Enacting resilient work practices

As mirrored by suicidal patients in psychiatric in-patient care

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Suicidality in psychiatric in-patient care

- Patients hospitalised in a suicidal crisis are complex to manage:
  - Multifaceted (Turecki & Brent, 2016)
  - Lack of clear means to identify patients at risk (Large et al, 2011)
  - Human interaction beyond technical terms and physical protection (Berg et al, 2017)

- Despite the complexity:
  - 99.92% of patients in Norway being treated in specialist mental health care does not commit suicide (Norwegian Patient Register, 2015; Norwegian Knowledge Centre, 2015)
The patient perspective

- Surprisingly absent in the RHC literature («talking with the patient»)

- Alternative view on successful outcomes (Laugaland & Aase, 2015)

- Literature review on suicidal patients’ experiences of safety:
  - Connection, protection, control (Berg et al, BMC HSR 2017)
Aims

- By using patients as sources of knowledge, provide a deeper (alternative) understanding of enactment of resilient work practices for suicidal psychiatric in-patient care
Design/ methodology

- Descriptive case study approach
- Qualitative semi-structured interviews
- Patients hospitalized during a suicidal crisis
- Six psychiatric hospital wards
  - Specialized, decentralized, closed, open
- 18 patients, approx. 73 min per interview
- Assessed as “stable enough” to engage in a dialogue
- Proximity to time of discharge
Ethical aspects

- Verbal and written consent
- No information to treatment personnel or others
- Interview timing in collaboration with patient
- Extra support available if needed after interview
- Adaptation of interview setting and time use (e.g. follow-up interview)
- No patient perceived anxiety or depression following the interview
- Feeling of improvement by dialogue in an anonymous setting

(Berg et al, BMJ Open, 2017)
### Sample

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N= 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men/women</td>
<td>7/11</td>
</tr>
<tr>
<td>Current suicidal behavior AS*/SI*</td>
<td>9/18</td>
</tr>
<tr>
<td>Number of hospitalizations</td>
<td></td>
</tr>
<tr>
<td>First time</td>
<td>4</td>
</tr>
<tr>
<td>2-10 hospitalizations</td>
<td>6</td>
</tr>
<tr>
<td>Multiple &gt;10</td>
<td>7</td>
</tr>
<tr>
<td>Current hospitalization</td>
<td></td>
</tr>
<tr>
<td>Open/closed ward</td>
<td>11/7</td>
</tr>
<tr>
<td>Forced/voluntary</td>
<td>4/14</td>
</tr>
<tr>
<td>Clinical psychiatric diagnoses (ICD-10)</td>
<td></td>
</tr>
<tr>
<td>Bipolar mood disorder</td>
<td>6</td>
</tr>
<tr>
<td>Major depression</td>
<td>9</td>
</tr>
<tr>
<td>Emotional instable personality disorder</td>
<td>3</td>
</tr>
<tr>
<td>Chronic alcoholism</td>
<td>2</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>2</td>
</tr>
<tr>
<td>Schizophrenia/psychosis</td>
<td>3</td>
</tr>
<tr>
<td>Attention deficit disorder</td>
<td>2</td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td>1</td>
</tr>
</tbody>
</table>
Patients’ experiences of enactment

1. Understanding acute suicidal deterioration and reading patients verbally and non-verbally
2. Understanding and adapting to the individual patient’s needs for surviving a crisis
3. Connecting to the patient at an inter-human level
Reading acute suicidal deterioration

- Dependent on someone reading their suicidality triggers during crisis
  - “They read me before I read it myself, they can see it”
  - Reading the individual patient’s non-verbal signs.

- Acute deterioration and impulsive plans can be diverted

- Someone beyond treatment personnel
  - Co-patients informing personnel when they do not detect acute suicidality

- Enactment when professionals understand and intervene to acute deterioration of suicidal behavior
Patient T («being read»)

- Borderline personality disorder, more than 100 hospitalizations and multiple serious suicide attempts.

“I constantly search for means to commit suicide when I am suicidal and hospitalised, and it is extremely important that they can see this and read me”

“I can say everything is ok when they ask, and it’s important that they understand that it is not okay at all”

“When they talk with me, distract me, the suicidality can be ‘turned around’. It does not mean that it is fixed, except for in that moment”

“For me it’s all about as many people as possible being able to read me, that there is always someone who can read me, so that I can hold out to the next shift if my contact does not understand me. Because this is very dependent on the person»
Understanding/ adapting to individual needs

- What is considered as vital to survive a crisis for one patient is not relevant for another patient
  - E.g. sleep & rest versus support & talking
  - E.g. protection & closed doors versus autonomy & open doors

- Daily work procedures are experienced with different meanings and outcomes

- Enactment when professionals understand and adapt to the individual patient’s needs
Patient J («adaptation»)

- PTSD and major depression. Multiple hospitalizations and suicide attempts

“When I get signs of flashback or loose control they put me on the belt in the bed and it gets worse and worse. And it doesn’t help me, it takes long long time to get better and to feel ok. It’s a bad experience in the belt and it worsens my flashbacks, and when I get strong flashbacks I don’t know what to do. I don’t remember anything and it is really painful. And I am afraid to hurt anyone or to hurt myself”

“But there are many options for me. Because when I have flashbacks in DPS they don’t put me on the belt. They treat me in a very good way. They know me, how to make me safe. What makes me feel safe, they do that. For example, they let me go to the bathroom in the darkness as staying there makes me feel safe. Because when I was in my home country and the person tried to abuse me, I hid in the bathroom in the darkness”
Connecting to the patient

- Feeling cared for and engaged with on a personal level

- The symbolic effect of small acts
  - E.g. bringing a book from home to the patient, small talks in the hallway, offer a cup of coffee, human touch

- Enactment when professionals help the patient’s to regain a sense of human dignity
Patient A («connecting»)

- Bipolar disorder, second admission, recent suicide attempt

«She seems interested and cares about me, and that is not just because it is her job to do so....She speaks to me and we go for a walk. We talk about everything... and then the suicidal thoughts start to fade a little... It prevents suicide. It’s much due to her that I have not done anything about it”

«and even when she is not my contact that day, she asks me how I am doing and offers to talk with me»

«She was important for me to feel safe-guarded during the suicidal crisis»
Underlying «potentials»

- Accessability (personnel, time, treatment, ...)
- Professionals’ clinical competence and interpersonal skills (reading patients, dignity)
- Knowledge of the patient
- Continuity (personnel, facilities, time)
- Co-patients and next of kins («speaking up on behalf», ...)
Takeaway

- Variability in practice as experienced by patients
- Strengthening of therapeutical skills (e.g. «reading»)
- Increased knowledge of patient-centered care
- Reflexive dialogue (professionals, patients, carers)

Sense of protection (routines, procedures) + clinical skills + individual adaptability
Thanks!