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ORIGINAL ARTICLE

Staff responses to self-harm by children and young people in mental health inpatient settings: Experiences and views of children and young people, parents and staff

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Abstract

This study aimed to understand the views of children and young people (CYP), parents and staff on how staff should respond to incidents of self-harm carried out by CYP in mental health inpatient settings. Semi-structured interviews were conducted with CYP ($n=6$), parents ($n=5$) and mental health professionals ($n=6$) with experience of this issue. Data were analysed using reflexive thematic analysis. Two superordinate themes were identified: (1) The threshold for intervening; and (2) Interpersonal attributes of staff. There was general agreement among participants about the interpersonal skills that staff should possess to work safely and effectively with this population. There was disagreement between staff and parent participants about the appropriate threshold for using restrictive interventions to manage incidents of self-harm for this group. Our findings suggest that further work is needed to develop effective approaches for addressing self-harm in this population which are considered acceptable to all key stakeholders. The results of this study could be used to inform future intervention development.

KEYWORDS

children, inpatient setting, mental health, restrictive practices, self-harm, young people

INTRODUCTION

Background

Rates of self-harm among children and young people (CYP) appear to be increasing (Griffin et al., 2018). This has been described as a major public health concern (Glenn and Klonsky, 2013). There is evidence that adolescents from non-clinical populations are at high risk of self-harm (Monto et al., 2018), and that these risks increase further for CYP admitted to mental health inpatient settings (Kipoulas et al., 2021). A recent retrospective review of medical records for 105 children admitted to a mental health inpatient unit found that 66% had reported thoughts of self-harm, and 61% had engaged in self-harm behaviours (Kipoulas et al., 2021). This is concerning in itself and because repeated self-harm is associated with an increased risk of suicide (Hawton et al., 2015; Morgan et al., 2017).

Use of restrictive practices for children and young people who self-harm in inpatient settings

Self-harm has been identified as a precursor to the use of restrictive practices in inpatient children and young people's mental health services (CYPMHS) (Pogge et al., 2011). High rates of self-harm among CYP can create challenges for mental health staff working in these settings. Staff are presented with difficult choices

about when it is appropriate, if ever, to intervene with the use of restrictive practices to prevent CYP from harming themselves (McDougall & Nolan, 2017). Restrictive practices are defined by the Department of Health and Social Care (2019, p. 51) as '…deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently'. This includes the use of seclusion, physical and chemical restraint, segregation and other restrictions on a person's ability to act independently (Department of Health and Social Care, 2019). Many CYP admitted to mental health inpatient settings are subjected to restrictive practices (Eblin, 2019). One review estimated that 26% of children in these settings had at least one seclusion episode and 29% at least one restraint (De Hert et al., 2011). Girls appear more likely to experience restrictive practices in inpatient settings compared to boys (Furre et al., 2017). This might be explained by research showing that rates of self-harm among girls are higher relative to rates among boys (Agenda, 2017; Bresin & Schoenleber, 2015; Morgan et al., 2017), leading more girls to be exposed to restrictive practices as a result.

The impact of restrictive practices on children and young people

Restrictive practices can result in psychological and physical harms for patients, including feelings of fear, distress, loss of control and dehumanization (Cusack et al., 2018). While a recent review concluded that little is known about children's first-person perspectives of being restrained (Nielson et al., 2021), it has been argued that restrictive practices are potentially even more harmful for CYP than for adults (Department of Health and Social Care, 2019). A recent themed review, for example, highlighted that restrictive practices are experienced as frightening by children and can potentially undermine attempts to establish therapeutic relationships (National Institute for Health Research [NIHR], 2021).

Impact of self-harm and restrictive practices on staff and parents

In addition to the potential for harm to children, there is evidence that both self-harm and the use of restrictive practices can have a negative impact on parents and mental health staff. Staff experience negative emotional outcomes in relation to the use of restrictive practices, for example, and have concerns about the impact of their use on the therapeutic relationship (Sequeira & Halstead, 2004; Wilson et al., 2017). A recent report highlights the distress that parents can feel when their child is experiencing mental health difficulties, and emphasized the importance of mental health services working in partnership with parents to improve outcomes and services (Young Minds, 2020). There is evidence that parents are often early to identify the signs of self-harm among children who they care for, but find self-harm difficult to understand and distressing (Curtis et al., 2018; Ferrey et al., 2016; Oldershaw et al., 2008). To the best of our knowledge, however, no research has been conducted that specifically explores the views of parents on the management of self-harm in CYPMHS inpatient settings.

Reducing the use of restrictive practices

In the United Kingdom, recent policy documents have set out an ambition to reduce or eliminate the use of restrictive practices for CYP (Department of Health and Social Care, 2019; NHS England, 2019). Exactly how this ambition can be achieved for CYP who self-harm in mental health inpatient settings, however, is not yet clear. Two recent systematic reviews have highlighted a lack of evidence-based non-restrictive approaches to self-harm reduction for children and adolescents who are admitted to mental health inpatient settings (Griffiths et al., 2021; Nawaz et al., 2021). Interventions based on principles derived from dialectical behaviour therapy (DBT; Linehan, 1993) were the most commonly described interventions. Both reviews, however, conclude that evidence in this area is very limited and generally of low methodological quality. Griffiths et al. (2021) argue that there is an urgent need to develop effective, non-restrictive approaches to self-harm reduction for children admitted to mental health inpatient settings. They also argue that intervention development should be informed by the perspectives of people who are directly affected by the issue.

Study aims

This study aimed to understand the views of CYP, parents and staff on how staff should respond to incidents of self-harm carried out by CYP in mental health inpatient settings. Understanding the experiences and preferences of these groups would represent an important first step in developing effective and acceptable non-restrictive interventions for CYP who self-harm in inpatient settings.

METHOD

Participants

Participants for this study were CYP, parents and staff with experience of self-harm carried out by CYP in mental health inpatient settings. Purposive sampling

(Campbell et al., 2020) was used to recruit participants from children and young people's mental health services (CYPMHS) in two NHS Trusts in Northwest England. Posters and presentations from the research team were used to raise awareness of the study among staff working in these services. Staff members were asked to identify CYP or parents who might be eligible to participate in the study. Staff who met the inclusion criteria were also invited to take part in the study. None of the participants were known to the research team prior to conducting this study. Potential participants were informed that this study was being conducted as part of a larger project that aimed to reduce the use of restrictive practices for CYP who self-harm in mental health inpatient settings. In total, 25 people expressed an interest in taking part in the study. Of these, eight CYP who initially expressed an interest in the study were not contactable. The remaining 17 participants took part in the study. Participant demographics are presented in Table 1.

Inclusion and exclusion criteria

Inclusion criteria for participants were as follows:

CYP participants: (i) Aged 13–17 years; (ii) current user of CYPMHS in participating NHS Trusts; (iii) experience of mental health inpatient wards and self-harm; (iv) judged to have capacity to provide consent by their clinical team; (v) have parental consent or assent to participate in the study; and (vi) able to communicate in written and spoken English.

Parent/guardian participants: (i) Responsible for the care of a CYP who has self-harmed in a mental health inpatient setting; (ii) have capacity to provide informed consent to participate in the study; and (iii) able to communicate in written and spoken English.

Mental health staff participants: (i) Experience of working with CYP who self-harm in mental health inpatient settings; (ii) have capacity to provide informed consent to participate in the study; and (iii) able to communicate in written and spoken English.

Participants were excluded if they did not meet any of the inclusion criteria. No participants who expressed an interest in taking part in the study were excluded.

Ethical approval

All ethical and regulatory approvals were in place prior to the start of recruitment (REC reference: 21/YH/0043; IRAS project ID: 291817). Consent processes were informed by Medical Research Council (2004) guidelines for seeking consent from children taking part in research. All CYP participants were asked for written consent to participate. Additionally, for children aged under 16, written consent was sought from their parent or guardian. For participants aged 16 and over, with the child's permission, written assent was sought from their parent or guardian. CYP were only recruited to the study if both CYP and parent provided consent or assent. Participants were made aware of their right to withdraw from the study at any time.

TABLE 1 Participant demographics.

Category	Participant ID	Sex	Age	Ethnicity	Role (staff only)
CYP[a]	CYP 1	F	17	Thai British	N/A
	CYP 2	M	17	White British	N/A
	CYP 3	F	16	British Pakistani	N/A
	CYP 4	F	14	White British	N/A
	CYP 5	F	17	White British	N/A
	CYP 6	F	17	White British	N/A
Parents	Parent 1	M	65	White British	N/A
	Parent 2	F	50	White British	N/A
	Parent 3	F	36	British Pakistani	N/A
	Parent 4	M	57	White British	N/A
	Parent 5	F	54	White British	N/A
Staff	Staff 1	F	24	White British	Support worker
	Staff 2	F	26	White Czech Republic	Support worker
	Staff 3	M	33	White British	Trainee advanced practitioner
	Staff 4	F	26	White British	Senior nurse
	Staff 5	F	52	British Pakistani	Consultant psychiatrist
	Staff 6	F	37	White British	Clinical psychologist

[a]Children and Young People.

Interviews

Topic guides are presented in Tables 2 and 3. Topic guide development was informed by a service user reference group, consisting of two young people with experience of self-harm in mental health inpatient settings. Semi-structured interviews were conducted by either videoconference or telephone (depending on participant preference by Robert Griffiths [RG] and Lucy Page [LP]. RG is a mental health nurse and researcher with experience of conducting qualitative studies. LP is a research assistant working within the research unit responsible for conducting the study. All participants were interviewed separately, and interviews lasted no more than 1 h. Interviewers made reflective notes following interviews. Interviews were audio recorded and transcribed verbatim by a professional transcription service and anonymized by RG and LP.

Data analysis

Data were analysed using the six-stage process for reflexive thematic analysis described Braun and Clarke (2022). An inductive approach to data analysis was used.

1. RG first familiarized himself with the data by listening to interview audio recordings at least once and reading each interview transcript at least twice. RG made reflective notes during this process.
2. Interview transcripts were uploaded to NVivo 12 Pro (released in March 2020) and RG worked through the whole data set, applying initial codes to segments of data that appeared relevant to the study's aims. An inclusive approach to coding was taken at this stage. Data were coded at a semantic and latent level. Discussions between RG and JB were used to refine codes.
3. RG then developed initial candidate themes based around groups of apparently related code labels. RG and JB discussed codes at regular intervals to develop and refine them further.
4. Candidate themes were reviewed in relation to individual coded extracts and the overall data set. Candidate themes were developed further through discussions with the wider research team.
5. RG continued to separate and collapse themes to ensure that they told a consistent and persuasive story about the data (Braun & Clarke, 2022). Themes were named and described in a brief synopsis.
6. RG produced a first draft of the research report describing themes and sub-themes, which were supported by illustrative quotes from participants. All authors contributed to developing and refining this draft to produce the final research report.

TABLE 2 Topic guide for CYP participants.

1. Experiences of self-harm in an inpatient setting
- Can you tell me about your experience of self-harm as an inpatient?
  - Prompt: What do you remember about these experiences?
- How did the inpatient staff tend to respond in situations where people harmed themselves?
  - Prompt: What were your experiences of staff in these situations? What were the immediate responses of staff? What about after the episode of self-harm had ended?
- Was there anything you found helpful or unhelpful about how staff responded to episodes of self-harm?
  - Prompt: Were there any helpful things that staff did? How did this help? What about unhelpful things? In what way was this unhelpful? Did the response of staff change over time?

2. Preferences regarding inpatient staff responses to self-harm
- Looking back on your experiences of self-harm, how would you have liked the staff to respond in these situations?
  - Prompt: What would be the most helpful thing that staff could do in these situations? How would doing this have helped? Is there anything you think that staff should avoid doing? How would you have preferred staff to respond in these situations?
- Is there anything else you would like to say about the topics we have discussed?

TABLE 3 Topic guide for staff and parent participants.

1. Experiences of self-harm by children in an inpatient setting
- Can you tell me about your experience of self-harm carried out by children in mental health inpatient settings?
- How do you think inpatient staff tend to respond to situations where children harm themselves?
  - Prompt: What is the immediate response of staff? What about after the episode of self-harm had ended?
- Is there anything helpful or unhelpful about how inpatient staff respond to episodes of self-harm?
  - Prompt: What are the helpful things that staff do? How does this help? What about unhelpful things? In what ways is this unhelpful? Do the responses of staff change over time?

2. Preferences regarding inpatient staff responses to self-harm
- Looking back on your experiences of self-harm by children who are in mental health inpatient settings, how do you think staff should respond in these situations?
  - Prompt: What are the most helpful things that staff can do in these situations? How would doing this help? Is there anything that you think staff should avoid doing?
- Is there anything else you would like to say about the topics we have discussed?

FINDINGS

Two superordinate themes were identified: (1) *The threshold for intervening*; and (2) *Interpersonal attributes of staff*.

The threshold for intervening

This theme relates to the point at which it becomes appropriate to use restrictive interventions in situations

where CYP are engaging in self-harm. It comprises two sub-themes: (1) *You're meant to be keeping them safe*; and (2) *We only use restrictive practices as a last resort*.

There were divergent views among the three groups of participants (CYP, parents and staff) about the helpfulness of using restrictive practices in response to situations where CYP children are self-harming, and at what point they should be used. All groups of participants agreed that some situations involving self-harm by CYP warranted the use of restrictive practices. Exactly where the threshold for intervening with restrictive practices was judged to lie, however, varied considerably between groups. The contrast between parent and staff views on this topic was particularly pronounced.

You're meant to be keeping them safe

The main priority of parents interviewed was the immediate safety of their children during their inpatient stay. Without the capacity to care for their children directly, parents looked to the staff who were working on the wards to keep their children safe. In this context, keeping their children 'safe' included the prevention of harm occurring as a result of self-harm. Parents described the distress caused by their children's self-harm.

> 'You know, it's really hard to see your child self-harming. I hate it, I absolutely hate it'.
>
> [Parent 5]

Proactively intervening to prevent self-harm was seen as an important part of caring for the CYP, and a reluctance to use restrictive practices among staff was perceived to be negligent. Parents reported feeling frustrated, for example, at how easily their children could find implements used for self-harm, and the apparent reluctance of staff to remove these.

> 'There's been a number of occasions where she's been able to get hold of staples, plastic which she's snapped, and certain things that they've told me, and I just think, well, why aren't those things… why are those things available to her?'
>
> [Parent 3]

> '…oh God, he's meant to be with you, and you're meant to be trying to keep him safe and you're not. So, yeah, I've found it very frustrating over the years'.
>
> [Parent 2]

This parent described how they sought to conceal objects that could be used for self-harm when their child was at home, but that their child seemed to be able to find implements which could be used for self-harm with relative ease during their inpatient stay:

> 'Even at home, I put things away as much as I can… With [name of child] in the past, she's concealed blades and she's hidden them in her room, and they weren't even aware of… in the hospital setting, they weren't even aware that she had anything like that.… they're not doing their job good enough to, you know, make sure that my daughter is safe'.
>
> [Parent 3]

Tensions appeared to exist between staff, who were aiming to avoid any potential unintended long-term consequences of restrictive interventions, and parents who had the goal of preserving the immediate safety of their child.

> 'I think what we've sort of constantly heard from [member of staff] is, oh we don't do one-to-ones because they get reliant on them. Oh, we don't want them to do this because they get reliant on them. It's like, well, I don't care, because I want my daughter to be looked after and safe at this point. If she's reliant on one-to-ones for this day or this week, that's a very short time compared to what we hope, you know, she won't be reliant on them. It almost seems at times to be a mantra of, "Oh no, we can't do X more often than 15 minutes because that's our protocol"'.
>
> [Parent 4]

This parent described the long-term consequences of their child's self-harm during an inpatient stay, which they attributed to the unwillingness of staff to use restrictive interventions:

> 'And before she left there and moved to [another inpatient unit], she had done so much harm to herself it's beyond repair, if you know what I mean? Like 200 cuts now. […] I just wished in the early days when she was doing all of that, they could have done a proper body search and removed everything off her […]. She's got to live with that now and that's the biggest problem she's got now'.
>
> [Parent 1]

From the perspective of the parents who were interviewed, part of what contributes the provision of 'care' in mental health inpatient settings for CYP is the willingness of staff to use restrictive interventions to prevent harm

arising from incidents of self-harm. In the view of this parent, their child could perceive an unwillingness to use restrictive interventions as an indication that the staff did not care about their well-being:

> 'But, yeah, I think if I'm talking about my son, yes, he'd see that as a form of extra care, if you know what I mean. "Right, you are bothered that I'm… you are looking after me and you are making sure that I'm safe. If you're not searching me then you're not going to find the piece of glass that I've just found outside, or whatever, when I've been out for a walk, and you're not going to keep me safe because… I can hide that in my room and, when I am feeling down, I can use it". So, yeah, I do think in his respect it's, yeah, feeling more cared for'.
>
> [Parent 2]

CYP who were interviewed described the distress arising from experiences of restrictive practices, although some CYP said that, in retrospect, the decision to use restrictive practices was appropriate because it maintained their safety at a time of high risk. This young person describes the experience of being restrained as distressing, particularly when multiple staff are involved in the process:

> 'Yeah, because I just can't cope in that situation, when there are like too many people, because it's just like, makes me feel overwhelmed and like embarrassed that, and like it makes me feel like… I don't know. I don't like it'.
>
> [CYP 2]

There was an acknowledgment among parents that restrictive practices could be distressing for CYP. The predominant view among parents, however, was that the ward staff should take whatever actions are necessary to prevent the occurrence of self-harm by CYP, and this includes the use of restrictive practices.

> 'I think every parent would want them to just do what has to be done in that moment to make sure their child is safe'.
>
> [Parent 2]

We only use restrictive practices as a last resort

In contrast to the views of parents, staff who were interviewed emphasized the importance of reducing, and, where possible eliminating, the use of restrictive practices. Staff acknowledged that some people might find it hard to understand this approach:

> 'Well, I think that our ward does work in quite a least restrictive way, which I do see as a positive, but I think it can be hard for people to adapt to because it goes against your instinct sometimes to not intervene massively straight away'.
>
> [Staff 1]

Staff reported that at a certain point, the use of restrictive practices became appropriate, but their threshold for when to use these practices was higher than for parent participants.

> '…rather than trying to stop the young person from self-harming is just, sort of, let them…I know it sounds horrible, but sometimes just let them do it until it is significant. To the point where, you know, this is too much'…
>
> [Staff 2]

The reluctance of staff to use restrictive interventions was not driven by a lack of concern about the well-being of the CYP who were admitted to the wards where they worked. As with the parent participants, staff participants reported that witnessing acts of self-harm by CYP was a distressing experience. Participants recalled numerous methods used by CYP to self-harm. These included cutting, use of ligatures, head banging, friction burns, self-poisoning with medications or cosmetic products, restricting food or inducing vomiting. Rather than being apathetic or inured to incidents of self-harm, however, staff participants described experiencing a range of difficult emotions in response:

> 'You know, when I saw my first significant self-harm, whether that was ligaturing or self-harming, I was shocked'.
>
> [Staff 2]

Staff were motivated to avoid restrictive practices, however, in order to minimize what they perceived to be the unintended consequences arising from the use of these interventions. Staff participants identified several potential unintended consequences of using restrictive practices inappropriately. These included distress among CYP resulting from the use of interventions such as restraint, seclusion, constant observation or personal searches. Another concern was that an excessive use of restrictive practices could prevent CYP from developing their own alternative strategies to the use of self-harm:

> 'So, rather than to intervene too quickly, give it some time, be there for that young person and then intervene. Just give them some time to, sort of, let it all out, let it all

> go… And then, when they have that time with staff members they'll reflect on it, and then they can come [up] with interventions themselves with the nursing team and go, actually, this is what helps me, I've noticed this is what helps me… Let's do this from now on'.
>
> [Staff 2]

Some staff argued that while restrictive practices might reduce the immediate risk of harm to CYP who self-harm, in the longer-term, this could be counterproductive, and might inadvertently lead to more severe problems in the future:

> '…a few of the parents will say like, if they've scratched their arm with a piece of plastic, they would be like, right you need to strip all the rooms. But it's like, actually, that's not going to be helpful in the long run'.
>
> [Staff 4]

Staff also made the case that creating a 'sterile' environment, where CYP had limited autonomy, would not prepare them for their eventual discharge from hospital:

> '…we don't think it's always helpful to be restrictive, to have a completely sterile environment. For young people who, as a general rule, we would want back out in the community in four to six weeks, so to be taking things from them, stopping them from self-harming, we don't think that that's necessarily helpful'.
>
> [Staff 3]

Staff reported that adhering to the principle of using a 'least restrictive approach' was dependent on the availability of sufficient numbers of suitably experienced, trained and supervised members of staff. The approach was undermined when staffing numbers were low, or where staff were unfamiliar with the ethos of the ward, and, in their view, this increased the risks for CYP who self-harm:

> '…when you get staff that aren't aware of the risk of young people, even if you do make them aware of the risks, they, I think, because if they've not seen it before they aren't quite sure what to do within the situation, so it's quite difficult for them to, sort of approach the situation'.
>
> [Staff 2]

> 'But I think, my view still is that, actually, more than whether they are a repeat self-harmer or recent self-harmer it's the training of the staff and the culture of the unit and how it is managed which I think has more of a bearing on their responses'.
>
> [Staff 5]

Conflicting views held by parents and staff on when the threshold for using restrictive interventions has been reached appears to be a significant source of tension between these two groups. This was exacerbated by the perception of some participants that there was inadequate communication between parents and staff:

> 'I've raised this as an issue, because the communication with the mental health… the staff on the ward is absolutely ridiculous. I'm still shocked at the way… obviously, I've always said, even if she does self-harm, and that's fine, but can you please make me aware, parent aware. Look, she's self-harmed and they won't obviously make any communication with parents to let them know if any incidents have happened'.
>
> [Parent 3]

Staff participants also acknowledged the importance of good communication with parents. This member of staff, for example, acknowledged that ineffective communication meant parents were less likely to be supportive of ward staff not using restrictive interventions in response to incidents of self-harm:

> '…it's really important to, obviously, work with the parents and carers as well because a regular thing that we will see is, we will report self-harm to a parent and they will say, well, you're meant to be keeping them safe. So, it's really important to have those conversations'.
>
> [Staff 3]

Interpersonal attributes of staff

While there were diverse views about the threshold for using restrictive practices, there was greater consensus among participants about the interpersonal skills and attributes that staff should possess to be able to work effectively with CYP who self-harm. Staff who were perceived to make efforts to engage with CYP and actively participated in ward life, conveyed a sense of caring for the CYP, and could respond flexibly to the needs of CYP were more likely to be perceived as helpful. CYP also reported that they were less likely to self-harm as inpatients when they were working with staff who possessed these interpersonal attributes. Conversely, staff were perceived to be unhelpful when they responded to incidents of self-harm in an invalidating or uncaring

manner, when they appeared disinterested in the CYP, and when they were unable to respond to the changing needs of CYP. In addition to being perceived as unhelpful, these staff were believed to increase the risk of incidents of self-harm among CYP.

CYP described the importance of working with staff who appeared to be genuinely interested in them, and who were willing to engage in meaningful shared activities. This was seen as particularly important in the context of a ward environment where CYP had their own bedrooms, potentially increasing the risks of feeling isolated and disconnected from others:

> 'So, it's, like, just say I really got on with the staff and they would help me quite a lot, they would sit there, talk to me or listen to some music, watch a film, stuff like that'.
>
> [CYP 3]

> 'If everyone's always engaged in something, there's less…well, more distraction and less space to be alone with thoughts where people might end up self-harming. So, just, you know, always having the option to go and do something is quite good'. [Staff 1]

Conversely, a perception that staff members were disinterested in the CYP prevented them from seeking help at an early opportunity, increasing the overall risk of self-harm incidents. This CYP talked about the impact of working with staff who seemed disengaged or disinterested, or who only appeared to react in response to incidents of self-harm:

> 'So, I've noticed some people that I've gone to before that I won't go to again have sort of, sort of just slouched, yawned, sort of not responded back when I've talked'.
>
> [CYP 5]

It was seen as vital that the staff convey care and concern about the well-being of the CYP they are working with, and that they respond to incidents of self-harm in a validating and non-judgemental manner:

> 'So, just things like, just sitting down and sort of, when somebody sits down and tells you it's okay for you, you can get upset. Like, sort of it like reassures you that it's okay. I think that's lovely, you know, and a helpful thing'.
>
> [CYP 5]

> 'I think it's an individual approach and, in our daughter's case, it's an empathetic approach, understanding, caring, loving, kind of approach. On the ward, yes, you're in a medical setting, you're on a medical ward, but you're perhaps acting as parent and families as well as medical professionals. So there has to be a caring, empathetic approach'.
>
> [Parent 4]

Staff who were seen as uncaring or invalidating in their responses were perceived to be unhelpful and harmful. CYP reported being less likely to seek help from these staff members during periods of distress, increasing their levels of distress and the risk of further self-harm.

> 'They'll be, like, sarcastic, but you think they mean it though. It'll be, like, "it's not my job to care", and it's, like, why say that, do you know what I mean? […] It's, like, some staff in here, I don't really talk to mostly because I just don't get on with them because of the way they've already treated me, it's just, like, there's no bothering interacting with them anymore'.
>
> [CYP 3]

> 'But if it's horrible staff, I'd probably just repeat, repeat, repeat the self-harm'.
>
> [CYP 4]

> 'I think it honestly just depends who you speak to, because, sometimes, like, there's a lot of staff that I absolutely adore in here, but there's other staff that I genuinely wouldn't go to'.
>
> [CYP 5]

Staff who responded to incidents of self-harm in ways that were aligned with CYP's preferences were seen as more helpful. CYP described needing different responses at different times, and valued staff who were able to respond flexibly to these changes:

> 'It depends on what type of risk and how overwhelmed I am. If I'm really overwhelmed, sometimes I will just say to them, get out, because I can't stand people trying to ask me stuff when I'm really at that high level. Sometimes, don't get me wrong, it will help me, but most of the time, it won't. So, I like to be left alone for a little bit and then to come back in, and if I'm ready to talk, I'll talk, but if I won't, just leave me be and I'll be alright in a couple of minutes or hours'
>
> [CYP 3]

Staff who adopted a highly protocolized and less flexible approach to care, however, were seen as less helpful by CYP:

> '…the staff were like, just trying to say how we're supposed to leave you after incidents, and they were saying it's part of the protocols'.
>
> [CYP 1]

The view that care should be individualized was shared by some staff participants, although they were also likely to value the use of protocols and policies to guide practice:

> '[Mental Health Trust] has actually updated the self-harm policy which I think came out at the start of last month. And within that there's a Ligature Care Plan, as well, which we've been using with the young people, some of the young people who tie ligatures more regularly, which is fantastic for the [Mental Health Trust] to do 'cause it, sort of, gives, it obviously gives us and the staff a, kind of, it reinforces our approach and it's a really clear…it gives a really clear safety checklist for the qualified nurse to follow'.
>
> [Staff 3]

Potentially, this creates a tension between the needs of staff, who are seeking clear guidance on how to respond to incidents of self-harm, and the desire of CYP to access care that is flexible and designed to meet their individual needs.

DISCUSSION

This study aimed to understand the views of CYP, parents and staff on how staff should respond to incidents of self-harm carried out by CYP in mental health inpatient settings. We aimed to understand participants' views regarding how staff should respond to self-harm carried out by CYP in mental health inpatient settings and their perceptions of helpful and unhelpful staff responses to these incidents. Two superordinate themes were identified.

The first theme related to how and when staff should intervene when incidents of self-harm occur. Participants' accounts suggest that self-harm by CYP is a common occurrence in mental health inpatient settings, which is consistent with existing research (Kipoulas et al., 2021; Monto et al., 2018). Also consistent with research in this area is the finding that parents and staff find incidents of self-harm by CYP distressing (Ferrey et al., 2016; Ribeiro Coimbra & Noakes, 2021). What this theme revealed in addition, however, are the divergent views held by different groups of participants about how staff should respond to these incidents. Staff participants strongly advocated for the use of a 'least restrictive' approach. Restrictive interventions were seen as potentially harmful or traumatic for CYP, and their use was thought to be unlikely to reduce (and may actually increase) self-harm in the long term. This approach is consistent with clinical guidelines for the management of self-harm in children (e.g. NICE, 2022). In contrast, the view of parents was that the threshold for the use restrictive interventions should be lowered substantially to maintain the immediate safety of CYP. CYP tended to report that restrictive practices were distressing when they occurred, but, in the longer term, some thought that this was the right course of action at the time because it protected them from more serious injury. There appears to be a disparity between the desire of staff to avoid the use of restrictive practices and the view of parents that the threshold for intervening restrictively should be lowered. Currently, it is not clear how these divergent perspectives can be reconciled.

The second theme related to the interpersonal attributes of staff. There was general agreement among participants regarding the kinds of interpersonal attributes staff require to work safely and effectively with this population. Staff who were actively engaged with the CYP, were caring and validating, and who were able to respond flexibly to the needs and preferences of CYP were seen as most helpful. Staff who were perceived to be disinterested, uncaring or invalidating, and who were either unable or unwilling to adapt their approach to CYP's needs were seen as unhelpful and as contributing to increased levels of self-harm. While there are likely to be multiple factors that determine how individual staff members will respond to incidents of self-harm, there is evidence that negative perceptions of self-harm among staff (e.g. self-harm as 'attention seeking' or 'manipulative') can contribute to unhelpful, prejudiced or stigmatizing responses to incidents of self-harm (Akinola & Rayner, 2022; Sandy, 2013). This suggests that there is a relationship between staff members' beliefs about the reasons for self-harm among CYP and the relative helpfulness (or unhelpfulness) of subsequent responses to incidents of self-harm.

Several participants talked about how single bedrooms can leave CYP feeling isolated, which, in turn, contributes to incidents of self-harm. Active and engaged staff were perceived to be helpful, in part, because they encouraged CYP to participate in shared activities in communal areas of the ward, reducing levels of isolation. Extant literature relating to the design of inpatient mental health settings describes the challenge of creating environments that are simultaneously safe, private and therapeutic (Curtis et al., 2013). A systematic review of studies exploring the effects of ward design on patient outcomes concluded that data on the design of psychiatric facilities were unclear, but single rooms might contribute to patient well-being

(Papoulias et al., 2014), and (Connellan et al., 2013) argue that single rooms are particularly important in adolescent inpatient settings because of the need for privacy among this population. While single rooms might be considered preferable for reasons of privacy and well-being, our findings suggest that patient safety is likely to be increased when staff can engage CYP in shared activities in communal spaces.

Participants also highlighted the impact inadequate or insufficiently experienced staff can have on CYP who self-harm. Although patient safety is an under-researched topic in mental health settings (Thibaut et al., 2019), there is evidence that low staffing levels can impede the implementation of programmes designed to minimize the use of restrictive practices (McKeown et al., 2019), and it can have a significant negative impact on patient outcomes in a variety of clinical settings (e.g. Francis, 2013). Staff highlighted the importance of supervision and training in improving patient outcomes, and for enhancing the well-being of staff who are working with CYP who self-harm. There is insufficient space here to review the voluminous literature relating to clinical supervision in healthcare settings. Our findings, however, are consistent with evidence suggesting that regular and good quality clinical supervision for health professionals is likely to improve patient outcomes (Snowdon et al., 2017).

Limitations

While the overall number of participants interviewed was relatively large for a study of this kind, the number of participants from each group might not have been of sufficient size to adequately capture the range of views that exist within that group. The advantage of interviewing CYP, parents and staff was that it enabled us to explore the topic of interest from multiple perspectives. While it could be argued that focusing on a single group of participants would have yielded findings with greater depth and which reflected the diversity of views that exist on this topic, it is worth noting that concepts such as 'data-saturation' are not consistent with the principles of reflexive thematic analysis, where meaning is generated through the *interpretation* of data rather than being *excavated* from the data (Braun & Clarke, 2021). Another limitation of this study is that it is dependent on staff participants accounts of their practice, and it is not possible to know to know how accurately this reflects their actual practice.

Practice implications

This study has several practice implications. First, our study suggests that staff and parents often hold different views about when it is appropriate to use restrictive practices for CYP who self-harm. While it might not be possible to achieve a consensus on this issue in all circumstances, parents should be meaningfully involved in decision-making about how incidents of self-harm will be managed. Second, it is clear that all groups of participants valued staff who were actively engaged, kind, validating, good communicators and who could adapt their approach to the preferences of CYP they were working with. Whether or not staff possessed these attributes was seen as playing a key role in determining outcomes for CYP who self-harm in inpatient settings. Staff training and supervision, therefore, should focus on supporting the development and maintenance of these interpersonal attributes. Third, this study adds to evidence that having sufficient numbers of suitably trained and experienced staff plays an important role in improving the safety, experiences and outcomes for this patient group.

Research implications

The findings of this study should be considered alongside the results of a systematic review that was completed as part of this project, which highlighted the lack of evidence-based, non-restrictive interventions for children who self-harm in mental health inpatient settings (Griffiths et al., 2021). While this study has provided an insight into the experiences and preferences of CYP, parents and staff on this issue, more research is required to develop effective approaches to working with this population that are acceptable to key stakeholders.

AUTHOR CONTRIBUTIONS

All authors listed meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors, and all authors are in agreement with the article.

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CONFLICT OF INTEREST STATEMENT

We have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICAL APPROVAL

Our study was approved by the Yorkshire and the Humber—Leeds West Research Ethics Committee (REC reference: 21/YH/0043; IRAS project ID: 291817). All participants provided written informed consent prior to enrolment in the study.

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