if we (MDT staff) come in for an hour here or there and meet with the young person, and then are able to leave the ward after...whereas the nursing staff don’t get that (...) I think the nursing staff have a really difficult role (...) it’s constant, constant, constant... (Barbara).

- Staff reported ‘stability’ on the ward to be essential for ward staff to take breaks and access appropriate support when needed. The stability was both in relation to the young people and the staff group.
  - ...the staff themselves need support within themselves to supervise each other and be able to be supported by each other, otherwise they are constantly pulled in every direction to try and meet the gaps or needs that are there. So, again, it comes back to the stability that they can have support, supervision...(Lucas).

- However they also reported that stability was often difficult to achieve due to staffing levels as well as to the chaotic nature of inpatient admissions (e.g., high turnaround of clients; emergency admissions).
  - ...thinking about times where I’ve been on the ward where there’s been a young person who’s ligatured... and it’s really affected some members of staff and they’ve needed to go off the ward in that instance, but one of the problems is always in terms of our staffing levels... (Barbara).
Results - Theme 3: not knowing

1) Not knowing the person
   
   ... if I don’t know someone very well, I always feel like I’m scared that I’ll say the wrong thing, or do the wrong thing, and that’s just gonna bring the situation way back up again, and that makes it more stressful (Laura).

Due to the chaotic nature of the unit - crisis admissions and quick turnaround of staff

...we’re having a lot of crisis admissions, young people...are coming and going very quickly. Ehm, so for the staff to be supporting these young people who they don’t always know that well (...) it is a massive challenge... (Barbara).

2) Not knowing the ”protocol” - stressful for some but preferred by others

...it can be stressful not knowing the protocol very well (...) feeling like you don’t know where you are going or what you are doing, that’s stressful for me ... (Laura)

...I just go with what, what’s the incident, what’s going on. Then based on what’s happening, I go along with the flow (...) ‘cause it’s better for me to do that rather than follow a set strategy... (John).

Need for more consistent training expressed by all staff members
Discussion

- Struggle between wanting to take therapeutic risks and fearing the consequences:
  - A recent report by the National Health Service Litigation Authority (NHSLA; 2011) found that legal claims against the NHS rise every year.
  - Between 2010 and 2011 it was estimated that the NHS had potential liabilities of £16.6 billion for clinical negligence claims.
  - The financial costs of a litigation culture within the NHS has led to preventative practice across most services within the NHS, which try to avoiding claims and litigation at all costs (Furedi & Bristow, 2012).
Discussion (continued)

- Privileged role of MDT staff:
  - Research on compassion fatigue - Compassion fatigue (CF) is a phenomenon that affects workers who hold clinical roles that require compassion while being extensively exposed to the suffering of others, either on a physical or emotional level (Hegney et al., 2014).
  - CF is believed to be mainly present in work environments where the constant exposure to suffering of others is combined with a lack of emotional support and necessary resources to allow for appropriate self-care (Boyle, 2011; Radley & Figley, 2007).

- Lack of ward staff makes it difficult to comment on these findings.
Discussion (continued)

- Not knowing

  - Importance of therapeutic relationship to guide intervention reported in another study (Thomson et al., 2008).
  - However participants in the Thomson et al.’s study reported establishing intense relationships with the young people they worked with.
  - Thomson et al. was conducted on community nurses - maybe a more settled environment? Longer relationships?
Some reflections

- Recruiting staff is better in terms of ethics

- It is also a struggle to recruit staff
  - Long working hours
  - Not a priority
  - Service constraints

- Things don’t always go to plan
  - Allow plenty of time for ethics and recruitment - it will most likely take double/triple the amount of time you originally thought it would.
  - Don’t make your recruitment criteria too strict
  - Often you will find out the best recruitment criteria when it’s too late to change things
  - Be careful about what you do - people may have ‘strange’ suggestions when things don’t go to plan - it is up to you to stick to your ethics and make sure you don’t do something which is against your protocol.

- Don’t despair - it will eventually get done
References


References (continued)


Thank you for listening