



Suicide and self-injury: a recovery based approach

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ABSTRACT

This article describes a new training programme for clinical staff working with those who present with self-injurious and suicidal behaviour using a recovery focused approach to promote safety and manage risk. The two-day programme was developed and piloted initially in a high secure setting before being adapted for multi-mental health settings. It was subject to rigorous review and reflects the current literature base for high-quality and effective care for working with people who engage in suicidal and self-injurious behaviours. The early indicators are that the introduction of a skills-based training approach to caring for those who pose a risk to themselves does increase staff awareness and improve staff attitude and competencies. The training course described is unique because it fully embraces the recovery approach, demonstrating a truly collaborative model of risk assessment and personal safety planning.

Excellence (NICE), 2004), with rates increasing year on year. The importance of this is that those who have had a previous experience of suicidal or self-injurious behaviour are more likely to complete suicide, 3% in the 10 years following self-injury (Suominen et al, 2004), with a further 40% repeating injury to themselves (Zahl and Hawton, 2004). Furthermore within the current economic climate this poses a challenge to services in the throes of cost savings, and a dilemma to health professionals who are committed to improving the quality of life for their service users.

Suicidal behaviour often imitates that of self-injurious behaviour in method and be distinguishable only by the person's intent. Intent or function of self-injury is not always obvious to either the service user or clinician and is made more complex by its interchangeable nature with suicidal ideation. Some service users experience suicidal thoughts and intent alongside self-injuring behaviour, whereby the function of the self-injury in these instances may be to survive (Spandler, 1996).

Although suicide rates among those with a diagnosable mental illness have decreased over the last 10 years there is still much which could be improved to reduce the number further. Suicide continues to demonstrate a major public health concern accounting for more deaths annually than road traffic accidents or any other illness in working age adults (Appleby et al, 2011). Caring for people who are experiencing such distressing and potentially life threatening behaviour requires skill and compassion from all mental health clinicians (this term includes doctors, nurses, occupational therapists, social workers and healthcare assistants). However, mental health clinicians may have received little or no training in this field, and may inadvertently demonstrate negative beliefs and attitudes.

Research has suggested that negative staff attitudes and a poor service user experience of care are associated with a lack of formalised training and education, and conversely that positive staff attitudes are associated with a greater understanding of the experiences of those who self-injure, indicative of participation in improved training (McHale and Felton, 2010),

There is plethora of interchangeable terms to describe the intentional harm to oneself via a range of behaviours; self-harm self-mutilation, parasuicidal and self-abuse.

For the purpose of this training the term 'self-injury' was chosen as it conveys a sense of intent, differentiating it from those who choose to partake in harmful behaviours, smoking for example. It is also the preferred term of those who actively engage in this type of behaviour (Longden and Proctor, 2012).

Self-injury, the intentional harm to oneself, accounts for at least 170 000 of hospital attendances annually (National Institute for Health and Clinical

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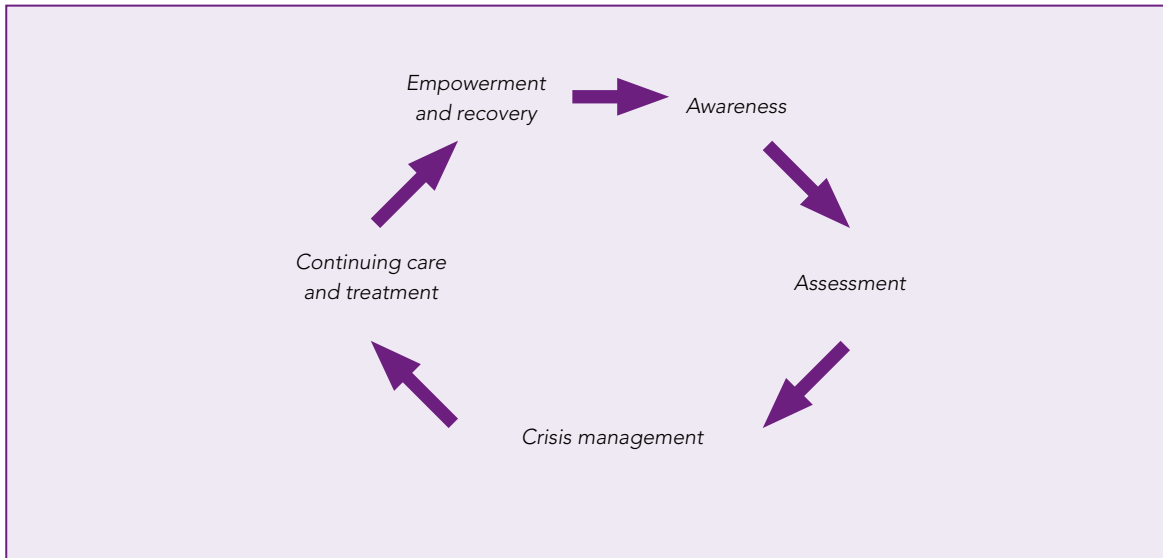


Figure 1. Challenging stigma: promoting safety

Historically there has been a dearth of standardised educational programmes and skills-based training for mental health clinicians working with those experiencing self-injurious or suicidal behaviour, (Centre for Mental Health (CMH), 2009). Of the few which do exist, training is restricted to risk assessment and crisis management with very little emphasis on skills acquisition to provide effective and evidence-based continuing care and treatment. Risk management approaches and procedures within inpatient settings have often prioritised the use of nursing observations as a valid and effective intervention, without the necessary emphasis on engagement and the importance of a therapeutic alliance. Continuous and intermittent nursing observations are often reported by service users as punitive and aversive, a negative view often shared by the nursing team (Department of Health, 1999). Also absent is the exploration of the relationship between 'risk and recovery' and the importance of collaboration whereby clinicians and service users work together, demonstrated by joint ownership of the co-production of individualised risk assessments and personalised safety planning to manage any ongoing risks the person is experiencing.

The rationale for developing a new bespoke training package for staff was to address these critical areas, providing a framework for learning which encouraged reflection on attitudes as well as offering practical skills and strategies to assist clinicians in the provision of high quality, effective and responsive care and treatment. Inherent throughout the package is the fundamental principle that managing risk can be undertaken proactively and collaboratively with the service user. A cultural shift in risk management from 'doing to—to doing with', the aim being that

ultimately the service user will be in control of their risk management and treatment, demonstrated by a jointly developed personal safety plan.

This approach was in line with the commitment to addressing one of the 10 *Key Organisational Challenges* (CMH, 2009) of the national Implementing Recovery through Organisational Change programme. Specifically targeting challenge 6, 'Changing the way we approach risk assessment and management', and in particular '...to evaluate risk assessment and management according to recovery principles' (CMH, 2009).

Methodology:

Plan of training:

Previous training had consisted of one day, which was mandatory for all clinical staff. It provided a theoretical overview of the concept of risk assessment and duty of care principles but did not provide skills training or an opportunity for reflective learning or care planning. The training had not embraced recovery principles nor had there been any service-user involvement in either its development or facilitation.

Implementation was phased with day one piloted within one service and adjustments made according to feedback before its implementation trust wide. Train the trainer sessions were facilitated to disseminate the skills-based training to maximise delivery to as many clinical staff as possible. To date the training has been delivered to over 600 multidisciplinary mental health professionals.

Content of training

Content of the training was written following a robust literature review and utilised experiential learning and

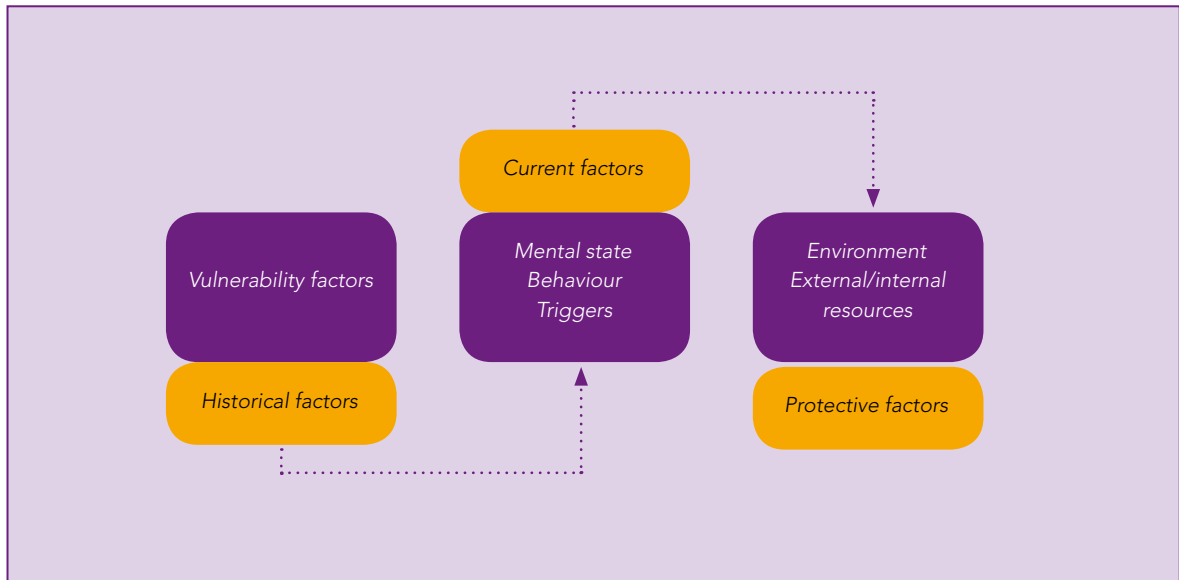


Figure 2. Risk assessment and management process

knowledge and skills from previous educational and psychological courses. The training package was then peer-reviewed by colleagues and senior management, informed crucially by people with lived experience (experts by experience of self-injury), from within and outside of the trust and finally from feedback from participants of the initial pilot sessions.

A new framework for training clinicians was developed to encompass the following areas; challenging stigma, promoting safety, personal safety planning and recovery using five stages of treatment. The stages are awareness, assessment, crisis management, continuing care and treatment and empowerment and recovery (see Figure 1).

The first three stages—‘awareness’, ‘assessment and crisis management’—are delivered on day one and are mandatory for all staff in contact with service users. The final two stages—‘continuing care and treatment’ and ‘empowerment and recovery’—are delivered on a second training day to clinicians, providing face to face clinical care and treatment on a long-term basis, beyond the initial crisis point.

Awareness: stage 1

The aim of the first stage of learning within the training package is to challenge the stigma surrounding suicide and self-injury by increasing the awareness and knowledge of participants. This is achieved by describing definitions of self-injury, its presentation and the reasons and functions of self-injury (Gallagher and Sheldon, 2010). Prevalence data and epidemiological information is also shared.

A key element of this stage is to encourage participants to consider the differences between self-harm, self-injury and suicidal behaviour.

‘Whereas self-harm can be perceived as culturally

acceptable, self-injury can be deemed shocking and unacceptable’ (Walker, 2004). There is often misunderstanding regarding the function of self-injury, with health professionals misinterpreting a coping strategy and action of survival as a failed suicide attempt (Spandler, 1996). This can then result in inappropriate care and treatment being prescribed.

Negative attitudes, often associated with poor training and education, are actively challenged by group discussion and research evidence. The cultivation of increased understanding and compassion is enhanced by the use of a short film of service users describing their experiences of self-injury and suicidal behaviour, including an evaluation of their care and treatment received from health professionals.

Assessment: stage 2

The second stage of learning focuses on the crucial aspect of risk assessment. It is still often the case that people are not involved in their assessment of risk to self (Royal College of Psychiatrists, 2010), and that risk is often seen as a threat to avoided at all costs rather than an opportunity to build resilience and the strengths required for recovery (Department of Health, 2006).

This training highlights the importance of a full psychosocial assessment, incorporating historical risk factors, current risk issues and protective factors rather than relying on the use of conventional ‘tick box’ risk assessments, which is completed with the person. Crucially the identification and naming of risks should be within a newly formed or already established trusting and therapeutic relationship. It is from within this relationship that therapeutic engagement occur, fostering hope, optimism and

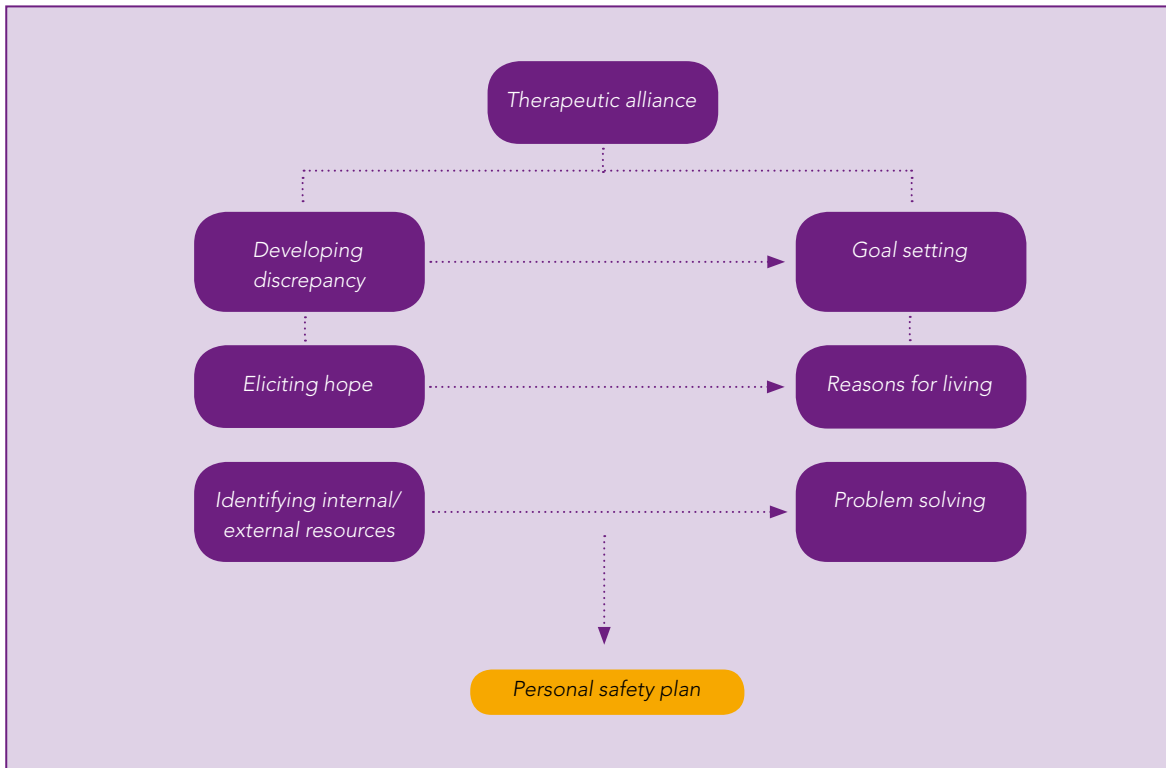


Figure 3. AaCce Approach: personal safety plan to recovery

creating opportunities for regaining personal control (Department of Health, 2007).

This approach is highlighted as best practice within the NICE guidance, which states ‘that all people who have self-injuries should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-injury, current suicidal intent and hopelessness’, as well as a full mental health and social needs assessment (National Collaborating Centre for Mental Health, 2004). During the training new skills are developed within the session via small group work and role play with observer and facilitator feedback given.

Crisis management: stage 3

Crisis management pertains to the crucial time when for whatever reason there is an impending danger to the service user which requires external intervention. A key factor of crisis management is the maintenance of immediate safety beyond that which can be provided by the individual themselves.

Participants are advised to give careful consideration to the context and environment in which safety can be maintained, whether it is within hospital or the community. Interventions described include increasing or introducing levels of observation and engagement and the use of external agencies and friends and family to provide support. Within session participants are presented with clinical case

studies illustrating crisis management strategies and are expected to develop plans of care which are then evaluated by the group.

Additionally to encourage a pro-active rather than reactive response, clinicians are encouraged to develop individual safety plans in collaboration with service users. These plans detail triggers, both historical and dynamic to self-injury and suicidal ideation and provide a plan of care and effective interventions to be actioned in any future time of crisis.

Continuing care and treatment: stage 4

Day two begins with a brief overview of the previous three stages before concentrating on continuing care and treatment. The purpose is to move on from the initial crisis to consideration of clinical strategies which can be used in the long-term to enhance the service users’ quality of life and reduce the use of maladaptive and self-defeating behaviours which the individual may be using to cope with their distress.

Four specific strategies are introduced to the group and a rationale which includes evidence base is given to support their use. It is expected that participants engage in role play to demonstrate skill and learning for each one. The four strategies are:

- Building a therapeutic alliance
- Developing discrepancy—goal setting
- Eliciting hope—reasons for living
- Identification of internal and external resources—problem solving.



Therapeutic alliance

Many researchers highlight the importance of the therapeutic alliance (Bateman and Fonagy, 1999), the backbone of effective mental healthcare. It is the conduit by which all care and treatment can be delivered. An effective therapeutic alliance is one in which service users are 'listened to and supported not judged', where the boundaries are clear and consistent and where the alliance can be established over time (Burke et al, 2008).

Within the session, participants are expected to demonstrate knowledge and understanding of the factors which both hinder and strengthen the therapeutic alliance with their service users and appreciate the impact this then has on the effectiveness of care and treatment.

Developing discrepancy: goal setting

Using motivational techniques (Miller and Rollnick, 2002), clinicians are advised to take a collaborative stance with the person they are working with, highlighting within sessions the discrepancies between where they are now and their current behaviour, with their goals for the future.

Setting realistic life goals and planning the steps to achieve these together is incredibly helpful in enabling the service user and clinician to plan, monitor and evaluate progress. This further assists in supporting the idea that life can be different. Particular attention is given to goals outside of the 'sick role' prioritising personal rather than the professional's goals.

Eliciting hope: reasons for living

A feeling of hopelessness is a key indicator and factor when determining future suicidal risk, and the provision of hope for recovery should be part of routine care (Royal College of Psychiatrists, 2010). It is therefore not surprising that the third strategy is to support and enable service users to identify reasons for living. Participants are made aware that it is sometimes the clinician who must 'hold the hope' for those who are so distressed that they struggle to find and maintain hope and optimism about the future (Anderson et al, 2003). To establish a sense of hopefulness, participants are taught a range of intervention strategies and communication techniques. These techniques include the development of reasons for living and reinforcing effective coping strategies (Shepherd, 2007).

Identification of internal and external resources: problem solving

The final strategy teaches the importance of identifying internal and external resources which

protect the service user from distress and from inflicting further injury by supporting and enabling them to solve problems effectively. This is important because deficits within problem solving skills can increase the risk of repeat self-injury and suicidal behaviour (McAuliffe et al, 2002).

Using problem solving techniques, service users are supported to identify, practice and evaluate a range of solutions to each problem or issue rather than to resort to maladaptive strategies such as self-injury or to believe there are no solutions and contemplate suicide. Participants complete problem solving exercises on allocated problems within the training program and receive feedback from peers and facilitators on techniques within a safe learning environment.

Empowerment and recovery: stage 5

The final stage of the training on day 2, specifically focuses on the support and encouragement required by clinicians to empower service users to actively and collaboratively be involved in their care and treatment and to ensure that the principles of recovery, which although a thread throughout all stages of the training, are consolidated and understood. The following principles and values are explored and transferability to practice discussed:

- Acceptance of the problem
- Collaborative working
- Choice
- Fostering independence and personal autonomy
- Interpersonal effectiveness
- Planning a future.

The training programme culminates in how to develop personal safety plans (Joint Commission Resources, 2007) using a specially designed tool, underpinned by the strategies taught within stage 4. Co-produced personal safety plans can assist to increase the understanding of both parties in identifying triggers, early warning signs and personal coping strategies and can foster improved therapeutic alliances. This approach enables people to evaluate their own risks and to take the necessary action to address them by utilising internal and external resources. Additionally there is an acceptance from both parties that although the future is uncertain and that setbacks are likely, support in achieving goals and positive expectations will continue (Shepherd, 2007).

It is made explicit that the strategies taught are not necessarily required to be undertaken sequentially but may run in parallel with each other and that often as one would expect with such complex and sometimes long-standing behaviours, these strategies will need to be revisited several times by the clinician and service user together, acknowledging the potential for lapses or setbacks to occur, or for previously used maladaptive



and self-defeating risky behaviours to re-surface.

Last, the training acknowledges that providing treatment and care for people who have self-injured or attempted suicide is emotionally demanding and requires a personal and emotional resilience and a high level of support to maintain emotional engagement and have a strong therapeutic alliance (National Collaborating Centre for Mental Health, 2004). The importance of clinicians accessing regular clinical supervision and attending reflective practice and debriefing sessions in which the emotional impact upon staff members can be discussed and understood is seen as vital and is actively encouraged.

Conclusion: implications for practice

The training continues to be in the early stages of evaluation and implementation with a strategically phased programme of facilitation. Initial signs are very encouraging, with extremely positive feedback from participants attending both days. The training package has also been subject to peer review by experts by experience externally and service users from the trust who have additionally contributed their knowledge and skills to the content of the training materials.

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KEY POINTS

- Although suicide rates have decreased, rates of self-injury continue to rise, demonstrating a major public health concern, accounting for more deaths annually than road traffic accidents
- Too often clinicians have received little or no formal training inadvertently adding to negative beliefs and attitudes
- Research has suggested that negative staff attitudes directly correlates to poor service user experience, whereas staff who have participated in training demonstrate positive attitudes and greater understanding

The next stage will be to conduct a thorough analysis of the effectiveness of the training using Kirkpatrick's model of evaluation (2009). Areas to be evaluated include: increase in participant awareness of key issues (particularly personal safety assessment and planning); changes in staff attitude; improved service user experience as demonstrated by a reduction in self-defeating behaviours and increased satisfaction with care delivery. The extent of service user involvement in the joint facilitation and delivery of the training package will also be evaluated and increased. **BJMHN**