KNOWLEDGE ATTITUDES AND PRACTICES OF CLINICIANS FROM MATHARI NATIONAL TEACHING AND REFERRAL HOSPITAL TOWARDS MANAGEMENT OF INTENTIONAL SELF-HARM

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A research project submitted to the Department of Psychiatry at the University of Nairobi in partial fulfilment for the award of the Master of Medicine in Psychiatry

2021

Declaration

The undersigned, declare that this project is my original own work and has not, to the best of my knowledge, been submitted either wholly or in part to this or any other university for the award of any degree.

Signed …………………………………………………Date …30/07/2021………………………

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Declaration by the Supervisors

This project is being submitted for the award of the Master of Medicine in psychiatry with our full approval as supervisors

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Dedication

This project has been dedicated to patients who silently battle with Intentional Self Harm, it is also dedicated to those who lost loved one's due to suicide and those who sought help when they intended to self-harm.

Acknowledgement

I would like to express my sincere gratitude to God the Almighty for everything availed to me during my studies.

To my dear 80-year-old mother for emotional support and never-ending love.

To Dr. Chitalu Chilufya for being a constant pillar of encouragement, unwavering support in all aspects and for being my source of strength during my post graduate studies.

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List of abbreviations

ADHD: Attention Deficit Hyperactivity Disorder

BPD: Borderline Personality Disorder

DALY: Disability-Adjusted Life Year

ICD: International Classification of Diseases

ISH: Intentional self-harm

MNTRH: Mathari National Teaching and Referral Hospital

NSSI: None Suicidal Self-Injury

WHO: World Health Organization

Operational Definitions

Attitude: Feeling, emotions or opinion about something or someone.

Intentional self-harm: All episodes of self-damage inflicted to one's body where the person survived, whatever the intention was.

Knowledge: Awareness, understanding, or information that has been obtained by experience or study.

Non suicidal self-harm: The direct and deliberate destruction of one’s own bodily tissue in the absence of lethal intent and for reasons not socially sanctioned.

Practice: The exercise of a profession. Something that is usually or regularly done.

Suicide: Act of deliberately ending of one’s life.

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Abstract

Background

With the current suicide rate of 3.2 per 100.000 population in Kenya, intentional self-harm (ISH) represents a considerable burden. In ICD-10, it is included under external causes of mortality and morbidity, with the codes: X60 – X 84. A study in the UK, found that mental health nurses had negative behaviors towards patients who engaged in intentional self-harm. Another study in Sweden found that, nurses made over realistic promises to patients in regard to their treatment. The experience from the other countries suggests that the care provided to patients with self-harm may be suboptimal.

Study Objective

The main objective of this study was to determine the knowledge, attitudes, practices, and challenges of nurses and psychiatrists of Mathari National Teaching and Referral Hospital (MNTRH) in regard to the management of patients with ISH.

Methodology

The study design for this research was an exploratory qualitative that was achieved by collecting data through interviews and analysis using QSR International NVIVO version 10 software application. This research was conducted at Mathari National Teaching and Referral Hospital (MNTRH) in July 2021, in Nairobi Kenya.

Study population

The 22 participants in this study were 10 mental health nurses, 5 resident doctors, 5 psychiatrists, 1 clinical psychologists and 1 social workers, of Mathari national teaching and referral hospital.

Data analysis

The audio data from the interviews was transcribed verbatim into text. After transcription, it was uploaded on the QSR International NVIVO version 10 software application for analysis. The researcher adopted an integrated analysis approach of both inductive/grounded and deductive methods to identify themes and sub themes.

Results

This study identified several themes and sub themes related to Knowledge, attitude, practice and challenges towards management of ISH. The respondents also described the triggers of ISH whereby psychosocial factors were the most reported triggers for ISH. Gender based violence and bullying in school were reported as environmental triggers of ISH while female gender, teenagers and young female adult were reported as the most at risk to suffer from ISH. In exploration of the knowledge of clinicians on ISH, discrepancies were identified even among health care workers in the same cadre.

The study also identified gaps in supervision and mentorship of the resident doctors as they mostly do “self-training” and are “Expected to do things they don’t know about”. Discrepancy was also reported in the attitude demonstrated towards ISH. Majority of the clinicians treat the patients with empathy while others judge them and use demeaning labels.

The respondents highlighted that there is no treatment guidelines and no collaborative care for ISH patients. This makes the management of these patients very challenging because of what the respondent described as “A systemic failure”.

Other highlighted challenges in this study were shortage of psychologist, lack of essential treatment commodities, negative effect of covid 19 pandemic, stigma and rejection by the community who view suicide as a criminal offence.

Conclusions

Effective management of ISH should be a multi-disciplinary approach that entail a collaborative care model delivered by adequately trained Health care providers capable of identifying triggers and managing patients holistically. A competently trained team of providers should develop ISH care guidelines that recognize the role for each member. The model should also appreciate the significance of relatives who happen to be home based care givers. Therefore, ISH management should go beyond the hospital premises and preventive measure should target the most at risk cohort in the community. In addition, the knowledge gap and stigma towards ISH patients should be addressed through adequate training of mental health care providers and community sensitization.

Chapter 1 Introduction

Intentional self-harm (ISH) is included under external causes of morbidity and mortality in ICD-10. It can be defined in different ways. One of the most used definitions, the one we shall use here is all episodes of self-damage inflicted to one's body where the person survived, whatever the intention was. It is responsible for 1.35%, 0.61%, and 1.35% of the total disability-adjusted life years (DALY) respectively in the world, sub-Saharan Africa and in Kenya (IHME, 2019). It affects 16.1% of the people in the world, even though this estimation may vary depending on the means of assessment used and the precise definition chosen for ISH. In the year following a ISH event, 1 out of 7 of these patients will repeat the act and of those managed for a previous ISH 1 in 7 will commit suicide in the following year. It is more common among people who are experiencing stressful life events, people with a family history of ISH, unemployed people, medically ill people and those with mental illnesses. ISH is often triggered by a feeling of tension, hopelessness, or in responds to an auditory command in the case of psychosis. In UK, in 90% of cases, it is associated to another mental disorder (Harrison et al., 2018a). In London, in a study representative of the population of the mental health nurses, Shaw and sandy found after a qualitative study that most nurses had negative behaviors towards patients who present with ISH and said they needed further training on ISH to be able to manage these patients appropriately. In this same study, the skills of mental health nurses were found to be one of the limiting factors to the good management of these patients (Shaw & Sandy, 2016). In Kenya, the current suicide rate is 3.2 per 100.000 population (World Bank Group, 2021). To be able to address these suicidal behaviors in Kenya, we need to have an understanding of the current view of mental health worker, starting with Mathari National Teaching and Referral Hospital (MNTRH) which is the referral mental hospital of the country. MNTRH is the only level six mental hospital in Kenya, with a bed capacity of 700, which makes it the biggest psychiatric hospital in the country. In 2009 in this hospital, Ndetei and al found a prevalence of suicidal behavior of 44.6% among in-patients (Ndetei et al., 2009). So, we ask ourselves: what are the attitudes, practices, behaviors, and challenges of nurses, residents and psychiatrists of MNTRH towards this patients who present with ISH.

1.1 Problem statement

ISH is a growing concern in the world and in Kenya, furthermore during the COVID 19 pandemic (The World Bank Group, 2021). One out of 7 patients with a ISH event commits suicide in the following year (Harrison et al., 2018a). Psychiatrists and psychiatric nurses are

the professionals who are supposed to tackle this health concern. But as reported in London, there is a possibility for inappropriate skills in regard to ISH among these professionals (Shaw & Sandy, 2016). So, the researcher is targeting the understanding of clinician knowledge and understanding of this condition and the sort of clinical practices that are considered for management. Furthermore, exploring how knowledgeable clinicians are about this phenomena and how provider attitudes and practices shape management and clinical outcomes of patients/individuals who engage in ISH. This study may also contribute to the development of preventive measures in hospital setting.

1.2 Study justification

In 2004, Ndetei et al found a prevalence of suicidal behaviors of 44.6% among patients admitted to MNTRH (Ndetei et al., 2009). The experience from other countries suggests that the care provided to patients with self-harm may be suboptimal. The researcher couldn't find a study assessing the management of patients with self-harm behaviors in MNTRH. So, this study will help in filling the gap in the literature in regard to the knowledge attitudes, and practices of nurses and psychiatrists of MNTRH towards ISH. Knowing this will allow health administrators to design effective and efficient programs targeted at nurses and psychiatrists to improve the quality of care workers to patients with ISH seen at MNTRH.

1.3 Study question

What are mental health practitioner's knowledge, attitudes, practices, and challenges in managing patients with ISH?

1.4 Objectives

1.4.1 Broad objective

Determine the knowledge, attitudes, practices, and challenges of nurses and psychiatrists of MNTRH in regard to the management of patients with ISH.

1.4.2 Specific Objectives

- Assess the knowledge of nurses and psychiatrists of MNTRH about ISH
- Determine the attitudes of nurses and psychiatrists of MNTRH concerning ISH
- Evaluate the practices of nurses and psychiatrists of MNTRH regarding ISH
- Document the challenges faced by nurses and psychiatrists of MNTRH concerning ISH

Chapter 2 Literature review

ISH including suicide represents the extreme form of psychological suffering; suicide being the 2nd cause of mortality among adolescents. ISH is more common among psychiatric patients (Harrison et al., 2018b). Despite this, ISH still represents a big challenge for the mental health care system. In this category of ISH, included is non-suicidal self-injury (NSSI) which is defined as the "direct and deliberate destruction of one's own bodily tissue in the absence of lethal intent and for reasons not socially sanctioned". This aspect of ISH is getting a growing concern, for this reason ISH was included in the DSM 5 under the category of diagnostics needing further research to be done on (Cipriano et al., 2017; WHO, 2016). In the following lines of literature review, we are going to see what is already known in terms of the attitudes, knowledge, and practices of mental health nurses and psychiatrists towards ISH and how effective are the current measures for the management of patients who engage in ISH. Some of the challenges we are going to face in this process are the discrepancy of the terms, definitions, methods used to study this condition, and the scarcity of literature on the issue.

2.1 Quality of services for Intentional Self-Harm

In 2017, Steeg et al, did a propensity score analysis using data collected between 2003 and 2011 in the Manchester self-harm project. This concerned 16 456 patients received at the emergency department because of self-harm. To this data set, was added data from 31 hospitals in England concerning patients who also presented with ISH and were followed-up for a period of 6 months. They realized that, during the 12 months following the ISH episode, those of these patients who received a psychological assessment while at the emergency department were less likely to repeat the behavior than those who left the emergency department without going through a psychological assessment. They also found that the patients who were admitted in a medical ward, admitted in a psychiatric ward, or sent to outpatient psychiatric consultations after the psychological assessment still had the same risk of involving in ISH in the following 12 months as those who just benefited the psychological assessment at the emergency department and were sent back home (Steeg et al., 2021). The fact that those receiving further treatment didn't have a better outcome compared to the initial treatment raises some questions about the type and quality of interventions deviled at those additional levels. But, this doesn't mean that these additional interventions were pointless. The lack of perceived benefits may be due to the fact that those receiving additional interventions might be patients at higher risk. These may include those with comorbidities or very severe suicidal behaviors.

The above findings can explain why in 2013, Kapur and al tried to find out if clinical management improves the outcome of ISH. From 2000 to 2009, they included 35 938 patients who presented at Derby, Manchester, and Oxford centers for ISH and followed them for 12 months. They found that on 12 months follow-up, 2 out of the 3 hospitals show a reduction of 40% in ISH after a psychological assessment. The patients who were admitted to a medical ward were less likely to repeat the behavior than those who were admitted to the psychiatric ward or who received a mental health follow-up. This last group had a statistically significant increased risk of repeating the ISH (Kapur et al., 2013). These findings are contradictory to the findings of Steeg in regard to the effect of psychiatric follow-up, admission to medical and psychiatric wards. This makes us think that may be what is important is not whether the patient is admitted, but instead what is done to the patient during the admission.

The findings of Kapur and Steeg are similar to the findings of Crawford who focused on the impact of initial management on ISH and found with a sample of 308 patient that of the patients who attended the accident and emergency department for ISH, those who left without a psychological assessment were 3 times more likely to repeat the ISH behavior in the 18 following months (Crawford & Wessely, 1998).

2.2 Attitudes of nurses towards patients with Intentional Self-Harm

Shaw and Sandy examined the attitudes of 8 379 mental health nurses of London towards ISH from 2003 to 2011 in a cohort study. They found that most of these nurses had negative attitudes towards patients who engage in intentional self-harm. They believed that part of these patients would continue to attempt self-harm despite whichever intervention was provided. These nurses with negative attitudes were also angry and frustrated. This was particularly true with the patients who repeatedly attempt self-harm, to the extent that these nurses were calling them "attention seekers" and "timewasters" (Shaw & Sandy, 2016). A minority of nurses believed that treating patients this way will aggravate their condition and make them go away from the health care workers. A minority of nurses reported a lack of flexibility and excess guidance by their colleagues thereby not allowing the patient a certain degree of autonomy. Some nurses yell at patients during clinical sessions, lock them in even though they said they don't know if locking the patient in is beneficial in the long run (Shaw and Sandy, 2016). This indicates a need for training but, some of the nurses refused to take any training, mainly those above 5 years of experience, saying that there is nothing they need to learn about the management of a patient presenting with self-harm. Some nurses believe that there is no need to listen to whatever

the patient who present with self-harm has to say and others think it is worth listening to them. Some nurses talk to patients carelessly going to the extent of saying to the patient: “if you want to cut yourself do it when I am not around”. This can lead to a more frustrated patient who will be more likely to attempt self-harm again and less likely to seek help from healthcare workers. On the other side, some positive attitudes were also seen during this study. Most of the nurses acknowledged that they didn’t feel they had enough knowledge and skills to manage deliberately self-harming patients appropriately and so needed additional training (Shaw & Sandy, 2016). Idenfors et al studied the experience of youths seeking care for ISH in Northern Sweden and found that these youths thought that when the mental healthcare worker was not aware of their specific problems, this led to a poor outcome. He also found that mental healthcare workers would often make over realistic promises about what to expect from the care and the care was not patient’s centered which all contribute to dissatisfaction of the patient (Idenfors et al., 2015). On the other hand, Tofthagen et al found in 4 psychiatric clinics in Norway that nurses there practice a patient centered approach, were nonjudgmental, optimistic and some of these nurses would still allow their patient to self-harm. These nurses found the relationship with self-harming patients not easy because of the emotions it induces (Tofthagen et al., 2014).

2.3 Risk and protective factors associated with patients engaging in Intentional Self-Harm

2.3.1 Risk factors of Intentional Self-Harm

The main risk factor of ISH is mental illness. It is present in 90% of people with ISH (Harrison et al., 2018b). The main contributing mental illnesses are mixed depression and anxiety and borderline personality disorder (BPD) (Harrisonet et al., 2018b)

Patients who engage in NSSI usually do this after experiencing depressive symptoms such as negative emotions, anger, loneliness, anxiety. After a NSSI, these patients usually report feeling better (Cipriano et al., 2017). Dalia and al found a significant correlation between mixed depression and anxiety and the intensity of suicidal thoughts. This was also correlated with higher intensities of suicidal thoughts. But they also found a high prevalence of suicidal thought among the comparative group of patients without a psychiatric diagnosis thereby letting the question opened for further studies (Ali et al., 2020).

NSSI is listed as one of the diagnosing criteria of borderline personality disorder (BPD). This does not mean it has to be there for the diagnostic of BPD to be made and also, a patient

presenting with NSSI may not have a BPD. In a hospital-based study conducted in Egypt by Dalia et al, they found that BPD was present among 59% of the patients who deliberately harm themselves. Also, they found that BPD was the psychiatric disorder with the strongest link to DSH (Ali et al., 2020). Other mental illnesses include, bipolar related disorders, and alcohol and substance misuse(Harrison et al., 2018b). Other factors include, a family history of ISH, impulsivity, being jobless, going through stressful life events, medically ill people, having a weapon and some socio-cultural factors (Bertrim, 2008; Harrison et al., 2018b; Knipe et al., 2019).

2.3.2 Protective factors of Intentional Self-Harm

Some of the protective factors for ISH include having problem solving and coping skills, cultural and religious believes that discourage suicide, connection in the society, supportive relationships with care workers, access to physical and mental care, limited access to lethal means(CDC, 2021). Caribe and al found in a case control study of 110 case and 114 control in brazil that religiosity is a protective factor against ISH (Caribé et al., 2012). In the united states of America , in a study done by Kleiman and Liu and in India In a study done by Borowsky and al it was found that social support is a protective factor against ISH (Borowsky et al., 1999; Kleiman & Liu, 2013).

2.3.4 Assessment and management of Intentional Self-Harm

For each patient who present to the hospital with intentional self-harm, an assessment must be done. The aims of this assessment is to evaluate the immediate risk of suicide, the subsequent risk of ISH and to identify his /or medical and or social problem. This assessment must be done in a supportive and none judgmental way. Precise information must be gotten about the intention at the moment of the self-harm, the current thinking of the patient, any issue the patient is going through, evaluate for any psychiatric disorder, evaluate the resource available for the patient. After this evaluation, the management consist of treating the any identified psychiatric illness, offer psychological support to dealt with the different stressors, admit in a mental health ward if the is the immediate risk of suicide is high or if there is any comorbid severe mental illness. We also have to make sure the patient is been managed for any comorbid medical condition that may have occur as a consequence of the self-harm (NHS, 2010, 2018).

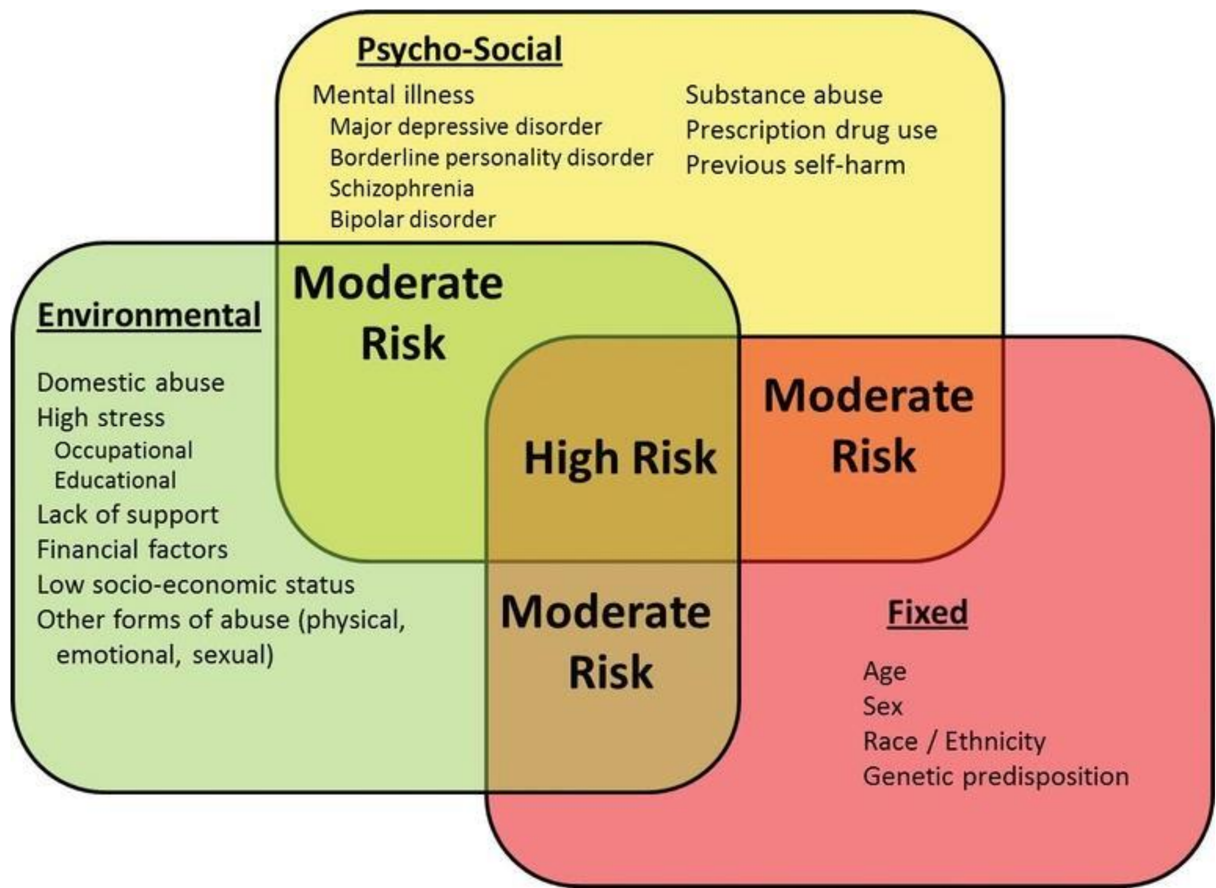

Figure 1: Factors that may contribute to violence and self-harm in the health care setting (Silmi et al., 2017)

The above figure shows the relationship between the different risk factors of self-harm in the health care setting,

Chapter 3 Methodology

3.1 Study design

The data collection was done in June/July 2021 in MNTRH by interviewing the nurses, resident Doctors and psychiatrists. The design for this research was an exploratory qualitative

Data analysis

The audio data from the interviews was transcribed verbatim into text. The researcher adopted an integrated analysis approach of both inductive/grounded and deductive methods to identify themes and sub themes

3.2 Study area description

The study was carried out in MNTRH, Nairobi. MNTRH was established in 1910 where it used to serve as a smallpox isolation center and later converted into a mental asylum. MNTRH has been a center of excellence and areas of referral from various health facilities, teaching, and doing research in the field of psychiatry. MNTRH is situated along the Thika road approximately 8 kilometers from the Central Business District opposite Muthaiga Police station. The facility provides mental health services and has also, integrated other fields of medicine to improve in and outpatients care. MNTRH offers a clinical experience to undergraduate and postgraduate Medical students from the University of Nairobi (UON) and other local and international universities, student Nurses, Occupational therapists, and psychologists. It is the largest psychiatric hospital in Kenya where a majority of mentally ill patients are admitted with a bed capacity of 700 patients. New psychiatric patients and critically ill are reviewed every day of the week in the outpatient department and those that need admission are admitted to the various wards in the hospital while those previously seen in the facility are reviewed as outpatient by doctors in the various wards booked every Tuesdays of the week.

3.3 Study Population

- Population characteristics

The population of this study consisted of nurses, psychiatrists, resident doctors in psychiatry, clinical psychologist and social worker of MNTRH.

- Inclusion criteria

The study included; nurses, psychiatrists, resident doctors in psychiatry, clinical psychologist and social worker who at the time of data collection were exerting clinical function at MNTRH.

- exclusion criteria

Study was designed to exclude nurses, psychiatrists, resident doctors in psychiatry, clinical psychologist and social worker who would refuse to give consent.

3.4 Sampling Procedure

The researcher used purposive sampling technique to determine the sample. Purposive sampling is a technique used in qualitative research for the identification and selection of information rich cases (Patton.,2002). This involves selecting knowledgeable individuals or groups with experience of the phenomenon of interest. Khan (2019) states that, in qualitative study where the sample is selected through purposive sampling, there is no need for a statistical representative sample. Any number of the sample indicating the sample size can be selected to serve the purpose of the researcher. In this study, the sample size determined by the researcher was 22, based on the criteria indicated below.

MNTRH has 14 psychiatric wards. 4 female wards (2F, 5F, 6F, MSU C), 7 male wards (Amenity, 5M, 6M, 8M, 9M, MSU A, MSU B), and 3 mixed wards (outpatient department, Methadone Assisted Therapy clinic, and the rehabilitation unit). MSU are the forensic wards which was excluded in this study. Sampling was as indicated in the table below:

Table 1: Sample Size

Number of participants	Description
10	Nurses (5 male, 5 female)
5	Consultant Psychiatrists
1	Social worker
1	Clinical Psychologist
5	Residents Doctors in Psychiatry
TOTAL: 22	

From 10 wards, excluding the forensic ward, one nurse was be selected from each ward to make a total of 10. From the 10 selected nurses, 5 of them were male and 5 female. Two of them had

less than 5 years of working experience, two between 10 and 15, two between 15 and 20 and two above 20 years of working experience.

5 consultant psychiatrists, 1 social worker, 1 clinical psychologist and 5 residents in psychiatry at MNTRH were also included in the sample for this research. The total number of the study participants was 22.

3.5 Data collection procedures

After the approval of the administration of MNTRH, the researcher approached psychiatrists, resident doctors in psychiatry, clinical psychologist, social worker and nurses engaged in clinical functions at MNTRH hospital and proposed to them to be part of the study by presenting to them the consent form. Thereafter, the researcher invited a participant to an intimate space and made sure that confidentiality was observed. The interviews were recorded with an audio recorder. During the interview, the researcher made sure that each question was well understood, after the answer of the participant the researcher would probe for further clarifications or if there are some aspects of the answer that need to be explored further. After the interview, the audios were saved following a serial code built by the researcher.

3.6 Data collection tools

The researcher used an audio recorder, a socio-demographic questionnaire and a clinical questionnaire built by reflecting on the questionnaire used by Shaw and Sandy in a similar study (Shaw & Sandy, 2016). The questionnaire was semi structured opened ended that allowed probing for more information on the knowledge, attitudes, practices, and challenges in regard to the management of patients with ISH and it had some questions that were specifically for residents.

3.7 Ethical consideration

This study was approved by Ethics and Research of Kenyatta National Hospital and University of Nairobi management before carrying out the study. The management of MNTRH was informed on the intention to carry out the study at their institution and the purpose of the study explained to them. The researcher waited for a written consent from the medical superintendent of the hospital in order to carry out the study. Confidentiality was observed in the whole process of data collection and data management. There were no identifiers on the study instruments, as serial numbers were used instead of names.

3.8 Data management

The recorded audio data was stored safely in a computer laptop with a password and only accessible to the researcher. All the 22 audios were transcribed verbatim to text. The researcher read through the data severally to have a deep understanding of the information. The researcher used an integrated approach of grounded/inductive and deductive methods to identify themes and statements around knowledge, attitudes, practices and challenges around ISH. The researcher identified key terms and statements that were grouped in 5 big categories: nurses, clinical psychologist, social worker, residents, and psychiatrists. These 5 categories were further divided into 4 sub-categories each: knowledge, attitude, practice, and challenges. The key terms and statements identified from the transcribed text were ranked in each of the above categories and the results presented in to categories illustrated by quotations.

3.9 Data analysis

The 22 audio recorded data for 10 nurses, 5 consultants, 5 resident doctors in psychiatry, 1 clinical psychologist and 1 social worker were transcribed verbatim. The transcripts were uploaded on QSR International NVivo version 10 software for qualitative analysis. Thematic content analysis was done by integrating deductive and grounded/inductive approach to identify themes and sub themes. The main themes which were identified in this study were; Risk factors for ISH, clinicians understanding of Intentional Self Harm (Knowledge), attitude of health care workers towards ISH patients (Attitude), Management of ISH patients at MNTRH (Practice), Challenges in Management of ISH patients and Effects of Covid 19 pandemic on care for ISH patients. This content analysis was preceded by intense reading through the 22 transcripts for familiarization prior to coding.

Chapter 4 Results

This qualitative study identified several themes and sub themes related to Knowledge, attitude, practice (KAP) and challenges towards ISH. In addition to KAP, the respondents also described the triggers of ISH whereby psychosocial factors were the most reported triggers for ISH. Gender based violence and bullying in school were reported as environmental triggers of ISH while female gender, teenagers and young female adult were reported as the most at risk to suffer from ISH.

In exploration of clinicians' knowledge on ISH, discrepancy in understanding was identified even among health care workers of the same cadre. It was also highlighted that supervision and mentorship of the resident doctors is inadequate as they mostly do "self-training" and therefore are "Expected to do things they don't know about".

Discrepancy was also reported in the attitude demonstrated towards ISH. Majority of the clinicians treat the patients with empathy while others judge them and use demeaning labels.

This study also identified that there is no treatment guidelines and no collaborative care for ISH patients. This makes the management of the patients challenging because of what was the respondent described as "A systemic failure".

The study also established that there is acute staff shortage and especially psychologist and therefore it is challenging to offer psychotherapy to all the patients who require this kind of intervention. The respondents also described that the facility does not offer comprehensive management due to lack of essential commodities like drugs and laboratory investigations.

ISH was termed repetitive and emotionally draining for clinicians who have to deal with aggressive patients, poor treatment outcome even after hospital intervention and extrinsic factors including lack of cooperation from care givers and stigma from the community.

The covid 19 pandemic also brought out challenges with observation of prevention guide lines which require keeping social distance and having a face mask. Literally, the patients mask facial expressions and thus clinicians cannot do a thorough full psychiatry assessment. The table below is a summary of the results as identified by the themes, sub themes and a brief explanation of the findings.

Table 2: Identified themes & Subthemes

Theme	Sub Theme	Findings
Risk factors for ISH	Psychosocial factors	Underlying psychiatric conditions are triggers for ISH; depression, anxiety, schizophrenia and substance use disorders identified as common triggers
	Environmental factors	Bullying at school, domestic violence and stress at home environment
	Fixed factors	Female gender, teenagers and young female adult more at risk of ISH
Clinicians understanding of Intentional Self Harm	Terminologies and description	Discrepancy in understanding of ISH among different health care workers even in the same cadre Wording used to describe ISH deliberate, intention not to die, seek attention, premeditated, planned. Some respondents view suicide as the same as ISH. The aspect of “survive” was not mentioned by majority of the respondents.
Attitude of health care workers towards ISH patients	Positive attitude towards ISH patients	Treating ISH patient with empathy, non-discrimination, non-judgmental. Despite the positive attitude identified among majority of the respondents, a significant number also demonstrated negative attitude towards ISH:

	Negative attitude towards ISH patients	ISH patient labeled as Attention seekers, should be them isolated ISH patients very stubborn, difficult to treat, violent Dismissive in management, will still commit suicide even after intervention,
Management of ISH patients at MNTRH (Practice)	Address the psychosocial issues; Treatment of underlying mental condition. Pharmacotherapy Psychotherapy (Individual & family) Close observation and use of Suicidal caution card.	No standardized patient management practice. (When to initiate pharmacotherapy, when to admit, when to involve a psychologist). Example - Some will admit if there is a severe mental disorder accompanying the ISH, other psychiatrist will admit all ISH patients.
	Isolation of ISH patients	Discrepancy in this practice. Some were for isolation of the patient while others were against
	Lack of guidelines and SOPs	All the respondents said that there is no guidelines or SOPs for managing ISH patients in MNTRH
	Forming a therapeutic relationship with ISH patients	All the respondents were in agreement that it is challenging to build therapeutic relationship because; It is difficult for patient to open up, the underlying conditions like depression make the situation harder. It is difficult to establish rapport with teenagers.

	Lack of collaborative care model	No proper follow-up because patient is probably attended by a different doctor during a subsequent visit No feedback after referring a patient, it takes long for a patient referred to be attended by a psychologist. No opportunity to discuss patient care as a team. "A systemic failure"
Challenges in Management of ISH patients	Inadequate training of health care workers on management of ISH	ISH not adequately covered in curriculum. Residents do self-training. "Expected to do things they don't know about" Trainers lack motivation to train the resident doctors.
	Institutional challenges	Staff shortage; especially psychologist Lack of conducive environment; long queues, less time spent with the patient and no patient privacy
	Lack of collaboration and inadequate follow up	The is lack of collaborative treatment model and this affects follow ups and continuous care.
	Poor treatment outcome despite the intervention	Intentional Self harm seems repetitive, relapses, some end up committing suicide even immediately after hospitalization. Emotionally draining for the clinician handling the patient

	Stigma and rejection by family members	Relatives not cooperative, abandon patient in hospital, general understanding that ISH is criminal offence, after recovery patient discharged to the same stressful home environment – a cause for relapse.
	Aggressive patients	Challenging to manage aggressive patients - can harm the health care worker.
	Delay in seeking intervention for ISH	Patients seek for help after many incidences of ISH, Care givers at home have no knowledge of ISH and hence the delay to seek intervention.
	Inability for patient to access the prescribed treatment due to lack of finances	Some patients unable to afford the prescribed follow up visit schedule. High risk suicidal patients who have no money for admission are managed at home despite the clinician's recommendation for admission
Recommendations	Train health care workers on management of ISH	Consultants/supervisors should be available to guide the resident doctors. Build the capacity of the clinicians at MNTRH on management of ISH.
	Collaborated care for ISH patients	ISH management should be a multi-disciplinary approach. Appreciate the contribution of each ISH care team member not "antagonizing the other"

	Develop guidelines for managing ISH patients	Guidelines will be helpful in making team work easier by clearly indicating who is supposed to what and when and how.
	Involvement of care givers and the community in prevention and management of ISH	Involve care givers in management. Sensitization of the community through media campaigns, Involve schools. This will help in early intervention
	Provision of safe environment for hospitalized ISH patients	"Padded safe rooms" "Friendship benches"
	Increase human resource for mental health care	The respondents identified that there is huge shortage of mental health human resource and especially clinical psychologist.
	Improve access to second line advanced drug therapy	Improve availability of drugs especially the second line
Effects of Covid 19 pandemic on care for ISH patients	Unable to deliver optimal care due to covid 19 prevention protocol.	Patients mask facial expressions – Difficult to assess them (emotions) No hospital admissions. Patients who have no insight are unable to adhere to Covid 19 prevention guidelines and therefore put clinician at increased fear and risk of contracting Covid 19.

4.1 Risk factors for Intentional Self Harm

The respondents highlighted the risk factors or triggers for Intentional Self Harm. Among the respondents, a male consultant psychiatrist indicated that, *"Most people who have got self-*

harm, either they usually have depression, so you'll start them on antidepressants. Or they have schizophrenia, where they're acting maybe on command hallucinations" Interview with CP_04.
Psychosocial factors were the most reported trigger for ISH as it was indicated by the female nurse that, *"Mostly depression and schizophrenia, those are very common (underlying conditions)" Interview with FN_03.*
This was also echoed by a female resident medical doctor who stated that, *"underlying psychiatric diagnosis, like depression, or anxiety, or through depression, ADHD can lead to intentional self-harm in terms of cutting." Interview with RMD_03*
Therefore, it was found that, specific underlying psychiatric conditions such as depression, anxiety and schizophrenia were the common triggers.

For environmental factors, bullying at school and stressful home environment especially domestic violence were identified as triggers for ISH. From the respondents, a female consultant psychiatrist stated that, *"all this begins with the family and if you find people are harming themselves because they are depressed and they are being bullied in school you will find all this information from careful history taking to determine the basis". Interview with CP_01*

A female nurse indicated that *"Most of the stresses are about home. The husband who beats the wife, it is the extended family." Interview with FN_01*
While a male nurse stated that, *"Some will do it as a result of the stress they have and we have so many cases or causes of stress, so it will vary depending on the trigger of an individual." Interview with MN_02*

There were also the fixed factors that trigger ISH as the respondents identified that Female gender, teenagers and young female adult are at more risk of ISH. This was drawn from the view of the male resident medical doctor who stated that, *"Most of them, in my experience, were adolescent girls who most times had underlying depression … I've only come across girls who have had intentional self-harm in terms of cutting." Interview with RMD_03*
One of the male consultant psychiatrists indicated that, *"most of times, and I think mine (experience with ISH) has been mostly with the young ladies, the teenage, or young adults presenting, most of the times, it's probably a cry for help". Interview with CP_03*

This sentiment was also alluded to by another female consultant psychiatrist who delved into their experience and stated that, *"My experience, I'd say, with self-harm, we're seeing it more and more in the young adults, late teenage hood to young adults." Interview with CP_05*

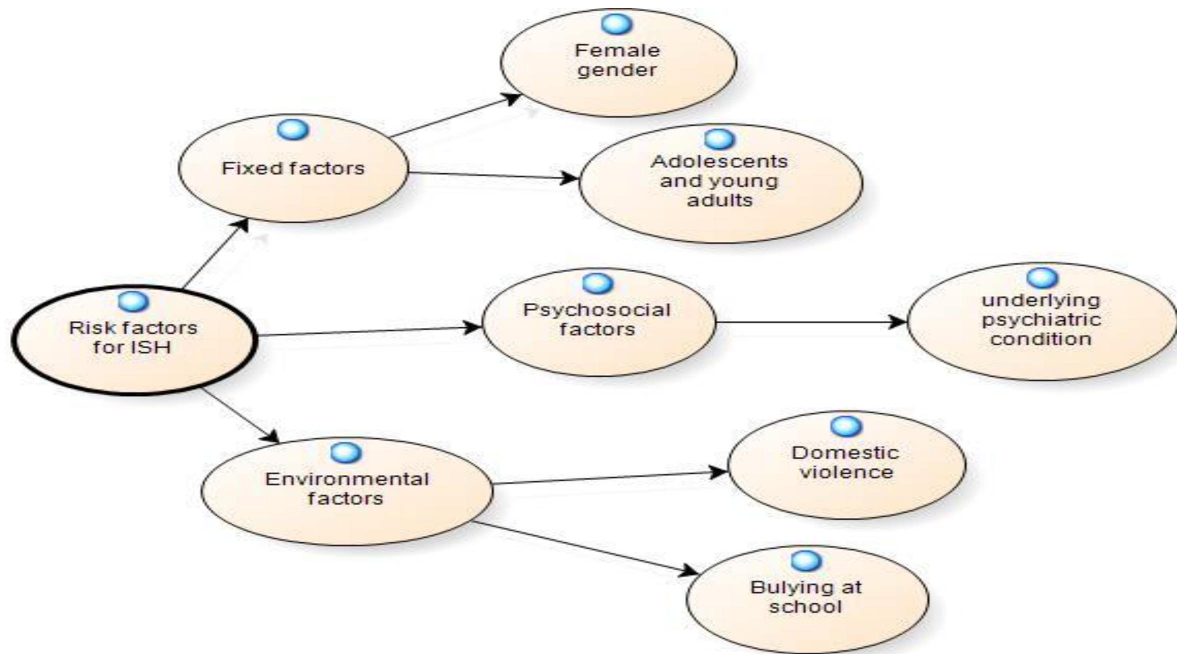

Figure 2: Triggers/risk factors for ISH

4.2 Clinicians understanding of Intentional Self-Harm (Knowledge)

The respondents used different words and phrases to describe Intentional Self Harm as they understood it. The psychologist stated that, *"Self-harm is deliberately harming yourself by maybe using a weapon, a sharp object and even at time your nails. It is usually with regards to survivor mental distress or just any kind of mental distress". Interview with Ps_01*

The social worker was of the view that, *"I think they are just the same only with a slight difference (suicide and Self harm)" Interview with SW_01*

While the male consultant psychiatrist during the interview stated that, *"We can give you so many different types of answers, I don't know how you will be able to code them… the difference between self-harm and suicide, I think they are one and the same thing." Interview with CP_01*

Discrepancy in understanding of ISH among different health care workers even in the same cadre was identified. Wording used to describe ISH were; deliberate, intention not to die, seek attention, premeditated, planned. Some respondents view point was that suicide is the same as

ISH. The aspect of “survive” a key word in ISH was not mentioned by majority of the respondent’s description such that a male nurse with reference to their own understanding stated that, *“In my own understanding, unintentional is accidental but intentional means it is premeditated, planned and executed.” Interview with MN_02*

A female resident medical doctor among the respondents indicated that he had not read about ISH, *“Intentional self-harm, I haven’t read about it but I think it could be for attention seeking but for suicide it is basically the person trying to end their life.” Interview with RMD_02*

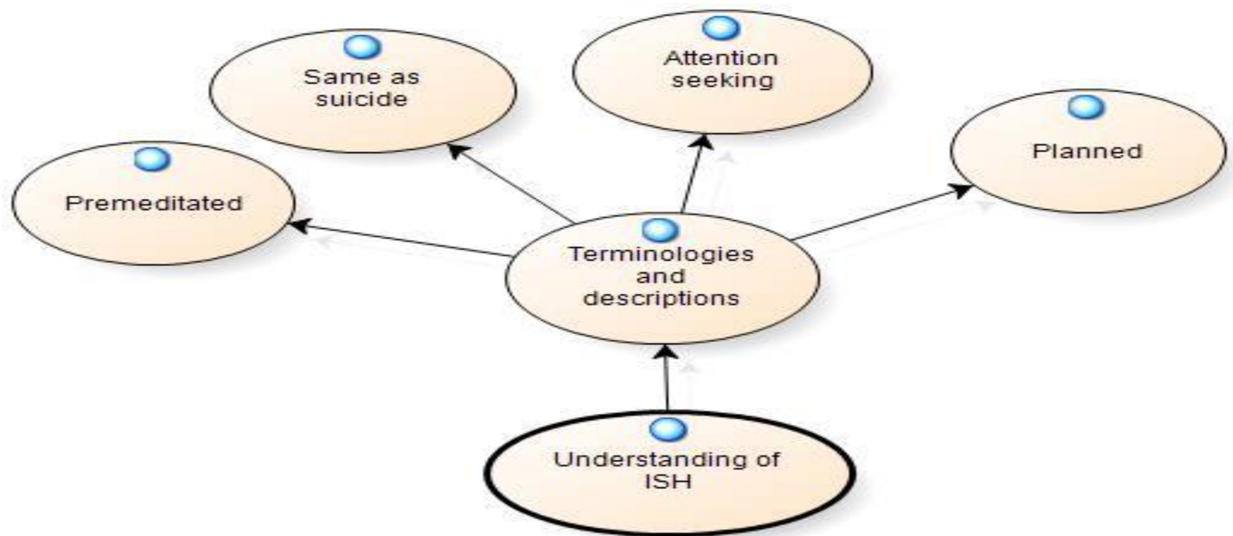

Figure 3: Clinicians understanding of ISH

4.3 Attitude of health care workers towards ISH patients (Attitude)

Despite the positive attitude demonstrated by majority of the respondents who treat ISH patient with empathy, non-discrimination and non-judgmental, some respondents demonstrated a negative attitude towards ISH. A male consultant psychiatrist in relation to patients who presented with self-harm stated that *“they are very difficult to treat. They are very stubborn cases it’s also affects you as the caregiver”. Interview with CP_01*

However, a female nurse responded that, *“I will treat this patient like any other person with mental illness without any discrimination or any attitude.” Interview with FN_02*

Some participants labelled ISH patients as Attention seekers, very stubborn, difficult to treat, violent and they should be them isolated at hospital setting. This was echoed by the male nurse who indicated that, *“It (seclusion) does help because it is like keeping him away from the*

freedom that these other guys are enjoying and they have to stay in solitude in the strong room, to some extent it does help." Interview with MN_01

Some respondents were dismissive in management of ISH patients and they believe that the patients would still commit suicide even after hospital intervention. A male resident medical doctor stated that, *"Me as a mental health practitioner. I can try my interventions, but most cases I'm only postponing the event. In some cases, it is really a matter of time until they're actually successful in that attempt. That's my belief." Interview with RMD_03* While another female resident medical doctor stated that *"I could not be as dismissive as I've been in their management". Interview with RMD_03*

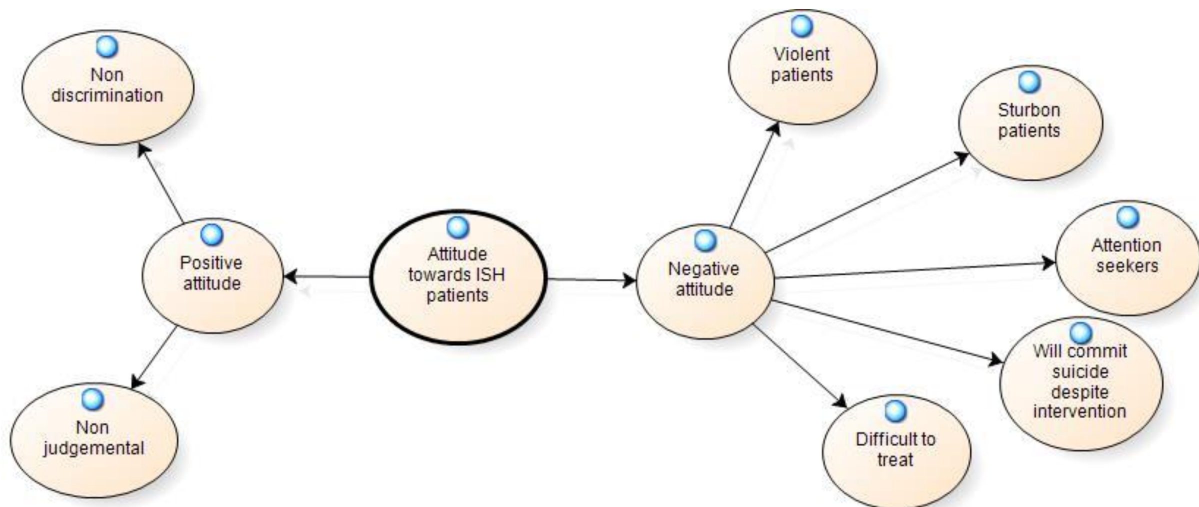

Figure 4: Clinicians attitude towards ISH patients

4.4 Management of ISH patients at MNTRH (Practice)

4.4.1 Therapy for ISH patients and discrepancies in practice

Study participants reported that care for ISH starts by intensive history taking and addressing diagnosed psychosocial issues. The management includes pharmacotherapy, psychotherapy (Individual & family), close observation and use of Suicidal caution card. Isolation of ISH patients was also reported. A consultant psychiatrist indicated that, *"First, intensive psychotherapy. Number 2, meticulous history taking. Number 3, is family therapy because of the background". Interview with CP_01* A female nurse indicated that, *"For this patient with*

self-harm, they are treated with medication to minimize the symptoms and you also have a suicidal caution card to observe them". Interview with FN_02

However, the respondents highlighted that there is no standardized patient management practice. (When to initiate pharmacotherapy, when to admit, when to involve a psychologist).

There is discrepancy in management of ISH patients. Some psychiatrist will admit a patient only if there is a severe mental disorder accompanying the ISH while others will admit all ISH patients who present in the clinic. A female consultant psychiatrist was of the view that, in terms of practice, *"I would say we admit when we see they have a severe disorder accompanying the self-harm". Interview with CP_02,* While another male consultant psychiatrist indicated that *"I admit all of them because suicide is one of the major psychotic emergencies we have". Interview with CP_04*

A male resident medical doctor indicated that, *"I admit them when they're accompanied, when they're under the influence, when they have done it repeatedly, and if they're under the security officer. They have been brought by a police officer". Interview with RMD_04*

There was discrepancy in the practice of isolation. Some clinicians were for isolation of the patient while others were against it. A male nurse was of the view that *"I think if they were isolated and they were taken care of more in an isolated place it might be better for them." Interview with MN_02*

However, a female nurse stated that *"Currently, we have a small room where we keep our patients. To me, those rooms look dangerous because those patients are stressed and they want to hit the walls and it is cement, so you find that some of them harm themselves." Interview with FN_01*

4.4.2 Lack of guidelines and SOPs

All the respondents highlighted that there is no guidelines or standard operating procedures for managing ISH patients at MNTRH. Therefore, treatment approach is subjective, and depends on the clinician handling the patient at a given time. A consultant psychiatrist stated that, *"There's no standard way which says that if you get somebody with self-harm, this is the approach, this is the guy to bring in. Nothing is going to be done. We don't have such a scheme in Mathari." Interview with CP_04*

A male nurse stated that, *"So far there is no guideline that I have interacted with, that is able to guide me so there is a gap there." Interview with MN_03*

These sentiments were also echoed by the resident medical doctor who stated that *"I know what a guideline is but I haven't come across any". Interview with RMD_02.*

4.4.3 Forming a therapeutic relationship with ISH patients

All the respondents were in agreement that it is challenging to build therapeutic relationship with ISH patients. First of all, it is difficult for patient to open up and the common underlying conditions like depression make the situation harder. This was evident from the consultant psychiatrist who stated that *"You see, it is very difficult to create a therapeutic alliance with these patients because they are always close up from the beginning and they are always brought against their will." Interview with CP_01* A female nurse stated that *"Patients with depression, you can talk to them for so long but still there is nothing from them, so I find it very difficult to deal with such patients. They are always just quiet and everything you say to them is quite okay." Interview with FN_03.*

ISH is common in adolescent and young female adults as described in the analysis of the risk factors section and the respondents described that it is difficult to establish rapport with teenagers. A psychologist observed, *"From my own practice, most of the ones I have encountered are teenager and establishing rapport with the teenagers is hard" Interview with Ps_01*

It was found that, the patient follow-up is also a challenge because probably after initial visit a patient will be attended by a different clinician during a subsequent visit and thus a therapeutic relationship cannot be sustained. A resident medical doctor stated that, *"It is hard because there is no one to follow up with a particular patient, because your time there is limited. You will see a patient and the next time another person will see that patient, so I would say there is no definite continuity of patient care." Interview with RMD_02*

4.4.4 Lack of collaborative care model

The study participants highlighted that they do not get feedback after referring a patient to other specialties in the facility and therefore an opportunity to discuss patient care as a team is missed. In addition, it takes a long time for a patient referred to be attended by a psychologist. One psychiatrist described it as "A systemic failure", *"I think it is just a system failure, if I would just say so. There is no collaboration in taking care of patients among all the departments." Interview with CP_02* Another consultant psychiatrist stated that *"I come as a psychiatrist, I see the patient, I prescribe my drugs. I refer, or I rather tell the psychologist to come and see*

the patient. Psychologist will come when they'll come. We don't have a proper feedback, like where you would sit as a team and discuss about this patient." Interview with CP_05. A resident medical doctor touched on the lack of collaboration when he stated that *"I would want the patient to see a psychologist as soon as possible and you find that the soonest the patient can see a psychologist is two weeks, which to me doesn't make sense because when the patient is experiencing self-harm chances are, they don't have that time to wait for that booking. There is no collaborative management of the same patient …. Especially between psychiatry and psychology." Interview with RMD_02*

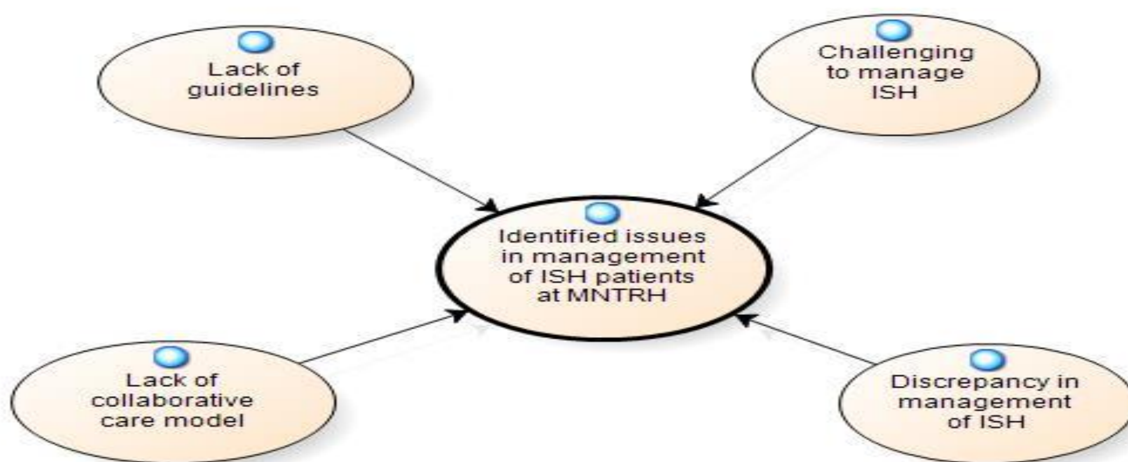

Figure 5: Identified issues in management of ISH patients at MNTRH

4.5 challenges in management of ISH patients

4.5.1 Inadequate training of health care workers on management of ISH

A resident psychiatrist observed that ISH is not adequately covered in the curriculum. This study also identified that resident doctors in psychiatry at MNTRH do "self-training" and supervisors probably lack motivation to train them. Consequently, they are "Expected to do things they don't know about". A consultant psychiatrist stated that *"I don't think it (ISH) was covered adequately in the curriculum and you know the reasons, I don't need to speak too much to you." Interview with CP_01* A resident medical doctor commented on skills and stated, *"First, there is a big problem with the skills, people are being expected to do things they don't know about, … I have just been training myself in this environment." Interview with RMD_01* Another medical doctor indicated that motivation was another issue and responded that, *"I feel like they don't have the motivation to teach us. They lack motivation." Interview with RMD_04*

4.5.2 Institutional challenges

The participants observed that there is acute staff shortage and especially psychologist. A consultant psychiatrist stated that *"There is a deficiency because we don't have enough human resources for mental health, that means there aren't enough psychologists to attend to all the cases that we have. I think we have about 5 psychologists to handle patients in a hospital that has a daily turnover of around 500 patients." Interview with CP_01*

The female nurse stated that *"At times you find that we have only one counselor looking after 50 patients and that consoler cannot manage." Interview with FN_01* This makes it challenging to offer psychotherapy to all the patients who have a prescription for the same.

The facility does not offer a conducive environment for care of ISH patients because of the long queues and therefore less time spent with the patient. This was evident from the response from a resident doctor who stated that *"The time that you are given to take care of that one patient is not enough because the queues are usually long, there is no privacy between you and the client, so the client might not be open enough to tell you everything because if you look at the situation in outpatient, everyone is there, the security is hovering there, the nurses the patients, so I don't think that is a conducive environment for anyone who is undergoing something deep in their life to open up." Interview with RMD_02*

The respondents also reported challenges in the patient comprehensive management due to lack of essential commodities like drugs and laboratory investigations. This was evident from the response from another resident medical doctor who stated that *"lack of medication at the facility especially Mathari, most of the time you will be told the drugs are OS. Thirdly, investigation is not comprehensive most of the time they are OS when you really need them, because some poisons may harm some organs like Kidney, liver." Interview with RMD_02*

4.5.3 Lack of collaboration and inadequate follow up

There is lack of collaborative treatment model and this affects follow ups and continuous care**.** A consultant psychiatrist observed, *"Here in Mathari we do our shifts in a hurry so even if you recommend psychotherapy we never follow up the same patient to see how they are doing. We never follow up any of our patients with culmination of therapy and treatment so that we can see their outcome." Interview with CP_01* Another consultant psychiatrist stated that *"The*

patient follow-up is not good and even the management is not comprehensive." Interview with CP_01

Collaboration with psychologists was another challenging issue as highlighted by another consultant psychiatrist who said, *"Because the services are not tied together, the psychologist and the psychiatrists don't work in conjunction with each other" Interview with CP_01*

4.5.4 Poor treatment outcome despite the intervention

Respondents observed that Intentional Self harm is repetitive and patients often experience relapses while some end up committing suicide even immediately after hospital intervention. A consultant psychiatrist stated, *"I think managing these patients has been a bit of a challenge, I have seen 2 or 3 and despite treating the comorbidities the self-harm seems repetitive" Interview with CP_02*. A respondent female nurse stated that *"at times you give all your attention to that patient and after treatment that thing recurs. I remember there was a time we had such a patient and once that patient went home he committed suicide and it was barely a week after discharge." Interview with FN_03* This was also alluded to by a social worker who stated that *"The difficulty is after you have talked and counselled your client then today you hear that he did what you told him not to do. That is always very bad scenario." Interview with SW_01*

4.5.5 Stigma and rejection by family members

It is challenging to address ISH if the relatives decline to cooperate in care and abandon patient in hospital. A consultant psychiatrist stated that *"the general understanding is that it's sort of like a criminal offense, or something of sort. People are quite hash towards somebody who would present with that, or even attempted suicide. Instead of bringing them closer, they probably push them farther away." Interview with CP_03*

The female nurse stated that *"Most of them (relatives) are not ready to cooperate at all because of the stigma, so it becomes very difficult." Interview with FN_01*

The community viewpoint that ISH is a criminal offence makes it difficult the relatives to cooperate and after recovery patient are discharged to the same stressful home environment that trigger relapse. A male nurse among the respondents stated that *"One of the challenges is that you find that at times these patients are abandoned by their relatives. But once they have had several attempts at home they become sort of a bother to the family, so once they are brought in they are abandoned." Interview with MN_03*

4.5.6 Aggressive patients

The respondents reported that it is challenging to manage aggressive patients because they can harm the health care worker. A female nurse stated that *"Sometimes it is difficult because if the patient intends to harm themself, they also intend to harm others. I remember when I was working in the female ward, there was a patient who was suicidal, she would bang her head on the tiles. I had to sedate the patient for a long time and I would find that I am actually sedating her day and night which is not very good because you cannot assess the progress of the patient." Interview with FN_01*

A male nurse in relation to aggressive patients stated that *"when the patient is aggressive and violent, handling them can become a challenge". Interview with MN_01*

While another male nurse stated that *"Yes, and again they can also be violent. If you get an aggressive patient, it can cause harm even to you". Interview with MN_02* Therefore, these patients are sedated and this becomes to assess the treatment progress.

4.5.7 Inability for patient to access the prescribed treatment due to lack of finances

Due to financial constraints, some patients are unable to afford the prescribed follow up return visit schedule and therefore end up missing subsequent therapy. A resident medical doctor among the respondents stated that *"Like I said, when you see a patient of high risk of suicide is not admitted or even those patients that are sent back home because they don't have enough money to pay for the deposit for admission." Interview with RMD_01*

While another resident medical doctor who was interviewed stated that *"First of all, lack of resources because some patients at times you realize they need admission and maybe the relatives cannot afford admission." Interview with RMD_02*

The participants also highlighted that even high-risk suicidal patients who have no money for admission are managed at home despite the clinician's recommendation for admission as one of resident medical doctor in their response stated that *"It's the administrative challenges of inability to admit because of the insurance status, or the financial status of the patient …. if somebody is highly suicidal and does not have the NHIF or the money, then we end up just managing at home. So, I didn't expect that." Interview with RMD_03*

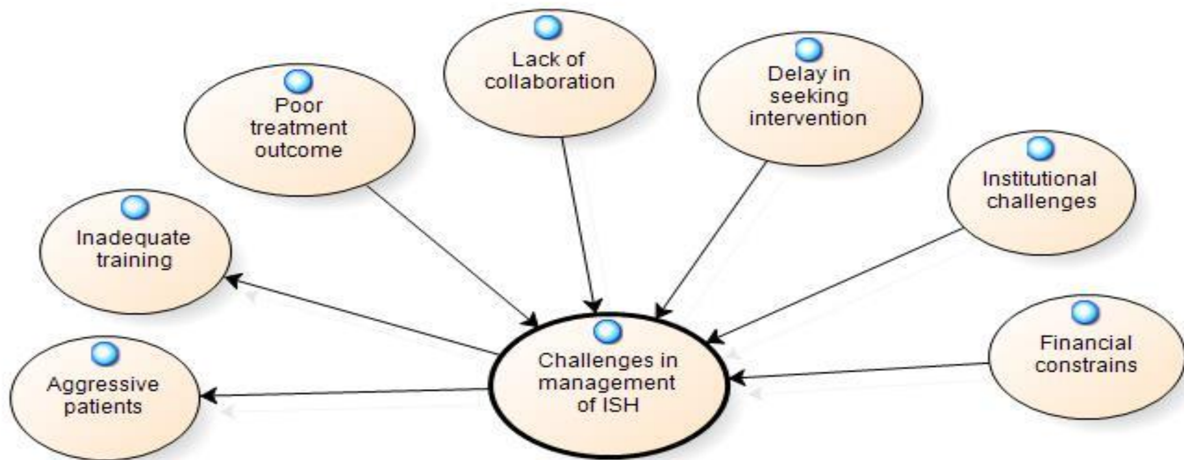

Figure 6: Challenging in management of ISH

4.6 Effects of covid 19 pandemic on care for ISH patients

The respondents reported that it has been difficult to deliver optimal care due to covid 19 prevention guide lines which require keeping social distance and having a face mask. Literally, the patients mask facial expressions and therefore clinicians cannot do a thorough full psychiatry assessment. A resident medical doctor stated that, *"When you are observing a patient, it is supposed to be holistic but now for the simple things like, the patient having a mask so the facial expressions will be hidden so you will not see. The non-verbal communication has been affected secondly there is no closeness have a connection." Interview with RMD_02*

While another medical doctor was of the view that, *"For me, Covid-19 made me angry about these patients because by the time it started there was a recommendation in Mathari Hospital not to admit patients any more. You would see a patient with high risk of suicide and then you are told you cannot admit the patient that was really annoying." Interview with RMD_01*

During this period of covid 19 pandemic, the facility minimized the hospital admissions and even those with ISH could not be admitted.

The participants also highlighted that patients who have no insight are unable to adhere to Covid 19 prevention guidelines and therefore put clinician at increased fear and risk of contracting Covid 19. This was echoed by the male nurse who stated that *"Most of these patients who come in with psychiatric disorder or intentional self-harm lack insight so even some of them will lack masks. As a provider despite having PPEs there is that fear of contracting the illness" Interview with MN_03.*

Chapter 5 Discussion

This descriptive study was able explore the knowledge gaps, attitude and practice of health care workers in the largest mental health referral hospital in Kenya. The evidence generated from the study will have positive implications on management of Intentional Self Harm not only in MNTRH but also other facilities which intend to have a paradigm shift from the contemporary stigmatizing way of addressing mental health to more appropriate approach that recognizes patient's quality rights.

Findings from this study identified an increased risk for Intentional Self Harm in female gender and young female adults. This implies that more focus should be on young people and especially the female gender in prioritization and mitigation for ISH. These young people are probably in schools or colleges and therefore community sensitization on ISH should include school environment. The factor of Gender Based Violence (GBV) was demonstrated as a stressor in the family that predispose a GBV survivor to ISH and therefore more support should be extended to patients who report incidences of GBV.

This study corroborates evidence by other researchers on increased risk of ISH in patients with underlying mental health condition and especially common stress disorders like depression and anxiety. (Harrisson et al.,2018) states that, the main risk factor of ISH is mental illness. It is present in 90% of people with ISH and the main contributing mental illnesses are mixed depression and anxiety. Therefore, Health care workers should be able to diagnose the patient and offer appropriate interventions before the problem escalates.

The clinicians limited knowledge on ISH hinders their ability to offer appropriate evidence-based intervention. This study pointed out some serious discrepancies and deficit in terms of knowledge and practices even among health care workers HCW of same cadre in addressing ISH. This can be remedied by improvement in curriculum and addressing the training gap especially for psychiatric resident doctors who are attached at the MNTRH. This implies that the consultant psychiatrists should be more available and interactive in order to pass the required knowledge and skills to the resident doctors.

Stigma and negative attitude towards ISH patients could cause mistrust and prevent them from accessing treatment or opening up at the health care facility. Labeling of ISH patients as "violent" "difficult" "attention seekers" is stigmatizing and does not reflect well on those seeking the services. This was also found by Shaw and Sandy (2016), who examined the attitudes of 8 379 mental health nurses of London towards ISH from 2003 to 2011 in a cohort study. They found that most of these nurses had negative attitudes towards patients who engage

in intentional self-harm. They believed that part of these patients would continue to attempt self-harm despite whichever intervention was provided. However, evidence indicates that there is a relationship between knowledge and stigma. Thus, improvement of knowledge on ISH could lead to reduction of stigma by HCW towards the ISH patient and translate to improved treatment outcomes.

This study identified that treating ISH at MNTRH is challenging for all cadres and this could be attributed to lack of guidelines/standard operating procedures and lack of collaborative care model among other factors. This is despite the evidence that effective treatment of mental disorders (including ISH and underlying comorbidity) requires coordinated multi-disciplinary collaborated approach.

As pointed out in other previous research such as Kapur (2013), who found that the patients who were admitted to a medical ward were less likely to repeat the behavior than those who were admitted to the psychiatric ward and those who received a mental health follow up from a care giver were less likely to engage in ISH. This study also observed that care givers should be in cooperated in management of ISH. They have a role to play in socio-economic welfare of the patient (funding for treatment, addressing psychosocial stressors at home, identifying signs of psychiatric condition and ensuring early intervention).

It will not be possible to comprehensively address ISH without resources and basic treatment commodities. Therefore, MNTRH should address the institutional issues which include staff shortage and challenges that needy patients face while seeking treatment. These include stockout of drugs and laboratory investigation as described in this study.

5.1 Conclusion

Effective management of ISH should be a multi-disciplinary approach that entail a collaborative care model delivered by adequately trained Health care providers capable of identifying triggers and managing patients holistically. A competently trained team of providers should develop ISH care guidelines that recognize the role for each member. The model should also appreciate the significance of relatives who happen to be home based care givers. Therefore, ISH management should go beyond the hospital premises and preventive measure should target the most at risk cohort in the community. In addition, the knowledge gap and stigma towards ISH patients should be addressed through adequate training of mental health care providers and community sensitization.

5.2 Study limitations

The main limitation of this study was that participants/respondents probably would say what they are supposed to do instead of saying what they actually do. To address this, the researcher made it clear to all participants that it was not a test, but instead, the researcher just wanted the facts so that the finding could useful in improving the management of ISH patients in MNTRH.

5.3 Researcher's Reflexivity

The researcher observed that although it was not so difficult to establish rapport with the participants, as they are colleagues, some participants didn't have so much time and felt that the researcher is asking questions with answers known to the researcher. Contacting the interviews at some point felt like interrogation especially in cases where further prompting was necessary. A slide difference in terms of the concentration flow in interviewing resident doctor's and Psychiatrist from nurses was noted, this may have been due to interruptions by patients calling, knocking at the interview room, as nurses were mostly found in close contacts with patients during the interviews.

The researcher observed that Psychiatrist and resident Doctor's were more confident with being interviewed as compared to nurses, social worker and psychologist. This was observed by questions posed to researcher by nurses asking how many other nurses the researcher interviewed. Overall all participants trusted the anonymity and none of the participants was worried if their identity might be revealed. Some participants thanked the researcher for the interview as they felt the interview reminded them on their need to improve themselves on managing patients with ISH, A Psychiatrist said '*actually im going to read on self harm today.* Although any questioning of another person and interview is not easy, all the participants acted answerable to the researcher and overall it gave the researcher motivation to move confidently from one participant to the other participant as all participants where quite cooperative.

5.4 Recommendations

- Develop guidelines for managing ISH patients – Guidelines will be helpful in making team work easier by clearly indicating who is supposed to do what and when and how.
- Collaborated care for ISH patients – ISH management should be a multidisciplinary approach. Appreciate the contribution of each ISH care team member not ”antagonizing’ the other.
- Involvement of caregivers – Involve care givers in management / beyond hospital setting, sensitization of communities through media campaigns, involve schools. This will help in early intervention.
- Provision of safe environment for hospitalized ISH patients – ‘Padded safe rooms, friendship benches
- Train health care on management of ISH – Consultants and Supervisors should be available to guide the resident doctors ,build the capacity of the clinicians at MNTRH on management of ISH
- Increase human resource of mental health care- The respondents identified that there is huge shortage of mental health human resource and especially clinical psychologists
- Improve access to second line advanced drug therapy – Availability of drugs especially second line.
- Hospital to come up with plan of assisting service users genuinely in need and unable to pay especially patients visibly unwell but no funds not to be sent back home in to communities while unwell.

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Appendices

Consent explanation Document

Title: knowledge attitudes and practices of nurses and psychiatrists of Mathari National Teaching and Referral Hospital towards intentional self-harm.

Participant Study Identification Number ……………………………………….

Date ……………………………………….

Dear, Introduction

My name is Dr. Magdaleena Ndapewa Shivute, a postgraduate student in psychiatry at the University of Nairobi. In collaboration with the University of Nairobi, we are doing a study on the knowledge, attitudes and practices of nurses and psychiatrists of Mathari National Teaching and Referral Hospital towards intentional self-harm. This is not an assessment nor test to any health care provider but instead, we need to know the fact about what is happening to be able to improve the care for our patients.

Requirements

For one to participate in the study you need to be either be a nurse or a psychiatrist occupying a clinical function at MNTRH.

Procedure

If you agree to participate in the study, we will have to interview you for approximately 20 minutes.

Benefits:

There are no direct benefits for participating in this study.

However, results from this study can help to have a better understanding about the care for patients with intentional self-harm and then help to improve this.

Risks:

All information will be treated anonymously. There is no risk associated to the participation to this study.

Voluntary Participation:

Your participation in this research is entirely voluntary and if you decide to participate, you are free to withdraw at any time. You may also choose not to answer specific questions or withdraw from the study at any time. Your choice not to participate will not have any consequence on you. Additional Information:

If you have questions about the study that are not answered in the consent information, please ask them. In addition, if you have questions in the future you may contact the following:

1. Investigator:

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Questionnaire

Demographics

1. Age? .
2. Gender? .
3. Qualification? .
4. Number of years of experience? .
5. Marital status?.
6. Religious affiliation? .

Clinical information

Knowledge

1- Could you explain how do you understand intentional self-harm based on your practice

2- What is the difference between ISH and suicide in your own view?

3- What do you think is the difference between intentional and unintentional SH?

4- How do you manage a patient who presents to you with ISH?

Attitudes

5- How do you feel about the current management practices you provide to patients with ISH? Can you comment on the quality and the guidelines, services put in place?

Prompts. Can you please tell me more about your approach about service users who present with this behavior? Unworthy of care?

6- Do you have any difficulty forming a therapeutic relationship with service users/clients who engage in self-harm?

Prompts. Is that the case? Please tell me about the difficulties you have experienced?

7- Do you think you have a collaborative care model for the management of patient with ISH? We are referring to a strong Alliance between drug, psychological and nursing intervention components to provide best care for the client?

Practices

8- How has COVID 19 affected your care for patients presenting with ISH? In your environment? At home? Your psychological well being?

9- Can you please tell me about your experiences of caring for service users who present with intentional self-harm?

10- How do you manage a patient who present with ISH? Do you prescribe any medicine? When? Why?

11- When do you recommend any psychological intervention to patients with ISH?

12- When do you admit patients with ISH?

13- Do you have any difficulty caring for service users presenting with self- harm?

Prompts. If that's so? Please tell me more about the difficulties you have encountered?

14- What factors can make it easier for you to form a helping relationship with service users who self-harm?

Prompts. What is it about training? Is there anything else?

Challenges

15- Which guide line do you use for the management of patients presenting with ISH?

Question for residents only:

16- What have been your experience in regard to your expectations from the care you provide for service users who self-harm?

Prompts. What about your lecturers? Anything else?

17- How is your training in regard to the management of users who self-harm?

Prompts. Any personal initiative? Anything else?

Question for nurses only

18- How do you care for a patient admitted in the ward with a diagnosis of ISH?