UNIVERSITY OF SOUTHAMPTON

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How do patients who have self-harmed, experience contact with mental health services in a general hospital?: An exploratory study using Interpretative Phenomenological Analysis

by

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ABSTRACT

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HOW DO PEOPLE WHO HAVE SELF-HARMED, EXPERIENCE CONTACT WITH MENTAL HEALTH SERVICES IN A GENERAL HOSPITAL?: AN EXPLORATORY STUDY USING INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

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The UK national policy on self-harm states that people who have self-harmed should be offered assessment by mental health services during an admission to a general hospital. However there is no empirical evidence underpinning this policy statement and there is a dearth of information regarding the experience of people who self-harm and are assessed in a general hospital. The aim of this research was to explore the lived experience of contact with mental health services for ten people admitted to a general hospital following self-harm. A phenomenological approach utilising Interpretative Phenomenological Analysis was adopted to explore this experience. Findings revealed the experience to encompass four superordinate themes which contained lower ordinate themes: (i) internal barriers to getting the help needed; (ii) the business of being human; (iii) traumatising environment; (iv) patient power. The study concluded that the interaction between mental health services and the person who has self-harmed has the potential to be life affirming and transformational but only if it is skilfully conducted and the relationship between practitioner and patient is a positive one. Further implications for both services and individual practitioners are considered alongside recommendations for future practice.

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Abbreviations

A&E	Accident and Emergency
AMU	Acute Medical Unit
BPD	Borderline Personality Disorder
CBT	Cognitive Behaviour Therapy
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
CT	Counter Transference
DoH	Department of Health
EBE	Expert By Experience
ED	Emergency Department
EUPD	Emotionally Unstable Personality Disorder
GP	General Practitioner
GPP	Good Practice Point
HCP	Healthcare Practitioner
IPA	Interpretative Phenomenological Analysis
LOT	Lower Order Theme
MAU	Medical Assessment Unit
MH	Mental Health
MHA	Mental Health Act
MHN	Mental Health Nurse
MHP	Mental Health Practitioner
MI	Mental Illness
NMC	Nursing and Midwifery Council
NHS	National Health Service
NSSI	Non-Suicidal Self-Injury
OD	Overdose
PIG	Policy Implementation Guide
PIS	Participant Information Sheet
PLAN	Psychiatric Liaison Accreditation Network
PTSD	Post-Traumatic Stress Disorder
SAE	Serious Adverse Event
SDM	Shared Decision Making
SH	Self-Harm
SOT	Super-Ordinate Theme
SW	Social Worker

DECLARATION OF AUTHORSHIP

I, ... [please print name]

declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

HOW DO PEOPLE WHO HAVE SELF-HARMED, EXPERIENCE CONTACT WITH MENTAL HEALTH SERVICES IN A GENERAL HOSPITAL?: AN EXPLORATORY STUDY USING INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. Parts of this work have been published as: [please list references below]:

Signed:.....

Date:.....

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Chapter 1 Introduction and Background

1.1 Introduction Outline

This study explores the lived experience of people who have had contact with mental health services during an admission to a general hospital for self-harm.

This chapter outlines the background leading to the development of the study, considers current rates of self-harm and service provision and demographic features of self-harm. It also considers terminology, operational definitions in order to clarify the field within which this work occurred and outlines the development of the research question. This work is written predominantly in the third person however, in order to differentiate the academic discussion from the experiential reflection the first person will also be used when appropriate (Hamill 1999).

Chapter 2 outlines the first of two patient consultations that occurred as part of this research project. The process of setting up the consultation, the aims of doing it and the outcomes and affect it had on the research process are all considered alongside an academic discussion on the concepts of patient involvement: experts by experience, shared decision making and co-production.

Chapter 3 outlines the literature reviews that took place to justify the project. The process undertaken, selection of literature, critique and thematic findings from the literature considered is reported.

The study design is the focus of chapter 4, this includes looking at underpinning philosophy; study design; ethical considerations and the analysis process. The methodology, Interpretative Phenomenological Analysis, is introduced and justified in this chapter along with an in-depth explanation of the expected process.

Chapter 5 concerns itself with the findings from the data collection phase. Each participant is introduced via a little vignette which helps to put their situation into context so that the quotes from their interviews are more comprehensible. The four superordinate themes plus their sub-themes are all introduced via

quotes from the transcripts ensuring that the findings can be justified within the data.

In chapter 6, each of the superordinate themes is discussed in the light of the literature on each topic. Then follows a discussion of the unique contribution to knowledge that this work provides, including individual practitioner implications; service alternatives and the impact that the Mental Health Act (MHA) has on mental health care. The chapter finishes with a section considering the second patient consultation which was concerned with sharing the findings with the attendees and asking who it was envisaged needed to know in terms of sharing the findings.

Finally, in chapter 7 issues concerning dissemination are considered and the strengths and limitations of the project discussed. There are recommendations for further research and the thesis is concluded.

1.2 Rates of Self-Harm

Self-harm is common in Europe and other parts of the world (Hawton et al, 1998. NICE, 2011. Lozano et al, 2013), it is one of the top five reasons for admission to general hospitals for emergency treatment with numbers between 170,000 and 200,000 in the UK each year for men and women (NICE, 2004., Hawton et al, 2007, NICE, 2011). Non-fatal self-harm is more common than suicide although it can be a precursor to actual suicide (Duffy and Ryan, 2004). Lewis (2004) states that rates of suicide in the year following self-harm is 1%, a rate 100% higher than in the general population where self-harm is not present. The national confidential enquiry into suicide report (DoH, 1999) clearly states that in those with diagnosed mental illness, 24% of completed suicides had been seen by mental health services in the year before death with 50% making contact with services in the week before death, for varied reasons. Of these suicides the mental health teams involved believed that 22% of them might have been preventable. The updated report in 2016 supports the assertion that 50% of people completing suicide make contact with services and points out that over a third of patients died whilst in contact with specialist mental health services (DoH, 2016). Bolton et al (2001) state that more than one quarter of psychiatric attendances at the Emergency Department were by patients who had attended more than five times in the previous year. Boyce et

al (2001) point out that self-harm is an increasing problem and that there is a high risk of repetition, especially during the weeks after an episode.

1.3 Demographics

Taylor (2003) states that self-harm in men is less acknowledged, accepted and understood than it is in women. He believes men are underrepresented as it is easy to pass injuries off as accidental and because men historically are less likely to seek medical help. He goes on to say that even in acute hospitals where dedicated mental health teams exist male patients have reported not being given the opportunity to discuss their self-harm. Rossow (2005) reinforces the belief that men are at higher risk of completed suicide and suicidal behaviour although the risk in women is equal to that of men where alcohol and substance abuse form part of the picture. Babiker and Arnold (1997) cite the problem of men who self-harm not having a voice in comparison to women and note that it can be difficult to engage men in discussions regarding self-harm. Gratz and Chapman (2007) point out that little research has examined self-harm in men despite evidence suggesting the gender difference in rates of self-harm is closing. These factors suggest it is likely that services may have been developed based on risk factors and needs associated with women who self-harm rather than men.

1.4 Current Service Provision

Liaison teams throughout the UK provide psychosocial assessments for people who have self-harmed in an acute hospital setting. Team structure varies nationally (Academy of Medical Royal Colleges, 2008), from a single nurse, to a nurse led team, to a full multi-disciplinary team. They are often based in the Emergency Department and all carry out assessments for people who have self-harmed but there is little parity, beyond this, between liaison teams nationally. Services for people who self-harm have been provided, historically, by Community Mental Health teams (CMHT) who operated in-reach to people in crisis. Following the National Suicide Prevention strategy (DoH, 2002) in-situ services became more common, a move reinforced by the update in 2016 (DoH, 2016) which reinforces the call for these services nationally. In 2005/6, a mapping exercise, funded by the South East Development Centre (SEDC), the

National Institute for Mental Health in England (NIMHE) and the Care Services Improvement Partnership (CSIP), was carried out to identify services available in the South Central and South Coast regions. They found a wide variety of services of variable quality and patients reported negative experiences of services (Stuart-Smith, 2006). These teams, which are provided at great cost, are currently under threat during recent financial change in the National Health Service (NHS) (Academy of Medical Royal Colleges, 2008) and provide interventions with little evidence as to their efficacy. Even the National Institute of Clinical Excellence (NICE) self-harm guidelines (NICE, 2004) provided by the Department of Health (DoH) are based primarily on good practice points rather than solid research. This is borne out by Leitner and Barr (2011) who state many of the common interventions, such as admission to hospital and medication, believed to prevent self-harm have no clear effective evidence base.

Self-harm is an important risk factor for completed suicide so it may well be that psychiatric assessment could reduce the likelihood of completed suicide (Hickey et al, 2001). This suggests that those who do not receive such an assessment following an episode of self-harm may be at higher risk. Historically, these assessments had been carried out by psychiatrists however, more recently, mental health nurses and social workers have been carrying out this role. There is research comparing the quality of assessment of these professions (Griffin & Bisson, 2001; Russell & Mitchell, 2000) but little comparing the outcomes. Russell and Owens (2010) compared the post assessment outcomes of 787 psychosocial assessments in the UK and found that outcomes were comparable for medics and nurses. They found a similar pattern of non-fatal repetition regardless of profession and that psychiatrists are more likely to admit to psychiatric hospital or refer to statutory services whereas nurses rely more on community follow up arrangements. They state their findings may suggest that nurse led services could be the way forward for Emergency Department services.

Boyce et al (2001) in a survey of Emergency Departments found that less than half of those admitted with an act of self-poisoning received a specialist assessment or follow-up and that those who self-discharge have a threefold risk of repetition of self-harm, in these cases the patients would only have been seen by Emergency Department staff and had no mental health input. It

is believed that only those whose lives are at risk are likely to attend the Emergency Department after self-harm (Hickey et al, 2001), therefore they represent just a proportion of people who self-harm and are at the severe end of the self-harm spectrum (Walker, 2013. See appendix B).

Of the evidence available there is more emphasis placed on the objective of reducing suicide, this may well be due to the fact that this is a target set by government (DoH, 1999., DoH, 2002) As such funding for this research into suicide has been made available. The effect of this is that self-harm has often been researched as part of the suicide prevention work that has been done and not in its own right. This is certainly the case in the study completed by Hickey et al (2001) and could be argued as being implicit in the objective of research into reducing repetition of self-harm as this is seen to be a major indicator of future suicide. As Hawton et al (1998) point out previous episodes of self-harm are the best indicator of future suicide and this is born out in Ovenstone and Kreitman (1974) who state that 40-50% of those who die by suicide have previously self-harm. Indeed it continues to be the accepted position (Neeleman, 2001. Cooper et al, 2011) that prior self-harm is seen to be the best predictor of further self-harm and also of completed suicide (Bebbington et al, 2010). The effective healthcare bulletin for self-harm (NHS Centre for reviews and dissemination, 1998. Bergen et al, 2011) points out, that in the year following self-harm the likelihood of suicide is one hundred times greater than that in the general population. This distinction is an important one for practice as one of the quality indicators used for mental health services is suicide prevention. This has caused a reduced focus in self-harm in its own right, despite it being a significant issue throughout mental health practice. This emphasis on suicide does mean self-harm, as a discrete phenomenon, remains under-researched and could mean that the current focus on risk for those who self-harm is over emphasised as the focus is on reducing suicide rather than understanding self-harm.

In 2004 the London Liaison Mental Health Nurses' Special Interest Group (LLMHNSIG) published a set of competencies in an attempt to provide a solid educational framework on which liaison teams could build. Thus creating a more standardised service model and improve practice. One of the specialist skills required, above and beyond that expected of any other mental health

practitioner, is expertise in assessment, risk assessment and risk management. They identify the broad areas of specialist knowledge and skill as follows:

Assessment

- The ability to engage and establish an empathic rapport with patients in difficult settings
- Knowledge of the different components of mental health assessments within a defined model, including risk
- Ability to undertake a comprehensive mental health assessment
- Knowledge of specific clinical risk indicators
- Ability to manage mental health risk factors following an initial risk assessment

(Hart & Eales, 2004. 5)

This instruction and the document as a whole is very vague as to the advised format of the mental health assessment and the practicalities of engaging the patient. After the competency for the assessment of risk and self-harm (Hart & Eales, 2004.13) the notes state that the nurse should be as competent in undertaking a full psychosocial mental health assessment as in assessing risk. Here the term is used without qualifying its meaning and in the rest of the document assessment is referred to as mental health assessment only. It also states that the nurse should demonstrate knowledge of approaches and therapies, plus demonstrate knowledge of models for providing the interventions in a single assessment (Hart & Eales, 2004. Pg.20). This introduces another dimension to the psychosocial assessment that is not universally upheld and demonstrates the way the term is interpreted differently.

In the 2007 Policy Implementation Guide (PIG) (Aitken, 2007) assessment is noted as a key component of the work of liaison teams. The above mentioned competency document (Hart & Eales,2004) is cited in the PIG, however, the focus is predominantly on risk assessment. The term psychosocial assessment is not used, but there is a recognition that a 'bio-psycho-social' formulation should be created after assessment that 'informs a management plan aimed at

overcoming the risks and disorders identified.' (Aitken, 2007. Pg 11). In the key component of engagement under Relationship the PIG acknowledged that:

'A prolonged interview facilitating the service user led agenda can improve engagement and is in some cases therapeutic'

(Aitken, 2007. Pg.12)

Additionally, in 2009, following years of collaboration between Liaison Services nationally, the Royal College of Psychiatrists and service users in the Better Services for People who self-harm project, an organisation called the Psychiatric Liaison Accreditation Network (PLAN) published its Quality Standards for Liaison Psychiatry Services (Royal College of Psychiatrists, 2009). These outline the ideal practical construction of a liaison team. Assessment is considered as part of these standards as follows:

- Standard 4: Mental Health Assessments take place in an appropriate and safe environment
- Standard 5: Mental health assessments are comprehensive, supportive and focus on patient needs
- Standard 6: Assessment includes consideration of issues around risk and mental capacity.

These are predominantly practical considerations apart from point 5.1 in Standard 5 (Royal College of Psychiatrists, 2009. Pg 12) which states that a consistent approach should be applied, although there is no attempt made to suggest what sort of assessment should be undertaken. Therefore we find, despite these guidance documents there is still a disparity in the quality, behaviour and construction of liaison services and the assessments that they carry out. This may mean variable experiences of services for patients nationally.

1.4.1 What are services for?

To help contextualise this work it is worth considering briefly what services are for. The answer to this question is likely to differ depending on perspective. Few would argue that a primary purpose of mental health services would be to recognise mental health need and deliver care for people with mental health

problems (Shield T et al, 2003). Pilgrim (2017), who could be considered a sociological observer of services, suggests that mental health services is a term used as a compromise label to describe services offer to, or imposed upon, people with a wide range of psychological problems. As a user of mental health services Beresford (2010) suggests that ideally services are there as a safety net, somewhere to sort out troubles and be cared for, but he suggests that very few actually experience services this way. This discrepancy between ideals/rhetoric and practice/reality is played out in multiple ways in mental healthcare. The Mental Health Taskforce (2016) and the DoH (2011) agree that mental health is as important as physical health, however it is still the case that the service is vastly underfunded compared to physical healthcare as widely reported in the mainstream news in 2016/17. Also widely reported are risk events that may occur related to someone with a current or previous mental health issue, an action that contributes to the focus on risk management in society (Laurence, 2003) as well as an explicit desire to address the national suicide rate (DoH, 1999, 2011, 2016). So whilst it may be hoped that mental health services are there to support people to recover from mental distress as idealised by Beresford (2010) above, in practice mental health services are often experienced as a form of social control with a focus on risk rather than recovery (ibid). Exploration of this subject forms an implicit theme throughout this work.

1.5 Self-Harm policy in the UK

In the UK there is much policy guidance related to suicide (NCISH, 2014. DoH, 1999. DoH, 2002. DoH, 2012), but only two policies that relate to self-harm (although they also included attempted suicide as part of their definition of self-harm so are related). In the patient version of these NICE guidelines (2004) they state that clinical guidelines are recommendations for practice, this is reiterated in the 2011 guidance with the addition that practice areas are expected to adhere to the guidelines where possible but it is recognised that due to the individual nature of care there may be times when this is not possible. With regards to the topic of this project the main area of concern that has a major impact on service provision is setting expectations.

The 2004 guidelines, were designed to cover the period 48 hours after self-harm when some will have accessed general hospital services. They state

clearly the goal of ideal treatment but there is no consideration given to the cost of the proposed changes and the effect of the lack of resource on potential availability of services. An example of this can be seen in the patient version where it clearly says if it is identified that someone is at risk of self-harm in the future they will be offered 'frequent access to a therapist and treatment at home when necessary', in practice this cannot occur due to lack of resources. This happens repeatedly throughout despite the assertion in the full guideline that cost-effectiveness has been taken into consideration, Greenhalgh (2006) points out this is a common drawback of guidelines. A guideline development group was assembled, although there was no patient presence on the group other than the head of the NICE patient involvement unit. The guideline states the qualifications of some members of the group as mental health but does not indicate if self-harm is an area of expertise. Other specialists were included on the review panel, which does not include a patient representative. As one of the stated aims of the guideline is to improve the experience of patients, it would seem pertinent to have involved a patient representative.

According to the guideline appendix outlining the type of evidence supporting it, Good Practice Points (GPP) are in the majority indicating that good quality evidence from more suitable sources, such as empirical research, was not available. GPPs are formed from expert opinion, consensus and experience of those on the development group. As Murphy et al (1998) point out, although in an ideal world all guidelines would be produced according to strictly controlled research, in practice there is often a lack of research based evidence. They go on to assert that consensus development methods are therefore needed in order to ensure that a wide range of experience is drawn on in forming the guidelines, although they also admit that the possibility of capturing collective ignorance is a risk. Although there is no reference in the guideline to a literature search and no citations are given, the full guideline shows that there was an extensive search and references are provided. The guideline is clinically relevant, comprehensive and flexible to a degree but it is very idealistic in that no account is taken of resource issues. This creates unrealistic expectations with regard to what the patient can expect from services making patients, the service and the professionals who work for it, vulnerable.

The most pertinent points for the purposes of this project from the guidelines are now considered. The 2004 guidance very clearly states that all patients should be offered a full psychosocial assessment following self-harm, it calls for advanced communication skills from the professionals providing care and states that patient experiences of care are often unsatisfactory. Other areas of note are that it suggests the use of patient narrative as being useful in assessment and promotes the inclusion of patients in decision making and the importance of individualised care. At the review dates (2006 & 2011) very little was changed but as the second review coincided with the advent of the longer term management guidance many of the proposed changes were incorporated into this document and users of the 2004 guidance directed there. This is cumbersome in practice and likely to reduce the effective implementation of the guideline. The 2011 guidance is designed to cover the longer-term management of self-harm and, as such, is less relevant to this project however it still covers issues of patient experience and it is interesting to compare how the quality of the guideline differs to that of the 2004 one.

The 2011 guideline is notably more engaged with patient involvement, several personal accounts are included in the guideline and there was a significant patient presence on the guideline development group. The clarity with which the supporting literature has been scrutinised is also helpful, allowing practitioners to make better decisions regarding the quality of the document. Where research does not exist currently this is stated and the rise of qualitative research as being considered valid is also notable in this document. Much of the guidance remains unchanged with regards to psychosocial assessment from the 2004 guidance although, here the guideline does not recommend the use of a standardised risk assessment tool which differs from and supersedes the 2004 guidance. The information about professional attitudes to people who self-harm and users' experience of services has not been updated however and again, reflects the dearth of new research carried out into this area. With regards to expectations there is still the asserted notion that patients will be able to access therapies, including intense interventions with a therapist immediately following self-harm which remains unrealistic in the context of modern mental healthcare and in 2013 when the guideline was revisited again it was removed. So whilst the guideline can serve a useful purpose in providing

something to aim for, if patients read them routinely it could set unrealistic expectations of service provision.

1.6 Personal History and Role

I have been a practising Mental Health nurse since qualifying in 1989, apart from a two year gap from 1993. Self-harm is a behaviour that I have witnessed in all fields of practice throughout my career. These include older person's mental health; acquired brain injury; adult acute; substance misuse; forensic services and liaison psychiatry. From 2003 to 2009 I worked as Senior Nurse of a Mental Health Liaison Team in a busy acute hospital's Emergency Department. On a day to day basis we carried out specialist mental health assessments for people coming through the department with various mental health problems but predominantly self-harm. I was involved with implementing the NICE (2004) guidelines for self-harm to the hospital. I was part of the team that helped with the development of the Better Services for People who Self-harm Project, a service development project hosted by the Royal College of Psychiatrists. Following these years I became Modern Matron for rehabilitation services, one of the units I was responsible for was a forensic unit where self-harm is common.

In 1993 I had a serious episode of mental distress following the birth of my second son and became a patient of mental health services at this time. During this period I was diagnosed with both post-natal depression and borderline personality disorder (now commonly called emotionally unstable personality disorder). The first diagnosis appeared to be logical and the three main episodes of mental distress in my life have occurred following childbirth. However the second diagnosis I did not support and refused to engage with mental health services from that point forward and was discharged by default. Whilst I did meet the criteria for the second diagnosis, including using self-harm as a coping strategy, I did not and do not support the use of this label due to the nature of negative stereotyping that accompanies it (in the 1990s it was often called the 'dustbin diagnosis') and the fact that the majority of people given the label have experienced abuse, invalidation and/or trauma as children. Whilst I acknowledge that some find receiving the diagnosis helpful in terms of accessing services in more recent years, it still represents a way of blaming the individual for behaviour that is often a direct result of previous

experience over which they may well have had no control. Recent moves to re-term the diagnosis as Post Traumatic Stress Disorder are more positive. I felt that my behaviour was logical in view of the circumstance I was in and refused to support the position of mental health services. I did not realise it at the time but this was an extremely risky route to take, especially in view of having three children under five years old at the time. In 1995 when I felt I was sufficiently recovered I had to convince a psychiatrist that I was 'safe' to work with others with mental health issues again so that I could return to nursing having been sacked in 1994 for being mentally unwell.

From these years I developed not only a serious interest in self-harm but also a desire to ensure that services were offering the best, evidence based care and assistance for people who self-harm. During my time as modern matron I was increasingly being expected to carry out tasks that were at odds with my values, particularly with regards to patient care such as forced treatments and enforce restrictions set by the Ministry of Justice that were ethically unsound. Patient centred care was a challenge to foster in my staff, particularly the medical team. In order to maintain my own integrity I co-developed a community organisation which was (and is) predominantly influenced by those with lived experience of mental distress. This organisation, The Good Mental Health Cooperative (www.goodmentalhealth.org.uk) originally focused on ways to improve perceptions towards people with mental health issues and more latterly has moved into community wellbeing. It was against this background and from this interest and desire to improve service provision for patients that this project has developed.

1.7 Operational Definitions and Terminology

The language used within services matters. The literature that inform services is replete with terms that are used interchangeably and have different meanings for different people. The subjective nature of this landscape suggests that emphasis on language and definition of terms should be carried out regularly in research and in practice. In order to reduce the risk of misunderstanding within this thesis clarification of terms is required.

1.7.1 Patient or Service User?

Taking the following arguments into account and considering my own time as a user of mental health services I have decided to use the term 'patient' throughout this work as it is more general in nature and points to the fact that we can all become ill without creating additional stigma. Bradstreet (2013), in responding to the Royal College of Psychiatry's decision to reclaim the term patient (Christmas 2013), states that any term which defines the person by their use of services is likely to be problematic. In mental healthcare the most commonly used term for people who use services is 'service user', however there are many critics of this term (Simmons et al, 2010. Deber et al, 2005. McGuire-Snieckus et al, 2003). Bradstreet (2013) agrees there are problems with the terms, 'service user' and 'patient', as they run the risk of encouraging exclusion and hindering recovery. Christmas (2013) makes the point that by seeking liberation from the paternalistically viewed 'patient', the term 'service user' has created a group of people who are defined primarily by the presence of mental ill health, thereby creating the means by which they may be further excluded. Another term often used in practice is 'client', Ritchie et al (2000) examined this term and discovered it was universally disliked and the term patient was preferred by those who used services. They hypothesise that the term client was so disliked due to the suggestion of a business arrangement and the lack of compassion and caring indicated by the word (ibid). Thus, whilst 'patient' is agreed by all parties to be far from an ideal term, it is a generally applied term which does not further marginalise any group. Baker et al (2008) assert that the term 'service user' has been co-opted by services in claims that they have 'consulted service users' to justify any action deemed necessary eg. closure of services and as such has lost any semblance of empowerment that it may once have held. Thus patient is the predominant word of choice in this thesis but when referring to research papers the text will reflect the terminology used by the respective authors so some of these terms will be used interchangeably.

1.7.2 Definition of Self-Harm

NICE (2004) define Self-Harm as

Chapter 1

'Self-poisoning or injury, irrespective of the apparent purpose of the act. Self-harm is an expression of personal distress, not an illness, and there are many varied reasons for a person to harm him or herself.'

(Para 1, 7. National Institute of Clinical Excellence, 2004)

Expression of personal distress is not the only possible explanation or function of self-harm, other functions such as taking control and ending dissociative states have been cited by service users (Pembroke, 2007). The definition does acknowledge this by saying there are many varied reasons for a person to self-harm suggesting that the apparent purpose of the act is indeed important. To say it is not an illness could be seen as correct overall as it does not exist as a discrete condition, but it can be a symptom of and driven solely by an episode of psychosis. It could also have implications for funding of services if not categorised in any way as an illness, as current service provision is built around diagnosis. In today's financial climate, suggesting self-harm is not an illness may indicate that it is believed that no medical treatment or service is required therefore money can be diverted away from these areas into other more 'deserving' areas (Laurance, 2003). This 2004 definition appears to be an attempt to move thinking away from the act of self-harm to the reasoning behind it.

In 2011 NICE (NICE, 2011) published it's guidelines on longer-term management of self-harm and defined self-harm further stating:

'The term self-harm is used in this guideline to refer to any act of self-poisoning or self-injury carried out by an individual irrespective of motivation.'

(Pg 4. National Institute of Clinical Excellence, 2011)

This definition is very similar to the one used in the 2004 guidelines above however, they go on to say that the motivation for self-harm is often unclear and the reason a person harms themselves may be different each time (NICE, 2011).

Favazza, an influential American writer and psychiatrist, wrote an early psychiatry book on self-harm which dispelled many of the myths about it and provided a wider cultural view of the subject including the functions of self-harm. Favazza (1992) uses the term self-mutilation rather than self-harm and

incorporates a multitude of self-harming behaviour that is considered to be artistic and increasingly acceptable as self-expression. His definition states:

'the deliberate destruction or alteration of one's body tissue without conscious suicidal intent'

(pg. xviii, Favazza, 1992)

The phrase 'without suicidal intent' is unsatisfactory as there are a number of people who come to the attention of services via the emergency department who do have suicidal intent at the time of their self-harm (Maddock et al, 2010). His definition also talks of alteration or destruction of body tissue which rules out overdose as a form of self-harm.

It is my assertion that intention is key to deciding whether any act can be considered self-harm or not (Walker, 2013. Fairbairn,1995). McAllister et al (2002) defined self-harm as 'intentional damage without a conscious intent to die' which is an improvement although this again limits the field to those who are not suicidal at the time of self-harm. Richardson (2004) gives a short definition 'deliberately inflicting injury on oneself'. This avoids any judgement being made about outcome or intent beyond the word 'deliberate'. It could be argued that there are a group of people who indulge in risky behaviour which can be life threatening without a care for the outcome. These people are most likely to come to hospital with 'accidental' injury even though if one were to delve a bit deeper into their reasoning it may become clear that they have more in common than is first apparent with people who self-harm deliberately. It is often difficult to differentiate between self-harm with suicidal intent and self-harm for other purposes, a problem that is reflected in UK policy. My own broad definition for self-harm, formed as part of the thinking for this project was: 'Any act intended to cause physical harm to the self' (Walker, 2013 see appendix A) which, upon publication, I was almost immediately unhappy with and revised it to 'any act intended to cause harm to the self'. In recognition of the fact that self-harm can cause harm to both the physical and the psychological self. However, my explorations into the field of broad definitions led me to the conclusion that it is not possible to define self-harm broadly in any meaningful way and that useful definition is only really possible in the context of the individual having considered both the meaning and function of the self-harm for that person.

For the purposes of this research the definition provided by NICE (2011) will be used 'any act of self-poisoning or self-injury carried out by an individual irrespective of motivation'**.**

Although imperfect, this definition allows for both those who self-harm as a coping mechanism and those who may have suicidal intention at the time of the act. There is much written about the link between suicide and self-harm but there is still much confusion and some controversy about this link. self-harm is one of the most reliable predictors of completed suicide (Hawton et al, 1998. Coyle, 2001. Skegg, 2005.) therefore in the light of the research done in order to try and reduce the suicide rate (DoH, 2002), there has been an increase in attention toward self-harm. The gender ratio for self-harm now most commonly quoted is 1.5:1 female to male ratio (Claassen et al, 2006) although a decrease in this ratio has been noted in the UK (Hawton& Harriss, 2008) and the ratio varies at different points in the lifecycle.

1.7.3 What is Self-Harm?

Self-Harm can take many forms from more socially acceptable forms of destructive behaviour such as smoking or excessive overwork, to more extreme and less socially accepted forms of harm such as jumping off a high bridge or overdosing. Self-harm behaviours can be categorised in several ways, for example: lethality or social acceptability. Much behaviour, classified as acceptable in one cultural circumstance, would be unacceptable and seen as self-harm in another. To illustrate, someone who ties ligatures for the purpose of auto-erotic asphyxiation in a sexual encounter would be unlikely to be seen as someone who self-harms, whereas someone who ties ligatures in an effort to starve themselves of oxygen and die in response to distressing circumstance would. So we see that culture and context matter. In an effort to clarify my thinking about this subject I created the self-harm spectrum (appendix B) diagram and used intent as the key factor to help professionals, decide which acts demand intervention and which could be deemed to be within socially acceptable bounds due to context and cultural norms. This is a grey area, there are often times when people are ambiguous about the harm they may do themselves and although they may not be clearly suicidal there may be a laissez-faire approach to life evident. The only way we can discover this intent is by talking to the individual concerned and asking them what they intended

by their actions. The intent behind an action or behaviour indicates the function of it.

In mental health services self-harm behaviours that are most commonly seen are cutting, overdose and attempted hanging. These acts are usually accompanied by mental distress and the involvement of services is therefore deemed necessary. It is worth noting that research indicates that self-harm is prevalent in the general population, with much of it not needing medical attention and as such it remains a poorly understood phenomenon in the community (Hawton et al, 2002). Norman and Ryrie (2009) provide a useful, although not exhaustive, list of possible ways people self-harm.

Breaks the skin and causes bleeding	More violent methods of self harm	Self harm with internal/medical effects
Cutting with knives	Pinching hard enough to cause bruises	Medication abuse (overdose)
Excessive scratching	Head banging against a wall	Ingesting small amounts of toxic substances
Excessive nail biting	Hitting head with fists	Deliberate ingestion of certain foods to cause a know allergic reaction
Burning skin with caustic liquids	Punching windows or walls	Interfering with current wounds to reduce healing
Using heat to burn skin	Bone breaking	Insertion of foreign objects
Friction burns – using abrasives	Jumping from heights without suicidal ideation	Binge eating or starvation

Table 1 (Norman & Ryrie, 2009)

1.7.4 Why People Self-Harm

Self-harm is a complex behaviour that people engage in for very personal and individual reasons (Baker et al, 2013), so despite much research exploring this topic there is still no definitive answer. There are clear links between childhood adversity and self-harm, Digby & Tantum (2009) list several factors that have been shown to influence self-harm such as abuse or trauma, witnessing domestic violence, parental neglect and bullying at school. It is important to note that adversity in later life for example: rape or combat experience can also lead to self-harm (ibid). Disadvantage such as poverty, is another factor linked to self-harm, social and financial hardship in particular is linked to self-

harm in men, but it should be noted that self-harm is not restricted to the disadvantaged groups and affects other social groups too (ibid). Mood disorders can influence self-harm, in particular depression, as can stigma and social rejection (Hawton et al, 2006). Another mental health issue that has clear links to self-harm is dissociation, alongside substance misuse and eating disorders (ibid). With each individual who self-harms it is important to ascertain from them why they harmed themselves on that occasion, in recognition that the reason why someone self-harms can be different on each occasion even if they regularly self-harm.

1.7.5 Functions of Self-Harm

Babiker and Arnold (1997), still considered a key text on self-harm, suggest five categories into which the functions of self-harm can be largely placed:

- Functions concerned with coping and surviving – such as regulation of distress and anxiety; dealing with anger; distraction: focusing pain to make it more manageable
- Functions concerning the self – such as increasing one's sense of autonomy and control: feeling reality: creating an opportunity for self-nurture
- Functions concerned with dealing with one's experience – such as demonstration or expression to oneself of your own experience: re-enactment
- Functions concerned with self-punishment and sacrifice – such as self-punishment: cleansing and excising: punishing the abuser: dealing with confusion about sexual feelings
- Functions concerning relationships with others – such as communication: punishing others: influencing other's behaviour

(Babiker and Arnold, 1997)

Again, the only way to understand the function of self-harm for that person is to communicate with them and strive to understand their world and the process behind the behaviour, so it is essential that mental health practitioners maintain a respectful curiosity at all times when dealing with people who self-harm and avoid making assumptions.

1.7.6 Self-Harm and Suicide

Skegg (2005) notes that historically people who self-harm used to be regarded as 'failed suicides' and it has taken healthcare policies some time to realise that this is very often not the case. She also states that self-harm is a behaviour, not an illness and the management of it is very dependent on the underlying problems. Conteiro and Lader, (1998) are of the opinion that self-harm is distinct from suicidal behaviour in that the aim is to 'sustain life' not to end it. Smith (2005) states that self-harm is widely misunderstood and many professionals confuse the issues of suicide and self-harm. He believes that the two are best seen as separate entities as a person could self-harm for one reason whilst being suicidal for another. In his risk assessment Smith (2005) considers five domains to help practitioners make a judgement on risk and safety for people who have self-harm, these domains are:

- Intent; what outcome was the person expecting at the time the self-harm occurred?
- Directness; were the person's life experiences and emotions directly linked to the current self-harm?
- Potential lethality; what form did the self-harm take, how life threatening was it?
- Control and distress; was this self-harm impulsive or planned and what are the current levels of distress?
- Repetitiveness; how frequent are the rates of self-harm?

Smith (2005) continues to assert that being unclear or ambivalent about intent is not a direct wish to die and therefore the person is not suicidal, he later goes on to contradict himself when discussing the intent domain of his risk assessment tool by saying people who are clear that they intended to stay alive would get a low score whereas people who are ambiguous, unclear or have the possible intent to die would score higher. Studies sugges that 1% of the patients presenting to general hospitals in the UK with self-harm kill themselves within a year of the act and states that improving outcomes for self-harm is important in order to reduce this risk (Hawton et al, 1998. Bebbington et al, 2010). McCann et al (2006) echo this point reinforcing the need for patients who self-harm to have an adequate assessment when they present to Emergency Departments. What is clear is that self-harm is a complex

behaviour and has varying purpose depending on the individual (Motz, 2001) and although self-harm can be separate and unrelated to suicide the boundaries are very blurred (Newham Asian Women's Project, 2007). It is important, in practice, that the differentiation between self-harm and suicide is understood for each individual, self-harm as a coping mechanism is very different to self-harm as a suicidal act.

1.7.7 Definition of Psychosocial Assessment

Engel (1989) in suggesting a new medical model, outlines his vision for a bio-psychosocial model wherein the psychological and social aspects of a persons experience are considered alongside the biological aspects normally considered by the medical model. This model gained some standing in healthcare particularly in mental health where the disease model is found to be less helpful and the variables considered as psychosocial are more important determinants of susceptibility, severity, and course of illness than had been previously appreciated by those who maintain a biomedical view of illness (Borrell-Carrió et al, 2004). Over time this phrase, in mental healthcare, as seen in multiple policy documents (see below) has been shortened to psychosocial with the original meaning of biopsychosocial being retained. This may be partially explained by the continued dualistic nature of care provision, ie. Mental vs physical healthcare. Therefore in this work the term used within the policies pertinent to this work has been retained (psychosocial) but with a proviso that the biological element is still an important factor in the holistic nature of human being and will therefore still play a key role. In practice, when undertaking a psychosocial assessment in mental healthcare the biological aspects of the person's life are also considered in terms of physical health, family health history and, depending on context, physical health test results.

In the NICE guidelines (2004, point 1.7) psychosocial assessment is not clearly defined but states that all who have self-harmed should have a 'comprehensive assessment of needs and risk.' This information gathering exercise, which does not appear to be treatment focussed but purely for the purposes of assessment, is demanded by the mental health service, indeed by the guidance prescribed by the Department of Health via NICE (NICE 2004 & 2011). Therefore practitioners have to create a situation with the patient whereby this, often very personal and private, information can be gathered whilst at the

same time providing an opportunity for that individual to look at options for next steps. Psychosocial assessment is a term widely used in UK mental health practice to cover a 'range of activities undertaken by services and clinicians, in collaboration with families and carers that aim to improve the social functioning of people with serious mental health problems.'(Baguley and Baguley, 1999). It is a concept used extensively throughout nursing and social services research articles and guidance without any clear definition (eg. Hawton et al 2002: Haw et al 2003: Ebbage et al 1994 and Dennis et al 2001) but appears to be an umbrella term used to describe an information gathering exercise which may or may not have therapeutic intention. It has become a reified abstraction in the literature relating to practice, representing different procedures and actions depending on clinical area.

This loose and unstandardised interpretation appears to have some connection to psychosocial studies in the social sciences, whereby the term is more fully explored in terms of theory and method. The individual is assessed/understood in terms of their internal, psychological and familial position and their external, social and cultural position (Brown 2009). The three dimensions of self and how the world is viewed and experienced by the individual, the wider social, historical and cultural context in which an individual operates and the overlap between them. The psychosocial assessment takes into consideration both the person's interpretation and experience of the situation they are in, the environmental, historical and cultural perspectives and their interactions (see fig 1).

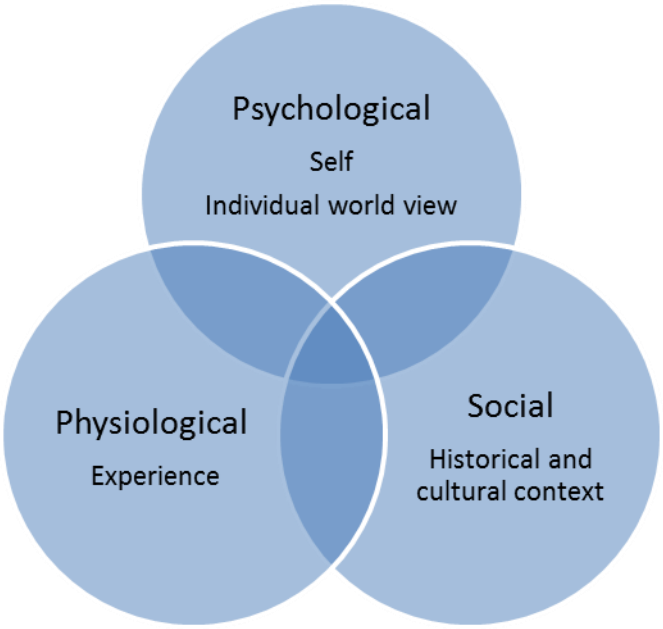


Fig. 1. Psychosocial Assessment (inspired by Brown, 2009)

For the purposes of this research the term psychosocial assessment can therefore be defined as:-

An assessment of the person which is intended to be therapeutic in nature. It includes an assessment of physiological, social and psychological factors and considers how these intersect in order to help the patient to see their difficulties more clearly and begin to find solutions in order to move forward and out of crisis. This assessment gathers information regarding:

- Current situation, how the patient arrived at the crisis
- History leading up to the crisis
- Mental state
- Physical health
- Substance use
- Medication
- Social situation including employment status
- Family history
- Children
- Forensic history
- Previous mental health history
- Strengths
- Previous abuse
- Housing
- Risk to self both intentional and unintentional
- Risk to others and from others.

(List created in practice as aide memoir c1995)

Once this information is gathered it should be used to create an action plan with the patient designed to assist the patient in moving forward in a way that minimises the likelihood of repeated self-harm or suicide (Aitken, 2007). Psychosocial assessments are carried out at various times in the journey of a patient through mental health services but for the purposes of this research the focus is on the psychosocial assessment that takes place in the general hospital following self-harm.

1.7.7.1 Patient view of psychosocial assessment

Patient reports vary as to the experience they receive during an assessment but Taylor et al, (2009), recommend that more research evaluating the impact of the psychosocial assessment and patients' experiences of this are required. McHale and Felton (2010) conclude that there are clear discrepancies in the views of practitioners and patients of what constitutes a positive and negative attitude towards perceptions of care that needs to be addressed. Patients continue to be dissatisfied with services whilst services often believe that the care being provided is good. Tate (2010), in her article describing one experience in the Emergency Department after she had injured herself, states that she had become used to Emergency Department staff 'getting it wrong'. The fact that they had done a good job on that occasion would stay with her for a long time. Examples of how staff can get it wrong include being judgemental, treating patients as time wasters, staff making assumptions and inappropriately demanding to see wounds (Tate, 2010a). Pembroke (2009) cites responses of staff as being frequently hostile and angry and states that being given choice over treatment and decision making is essential for patients following self-harm.

1.7.7.2 Clinician View of Psychosocial Assessment

Redley (2010) undertook a qualitative study of 26 mental health clinicians who had contact with patients who had overdosed, to consider how they made sense of their patients' overdoses. He found that clinicians constructed a 'normal' model of self-harm for more socially deprived patients which was seen to be understandable in light of the hardship they must endure, but that this did not apply to more well off patients who were viewed as having less hardship. The staff studied, viewed suicidal acts as ultimately mysterious and unknowable and they tried to avoid engaging with 'why' the self-harm had

taken place as opposed to any other strategy. This professional distance, Redley (2010) hypothesises, may be an essential requirement for the emotional and psychological safety of the clinician. He points out that this 'point of view' may silence the patient and this certainly raises the issue of staff attitude having a potentially detrimental effect on the patients experience of the assessment. Maddock et al (2010) discovered that depressive motives for self-harm were viewed more sympathetically by both nurses and doctors than perceived 'manipulative' motives in their study looking at suicidal and non-suicidal self-harm in patients with borderline personality disorder. Mackay and Barrowclough (2005) whilst exploring perceptions of Emergency Department staff towards people who self-harm, found that if staff felt that the patients self-harm was triggered by a factor they felt was controllable in some way eg. substance misuse, they were more likely to be irritated and frustrated with the patient and less likely to be optimistic and helpful. In both studies the cohort that self-harmed for coping purposes were considered alongside those with suicidal intent, a position widely adopted in the literature. There is often no delineation between those who self-harm as a coping strategy, ie to remain alive, and those who intend to die. A focus on self-harm rather than views of assessment is necessary here as clearly, the attitude to the self-harm affects the assessment.

In considering this complex arena where terminology and attitude is confused and lacks standardised interpretation it is clear that more research is required to begin to illuminate the issue and provide additional information to guide practice and thinking on the subject. The most notable voice missing from the current research literature is that of the patient themselves.

1.8 Research Question

The research question is:

How do patients who have self-harmed, experience contact with mental health services in a general hospital?

The final research question was formed from considering the discussion above; a more in-depth literature review (Chapter 3); and a patient consultation event

which was held to gauge the reaction of a group of people who had used these services in previous years to check the real world value of the proposed project. This is discussed in chapter 2.

Chapter 2 Patient Consultation

2.1 Introduction

This chapter reports on the first of two patient consultations that were carried out at the beginning and end of the study. The first consultation considered the study design, the second (which is reported at the end of chapter 6) considered the findings and dissemination strategy. The process and influence of both consultations is reported and then the consultation is discussed in the light of three current concepts in mental health, experts by experience, shared decision making and co-production.

Patient involvement is increasingly recognised as being central to health and social care policy and practice (DoH, 2005), education (Tew et al, 2004) and research (Leiber 2010). Grant and Ramcharan (2006) agree that service user involvement is now firmly embedded with the NHS service delivery and research and development policy. Wallcraft (1998) points out that historically, mental health research has mainly ignored the views of the recipients of care and points out that the service user's subjective experience is often transformed into some kind of quantitative measure of observed behaviour. This is supported by Tew et al (2004) who state that service users have invaluable insights to offer into both the conditions they are diagnosed with and their experience of using services. Furthermore, Involve (2004) assert that service users offer different perspectives and priorities which can enhance the validity of the research and that they are often empowered by taking part in the process. Beresford (2005 pg 7) defines a service user as a person who is 'on the receiving end or eligible to receive health and social care services.' Trivedi and Wykes (2002) state that involving service users shaped their thinking with regards to measurable outcomes and aims of the research due to the broader perspective introduced. This is echoed by Faulkner and Thomas (2002) who state that research undertaken with service users results in issues being examined and outcomes seen that are more meaningful to service users.

Leiber (2010) states that it is essential to involve the service user as early as possible in the design and planning of research as they can have a real impact on the direction of the research and ensure that it remains valid from a service

user perspective. There are differing levels of involvement; Grant and Ramcharan (2006) suggest three.

1. Consultation – In this, rather more traditional level of involvement, service users may be asked about the research idea in general terms or involved in it as participants but have no further active role.

2. Collaboration – This is more participatory level whereby services users are more involved with aspects of research such as design, recruitment of participants, collection of data and so on.

3. User Control – This emancipatory level sees the service users having control over the research, from conception to dissemination.

As this is a PhD project it was not possible, in this case, to consider level 3, however levels 1 and 2 were considered more possible, and indeed essential, to the real world value of the project. In view of this and the discussion above, as part of the research design, a service user consultation was carried out. Via an email to the head of the local regional ethics committee it was ascertained, prior to this event, that ethical approval was not required to carry out this consultation (appendix C)

2.2 Consultation 1

2.2.1 Process and Aims

The service users were comprised of eight current and ex-patients (two male and six female) all of whom had experience of self-harm and psychosocial assessment whilst in the Emergency Department. Volunteers for the consultation were recruited via the local Service User Involvement Worker for a local trust. This was done via regular service user meetings for example; MIND group and via posters, email and word of mouth. In addition I attended a regular breakfast meeting to outline the event in person to those attending. The reason for the consultation was:

- To explore whether the research question was valid and worth asking
- To ascertain what questions they felt were important to ask the participants

- To ascertain what outcomes they would like to see from the research
- To gather volunteers to be part of a steering group to advise the project
- To recruit volunteers to help with writing articles at the completion of the research for publication

It was hoped that this consultation would explore if the group felt the research idea was valid from their perspective. Did they think it was likely to add valuable information to what is already known and ultimately contribute to an improvement in services over time? The research idea was presented to them via a short PowerPoint presentation during which they were invited to interrupt and ask questions at any point. Tea and coffee were provided and the atmosphere was informal throughout. The meeting took place in a local community centre in a room regularly used for service user events. In this setting an informal discussion regarding the research and their experiences took place. The opportunity to respond via suggestion slips and email was also an option in case anyone was unhappy to speak in a group, in the event this was not required.

The short PowerPoint presentation shared the proposed research question; the study outline as seen at this time; the potential outcomes; the requests being made of the volunteers and the researcher contact details to enable further communication should it be required.

Some questions had been prepared to stimulate discussion: 'What does psychosocial assessment mean to you?' and 'What should I ask the research participants?' both of which generated some interesting and unexpected responses.

2.2.1.1 Initial Research Question

Prior to the consultation the research question was as follows:

> How do adult service users, admitted following self-harm, and clinicians experience the psychosocial assessment in a general hospital setting?

2.2.2 Outcomes

As previously mentioned (1.4.2), the term psychosocial assessment is a concept used extensively throughout nursing and social services research articles and guidance without any clear definition (NICE, 2004, Hawton et al 2002: Haw et al 2003: Ebbage et al 1994 and Dennis et al 2001), it appears to be an umbrella term used to describe an information gathering exercise which may or may not have therapeutic intention. As part of this process the term was explored since the intention was to include it in the question schedule.

2.2.2.1 'What does Psychosocial assessment mean to you?'

One of the main findings of the patient consultation was that the term 'psychosocial assessment' meant nothing and required explanation before any further conversation could usefully continue. This is in line with Hunter et al (2013) findings who state that patients did not know what the term meant. On exploring this further, it emerged that the word 'psychosocial' was dismissed as meaningless. The group had no preconceptions of what this was therefore did not have any strong feelings. They asked for an explanation of the term and in discussing this it became clear that the processes they had experienced as having been labelled 'psychosocial' were very different depending on where they had been seen. This concurs with the evidence that services have interpreted the process of psychosocial assessment differently and in practice the delivery of this assessment can vary considerably in comprehensiveness according to the service (Stuart-Smith, 2006).

The most surprising outcome of the consultation was discovering that the term 'assessment', in contrast to the dismissal of the word psychosocial, had many different and complex meanings for the group. The general consensus was that the term assessed means being judged with regard to whether the person is 'good enough', 'mad', 'needing hospital', or being 'tested'. The word was universally disliked but no one could think of a better word to use. One attendee, who self-identified as a perfectionist, stated that the assessment was seen as a test to be passed, therefore all questions in the assessment were answered in the way it was believed the assessor wanted them to be. If the patient had decided on a criteria that they believed would enable them to pass eg. to be discharged would represent a success, then the questions were answered in such a way as to ensure that this outcome was forthcoming. There

was a sense of them having to choose what they said to avoid certain outcomes although they acknowledged that this would then affect the care they subsequently received. This meant that some did not get the help they needed and others received help they did not really need. Balancing being 'ill enough' to be offered some help but not so ill that hospital admission was expected when this was not felt necessary by the individual. This group were of the general opinion that the assessment is primarily service driven and has little to do with service user need. If this was reflected during the interview process it would damage the participant perspective of the research, as having to explain and clarify terms would inform participant views and potentially influence their perspective. Therefore the term 'psychosocial assessment' was removed from the question and participant information paperwork.

2.2.2.2 Question Adaptation

The development of an appropriate question is key to the success of the thesis as it introduces constraints and provides key terms which can be used later during analysis (Titler & Adams, 2010). In light of the response to the first question above it was now considered counterproductive to have the term 'psychosocial assessment' present in the question hence its removal as stated above. Additionally it was considered by the group, and borne out by subsequent literature searches (McAllister et al, 2002, Mackay & Barrowclough, 2005, McCann et al, 2006, McHale & Felton, 2010.), that the views of practitioners were often sought and therefore there was little reason to repeat this. There may be pragmatic reasons for this as the staff group are easier to access for research purposes and there are less issues with researching sensitive topics as the staff would probably not be assumed to be in crisis. Staff attitude towards people who self-harm, in particular is considered (see Chapter 3.7.3). The group could see no valid reason for inclusion of staff perspectives in this research but clearly stated that they felt that the views of service users in crisis were vastly under-represented. A view supported by Beresford (2010) and Shaw (2013). In light of this the question was changed:

How do people who have self-harmed, experience contact with mental health services in the general hospital?

2.2.2.3 'What should I ask the research participants?'

In addition to being asked to consider the possible usefulness of the research, the group were asked to consider questions they thought it would be pertinent to ask of the research participants. During this discussion several points were raised, the importance of good communication and the relationship between practitioner and patient were discussed in some detail. The group felt it was essential that the practitioner endeavoured to see the situation from the patients' perspective and stated that the process of assessment was transactional, sometimes leading to dysfunctional communication in order to secure the care required. The group stated that they were often looking for an inspirational interaction, one that inspired hope and recovery, and that this could be enough to provide them with the hope they needed to carry on after a crisis.

Cleary et al (2013), in discussing role models in mental health nursing, state that providing inspiration by behaving professionally, responsibly and confidently is part of a mental health nurses role and whilst that article is concentrating on the issue of inspiring junior professionals it would be feasible to suggest that this same effect could be part of the nurses relationship with the patient. Catalino et al (2011) remind us of the importance of engaging in spiritual activity in mental health as it increases positive emotions thus the inspirational aspects of a therapeutic relationship could promote this, particularly in terms of 'hope', one of the main themes salient in considering the issue of recovery in mental health (Jacobson & Curtis, 2000). Perhaps then, the inspirational element in the relationship could be that of helping the patient find hope in the future.

Timing of assessment and increasing pressures on staff was something the group were very conversant with. They acknowledged that staff are often working in imperfect circumstances and that this can affect their demeanour during the assessment process. In order to combat this, the group felt that honesty was the best policy, acknowledging difficulties and not promising resources that are not available. They described the experience of assessment as often invalidating, particularly if the assessor is unable to stop their own values impacting on the outcome of the assessment and they felt that it was important that questions were framed positively. One question they suggested

was 'Would you seek help here again?' and this was added to the question schedule as a prompt to use if the participant was struggling to create narrative without prompting.

2.2.2.4 Methodological Considerations

From the discussions above it became clear that the group felt the need for the issue of patient perspective during assessment by mental health services in the general hospital to be of paramount importance. This position is echoed throughout policy literature nationally (DoH, 2001 & 2005) in all aspects of mental health recovery, service delivery and research. At the stage of the consultation the research methodology (further discussed in chapter 4) had not been decided, but this emphasis on the perspective and experience of the individual was instrumental in the decision to use Interpretative Phenomenological Analysis (IPA) as the framework for this PhD project.

Smith et al (2009) state a founding principal of phenomenological inquiry is that an experience should be looked at from the perspective of the way it occurs and on its own terms. As this PhD project focuses on the person's experience of talking to a mental health professional, where some form of therapeutic alliance is likely to occur, this suggests that the IPA approach is suitable. Group members were clear that each person views the world from their own perspective and so judges others experiences, and could come to conclusions that would be valid for them but not valid for others. This happens in a reciprocal way in the assessment process. However, the group pointed out that the clinician has a responsibility, in an assessment scenario, to 'enter into' the world of the patient so as to be able to assist them in finding solutions that would be valid for the patient. They described this as a highly validating experience in line with Barker (2004). This description of the ideal assessment scenario is echoed by the principles of IPA (see Chapter 4) and as such this methodological paradigm was adopted.

2.2.3 Summary

A summary of issues that demonstrate the impact of this consultation on this proposed research are as follows:

1. Influenced the methodology – Interpretive Phenomenological Analysis (IPA) – this was guided by the desire to see the situation from the service user perspective, a decision that was clarified by the consultation

2. The original intention to include clinician's views was reconsidered, as this is not in keeping with 1 above and much work has already been done regarding staff attitudes and views.

3. The question was reformulated

4. Steering group volunteers secured – the intention was to run this every 4 months during the 2 year data collection and analysis period. In the event this was unrealistic as several of the group members moved out of contact and these did not occur.

5. Interest was expressed in assisting to write up and disseminate research findings once data analysis complete. This is expected to occur shortly after completion of the PhD thesis and VIVA.

6. The group gave full support for the research aims and objectives, seeing it as a very valid and necessary piece of work.

7. The question schedule was influenced by the suggestions made by the group and this was further refined to one grand tour question (Smith et al, 2009) with additional prompts to assist those who are uncomfortable with unprompted narrative.

A brief report of this first consultation is in press in the Journal of Nursing Research at time of writing (appendix D).

2.3 Experts by Experience, Shared Decision Making and Co-production

Greater involvement by service users has been demanded since the late 1960s, however application of this across healthcare has been inconsistent (Weinstein, 2010). Indeed Lathlean et al (2006) found that organisations stated a commitment to service user involvement, but service users themselves continued to report not being listened to. The term 'Experts by Experience' (EBE) has grown in popularity in recent years in an attempt to raise the status

of those experiencing illness to a more equal footing with professionals and to recognise the fact that they have essential information about their bodies and social situation which the healthcare professional should take note of (Mclaughlin, 2009). In a discussion considering if EBE could ever gain positions of real power, Clewes (2014) found that placing EBE in key positions is rare and that power location is restricted by means of techniques such as withholding resources (money for payment) and is still routine. Clewes (2014) defines the EBE as someone who has lived experience of health problems but has also gained the skills and training required to fulfil wider roles in mental healthcare, he states that they have high levels of commitment, understanding, resilience and know what is important and needed for those receiving care. Starcevic (2015), in a letter reacting to advice from the Australian Health Ministers' Advisory Council, is critical of the term EBE as mental health terminology and states that it is unusual for experts to seek help to manage the health condition they are expert in and that they are still subject to hospitalisation against their will, so may even be punished for their own expertise. The first of these arguments, that experts do not need help managing the issue they are expert in, is spurious. It is perfectly possible to be an expert in diabetes but still need help to manage it, so why not mental health? The second argument has more weight, as any argument or position suggested by the EBE that is contentious to the organisation or professionals they are working with can be dismissed as a symptom of them becoming 'over emotional', 'feeling a bit defensive' and so on.

If people with lived experience are considered to have expertise to share in their own wellbeing then it is logical to include them in decisions made about their care. In looking at the assumptions underlying the practice of Shared Decision Making (SDM), Mikesell et al (2015) highlight the transactional process of information management. In mental health contexts SDM has been criticised as yet another way of upholding the traditional medical model and encouraging patients to greater behavioural conformity to the practitioner's view of optimal treatment. Human beings are open systems in constant interaction with the environment (King, 1999) with vast differences in motivation, desires and needs even between those within the same cultural group (Caceres, 2015) thus a one-size-fits-all healthcare solution would be inconsistent with person centred care. We know that people are more likely to

feel hopeless and helpless when they are unable to control their environments (Evans, 2003) and that in order to develop a system that prevents crises from occurring people need to be able to take decisions about their care (CQC, 2015) so it is clear that negotiation with healthcare is absolutely essential. Epstein and Street (2011) propose an interactional approach as one anchor for a continuum of decision-making processes in which relational autonomy emerges through shared information, shared deliberation, and shared mind. They consider a two way conversation to involve three minds, the patients, clinicians and that which is shared between them. They discuss what they see as the three main areas of shared mind:

- Collaborative Cognition – having more than one mind focussed on a problem can help compensate for cognition that is compromised by eg. tiredness, information overload or heightened emotional states. It has been shown to help people work through complex decisions, reduce anxiety and enable more effective information processing.

- Attunement – The feeling element of being on the same wavelength. This has an important role in decision making and empathy, it helps promote a stronger belief in and commitment to decisions made. Attunement is demonstrated by the way patients participate in the interaction; the way clinicians respond to patients and how they adapt to each other's communication styles.

- Sensemaking – brainstorming and sharing experiences to generate meaning, solve problems and make decisions.

(Adapted from Epstein and Street, 2011)

This iterative process helps generate new ideas, find new perspectives and increases understanding of complex situations thus enhancing decision making for the individual. Although in this instance the people at the consultations were not making decisions about their own care they were asked to share decisions about the PhD project and those may have a direct impact on someone else's care in the future. Doing something that might benefit others has a positive impact on wellbeing for the individual and the consultations also provided an opportunity for venting of more challenging experiences in a way that did not jeopardise any current care, and could have

prevented the PhD project repeating mistakes made by others. As such the principles of SDM were upheld.

Co-production, a more recently utilised phrase which is closely linked to EBE and SDM, is an attempt to deliver public services in an equal and reciprocal way between professionals, people using services and their social networks (Boyle and Harris, 2009). It emerged as a concept in the social sciences four decades ago and has recently become more prominent possibly due to the lack of resources required to care for people dependant on a service. The core tenets of the approach are:

· Recognising people as assets, because people themselves are the real wealth of society.

· Valuing work differently, to recognise everything as work that people do to raise families, look after people, maintain healthy communities, social justice and good governance.

· Promoting reciprocity, giving and receiving – because it builds trust between people and fosters mutual respect.

· Building social networks, because people's physical and mental well-being depends on strong, enduring relationships.

(Cahn, 2001)

Although these three concepts have co-existed for many years and have much in common, they have moved in and out of fashion in mental healthcare as policies change. All can be seen as positive moves towards more empowered people with lived experience of mental distress but all are open to abuse from agents of a system that have a vested interest in maintaining the status quo (Slade et al, 2014). The current economic climate however demands that clinical services in particular need to actually change in order to manage the demand and thus co-production is seen as a tool to reduce costs via peer delivered services and removal of services offered if the patient is deemed not to be doing their part (ibid). From the perspective of this PhD project co-production has been demonstrated to be valuable and influential in the development of the project and is likely to be influential in the dissemination of the project upon completion.

Overall, the group were very interested in the results, found many areas of resonance and made some useful suggestions as to where the information could be usefully disseminated. In the next chapter the literature search that further influenced the study is discussed.

Chapter 3 Literature Review

3.1 Introduction

This chapter outlines the literature search that was carried out to examine the pertinence of the prospective study, the search strategy is outlined and literature inclusion and exclusion criteria are examined. The literature which was selected for review is then critically analysed.

3.2 Literature Search

Smith et al (2009) argue that the purpose of IPA literature reviews is to identify gaps in current knowledge which the research question can then address, as the aim is that the findings will emerge from the data rather than from already existing literature (Smith et al, 2009). This often means that IPA literature reviews are 'quite short and may be more evaluative than most' (ibid, pg 43). Pragmatically though, every project needs justification and a review to aid the ethical process and guide research direction, therefore an initial literature search is required in order to explore current research on the subject. This will help in formulating the topic to be explored and assist in defending the line of inquiry. The search serves to introduce the field and clearly show where my research has the potential to make a valuable contribution.

Further literature searches were carried out for each of the themes once the data were analysed and the initial literature search was repeated to ensure that any new data that had emerged since the last search was included in the discussion. The same strategy was used to search as outlined in this section.

3.3 Search Strategy

Initial literature searches, (in 2007, 2008, May 2011, September 2014, September 2016 and Feb 2017) using Cochrane library and databases, including Cinahl and Medline, revealed that there is a dearth of research looking at the impact of the psychosocial assessment itself on suicidal behaviour and self-harm. No pertinent new literature was found after the 2014 search. This position is borne out by literature searches carried out by others

in the course of their research and written about in the literature (Hickey et al, 2001; Hawton et al, 1998). There is much evidence showing that self-harm is likely to be repeated (Boyce et al, 2001: Bolton et al, 2001) and that it is a behaviour closely linked to suicide (Coyle, 2001). There are some suggestions that psychosocial assessment may influence the rate of repetition of self-harm (Camidge et al, 2003) and that those who self-discharge before receiving assessment may be at greater risk of repetition (Crawford et al, 1998). Since these initial searches were carried out the focus of the question has changed slightly so it was necessary to repeat the process, something which should be done periodically in order to incorporate new research (Flick, 2014). Published literature was identified in a number of ways but predominantly via electronic databases. Few libraries now stock paper copies of journals so a hand search was not deemed necessary. The search methods employed were; 1) electronic databases; 2) website exploration; 3) google scholar; 4) cross referencing (references from appropriate articles were accessed for information relevant to the research topic); 5) Grey literature (often accessed via websites). A number of different search terms were used reflecting the diversity of language used to represent self-harm (for a list of search terms see appendix E).

Whilst most hierarchies of evidence suggest that grey literature is weak in terms of academic enquiry, in order to be thorough it was thought important to consider (Newell & Burnard, 2011). Grey literature is the name given to work that is not clearly underpinned by research and this includes literature produced by those who draw upon personal experience (Coad & Hardicre, 2006). Whilst this form of evidence has limitations, including that it may not have been peer reviewed and is not highly placed within the hierarchy of evidence, it has many strengths. These include offering more detail than other forms of evidence and being able to be produced quickly, thereby may be more current (Coad & Hardicre, 2006). In this context, it was considered necessary to look at this literature particularly in view of the upsurge of emphasis on personal experience in mental healthcare generally and the growing strength of the patient voice in healthcare. Articles that are clearly grey literature however, were not included for critique and only used to draw comparison in the discussion section in chapter 6 with others experiences (including participants) and caution must be exercised in making broad generalisations on the basis of it.

3.4 Defining the focus of the review

The research question was changed as part of the service user consultation (see Chapter 2) and therefore the literature review was also updated in September 2014 (after initial analysis had begun), again in September 2016 and a final review in February 2017 just before completion of the thesis. The literature was searched for published research on the experience of people who self-harm of care following admission to general hospital. Initial forays into the field had shown there would be little to consider if the field of enquiry was too narrow due to a dearth of research into the patient experience whilst in the general hospital environment so a wider practice area was allowed for as it is likely that the information from the papers considered would still be useful in illuminating the subject under review. In terms of critique, there were fourteen papers identified to undergo more intense scrutiny following the literature search that were decided upon with help from the criteria outlined below (for a summary of the articles included please see appendix F).

3.5 Inclusion Criteria

- Reporting on the experience of care received by people following self-harm (including suicidal thoughts and suicide attempts)
- Written in English
- Reflecting health and social care perspectives
- Policy documents, research studies, project reports, personal reflections and expert opinions
- Published in recognised peer reviewed journals or other credible sources eg. government policy documents or registering bodies.
- Concerning adolescents and adults
- Published after 2000

3.6 Exclusion Criteria

- Literature concerning children only
- Opinion pieces published on websites only and not subject to peer review
- Published before 2000

Articles in English were considered necessary to prevent meaning lost in translation and the inclusion/exclusion criteria reflect the requirements of the study title. Adults are the identified population within the question however the manifestation of self-harm within the adolescent population has much in common with adults (Hawton et al, 2006) whereas children represent a very different demographic group and were excluded as such. The landscape of healthcare has changed dramatically in the last fifteen years so literature published before 2000 was excluded from critique as the clinical environment applicable to this work may have differed considerably from that experienced today. This excluded literature was included in the discussion where appropriate however reflecting the limited nature of empirical work in the topic of study. Including peer reviewed pieces only helps to maintain the quality of the work considered, so opinion pieces on websites were also excluded.

3.7 Selection of Literature for Review

In total, 683 full text articles, reports and policies were considered and reviewed independently against the inclusion criteria for relevancy, 579 as detailed in the table below and four additional articles found by alternative means as described in the text. As mentioned previously concentrating the search to the environmental focus of the general hospital would not have produced enough material for a meaningful literature search due to the limited amount of research that has been carried out into this area. In the event only three articles were found that pertained to the general hospital environment (these are: Eales et al, 2006, Cerel et al, 2006 and Palmer et al, 2007). By opening the search to explore the experience people have of healthcare following self-harm (including suicide attempts and suicidal thinking) it allowed for an increased opportunity to find literature that, whilst not focussed on the same area, may still cast light on the patient group and their experiences of the response of services following self-harm.

Databases searched were; the Cochrane database; Cinahl; Embase; Medline; Psychinfo; Web of Science, Amed and Google Scholar as an increasing number of journals are to be found on the internet rather than formal databases. Table 1 below shows the number of articles found via databases in May 2014.

Database	Found	Fitting inclusion criteria
Cochrane	0	0
Cinahl	81	3
Embase	297	2 (1 was repeat)
Medline	5	0
Psychinfo	44	3 (1 was repeat)
Web of Science	93	4 (3 repeats)
Amed	0	0
Google Scholar	159	10 (7 repeats)
	Total	10

Table 2: Databases searched

When a large number of articles were found eg. Embase search, the titles were read and if it was clear that they were unsuitable then they were disregarded. Abstracts of the remaining articles were read which allowed for further reduction in numbers. In the case of Google Scholar, the first fifteen pages of results (ten per page) were scrutinised and following that the results did not resemble the search criteria so the search was stopped. In addition to the ten found via the search, the two existing policy documents regarding the service response to self-harm were included. One of the articles found (Taylor et al, 2009) was a systematic review and an additional two articles were found by cross referencing the list they provided as part of their search. A lot of studies regarding the needs of people who self-harm, from the perspective of staff, was found via the searches; as were articles regarding attitudes towards people who self-harm, these articles were excluded as they did not focus on the lived experience of the patient. One IPA study which appeared from the title to be suitable, an unpublished thesis by Larkin, (2013) was subsequently excluded. The lived experience under scrutiny as suggested by the title 'the experience of Emergency Department Self-Harm patients' was actually focussed on how patients who have cut or overdosed make sense of their self-harm.

Of the fourteen articles critiqued (see appendix F) only three were quantitative, two were mixed methods and nine were qualitative studies. It was notable that although they met the inclusion criteria, the quantitative work revealed little of value with regards to patient experience. To illustrate, Pirkis et al (2001) explored the self-reported needs of people who have suicidal thinking or attempted suicide, however they structured their survey with the needs that they felt were relevant only allowing for self-report on the items presented. These items were decided upon by use of the Australian National survey of

mental health and well-being, so the needs of the respondents that may not have been on the survey were unknown. Thus, though it discovered that more than half of respondents had not had their needs met, they were not able to tell us what these unmet needs were. This is useful in terms of recognising a subject for further research but would have little or no impact on practice or theory. In contrast, Cerel et al (2006) carried out a survey which was predominantly quantitative but had one open ended question that allowed respondents to note what was 'helpful or hurtful' about their experience in the Emergency Department. This yielded much useful information. Although the quantitative element of the survey suggested that over half the cohort felt they were treated with respect and had their ethnic and cultural needs addressed appropriately, of the 465 consumer respondents there were 490 negative comments regarding unprofessional behaviour; feeling unvalued as a person; feeling lonely or ignored and not having their suicidal feelings taken seriously. No literature pertaining to the experience of being seen by mental health staff whilst in a general hospital was found post 2014 and that which existed before was scarce. This indicates a clear gap in the literature. The main themes from the literature considered are outlined below.

3.7.1 Overview of experience of people of contact with mental health services following Self-Harm

The heterogeneity of people who self-harm and the need for individualised care is a common trend in the literature (Pirkis et al, 2001. Warm et al, 2002, Hume & Platt, 2007) with the functions and methods of self-harm being varied and social, psychological and physical needs differing greatly. However, Taylor et al (2009) point out that the needs of people following self-harm are remarkably similar regardless of country of origin or background. There are three clear themes emerging from the fourteen papers reviewed; the psychosocial assessment ; Communication and attitude; and Outcomes related issues. These themes have been used as headings to structure the discussion.

3.7.2 The Psychosocial Assessment

Hunter et al (2013) note that the function of the psychosocial assessment is unclear and it is seen as a routine part of hospital care. This was supported by Sinclair & Green (2005) whose cohort saw assessment as something that had to

be agreed to in order to be allowed home. In Eales et al (2006) study the assessment was seen as an opportunity to talk, however the experience was often viewed negatively. This was mainly put down to the assessment being time limited and the mental health practitioner not asking enough questions about background, so not gaining a full understanding of the context the individuals were in that had led them to the Emergency Department. The assessment being an opportunity to talk also appeared in Smith's (2002) study although there, there were concerns that some patients were not asked the reason for their self-harm, a requirement in the guidance (NICE, 2004 & 2011). In Taylor et al's (2009) systematic review the psychosocial assessment was highlighted as something that needed improving and they raised the issue that many individuals who self-harm are still not receiving psychosocial assessment and when they do it is often superficial and rushed. Sinclair & Green (2005), Suominen et al (2004) and Cerel et al (2006) cite timing of the contact as poor, some stating the contact occurs too soon to meet their needs (Suominen et al, 2004. Sinclair & Green, 2005) or that waiting times are too long (Cerel et al, 2006. Eales et al, 2006). In their study of interventions following self-harm it is interesting to note that Hume & Platt (2007) did not consider the psychosocial assessment as an intervention after self-harm completely overlooking the extant evidence that the psychosocial assessment itself can have therapeutic effect (Walker et al, 2013. Barker, 2004). In some cases this assessment will be the only contact required of mental health services for that individual and as such could have a potential benefit to costs in the overall provision of service if done well in terms of reducing repetition (Ebbage et al, 1994).

3.7.3 Communications and Attitudes

Good communication skills and a positive attitude are highlighted in the NICE guidance as being essential in caring for people who self-harm (NICE, 2004, 2011).. Hunter et al (2013) found that good communication, allowing someone to talk, alleviates distress and aids recovery of self-worth but that some participants felt judged and shamed by their Health Care Practitioners. In exploring perceptions of services from both patient and staff perspectives, Smith (2002), found that patient participants believed they were seen as failures or 'naughty children' and the staff results suggested that generally the view of people who self-harm was negative and this attitude impacted on the

care they gave. In Cooper et al's (2011) study it was found that a proactive, early and genuine intervention was most helpful, for the patients the focus was on genuine and sincere. However, in contrast to what the title of the article suggests, this study was clearly driven by a desire to introduce a particular intervention, a standard support letter, so these results refer mainly to how participants would have felt receiving such a letter. Whilst a sincere and genuine response would seem to be a perfectly reasonable desire for someone being assessed following self-harm this result is not clearly transferable.

Warm et al (2002) found that nurses and medical professionals were rated as least helpful in supporting people who self-harm with self-harm specialists providing the best support. This was a quantitative study with closed choice responses to questions formulated from extant medical literature and adds nothing to value to the field beyond that mentioned above. Poor communication was mentioned as a theme in Taylor et als (2009) systematic review findings and participants in Sinclair and Greens (2005) study described wanting someone to hear and validate their distress, however they found engaging with a potentially helpful but new relationship difficult. In Cerel et als (2006) mixed methods study, feeling unvalued as a person was one of the main themes raised, reinforcing the importance of staff attitudes.

3.7.4 Outcomes

Several studies highlight the need to include patients in the decision making process during assessment and the importance of patients retaining a sense of control (Taylor et al, 2009. Hume & Platt, 2007. Palmer et al, 2007), with Sinclair and Green (2005) noting this as being a factor in the resolution of self-harm longer term. There were many comments noted regarding outcomes of the interaction where unclear follow-up arrangements (Hunter et al, 2013), lack of information regarding local services (Eales et al, 2006) and access to aftercare (Taylor et al, 2009) were flagged as important issues. Two studies found stagnation, where little or no change following assessment (Hunter et al, 2013) or feeling they are viewed as failures due to the cycle of repetition (Smith, 2002). There are repeated calls throughout the literature for more staff training on self-harm and the potential positive effect this can have on staff attitude and the resultant care because as Hunter et al (2013) point out, interactions with staff ultimately, often shape future help-seeking intentions.

The information gathered began to suggest some generalisable themes but more research is required to enhance the field. It is notable that an extensive debate within the grey literature, predominantly opinion based, exists within contemporary anti-psychiatry fields which, whilst not considered for critique will be conversed with extensively in chapter 6.

In considering this reviewed literature it is clear that the lived experience of contact with mental health services whilst in a general hospital following self-harm remains under researched. None of the 14 studies found in the search were conducted with participants as close to crisis as was the aim of this study; four studies had more information gathered from staff then from service users and the one other IPA study in this area was focussed on help seeking after the event more than on the experience of contact with mental health services themselves. Therefore this study will add valuable information to that already in existence and extend the empirical evidence base via consideration of the question:

How do patients who have self-harmed, experience contact with mental health services in a general hospital?

The next chapter considers methodological issues and outlines the design of the study.

Chapter 4 The Study Design

This chapter considers both the philosophy underpinning the study, the practicalities of study design and ethical considerations related to the study.

4.1 Philosophy of Method

As previously noted in chapter 2, the methodology utilised in the study was Interpretative Phenomenological Analysis (IPA). The philosophical origins and importance of this method are now considered within the wider paradigm of qualitative research.

4.1.1 Qualitative Research

The general purpose of research is to address questions or to solve problems (Polit and Hungler, 2001). Early health research continued the tradition of quantitative research, using standardised methods to discover causes and effects to measure phenomena in the expectation that results would allow generalisation of findings and the formulation of general law (Flick, 2014). Qualitative research examines people's words, actions and experiences more closely, seeking to represent the situation as experienced by the participants (Maykut and Morehouse, 1996) rather than just measuring phenomena. Qualitative research comes from a naturalistic position; understanding evolves from the field itself, so the context and content of the phenomena being studied are important (Flick, 2014). Whilst quantitative research typically adopts a positivist standpoint, involving scientific enquiry based on observation of, and less on interpretation of data, one could argue that the data gained from quantitative studies is still interpreted. The positivist theorises that the truth can be deduced by applying methodological rules, independent of the whole, the content or the context of the investigation (Flick, 2014). Rolfe (2006) suggests that the quantitative-qualitative dichotomy could be considered a continuum rather than as opposing camps.

As well as methodological issues there are epistemological tensions apparent between the two paradigms in terms of theoretical positions (eg. Positivism and interpretavism as mentioned above). Increasingly the once asserted dominance of quantitative research is questioned, indeed the opposite position

of qualitative research being dominant can be argued (Flick,2014). So whilst quantitative research provides evidence of the extent of a phenomenon; the frequency of occurrence and possible links with other phenomena, this information is limited in the amount of information it can provide about why that is the case, what causes this to happen and how it could be changed to improve the situation being studied. In healthcare the contextual and personal nature of experiences suggest that qualitative research is likely to be the most efficient at helping improve quality of care. So whilst quantitative research is more likely to prove which type of treatment might work most often it will not tell us why. The validity of each of these positional paradigms is perhaps best considered contextually, in the light of research questions or issues under scrutiny. If we are concerned with epidemiological issues then quantitative methods are likely to be superior, if with issues of the quality of human experience then qualitative methods are likely to provide insights. Guba and Lincoln (2005) raise the importance of axiology, the need to be concerned with the way values feed into the enquiry process. Axiology has an influence on the major decisions and choices that are made as part of all research process, from choice of paradigm, theoretical framework, methods and so on. Therefore, they assert, axiology should be an explicit in discussing the basic philosophical dimensions of paradigm proposal in order to enable us to better engage with the ethical issues within paradigms.

Flick (2014) states that the main reason for using qualitative research should be if the question posed requires the approach. The question posed by this research project clearly sits in the qualitative paradigm. Frankel and Devers (2000) state that qualitative researchers often devise research because the existing literature does not adequately reflect practice. In this case the existing literature does not include the experience of patients who have had contact with mental health services in a general hospital following self-harm so close to the event. Qualitative research often focuses on meaning, making sense of experiences and communicative action (Flick, 2014), so the concern in this research is with the personal meaning in a particular context for a group who share a particular experience. There is a danger in patient research that we homogenise experience and miss out on the rich variety of the experiences of differing patients. Claims could be made that are not reflective of experience as could be the case, for example, if self-harm services have been modelled on

the needs of women rather than men due to the level of women accessing services compared to men.

The philosophy behind IPA (explained further in 4.1.3) is very much in keeping with my own, predominantly existentialist, ontology. Existentialism, in brief, is an ontology that emphasises the existence of the person as free and responsible, with a fascination for human action and interaction (Moran,2000) It allows a commitment, as IPA demands, to examination of how people make sense of their life experiences in their own terms whilst accepting that the researcher will interpret their story influenced by their own world view, but whilst attempting as far as possible to remain true to the essence of the subjects experience. Thus the existentialist approach lends itself very well to the IPA approach. The aim of this research is to explore the experience the patient has of contact with mental health services in the general hospital environment whilst acknowledging and taking account of the person's expressed past and present experiences. This approach allows for the dynamic relationship between the whole experience and parts of it to be considered. Taking these points into account and recalling the points raised during the patient consultation, IPA was chosen as the best means of exploring the patient experience in the particular circumstance of contact with mental health services in the general hospital environment.

4.1.2 Phenomenology

The word Phenomenology comes from the Greek:-

Phenomenon – To show or appear. Offering two different levels of interpretation, firstly a visible meaning and then a hidden meaning. Thus the understanding is of the thing as it shows itself but also as hidden aspects become clear, ie perceptual meaning.

Logos - discourse reason and judgement. Leading to a more analytical perspective.

(Moran, 2000 pg 229)

Although precursors to phenomenological thinking can be found in earlier philosophical writings, the phenomenological movement was instigated by Husserl in 1900 (Moran, 2000). Being concerned with the clarification of

epistemological concepts he posited the requirement of a broad theory of knowledge based around the 'phenomenon of the experiences of thinking and knowing.' Throughout the 20th Century the concept of phenomenology grew to become the most important and influential development of European thought (Moran, 2000). This philosophical approach to the study of experience attends particularly to what the experience of being human is like in all its various aspects. It lays out a rich vein of ideas that assist in examining and comprehending lived experience. Merleau-Ponty (1962) states that phenomenology is both a method for exploring the essence of experiences and a philosophy that puts the essences back into existence.

4.1.2.1 Mental Health Nursing

The philosophy of mental health nursing is indistinct. The NMC (2015) code of conduct states that nurses must always strive to provide person centred, high quality care that is guided by high order values and integrity, it does not however, suggest what these values should be. In practice, the philosophy of mental health nurses tends to be that which appeals to them most as individuals (Pryjmachuk, 2011). This can lead to tensions, with the two most dominant strands of nursing being 'psychiatric' and 'holistic'. The former historically focussed more on illness, orientated around the medical model of psychiatry, as the name suggests. 'Holistic' being more focused on the whole person both physical and psychological and focussing more on wellbeing, autonomy and recovery which does not always include cure. There are parallels here that can be drawn between the paradigms of positivist (psychiatric) and naturalist (holistic) research and again between the nomothetic branch of psychological study and the phenomenological. Thus the psychiatric style nurse may want to understand the patient and manage their issues in terms of statistics, proven theories and evidence from Randomised Controlled Trials (RCT) and other sources at the top of the hierarchy of evidence and may view patient/carer opinion as of a lower value or worth. Whereas the holistic nurse may view the patient as an expert in their own condition with valuable insights into the path most likely to lead to recovery, be interested in the overall picture of the person in view of their cultural, physical, spiritual and psychological needs, both from their own perspective as practitioners and from the personal viewpoint of the patient. This second illustration is clearly leant towards phenomenology as a philosophical paradigm for exploration of human being.

In practice it is unlikely that nurses' philosophical positions would be so clearly polarised and a spectrum between the two positions would be apparent.

In this PhD project, phenomenology is an approach that will allow me to delve into and gain insight into an otherwise poorly understood phenomena, that is, the experience of the person who has had contact with mental health services following an episode of self-harm and subsequent attendance at the general hospital. This approach allows the exploration of each individual participant's perception of the event (Smith, 2009), in examining the experience it is possible to get closer to the essence of the experience (Field & Morse, 1991) and would yield insight into the experience of contact with mental health services in a general hospital following self-harm.

4.1.3 Interpretative Phenomenological Analysis (IPA)

IPA began in psychology in the 1990s and is richly grounded in the philosophical thinking of Husserl (1931), Merleau-Ponty (1962) and, in particular, Heidegger (1967/1927). There are many perspectives of phenomenology, Husserl's more positivist stance; Merleau-Ponty's post-positivist stance; Heidegger's interpretivist stance and the constructivist position of Gadamer (Dowling, 2007). However, Smith (1996) argued for an approach that was able to capture both the qualitative and experimental aspects of psychology, aiming to create a coherent approach that was centred in psychology rather than using approaches from other disciplines. Although originating in psychology, this approach is now increasingly used in health and social sciences (Smith et al, 2009). As Smith et al (2009) state a founding principal of phenomenological inquiry is that an experience should be looked at from the perspective of the way it occurs and on its own terms. This was the standpoint of the philosopher Husserl (1931), who saw science as a second order knowledge system, dependant on the first order personal experience. Husserl (1931) proscribed a reduction of experiences by way of bracketing to describe the different aspects of a phenomenon, moving the enquirer away from their own preconceptions towards the essence of their experience of a phenomenon. This thinking was extended by Heidegger (1962/1927) who felt Husserl (1931) was too abstract and considered his own approach to be even more phenomenological. He believed that we can consider ourselves 'thrown into' a world of things, relationship and words and that our 'being-in-the-world'

is always perspectival, time limited and in relation to something. Therefore the centrality of people's meaningful activities becomes central to IPA.

Reid et al (2005) state that the key elements of IPA are as follows:

- IPA is an inductive approach (bottom-up rather than top-down). It aims to discover and then explore the meanings assigned to experiences by the participant
- There is a prior assumption that participants are experts on their own experiences and can offer the researcher a deep understanding of their experiences via their own stories, told in their own words in detail. Participants are generally recruited because they have experience of the phenomena being explored
- Rigorous and systematic analysis of data reduces the complexity of the data. Analysis occurs firstly for the participant, secondly for the researcher analysing the data
- Analyses retain a focus on the distinct aspects of the persons experience (ideographic elements) whilst balancing this with what is shared, commonalities across a group of people with similar experience
- Successful analysis is:
    - Interpretive (and unavoidably subjective) so results do not become facts
    - Transparent (examples can be found within the data)
    - Plausible (to all reading including the participant)
- Continuous reflection on the part of the researcher of their own role in the interpretative and collaborative nature of the IPA interview is essential

Reflexive Log Note – IPA training November 2012

I have a better understanding of the intricacies of each level of analysis and a realisation of the importance of phenomena coding before interpretative coding. It is doable! It is a huge job, we practiced on a bit of text from another study, oh boy. My head will be swimming when in data analysis phase. It is like an onion, how many layers do we reveal before we start to cry!

4.1.3.1 Hermeneutics

Heidegger, clearly drawing on the work of Schleiermacher (Moran, 2000), was the first to incorporate hermeneutics and phenomenology. As a major underpinning of phenomenological thinking, particularly IPA, hermeneutics is a theory of interpretation, originally used to interpret religious and other important texts. A premise of hermeneutic phenomenological methods is that understanding and making sense of experience is a driving human force (Cohen et al, 2000). An IPA researcher must ask questions regarding the methods and purpose; original meanings and context of the authors (participant being interviewed in the case of this research) interpretation of the phenomena being examined. Additionally the context the researcher is interpreting in has a bearing on the interpretation.

4.1.3.2 The Hermeneutic Circle

The Hermeneutic circle is a well-respected idea from hermeneutic theory, it is concerned with the relationship of the whole with the parts. That is to say, the varying degrees of relationship each part of the phenomena has with the whole phenomena at differing levels. So in order to understand the whole, one must look at the parts and vice versa, in the manner of stepping back to look at a painting as a whole entity (Cohen et al, 2000). Although seemingly a little illogical due to its clear circularity, it does represent an effective portrayal of the process of interpretation. Smith et al (2009) give us a nice demonstration of this:

The part	The Whole
The single word	The sentence in which the word is embedded
The single extract	The complete text
The particular text	The complete oeuvre
The interview	The research project
The single episode	The complete life

(Smith et al (2009) Pg 28)

Following this dynamic, non-linear style of thinking it becomes clear that it is possible to understand the word in the context of the whole sentence and the meaning of the sentence only becomes clear when we consider the meaning of the words used to construct it. The interpretation of phenomena being examined is carried out in light of the readers' history and that history is influenced by the act of interpretation and exposure to the phenomena. This

iterative process becomes the means by which the phenomena is reduced as closely as possible to its essence and reconstructed into research data. It is also important to realise that this circle can be entered into at any point or level, repeatedly and with each level offering a different viewpoint or perspective on the meaning of each part and the whole.

Thus, using IPA I can ensure the dynamic relationship between the whole (the contact with mental health services in the context of that person's life) and the parts (the individual occurrences within that contact and meanings given to events) is considered. There is a double hermeneutic present as the experience is first interpreted by the participant and the researcher then strives to interpret this interpretation to begin to understand their experience. The data are analysed as a whole, as sentences, as individual words and all in light of the fore-structures of the researcher, this idiographic representation for each individual, allows the possibility of general claims being made after an interpretation of a small number of interviews.

The hermeneutic turn (Smith et al, 2009) provides a useful framework for us to consider the process at work in IPA. At the beginning of the process I have decided, with all my incumbent preconceptions, experience and concerns, to enter the circle. At this point I have attempted to note my fore-structures before I begin the exploration of the phenomena concerned with the participant. As I move towards the participant on the circle my focus changes to the encounter with the participant where they outline their experience of the phenomena. Inevitably, once this encounter is over my focus will change again as I move around the circle to considering my own perspectives again in light of the encounter outlined by the participant. At this stage further fore-structures may become evident and I am therefore back to the beginning of the circle and the process is repeated, without another encounter with the participant in this case, until I reach a stage where the phenomena has been considered in all its parts and as a whole. Then, once the interpretation of the phenomena is felt to be as close to the phenomena as possible, I leave the circle. Considering this double hermeneutic whereby the researcher is interpreting the participants interpretation of the phenomena it is important to realise that, as illustrated by Fig 2 (created to help visualise the process) below, the parts of the participant known to the researcher will be limited to that which relates to the phenomena being explored. This is therefore just the

smallest snapshot of the person and their cultural and historical influences. It could be argued that the data generated must be supported by the evidence from the transcriptions of the interviews otherwise it may be totally based in the preconceptions of the researcher. The potential for data that begins to be true to the essence of the experience only exists where the contexts of the participant and researcher overlap, the data generation space (Fig 2) and even then could be subject to other interpretations by another researcher.

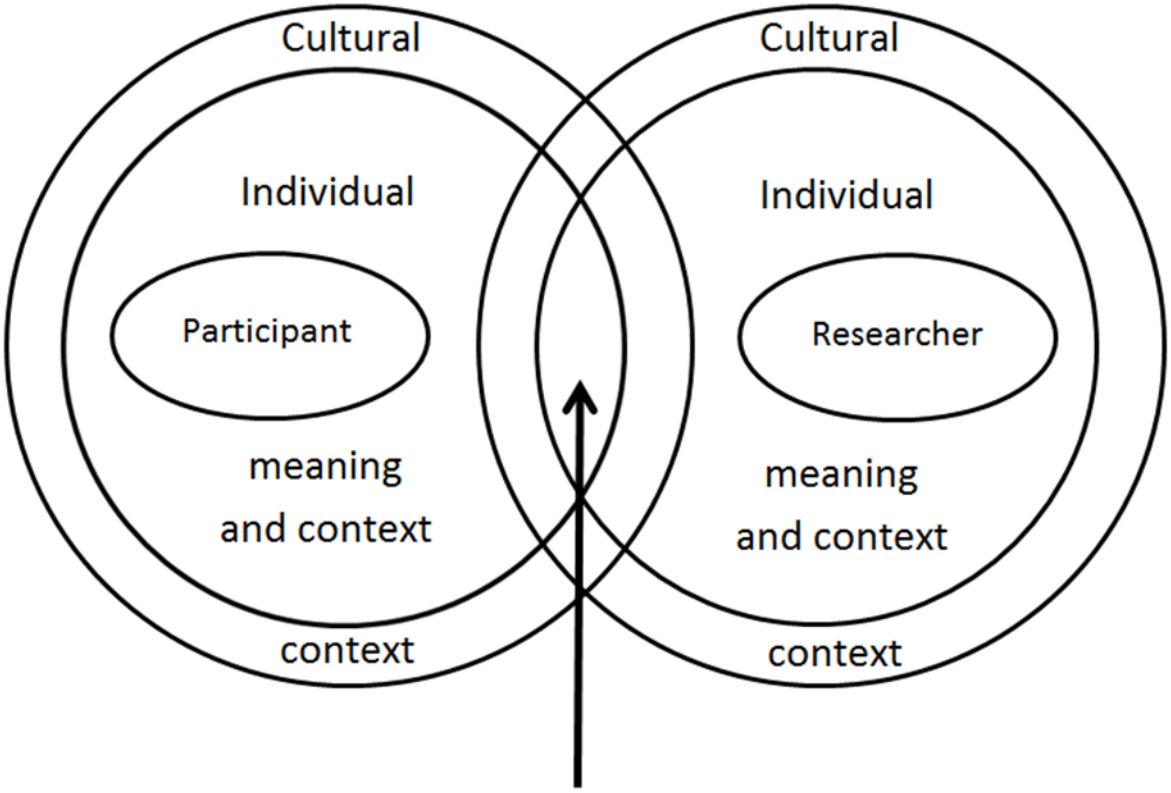


Fig 2:The Hermeneutic Circle
Data Generation Space

An important competency already referred to is the ability to establish an empathic rapport. This has links to practice which reflect the phenomenological interpretation of empathy. Ricoeur (1970) points out that the hermeneutics of empathy are an interpretive position which tries to reconstruct the original phenomenon in its own terms. So the IPA researcher is attempting to create an 'insider perspective'. This is echoed by Binswanger (1975) who talks in terms of 'being with' the participant. As Smith (2009) states, this is the stance from which Interpretive Phenomenological work begins. This approach reflects practice in that Barker (2004), in his

comprehensive book on assessment, posits empathy as a key skill practitioners need. He talks of 'seeing through the persons' eyes' and striving to see the patients world through their eyes whilst at the same time maintaining emotional distance, as he perceives over connection with the patient a danger that can serve to reinforce the perceived desperateness of the patients position. The Nursing and Midwifery Council standards (NMC, 2010) state that mental health nurses must practice in a way which demonstrates 'therapeutic use of self', standing alongside the patient and helping them make sense of things in their own way rather than imposing their own values and judgements on them. In the Centre for Outcomes, Research and Effectiveness (CORE) competencies (Roth et al, 2009) the 'Ability to foster and maintain a good therapeutic alliance, and to grasp the clients perspective and world view' is cited as a generic therapeutic competency for practicing psychologists and the ability to experience and communicate empathy are key to providing effective humanistic therapy. IPA fits well with a commitment to empathy in mental health.

4.1.3.3 Idiography

Another underlying principle of IPA is the concern with the particular. This idiographic standpoint is in contrast to the nomothetic nature of much psychological research which makes claims at group or even population level (Smith et al, 2009). Idiography insists on a commitment to the details and depth of the experience (Smith et at, 2009), in this case the experience of contact with mental health services in the Emergency Department. This examination must be both thorough and systematic in order to maximise the possibility of reaching the essence of the experience for the participant. Additionally, as intimated in the previous sentence, idiography is committed to understanding the experiential phenomena in light of the experiencer's perception and the context in which the phenomena occurs. In this way, generalisations can be developed by explaining details and carefully generating theories that can then be tested against other cases and other levels of examination of the same case (Smith, 2009). This analytic induction may lead to conclusions that can be generalised, although this is not always the case. Heidegger (1967/1927) states that the experience of a phenomenon is not just the property of the individual as such but the person does offer a unique perspective on it.

4.1.3.4 Reflexivity

Quantitative designs were constructed so as to minimise the influence of the researcher and others related to the facilitation of the research, thus theoretically providing objectivity (Flick, 2014). In practice this is not possible as factors such as paradigmatic standpoint, personal values and assumptions will inevitably influence research design, question formulation, hypothesis generation and analysis of data (Guba & Lincoln, 2005). In order to meet the strict methodological standards required, findings can often be too disconnected from everyday questions and occurrences resulting in scientific results being used little in everyday life Thus we may not find 'absolute truths' which can be universally and uncritically adopted (Flick, 2014). The qualitative approach acknowledges the researchers influence in the field and incorporates this knowledge explicitly as part of the research process rather than as a confounding variable. Thus the subjectivity of both the researcher and the participant become part of the process. So the research diaries, reflections and insights of the researcher become data too, forming part of the interpretation (Flick, 2014).

The IPA researcher must be reflexive. This is a process of self-examination (DePoy and Gitlin, 1998) and involves looking at values, preconceptions, behaviour or presence of self or the participant which may affect responses in the interview process (Parahoo, 2006). The use of diaries, notebooks and supervision notes assist in the quest for reflexivity and were kept throughout the research process. Prior to each interview I carried out a pre-interview write up reflecting my thoughts and preconceptions on the day, along with environmental factors both physical and psychological, that may have impacted on my questioning. This helped to ensure that I was reflexive about my role in possible co-construction of the data and allowed me to, as closely as possible, represent the world of the patient whilst allowing for the fact that as a researcher, I interpret the data. Fore structures (see below) represent a danger in drawing the researcher away from the lived experience of the subject and it is therefore essential to be aware of them and allow them to be challenged by the data.

It is also important to consider the 'insider outsider' perspective in IPA (Smith et al, 2009) research. Due to the importance of both the researcher and the

participant in qualitative research it is virtually impossible to adopt a neutral role with the field and those being interviewed (Flick, 2014). As a researcher I am a stranger to the participants and the staff in the area of interest, however as a trained mental health nurse previously having worked within liaison psychiatry I have an insider perspective which will inevitably influence observations and interpretations. Additionally I have been a patient in the past and have personal experience of both self-harm, suicide attempts and suicide of close friends. This dialectic could create a tension between roles, the researcher, the patient and the clinician. With the amount of experience I have in the field of liaison psychiatry I am operating as an insider, as I am researching the lived experience of people in this field who solicit mental health services. This makes the process of reflexivity even more important as it is not possible to drop years of training, personal experience and practice on becoming a researcher. An additional, important element from an IPA perspective, is the effort to see the world from the participants perspective, so the IPA researcher is always striving for the insider perspective (Smith et al, 2009)

Reflexive Log Note – Boundaries – Sept 2014

I struggled with the clinician in me with this interview, as he so clearly hadn't been able to tell the mental health team what he needed to. I knew he would tell me and felt the need to assess him but was restricted by the researcher role and had to remain boundaried. It was very hard to do.

4.1.3.5 Fore-Structures

Moran (2000) states, in discussing the philosophy of Brentano, that when studying a phenomena, the act of introspective observation can only have a distorting effect, we cannot observe the phenomena without changing it in some way. Additionally, Heidegger (1967) asserts that the inherited lore and experience we have acquired from cultural and familial origins, influences our 'average' understanding. Whilst this average understanding is required in order to enable the asking of questions, it can also prevent us from finding and rendering an answer due to perspective distortion. Gadamer agrees that human understanding is situated historically and states it is understood through the medium of language (Moran, 2003). Understanding another's perspective in an intuitive, imaginative way is possible but the others

experience can never be felt in its original fashion (ibid). Hence, empathy is an experience founded on how another is constituted for us, this vicarious representation of the experience of another becomes a verifiable account of an experience that was not originally accessible (Husserl, 1931). This previous experience, historical influence, assumptions and desire for answers to questions forms the phenomena of fore-structures. The fore-structure is always there and if un-noted, can represent an obstacle to interpretation (Smith et al, 2009), a barrier to understanding from another's perspective.

In considering what my own fore-structures could be I asked myself the following questions:

4.1.3.5.1 What did I see happen when I worked in liaison psychiatry?

My experiences with the Better Services for People who Self-Harm project (Palmer et al, 2007) was instrumental in motivating me to undertake this research. As a manager of a liaison service in a busy Emergency Department I undertook and observed many psychosocial assessments of variable quality, undertaken by nurses, social workers, medics and psychiatrists. Rarely did I see anyone that appeared to understand how powerful the interaction could be, the emphasis was most often on the information gathering aspect of assessment and speedy discharge, elevating the needs of the service above the needs of the individual. In overhearing conversations in the office after assessments and in supervisory contact with staff I noted a great deal of judgement conversation and assumption making which I found disheartening. The assessments I observed were generally of staff on their best behaviour, as I was the manager and they knew how I behaved having all observed me work many times. However anecdotal evidence from ex-patients received since leaving, complaints at the time and the office conversations led me to believe that, for some, this quality was not maintained at all times. I recognise that each person will have certain vulnerabilities that may affect performance on a daily basis, however my experience and the literature (Palmer et al, 2007) supports the theory that it was more complex than that. It seems likely that the issue was influenced by prejudicial and stigmatised thinking within staff. Some patients were seen as more deserving than others and so if they were able to activate individual staff empathy they were more likely to get a better assessment that those who weren't able to. Those who had history of

repetition of self-harm or indeed had proved difficult in the past found this task more difficult.

4.1.3.5.2 Analysing My Fore-structures

It is possible to have a secondary question which can only be answered at the point of analysis and even then may not be answerable (Smith, 2009). In this case, and bearing in mind the origins of the research question and my preconceived fore-structures, the supplementary question is :

'To what extent is the provision of a psychosocial assessment in the acute hospital, following admission for self-harm, justified by patient experience?'

I am interested in the implications that may be drawn from this question, for practice and policy for psychosocial assessment as carried out with patients who have self-harmed. From this research it was envisaged that the objectives that may be met were to:-

- Develop an understanding of patients' experience
- Provide an up to date literature review
- Gather patient narratives of contact with mental health services in the general hospital following self-harm
- To improve assessment practices for this patient group

Information that contributes to current knowledge on these topics may be is identified from the data once analysed, however, the nature of IPA demands that the participants themes are of paramount importance and it is only by exploring these themes that rich data will be generated. It may be that the participant themes will align with my fore-structures at times but they may not. It is very important that I spend time becoming aware of my fore-structures both before the analysis, or even interview, begins and during the analysis, as issues raised in previous interviews can add new fore-structures which can interfere with the intended meaning in the next interview. These fore structures might lead me to want to answer practitioner questions rather than immersing myself in the experience of the participant. As Wallcraft (1998) states an observer cannot see and describe events without having a set of prior

assumptions and is one of the reasons Smith (2009) advocates talking about themes in supervision.

At the start of the data collection phase, these fore-structures were represented by the following questions:

- Was the acute hospital the best place for assessment to take place?
- What was beneficial about the experience and assessment?
- What was not beneficial about the experience and assessment?

Having considered the theoretical underpinnings of the proposed research method the second part of the chapter will now turn to application of this approach in carrying out the research.

4.2 Study Design

Primary research questions, in IPA, are not usually theory driven. They are open-minded questions that aim to allow participants to share their experiences and make claims regarding a significant event on their own terms. In this case the significant event being explored is patient contact with mental health services, including psychosocial assessment, whilst in the general hospital environment following self-harm. This question is committed to examination of how people make sense of one aspect of their life experiences. It aims to understand the process of assessment in light of how the people experiencing the process perceive it and the context in which the experience occurs. I want to know how the patients make sense of the assessment and to explore this in its own terms whilst acknowledging and taking account of each person's history and experiences.

4.2.1 Methods

The research seeks to explore the experiences and understanding of the participants, thus it is felt that semi-structured interviews would be most effective in facilitating this. Semi-structured interviews comprise a loose structure of open ended questions that guide the area to be researched (Mays and Pope, 1996). They are widely used in qualitative research (Flick, 2014), the open nature of the interview design meaning that the viewpoint of participants

is more likely to be expressed. The course of questioning may then diverge to allow examination of the issues that arise in more detail. However, in keeping with IPA there is only one question on the schedule (see 4.2.5.1) with the other questions merely being prompts to assist should the participant not be able to narrate their experience without assistance. This design is to maximise the space for the participant to tell their own story and to minimise the likelihood of researcher interference. It is important to be sensitive to the interviewees needs, particularly in dealing with such sensitive subjects and people so close to crisis (see 4.3.1). During the service user consultation (see Chapter 2) the group were asked if there were any questions they felt should be asked of the participants. One question they suggested was 'Would you seek help here again?' and this was added to the question schedule as a prompt and proved to be a useful closing question to help bring the interview to a close.

Because an IPA researcher wants to make detailed sense of experiences that have occurred to others, a flexible data collection instrument is required. Semi-structured interviews are considered one of the best ways of collecting data in IPA (Smith and Osborn, 2009). It is possible, in this form of interviewing to have a dialogue which can be modified according to participants' responses. Although the theme of the interview will be influenced by the research, the interview itself and the data forthcoming is led by the participant. This echoes the person centred nature of ideal mental healthcare in which the patient leads on the episode of care (DoH, 2011). This requires a level of power reduction on the part of the researcher/practitioner (research/practice) which, in mental healthcare is rarely managed (Vassilev and Pilgrim, 2007) effectively despite the rhetoric stating it must happen. As I am looking for data regarding the experience of a particular phenomenon (contact with mental health services in the general hospital) more loosely structured interview styles, such as narrative and creative interviews were considered however the ability to create a dialogue that semi-structured interviews offers (Flick, 2014) was decided upon as the most likely method to generate the data required for this project.

4.2.2 Sampling

Due to the in-depth, rich nature of qualitative research the number of participants required is smaller than that of quantitative research where large numbers of data can be analysed at once. Within qualitative research we are

searching for insights into a phenomena rather and it is possible to glean this from a single case (Denzin & Lincoln, 2005).

4.2.2.1 Sample Type

The main sampling strategy employed was convenience sampling as, due to the sensitive conditions of the potential recruitment pool it was anticipated that it would be difficult to engage participants. Convenience sampling (Patton, 2002) refers to selection of cases that are easiest to access under given conditions. The intention was to recruit a balance of men and women but this was subject to the uncertainties of recruitment and could not be predicted. In the event equal numbers of men and women were recruited. As previously mentioned ethnicity and sexuality are recognised demographic factors but it is not practical to cover them all in this research project and the most obvious lack in evidence is that of the male perspective in self-harm. Considering this, I sought to include men in my sample so that this could be investigated and analysed. There are issues relating to ethnicity and sexuality that have a bearing on the demographics of self-harm however, due to the limited nature of this project they are not considered in detail at this time and as they were not raised as pertinent for any of the participants.

4.2.2.2 Sample Size

Field and Morse (1991) state that sample size is determined by the purpose of the research project and since statistical representativeness is not the aim of the research large numbers are not required (Mays & Pope, 1996). Smith and Osborn (2009) state that there is no definitive sample size in IPA, it will depend on various factors such as, richness of individual cases and constraints of the project. This is echoed by Cohen et al (2000) in that a number of practical considerations influence sample size, also they state that sampling implies choosing participants because they will have something to say about the phenomenon being studied. Smith (2009) states that most IPA studies are carried out with small sample sizes. Mason (1996) suggests that sample sizes in qualitative research may be small due to cost, particularly in terms of time spent on analysis. When such in-depth, comprehensive case-by-case analysis is expected each transcript takes a long time to analyse and since the object is to understand the individual experience as well as possible it would not be doing service to the data to try and rush the process. For this project it was decided

that ten to twelve participants would be recruited. It was also decided prior to the recruitment phase that, since it was such a sensitive area of research, if it were difficult to recruit people to the study and/or the data was of such rich content as to justify it, ten interviews would be enough. Smith (2009) recommends that up to six participants are sufficient for a student project using IPA for the first time. Despite the assertions as to the validity of the methodology Smith (2009) still asserts that it is usual in IPA to show the number of times a theme has been noted for a participant. This, somewhat positivist, instruction has not been adhered to in this work as it does not feel quite true to the method. The issue of saturation cannot necessarily be held to apply to this type of research (Streubert & Carpenter, 1995) as the idiographic nature of the data would mean that each participant would provide unique data and so each interview would potentially provide new insights.

4.2.3 Inclusion and Exclusion Criteria

Bond and Gerrish (2006) point out that it is important to clearly outline the type of participants required for a research study from an early stage. Smith et al (2009) also point to the challenge of analysing, to the depth required of IPA, a group of participants from a very heterogeneous population. Inclusion and exclusion criteria can help reduce the variability of the participant group and this may assist in generating themes/outcomes of a more generalisable nature.

The inclusion and exclusion criteria for this project were as follows:

Inclusion	Exclusion
Male and Female Over 18s Patients who have self-harmed (Using the NICE, 2011 definition) Patients who have undergone a 'psychosocial assessment' during their admission	Children and young people under 18 Patients who are sectioned under the Mental Health Act (MHA) after being recruited but prior to the interviews will be excluded due to capacity issues Patients with organic brain disorders. Patients who are acutely psychotic when attending for interview Patients being admitted to psychiatric hospital following assessment

Table 3: Inclusion and Exclusion Criteria

Hogg (2010) states that self-harm has become stereotyped as a predominantly female activity and suggests that this has led to male self-harm being side-lined, creating an 'invisible population' (Taylor, 2003). Skegg (2005) states that

self-harm behaviour may be just as common in men; hence it was an aim of this study to include the male experience. In this case, recruitment could be difficult and as more women come to the attention of services than men (Hawton& Harriss, 2008) it would be difficult to recruit men only, even though there may be value in doing so. Therefore by leaving the question and study design open, the study could still have gone ahead even if not enough men come forward to allow a balance of gender in the participants.

The needs of adolescents who self-harm have been extensively researched (Hawton et al, 2006., Fox and Hawton, 2004., McVey-Noble et al, 2006., D'Onofrio, 2007) and as a distinct group, with differing needs from the wider adult population, they were not included in this study. This represents a mainly practical decision in that the project is being carried out by one researcher who has little experience in dealing with adolescents in a professional capacity. In order to explore the patients experience of self-harm it was deemed important that the person concerned had mental capacity to consent and therefore, by implication, to disclose their experiences to the researcher. Thus the decision to exclude those who have been sectioned under the MHA or who have diagnosed organic brain disorders such as dementias. It was originally intended to exclude those patients currently open to mental health services, however on reflection as they may have experienced the service more than once it was felt likely that they would have a wealth of experience to share that would provide rich data, therefore the decision was taken to include them. Patients admitted to psychiatric hospital following discharge from the general hospital were excluded from the recruitment group as it may be likely, due to risk and mental ill health, that patients unable to remain in the community may lack the required capacity to consent and may be ill to such an extent it would be likely to interfere with the interview process. Also, due to complications that can occur in communication during psychosis (Bowers et al, 2009) patients who were obviously psychotic were not included.

4.2.4 Recruitment

This section considers the recruitment process and outlines the steps taken to recruit the ten participants who eventually made up the study cohort. In actuality seventeen participants were recruited but only ten progressed to interview.

4.2.4.1 Gatekeeper

The gatekeepers, who were responsible for recruitment of participants, were highly qualified consultant nurses who had specific responsibility for vulnerable patients and worked within the Emergency Department. The gatekeeper approached patients after contact with mental health services but prior to discharge from the hospital, explained the opportunity for inclusion in a research project and gained permission for me to make contact. Following normal protocols, the nurse consultant made a judgement at the time about the patients' capacity to consent; administered the consent to contact form and gave them the Participant Information Sheet (PIS) (see appendix G).On a daily basis these nurse consultants make judgements about a patients' capacity to consent and employed this same judgement in deciding if a patient would have the capacity to be a participant. They did not brief me on the potential participants but simply stated their willingness to consider involvement and that they felt the individual concerned had capacity at the time. I went through the participant information leaflet with the nurse consultant prior to the recruitment phase to ensure they were fully conversant with the research proposal and clear with regards to the potential issues for any patient who agreed to take part. It was reinforced that the nature of the research was voluntary and that participation or refusal should not affect the patient's current or future care in any way.

4.2.4.2 Information Packs

The gatekeepers were given packs containing the literature required for the recruitment phase in order to assist and clarify for the role the purpose of the research and the process to be followed. Within this pack was a brief synopsis of the requirements of the role of gatekeeper for this research (appendix H) which also clearly showed the inclusion and exclusion criteria (4.2.3 above). A copy of the consent to share contact details (appendix I) was included in the pack and the flow chart of the recruitment process (fig 3 below). Also included was a copy of the participant information sheet so they were familiar with the information that the potential participant would receive.

In addition to this the gatekeepers were given twelve participant information packs which could be given to potential participants in the event that they agreed to consider taking part in the research. More packs were given then

numbers needed as it was considered likely that some participants would decide that they did not want to take part after initial consideration. Initially ten packs were given out and subsequent recruitment only took place if there was a withdrawal from the study. Each pack contained the initial consent to share details form, which was completed at the time of exchange, the full PIS which the potential participant was encouraged to read at their leisure, and the second consent form which would be completed after full consideration of the PIS and at the beginning of the interview itself with the researcher. The pack ensured the participants had all the information they needed to help them make an informed decision as to whether to take part in the research or not.

4.2.4.3 Recruitment Process

Potential participants were approached by the gatekeeper in either the Emergency Department or the Acute Medical Unit (AMU), shortly before they were due to be discharged following their contact with the mental health team. It is essential that the recruitment is carried out by a third party (Tee and Lathlean, 2004) to ensure that the participant maintains autonomy of choice by minimising the likelihood of them feeling coerced into taking part. The process was as follows (also see fig 3) :

The potential participant was given a leaflet, explaining the research and the process they would be part of should they agree to take part, by Gatekeeper

The consent to share contact details form administered by the Gatekeeper and they then contacted me to alert to details waiting in Emergency Department.

The researcher contacted the participant and arranged an interview at either the hospital or the university main campus.

At time of interview the consent form (appendix J) was revisited and participant understanding clarified before signing.

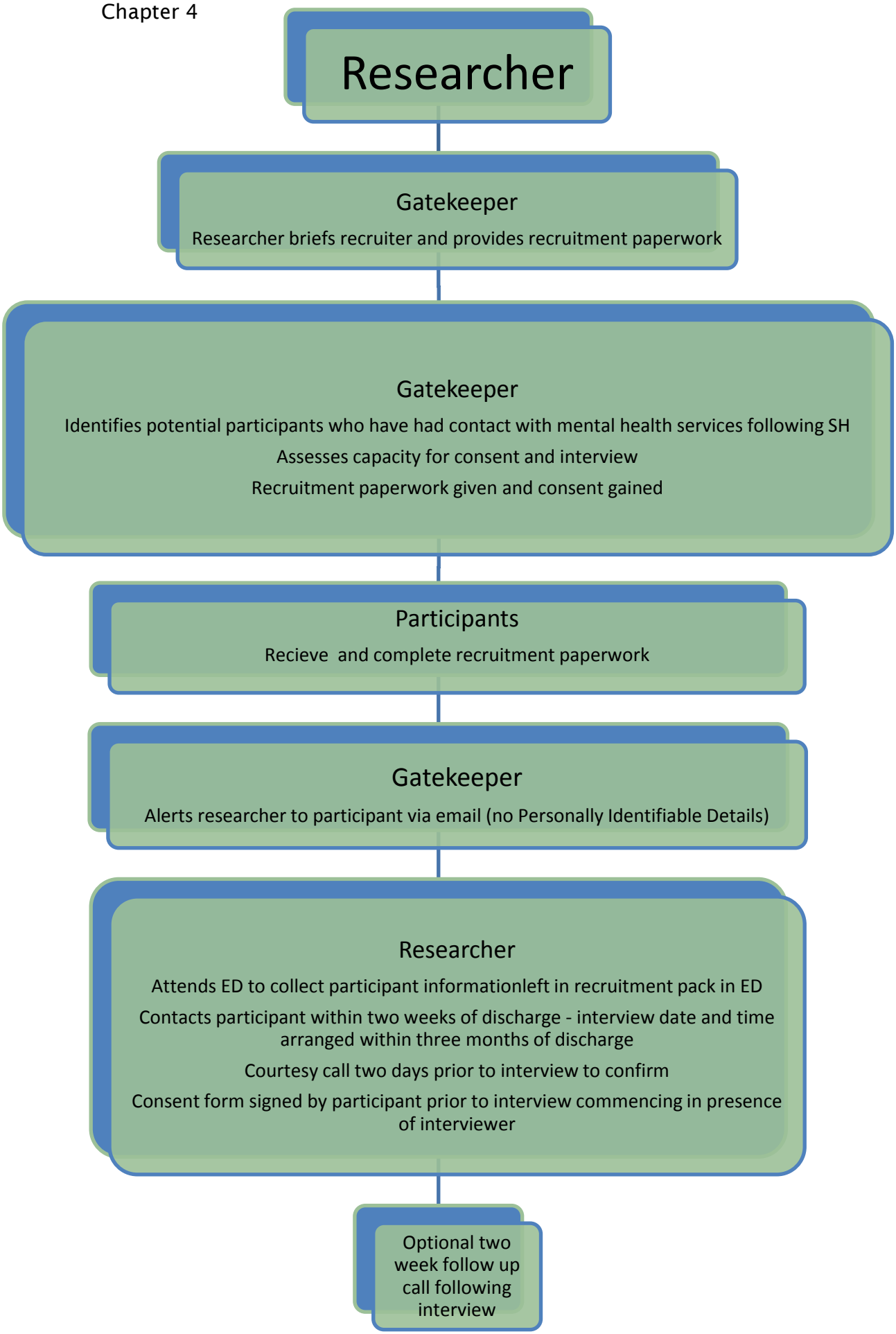


Fig 3 **Recruitment Flow Chart**

4.2.5 Interview Process

The data source in this research is the recounted experience of patients who are admitted to the general hospital having self-harmed. The interviews had an informal style, allowing interviewee narrative to take precedence. IPA requires 'rich' data (Smith et al, 2009) which means allowing the participant to tell their own story in a way that is meaningful to them. This one to one interview was a conversation with a purpose, that purpose being implicitly informed by the research questions. The interview took place as soon as possible after the assessment, all interviews being completed within a three month period and data analysis occurred throughout the process.

These interviews were carried out as follows in the table below:

Table 4 - Interview Process Guide

Aspect of the Interview	Rationale
Initial warm-up	Ice-breaking to establish initial rapport with the participant Clarify the purpose of the interview Revisit Participant information sheet Check and gain consent
Initiation of interview	Ask grand tour question - 'You were recently seen by a member of the MH team following an admission to hospital with SH. What was this experience like for you?'
Maintaining focus	Encourage description Use prompts to assist if required Ask 'how' rather than 'why' questions
Maintaining purpose	Focus on individual experience Allow silence when required No 'leading' questions Clarify any unclear points or ambiguities
Maintaining rapport	Confirm the importance of the persons contribution Non-verbal responses – Active, attentive listening Be respectful at all times
Interview closure	Reassure the participant that the information has been invaluable Ask if the person has anything further to add Confirm that there is not more information required Two week follow up phone call offered
De-briefing	Thank participant Reiterate closure Answer any further questions about research Remind the participant of the contact numbers for further support if required

(based on Shawley, 2012)

4.2.5.1 Question Schedule

The following grand tour question and prompts were used to facilitate discussion in the interview process.

Grand Tour Question

1. You were recently seen by a member of the Mental Health Team following an admission to hospital with self-harm. What was this experience like for you?

Prompts (Use only if required)

1. Can you remember any thoughts you had when you were told about seeing the Mental Health Team?
2. What hopes did you have for the experience?
3. How did you feel before you were seen?
4. How did you feel after you were seen?
5. What do you remember about the person that saw you?
6. Was there anything about the experience that struck you as very positive? What was it?
7. Was there anything about the experience that struck you as very negative? What was it?
8. Would you seek help here again?
9. Is there anything else you would like to add that feels important?

Table 5: Question Schedule

Reflexive Log Note - What to ask in the interview – Aug 2014

Although there is a question schedule, the topic often went off piste and I was a little unsure regarding what I could/should ask, it felt like I should have asked as little as possible but I wanted to have a full blown conversation with him. I was constantly holding myself back to make sure I was getting his experience and not colouring it too much with mine.

4.2.6 Transcription

There are coherent arguments (Cohen et al, 2000) for the IPA researcher transcribing the interviews of their participants as another way of immersing oneself in the data. However, for pragmatic reasons mainly centred on time

management, it was decided that university transcription services would be employed in this instance. Due to the sensitive nature of self-harm and the possibility of some of the material requiring transcription being disturbing, the transcriber was advised of routes to follow should she become distressed. Following interview completion the recordings were immediately uploaded to an encrypted/password protected file on the university network to which only the researcher and transcriber had access. The interviews were transcribed verbatim and all had any identifying names of family members, places and hospitals removed to protect identity. Two recordings were made of each interview which proved helpful when clarification of words was required. Once the interviews were uploaded to the network the recording devices were immediately wiped of the recordings.

4.2.7 Rigour in Qualitative Research and Trustworthiness of Data

Interpretive rigour is an important consideration in qualitative research (Guba and Lincoln, 2005) as it is a clear challenge to maximise the possibility of the conclusions arrived at, providing some insights into the phenomena being studied. Mays and Pope (1996) state that qualitative research is often criticised for lack of scientific rigour, they suggest that it is inescapable that purely objective observations or interpretations are not possible in judging the credibility of someone else's account. They go on to state that reporting on qualitative research is more about creating a convincing account and that to do this it is important to remain as close to the phenomena being studied as possible. Smith (2009) proposes the IPA framework which allows for these theoretical principles to be put into action. For the purposes of this study the principles of IPA were closely followed and the following actions were carried out in order to maximise the trustworthiness of the data, or the rigour of the study.

- Two sets of data were checked with my supervisors. Themes and the data were presented to see if core meaning or essences within and across cases were being found.
- An audit trail was kept by the researcher for each participant (appendix K) which is a systematic collection of the data used to come to conclusions about the data and processes via which it was analysed

after collection, allowing for an independent auditor to check if required.

- Reflexive accounts of the research process from start to finish were kept throughout (see appendix L for example page)
- Data analysis was carried out both individually and in conjunction with supervisors
- Super-Ordinate themes and Lower- Order Themes were presented and discussed in supervision

4.2.8 Reflexivity

The importance of reflexivity has been discussed previously in this thesis and the influence that the researcher's fore-structures, and past experiences, have on the IPA process. Reflexivity is a process of self-examination whereby the continuous process of reflection by the researcher on values, preconceptions and behaviours is carried out (Topping, 2006). Reflection is not a new process to nursing (Gibbs, 1988) and as such the process of reflexivity is quite similar in practice. In IPA, reflexivity is the most important part of the transparency of the study (Smith 2009) which may mean something as simple as describing how features of the study may have influenced the data or interpretations of transcripts.

In order to ensure reflexivity the following actions were taken either throughout or at pertinent points within the research pathway:-

- Use of the hermeneutic circle during data analysis
- Keeping logs of my own state eg. Anxious, hungry, prior to and after each interview
- Noting initial thoughts prior to and following each interview
- Sharing the process of conception of the research study to dissemination of findings with two supervisors
- Keeping a reflective diary of the whole process of the research journey
- Use of points regarding rigour above (4.2.7)

Throughout the process I have tried to keep an open mind to the findings that would emerge from the analysis, including the possibility that none of the questions I asked at the outset of the project may be fully addressed. In these ways I have been reflexive and taken steps to be aware of fore-structure, acknowledge my preconceptions and examined my own beliefs, values and feelings.

4.3 Ethics

I am in an ideal position to carry out this research due to training and experience of working with vulnerable people. I have over twenty five years of professional nursing experience working with people with mental health problems. As previously stated I spent six years in the Emergency Department running a Liaison Team and have extensive knowledge of the assessment process. I have also worked in Crisis teams, Acute mental healthcare and forensic mental healthcare at matron level and have a wide knowledge of different assessment styles and tools. I also do voluntary work where I work closely with people, with lived experience of mental distress, facilitating involvement in events aimed at reducing stigma around mental health. At all times, as a professional, my practice is guided by the ethical guidelines laid out by the Nursing and Midwifery Council (2014). As a researcher, the Good Clinical Practice training, undertaken as part of the preparation for clinical research, and ethics process acts as a guide.

4.3.1 Researching Sensitive Topics

Lee and Penzetti (1993) define a sensitive research topic as:

> 'One that potentially poses for those involved a substantial threat, the emergence of which renders problematic for the researcher and/or the researched the collection, holding, and/or dissemination of research data.'
>
> (Lee and Penzetti, 1993. Pg 5)

This topic is likely to be considered sensitive by this definition due to its links with self-harm. Although the topic under scrutiny is actually the contact the person who has self-harmed has with mental health services in the general hospital, it is likely that the events leading up to their admission, ie. self-harm,

will have had a bearing on the events that follow. Although public perception of self-harm has improved over the past few years (Walker, 2013) it is still primarily thought of as a 'deviant' activity by the community, although it is clear that different groups within the community will see self-harm risks in very different ways (Favazza, 1992). So a group who regularly use self-harm as a coping mechanism are likely to view the sensitivity of this research very differently to those who believe that self-harm is an indicator of illness. Those who choose to self-harm are likely to be habituated to it and thus the sensitivity to it may be diminished as it becomes a cultural norm. Additionally, there would be occasions where both these viewpoints occur, making the landscape even more difficult to navigate.

Self-harm is a personally and culturally sensitive topic. People who self-harm may be experiencing symptoms of distress to varying degrees and considering the nature of self-harm it is likely that recent distress occurred even where no symptoms of mental ill health are present. Researching this group of people so close to the episode of self-harm requires extreme care and skill. Additionally, it is recognised that this research project is aimed at approaching people who have recently been in crisis and as such this poses an ethical question. Should the interview be conducted at a later stage? This was one question asked of the patient consultation (see Chapter 2) panel who were unanimous in their belief that it is essential to ask recent users of the service what their experiences were like and that waiting allowed both memory to dull the recollection of the experience but also, as time goes on, many do not wish to be reminded of events that occurred when they were in crisis. People in crisis are a group that are rarely researched and yet they are a group for whom it is essential they receive the right care at the right time. Therefore it could be argued that it is ethically required that we ask the opinion of this group of people to justify the interventions offered at these times.

The safeguards of consent and ability to withdraw at any time protect the participant, and pointing participants to local care resources, should they become distressed, are important. This coupled with sensitive handling of the recruitment process and interviews will ensure, as far as is practicable, that the participant comes to no harm. This patient group is under researched, according to the literature, and as such there is a gap in the knowledge which this research aims to help fill. I was confident that my previous role as a mental

health liaison practitioner and the experience of the gatekeeper meant that potential participants would be approached with utmost caution and tact. If someone approached by the gatekeeper had become more distressed since agreeing to be a participant and was judged to be too distressed to take part they were offered the options of terminating the interview, trying again another day or withdrawal. At all times the welfare of participants takes precedence over the research.

4.3.1.1 Informed Consent

Informed consent is an essential ethical consideration in any research project (Johnson and Long, 2006). Informed consent is the willingly given agreement of a participant to take part in research that they have received an explanation for and understand (Flick, 2014). All participants were given the PIS when approached by the gatekeeper. Prior to asking the participant to sign the main consent form, just before interview, the researcher went over the PIS to ensure it was fully understood by the participant and to answer any questions they may have. As part of the consent process the participant was reminded of the need to record the interview and asked to agree. Additionally as part of this process participants were reminded that they could withdraw from the study at any time without giving a reason and reassured that doing this would not affect their current or future care in any way. Smith et al (2009) point out that it is also important that consent is gained for the possibility of using verbatim quotes in the analysis and dissemination phase. To ensure all this was clearly understood the consent form was not signed until after the participant had had ample time to discuss the PIS with the researcher and to ask any questions. The consent form was then signed and a copy given to the participant to keep.

4.3.1.2 Confidentiality

It is essential to develop mechanisms for ensuring participant confidentiality in research (Streubert and Carpenter, 1995). As per suggestions in Smith et al (2009) raw unedited transcripts would only be seen by the researcher, supervisor and transcriber, any data for wider use has been anonymised to ensure confidentiality of personally identifiable data. In the Participant information sheet (PIS) it was made clear that under the requirements of the NMC code (2015), as a registered nurse, I was bound to share information, including personal data, if I believed anyone to be at risk or if criminal activity

was shared during interview. Maintaining the anonymity of those taking part in the research is of paramount importance. Illustrative quotes and phenomenological detail have been used, as well as overarching themes therefore this minimises the likelihood of any patient being identified at any point in the write up. Local data protection guidelines were followed at all times to protect the research data and ensure no breaches of confidentiality. All files were password protected and physical data eg. transcriptions will be destroyed after ten years and kept in a locked filing cabinet until that time.

4.3.1.3 Avoidance of Harm or Distress

The principle of non-maleficence has long been considered important in healthcare (Gallagher and Hodge, 2012) requiring that professionals working within the sphere should not inflict harm on others (Beauchamp and Childress, 2009) and in relation to this the principle of beneficence. As part of the research process it is essential that the researcher consider the potential effect of the study on the individual participants and the consideration of potential harm just from discussing sensitive issues must be considered (Smith et al, 2009). The following points, adapted from Tee and Lathlean (2004) were helpful in ensuring that ethical principles were considered and that no harm should ensue:

- Researcher skills to build and maintain a sensitive relationship with the participant
- Agree clear ground rules and boundaries of confidentiality
- Be sensitive to potentially traumatic disclosures
- Provide a debriefing opportunity after the interview

4.3.1.4 Participant Distress

During the interviews it was possible that participants may become distressed therefore it was important to have a range of support methods available to signpost the person towards in order to address any issues that went beyond the interview. The researcher had to make an informed judgement based on observation, interview and past experience (Tee and Lathlean, 2004), regarding the vulnerability of the individual and ensure that the participant understood as fully as possible the requirements of them with regards to this

research. Some have asserted that people with mental health problems should not be expected to participate in research (Koivisto et al, 2001) however this is disputed by services users themselves (Leiber, 2010) and policy (DoH, 2011). If the patient was already known to adult mental health services and it became clear that they needed additional support, a permission to share form would be completed to allow communication with the care-coordinator following the interview. If the patient was not known to adult mental health services then the GP was informed if further help was required. In the event these measures were not required. As an additional precaution the GP of each participant received an email stating only that they had taken part in the research project (appendix M).These courses of action did not act as a disincentive to take part as they did not represent any change from the normal course of events following assessment in the Emergency Department following self-harm.

4.3.2 Formal Ethical Procedure

The following ethical procedures have been carried out to gain approval for this study:

1. The University of Southampton agreed to act as the sponsor of the research project and provided indemnity insurance on the 05th August 2013

2. Research and Development (R&D) permission granted on 20th November 2013 (appendix N)

3. Approval from the local ethics committee was granted on 15th October 2013 (appendix O)

4.4 Analysis

Data analysis began as soon as the first interview was completed. The interviews with the participants were all analysed and themes identified. According to Polit and Hungler (2001), a theme is a broad unit of analysis and might be a phrase or paragraph that points towards ideas or assertions on a topic. Analysis of the data is carried out in order to organise, provide structure

to and elicit meaning from the transcripts of the semi-structured interviews. In order to analyse the data the transcripts were interpreted for themes that recur and these were made sense of. There themes were then transformed into tables and text where the researchers analysis is detailed and supported by examples of text from the original transcripts (see chapter 5). It is important to achieve a thick description of the perspective of the participants in all its complexity. This meaning was gleaned by careful and repeated listening to the interviews, reading and re-reading transcripts and reflecting. The process of this analysis is informed by Smith et al (2009). They assert there is no clearly correct way of conducting this type of analysis and IPA researchers are encouraged to be creative in their approach. The principles of commitment to an understanding of the participant's point of view and a reflexive focus on personal meaning making in particular contexts was applied throughout. As themes are identified within the analysis it may be possible to group these smaller themes into superordinate themes which can then be prioritised and analysed further.

4.4.1 Reading and Re-Reading

Following transcription, the first step was to immerse myself in the data. For each participant, the interview was listened to along with the transcript and any corrections made, then the text of the transcript was read and re-read. During subsequent readings the voice of the participant could be heard in my head assisting in a more complete immersion in the data. Prior to and after the interview taking place I had taken notes regarding my impressions and state on the day and this was also read in order to recall this information.

Repeated reading allows active engagement with the data (Smith, 2009) and following each reading thoughts were recorded and a global summary of each transcript was completed after the re-reading. This provided a good overview of the experience of the participant and helped maintain an idiographic focus whilst at the same time providing me with a quick way of accessing the correct interview whilst working on emergent themes. This summarising also assisted in ensuring I had identified the essential characteristics in the data from each interview.

4.4.2 Initial Noting and Descriptive Comments

The first level of noting was to identify content. Highlighter pens were used to assist in identifying aspects of the transcript that were similar and descriptive comments were made in the left hand margin (see eg of notated transcript appendix P). The points raised initially are likely to be influenced by my experience as a mental health practitioner and it was necessary to re-read the text following the content noting to check again for issues I may not have picked up initially. This first level also ensures a growing level of familiarity with the text and begins to identify the individual nature of the participant's way of thinking and understanding the phenomena. Once this level of noting was complete I re-read the text this time carrying out interpretive coding, looking for the prominent themes rising from the transcript. Descriptive notes were written in the right had margin for these interpretations and underlining was used to highlight the areas of text considered important for interpretative purposes.

4.4.3 Deconstruction

With a growing understanding of the overall text it then became necessary to focus on the participants' use of particular words, phrases, and sentences and consider the meaning that these held. In this way I was able to get closer to what they were actually saying rather than what I thought they were saying. So my initial interpretation of their words on hearing them was added to by closer consideration of the actual words they had used in the transcript. The meaning making or quest for sense in the text was carried out at sentence level in order to assist in the interpretative process. Particular key phrases or words that appeared particularly relevant to the phenomena were extracted and written on separate paper which was colour coded for theme. This particular phase is not unlike editing where decisions are made about what is and is not relevant to the text (Cohen et al, 2000). These colour coded papers where the text had been physically cut and piled into related themes or ideas is a common practice in IPA (Smith et al, 2009. Cohen et al, 2000) and can allow for connections to be made at levels not considered whilst viewing the text as a whole and open the text to more in-depth interpretations.

4.4.4 The Hermeneutic Circle in Action

Fig 2 (4.1.3.2) illustrates the process of hermeneutics at work. The inner circle represents the way in which I re-visited the interview, mainly at home, to rehear the story told by the participant, asked questions of it, tried to make sense of their experience in light of my own viewpoint and experiences. I considered the single word, the sentences within which the words were embedded, the extract this sentence emerged from, the text within which the sentence was employed (the transcript), the single episode (interview) that the transcript arose from, all ten texts together and the overall experience of the phenomenon of contact with mental health services in the general hospital following self-harm. Throughout this process analysis is constantly taking place and interpretation is possible. The circle could continue ad infinitum but at some point I made the decision that the interpretation was good enough and exited. The skill here is knowing when the point is reached that there is nothing new emerging from the data.

4.4.5 Identifying Themes

One by one each transcript was examined to get a clear picture of the experience of the individual. The transcript was already numbered by paragraph and phrases directly related to emergent themes were extracted and further considered. Flipchart paper was used to group, label and arrange these extracts which allowed for theme headings to be considered. At this stage the themes related to the individual cases however as Smith et al (2009) point out it is likely that emergent themes that occur across cases will be starting to emerge here but the process of looking for patterns across cases is resisted at this stage to ensure that each case is considered as fully as possible before turning to look at patterns and inter-case connections. A table was created for each participant outlining the themes for each case (appendix K).

Reflexive Log Note Sept 2014 - Struggle with Interpretative

I realise I cannot truly represent what the experience was like for the other person. I can only give what I believe they are trying to say to the best of my abilities. Can we ever really discover what an experience is like for someone else? No. But don't we, well some of us, live our lives trying to understand others perspectives but only ever being able to understand our own version of reality? So we can never be objective. We look at everything through our own lens so trying to understand someone else's reality will inevitably fail. If I stay close to the words to explore the phenomenon but move away from the interpretation except to discuss in the light of the themes raised. Perhaps this will get me closer to their reality. The feeling of 'weaving air' in data analysis using this method has thrown me. It seems likely that phenomenology may well be the correct way but I am increasingly uncomfortable with the 'interpretative' element. I don't want to write a thesis that is essentially just my opinion.

4.4.6 Next Case

These steps were completed for each transcript and then the next case was considered. Each case was considered individually at first and following 4.4.5 the recording was re-listened to, to confirm as far as possible the idiographic nature of the meaning found.

4.4.7 Patterns Across Cases

Once the initial analysis of each case was complete the themes that had emerged were considered in a cross-case analysis. Key emergent themes became clear for the whole cohort although when illustrating these themes, the text used still comes from individual transcripts. The information already in the tables for each case was used to amalgamate themes of a similar nature, this process produced lower-order themes, related to some cases, and super-ordinate themes which related to all cases. Patterns and connections were then looked for across these themes and the super-ordinate themes became clear via this process as suggested by Smith et al (2009 Pgs 66-75). There is no specific guidance on the number of times a theme should appear for it to be

considered lower-order or super-ordinate, it is possible for a theme to be considered important even if it only appears once, as a theme that unlocks further understanding of the experience under scrutiny is as important as a less impactful theme that occurs many times (Smith et al, 2009). These super-ordinate themes are closely linked and central to the main themes noted during individual analysis of participants' transcripts. Overall four main themes arose and these are further documented in Chapter 5. The data were also used to converse with mental health nursing literature, particularly Barker (2004); with anti-psychiatry literature particularly Sayce (2016); patient literature particularly Beresford (2015) and Russo and Sweeney (2016). This is discussed further in chapter 6.

Chapter 5 Findings

5.1 Introduction

This chapter presents and explains the data from the participants, exploring their experience of contact with mental health services in the general hospital environment following self-harm. Ten participants were interviewed and they are each introduced by way of a short vignette, taken from their own words and descriptions of themselves within the interview. This gives slightly more context for each individual and allows for a more in-depth understanding. I also discuss some fore-structures that influence my interpretations of their experience and discuss the nature of the cohort in brief.

Four Super-Ordinate Themes (SOT) emerged from the analysis, informed by thirteen Lower-Order Themes (LOT). These themes were discussed and ideas checked in supervision sessions to assist in naming of the themes and to help to ensure rigour. The second half of this chapter is devoted to portraying the themes via the participants' words which are used to illustrate them.

5.2 Fore-structures

Most participants chose not to discuss details of their self-harm and I had decided not to ask questions about this. This chosen boundary was accepted and adhered to where it existed. In all cases the base assumption was that the participant had come to hospital following a serious crisis in their lives that had led to them doing something potentially catastrophic. Knowing the details of the situation or the self-harm would not help me understand their experience of seeing the mental health team and may lead me to other fore-structures regarding the situation and the act of self-harm which would potentially cloud my immersion in their experience. The same is true of diagnosis, with every diagnosis comes a host of preconceptions and stereotypes which could have affected the way the person was viewed and further clouded my understanding of their experience of services. Thus diagnostic details were not sought and the participant notes were not scrutinised at any point.

Reflexive Log Note – August 2014

IPA is leading me to do what I did as a clinician. This feels like it is moving me closer to my position as a clinician and not further away as I had hoped. I practiced intuitively a lot, I am good at interpreting body language, unspoken undercurrents and understanding people. This method is very close to how I work. I feel a bit disenchanted with IPA as a methodology having been convinced of it's rightness since the consultation. It feels the same as when I lost my faith! I was almost unquestioning of the method, truly believing it to be right but now it feels a bit wrong. Perhaps there are many overlaps at this interview stage because the research interview needs the same skills that are needed in an assessment situation clinically. So perhaps it is no surprise that there is a movement towards the clinician in me. So many hats!

I had an emotional reaction to one of the participants; she was describing such distress as a result of her experience in the ED that I felt the pain myself and found my eyes were full of tears and my body felt heavy and hopeless. She said she felt the person was so uncaring that she thought she would have been better off dead as she had originally intended. I felt so deeply sad at that. Clinically I would have shed a tear and sat with the person stating how sad that made me feel and therefore imagining that the reality for her must have been so hard. I did the same in the interview, it would have been inauthentic to have acted otherwise. So the same response but with different hats on.

5.3 Participants

Pseudonyms have been used to protect the identity of each of the participants and no names used in the interviews of people or places have been mentioned throughout or in the transcripts from which the quotes are taken. There were ten participants who were recruited for interview, the participants were five males and five female. Details about their self-harm and demographic details were not considered relevant for the purposes of exploring the experience of seeing the mental health team so were not gathered, however a brief summary

of the details they shared naturally as part of the interview is provided in the table below.

Pseudonym	Gender	Estimated Age	Type of self-harm	Reason given for self-harm	Relationship status
Dave	Male	19	Overdose (OD)	Relationship breakdown	Single
Fran	Female	Early 30s	Overdose	Not shared	Married
Jane	Female	Late 20s	Overdose	Bereavement and having to wait to talk to mental health	Single
Alex	Female	20s	Overdose	Impulsive act	Single
Jim	Male	Early 40s	Jumping	Relationship breakdown	Single
Seth	Male	20s	Overdose	Lack of help with alcohol issues	Single
May	Female	50s	Overdose	Not coping	Single
Fred	Male	Late 40s	Overdose	Relationship breakdown	Single
Alan	Male	20s	Overdose	Relationship breakdown	Single
Ann	Female	30s	Overdose	Not shared	Single

Table 6: Demographics of participants

For each participant a short vignette outlining how they viewed themselves is presented. In some interviews the participants outlined certain aspects of their self-harm or the events leading up to the admission if they felt it was relevant. These vignettes are integral to a phenomenological approach and will help provide context with regards to the personal world of the participant, allowing the reader to more fully understand the verbatim quotes used.

5.3.1 Dave

Dave states he is not a natural talker, a young man, not yet 20 and in need of reassurance in order to open up and talk about his life. He says that for most of his life he has had a mental blockage about being talkative and emotional which has sometimes made it difficult to say enough in order to get help when he needs it. He states he is a man who is looking for understanding and has a fear of being judged negatively. He is still being supported by adolescent services so has a psychologist and support team. A serious incident had occurred in his life leading to self-harm and he hoped that his contact with the mental health team would lead to the 'chance of an understanding.' In the event this did not occur and he felt like nothing had been done and he had hit a dead-end leading to him feeling like he was going nowhere, he was just trapped.

5.3.2 Fran

Fran is a woman in her 30s who had reached a point whereby life did not seem worth living. She had given up and felt unworthy of living. She sees herself as an aberration, feeling under societal pressure to be a certain way which she finds hard to attain. She clearly expresses a wish for a live and let live society in which she can be allowed to exist accepted just as she is. She is constantly striving to see other people's opinions and perspectives. She tries repeatedly to make sense of the behaviour of those around her, attempting to walk in their shoes. Life is a traumatic struggle and by understanding others she begins to understand herself. Coming across someone who is so hard to comprehend as the mental health practitioner she encounters at the hospital is disturbing to her. It caused her to question her very existence again. How can they not have a modicum of understanding about what people go through if they are 'A person caring for another person'?

5.3.3 Jane

Jane is a woman in her 20s, recently bereaved of her father who had a long history of mental health problems along with her mother, so she is familiar with services and the way they work. Jane had initially been brought to the Emergency Department in order to see the mental health team urgently and

had not self-harmed at this point, the initial staff she dealt with on her way to hospital and on first arriving suggested she would be seen quickly, she subsequently discovered that she actually had a very long wait to see them and the distress she felt at this led her to overdose in the department. She does not feel able to trust herself so relies on the opinions of others to help her figure out what to do next. She feels very guilty for her self-harm as she realises her family would have been further bereaved had she died. She is quite used to the patient role but can see flaws in the treatment she receives whilst in the Emergency Department and suggests ways to improve things. Her inner turmoil is extreme and she finds the long waits that are commonplace in the general hospital difficult to manage. The service made her bad experience just a little bit worse and pushed her to the point where she went what she describes as that 'extra mile' and overdosed. The 'waiting game' was unacceptable to her and she discusses the aftermath of it and the ways she can see of preventing it for others.

5.3.4 Alex

Alex is a young woman in her 20s who has had a very abusive past and is on a journey from that negative place to a future that is more positive and hopeful. Every step on her 'upward spiral' is hard work. She sometimes loses hope and runs out of idea so she values others opinions and points of view as they increase her options. She describes herself as a 'you scratch my back, I'll scratch yours' person and as long as balance and fairness are maintained in her world she copes well, however when the balance is disturbed she becomes very frightened and isolated. She sees herself as a protector of the vulnerable, particularly children and has a clear role caring for them within her extended family. Alex presents a continued struggle on her travels from a predominantly frightening past to a more positive future. She is striving to create some balance and consistency from chaos, also to help others who find themselves in similar situations to those she has found herself in both past and present. She sees the contact with the mental health team as a positive step on her journey, helping her to move up the spiral rather than down it.

5.3.5 Jim

Jim is a middle aged man who is in a lot of pain as he sustained many physical injuries after jumping from a great height. This pain appears to be both physical and psychological and it is all pervading, making it difficult for him to concentrate on anything else. He feels embarrassed to be in hospital as a result of his own actions and feels he is not as legitimate a patient as others. He finds taking difficult and states a few times that it is 'too difficult' and 'hard' to look at his current situation beyond dealing with the pain. He called a halt to the interview because of the pain he was in. He sees himself as someone who is at risk of further self-harm and states he was unwise to stop the anti-depressants he was on four months prior to the self-harm.

5.3.6 Seth

Seth is a young man who has a pre-existing alcohol problem alongside his self-harm. He expresses multiple times his 'annoyance' at the fact that practitioners repeatedly tell him that he must give up drinking before he can get help with his mental health problems. He is quite sure that this is not possible. He yawned many times during the interview and, whilst it may have been quite possible that he was tired, it seemed that he was rather bored by the cycle of non-care he was caught in. He sees himself as a person with depression who drinks rather than a drinker first. He knows he needs help and is annoyed he cannot get it. He doesn't see how he can stop drinking when he's got the problems he currently has. He describes himself as really shy and disliking groups during which he freezes up and can't talk.

5.3.7 May

May is a woman in her fifties who looks like a little girl in stature. She describes herself as someone who just is not coping as she has a lot of issues including an eating disorder. She is ready to accept help, particularly practical help with her flat. She feels she is not helping herself especially with her eating disorder which she states she nearly beat once. She states she has lost her way and needs to get back on track as she predominantly lies there worrying about everything or staring at the wall. She feels physically weak and this affects her psychologically, she states her coping mechanisms are currently not good. She

feels all alone without a good family network. She was preoccupied with the worry of her current situation and ended the interview early as she received a distressing phone call that made her unable to continue.

5.3.8 Fred

A man in his late forties who identifies as a Christian, part of him anyway. He describes himself as a loving, caring, nice chap who isn't cynical. He states he wears a mask to hide his real face, although is at pains to say he is not wearing it during the interview, so he appears to act normally but doesn't feel it inside. He believes this to be a sign of mental illness. He is extremely angry about his contact with the mental health team on this admission and raises his voice many times in his distress at discussing it.

5.3.9 Alan

Alan is a young man who states he finds it hard to talk to anyone since he was sixteen, when his grandad died. He had been feeling quite hateful towards himself but that had improved. He also feels he has a guardian angel watching over him in the form of his sister who rescued him on this and a previous attempt on his life. He states he has been through hell since he was seven although does not elaborate why, he tried to sort himself out mentally and physically by joining the army which helped a bit but he soon reverted to someone who did not talk about issues on discharge. He finds it easier to talk to stranger than to people he knows as he feels they are less likely to judge him.

5.3.10 Ann

Ann is a woman approximately in her thirties who has judged herself for having self-harmed in the first place, causing extra work for staff who wouldn't have had to do it otherwise. She feels ashamed by her actions and as someone who has a complex history; she was embarrassed that she had become distressed. She describes herself as struggling emotionally, often frightened and scared, still experiencing the urge to self-harm whilst waiting for the mental health practitioner. She finds women easier to be distressed in front of

than men. She also finds it hard to see someone new each time she is in hospital.

5.4 Diversity of the participants

As per the inclusion criteria all participants were adults who had self-harmed and been seen by a mental health team prior to recruitment to the study. Apart from these factors the participants came from varying social backgrounds, with differing relationship statuses and circumstances. Information about this was only available if they specifically brought it up they were not asked directly for this information as previously discussed. Eight of the participants reported using general hospital services on more than one occasion and nine were known to mental health services prior to their attendance on this occasion. All but Alex described being suicidal at the time of self-harm so this group represents a particular demographic of people who self-harm who are not necessarily representative of those who self-harm as a coping mechanism without suicidal intent.

5.5 Super-Ordinate Themes

Analysis of the interviews suggested four Super-Ordinate Themes (SOT), with a total of thirteen lower order themes (LOT). A super-ordinate theme is a construct which usually applies to each participant within the cohort although it may be manifest in several different ways (Smith et al, 2009). A Lower order or emergent theme is one that informs a super-ordinate theme and there may be several of these in one SOT (ibid). A table outlining each of the super-ordinate themes with lower order themes and the rate of recurrence of each theme from within the data can be seen in appendix Q. In brief table 7 below outlines the themes.

Super-ordinate Themes	Lower-Order Themes
Internal Barriers to getting the help you need	Being a non-talker in a talking encounter
	'Emotions run high'
	Guilt and shame
	Re-living Trauma – 'I'd already told'
The Business of Being Human	'A person looking after another person'
	Stigma – 'an aberration?'
	Perceived judgement
Traumatising Environment	Physical Space
	Systems Driven Care
	The Assessment – helpful or traumatic
Patient Power	'You don't want to lie to them, yet you don't want to tell them the truth'
	'You scratch my back. I'll scratch yours'
	Expert by experience

Table 7 – Theme Outlines

What follows here are the themes outlined with supporting evidence from within the data:

5.5.1 SOT 1: Internal Barriers to getting the help you need

This superordinate theme represents the internal factors that created blocks to deeper understanding and ensuring needs were met. They took many forms for each of the participants; however all fit into the four LOTs presented here. The title of this SOT draws on language used by Dave in particular who often used military words to describe his experience. Here the participants raise issues that form part of their internal world that influence how they interact in the encounter with mental health services that may present a barrier to getting the help they need, all these LOTs present a difficulty that must be overcome in order to allow clear communication of need to ensue. This SOT is informed by four LOTs; Being a non-talker in a talking encounter; 'Emotions run high'; Guilt and shame; and Re-living trauma - 'I'd already told'.

5.5.1.1 LOT 1a:Being a non-talker in a talking encounter

The meeting with mental health in the general hospital following self-harm is one in which an assessment is expected to take place (NICE, 2004), this assessment is a talking encounter. Viewing themselves as a person who is not a natural talker had a distinct impact on their help seeking behaviour both in the past and in the present.

Jim is in so much pain he finds it hard to talk at all (clearly demonstrated to me during the interview) and describes the 'chat' he had with the mental health practitioner: *'it was too difficult.'* Very early on Dave asserts: '*I don't usually like to talk to people'* and reasserts this position several times in the interview. He cites fear of judgement as something that influences this: *'you can't help but feel that they're starting to judge you more and more, so you don't really want to talk about things'* He goes on to describe actively avoiding questions by trying to seem disinterested, *'just so that then I could avoid the conversation'.* He clearly shows that he is aware this effects his opportunities for help:

'I don't usually go into, like, a talkative, emotional, um state of mind. Um, and that has, like made me miss out on a lot of opportunities in the past to get um, help and support for my mental health.'

In order to moderate his difficulty in being in this talking encounter Dave takes steps to make himself feel less threatened and enable himself to share at least some of the information he needs to:

'I remember I didn't make any eye contact, and for most of the conversation I was just staring at the walls or the ceilings, like I also had my body turned to her, so I wasn't face on with her. Because then it didn't feel like, so much of like an interrogation or an interview.'

In this way he was able to change his emotional state enough to allow him to participate, at least to some degree, in the interaction.

Alex felt the questioning was '*invasive and personal'*, finding the assessment process difficult, primarily because it involves looking into the past. She says: *''I can't really open up to strangers that well,'* She had a particularly metaphorical way of speaking and when asked a question would respond by telling a story which, at first glance, seemed to have little to do with the question just asked. This illustrates a different form of communication, a non-direct method, which would potentially be difficult to interpret within the confines of a busy department. Alex appeared to be able to talk as long as she could approach the subject from a metaphorical angle which she appeared to find less threatening, but otherwise finds it difficult to open up.

Not talking about problems appears to be a pattern for Seth who states: *'I just hid it away and not told anyone'* He describes not getting help the first time he approached services, a time at which he believed he would get help and subsequently when he has attended hospital he has reached a point where it feels relatively pointless talking because he gets: *'just the same old same old.. they, they, all they say to me every time is 'Can't help you'.* One form of help he has been offered is group work and in response to this he states: *'I'm really shy…….I freeze up and can't talk'* Illustrating the difficulty he has in talking to others.

This pattern is also evident for Alan who states: *that's what I can't do, I can't talk',* he describes having lost the ability when he was an adolescent: *'I haven't been able to speak to anyone since I was 16 years old when my Grandad died.'* Suggesting a possible link here between emotional intensity and expression of this via language which may contribute to his difficulty in talking.

Essentially for these six participants, five of whom were male, talking to others represents a significant barrier it getting help for mental distress. The metaphors eg interrogation, used to describe this difficulty were often military in nature suggesting a kind of battle. This was the only theme that may have been influenced by gender which raises questions about the efficacy of a talking encounter for men at this point following self-harm.

5.5.1.2 LOT 1b: 'Emotions run high'

All participants cited fragile emotional state, unsurprising when recently in crisis, as being a barrier to receiving the help they need. Inner turmoil which affected their ability to communicate needs clearly.

Dave was frank about his frame of mind, declaring: *'I was in an emotional state and I wasn't in my usual frame of mind'* He spoke often of '*blockades*' and '*barriers*' and described this emotional state as something that created these barriers, also stating that they increased with the questions posed by the care staff in his admission: *'questions were already being asked by nurses and doctors, um, so instantly my shield sort of stayed there.'* He could see that when he was in a more stable condition he was better able to understand events around him: *'I was in more of a stable condition did make it easier to understand'* He cites this emotional barrier as being a longstanding one:

'throughout most of my life I always had like this bit of a mental blockage, like I don't usually go into, like, a talkative, emotional, em state of mind.'

The influence of emotions on help seeking is also demonstrated in the data for Alex who found having to repeat situations from the past made her '*emotions run high*' and she described how this made her feel:

'It feels like you're in a room and you're just shut away from the world. Um, like your mind is trapped in a box. Um, it's not very nice at all. It makes you feel very isolated, away from people; makes you feel very vulnerable, very scared.'

She also refers to the importance of being able to find: *'time to cool our heads, time to clear our heads'* in re-establishing good communication to enable help and support. When her mental health practitioner inadvertently upset her she states her reaction: *'made me feel quite uncomfy, didn't want to talk any more, didn't want to tell her any more,'* Meaning she had to take steps to calm herself down again.

Mixed emotions were described by Alan who was positive in his emotional state at contact with his mental health practitioner but described how he had felt prior to assessment by his mental health practitioner: *'Like crap….I'd see everyone, hear everyone, but it was just…you know, it's just like….I assume…it was like I, I wasn't here in person.'* suggesting a numbed emotional state. He described his current state as: *'happy, and not, not emotional like I have been'* This indicates not only that he is not noticing that happy is an emotion but perhaps that emotional means negative emotions which are to be avoided if possible. *'I was emotional all morning, um… thinking about what I could do to make things go away'* clearly suggesting that he felt emotions should go away.

The effect of managing emotions is demonstrated in the data from Ann who was having to moderate what she said in order to maintain a hold of her emotions from fear of being publically shamed: *'I had to be very careful about how I did that, because I was scared of actually losing the plot completely'.* She refers within her interview to fearing that she would become over emotional and this, as she states above, meant that she had to think carefully about what she said. By logical conclusion then she may not have been able to be as open as she needed to be in order to receive the support she needed so this

represents a barrier to getting the help she needed. In common with Alan, Ann seems to see emotions as something to be avoided if possible. she says: *'I had all these feelings going round in my mind, absolutely agonising and excruciating.'*

At the time of the research interview, Fran, Jim, May and Fred were still palpably emotional. Fran and Fred were angry using language such as '*out-of-order'*; '*as much use as a chocolate fire-guard*'; '*it's not good enough'*; and '*not acceptable'*. May and Jim were still in distress, Jim from the pain he was in physically, clear in the way he moved, and emotionally. He used terms such as '*the pain'* and '*it's hard'*. May, convinced she was incapable and desperate to be rescued, was disconsolate when her brother refused to come to her aid. Fran states early on that: *'I was worried and I was scared'.* She noted that she was not explaining herself very well and that she had given up at the time, so her thinking was quite nihilistic: *'I'd given up, I didn't really um… so yeah, there was no future, there was nothing to look forward to: there was… there was nothing.'* Viewing herself in this way may have had quite an impact on how receptive she was to help at the time of assessment. Jim's interview was painful from start to finish, he repeatedly noted '*the pain I been through'* and talked about how hard things were so it was no surprise when he wanted to end the interview early. The same could be said of May only her pain was caused by worry and distress rather than physical too. She states about her current situation: *'all I'm doing is lying here worrying about everything all the time'* She was frightened that she wouldn't be able to cope on discharge as she was overwhelmed by her social situation.

Fred used humour to hide hurt and as a mask to hide his true feelings, but he was so angry throughout his interview that I interpreted this humour to be more to do with pain than anything positive. Phrases like: *'Are you having a laugh'* where '*you'* represented some kind of cosmic entity like the gods playing games with him, peppered his interview. Occasionally he would add in a poignant phrase like: *'I am absolutely at my wits end!' and 'I have feelings and they've not been addressed.'* Both of which indicated that he was struggling but had not managed to make himself heard by the mental health practitioners who saw him, indeed using humour may have been interpreted as a person who was coping well. He also talked of his 'mask' which he utilised to keep his emotions and true nature hidden from those he did not want to see it.

From the outset, Jane states that she felt the assessment was *'nerve wracking'* she described her mental state as: *'Everything is going round and round and round in your head.'* And her focus was clear: *'All I was thinking about was me, me, me ,me'*

Seth stated he was continually annoyed in his interview, although his demeanour did not really support this. He repeatedly yawned leading me to believe he was either very bored of his cycling through the process of being in the Emergency Department, as he had had repeated admissions for overdoses whilst under the influence of alcohol, or that he was discharging emotion that way rather than directly engaging with it. *'I get a bit annoyed sometimes that they, they can't do a , a lot more for me 'cos obviously, cos I dr- I drink, so that's a bit annoying.'* He characterised himself as someone who is '*always depressed'* which could also be a barrier to receiving help.

The emotional state of the individual is likely to interfere, as illustrated above, with the ability to engage the sort of help one might like. Whilst other factors are likely to have a bearing, in this instance being emotionally overrun, whether by anger, worry, annoyance or fear influenced ability to communicate and may have set negative expectations of help thus creating an additional barrier to getting the help needed.

5.5.1.3 LOT 1c: Guilt and Shame

The effects of shame and guilt were evident in the data, primarily expressed due to being there by their own hand. This had an impact on the information shared with the practitioner who saw them and as such may have represented a barrier to the help they wished for and subsequently received.

Ann mentions early on that she already feels a burden for being in the busy Emergency Department: *'you already feel that you're causing them quite a bit of bother.'* She cites her own actions for being the reason for this as demonstrated by:

'when you've gone into A&E through actually having self-harmed because you'd done something to make them extra work which they didn't have to do in the first place and that sort of added to it.'

Ann felt this embarrassment and shame: *'I was so ashamed by it'* exacerbated by the thought that someone might overhear what she had done and the reason she was in the department: *'I was really, really embarrassed that they'd hear me in the next, in the next bed'* She returns again to the state of guilt when considering her impact on the staff in the Emergency Department: *'the huge amount of guilt I felt because A&E was really busy….they were really really busy with people that hadn't made themselves unwell.'* This comment demonstrating her own judgement of her actions by way of comparing herself with those who were there for, what she suggests as, more legitimate health reasons in line with Jim.

Jane felt guilty for being there by her own hand, but also for putting her family through another trauma right after another family member had died: *'I was feeling guilty ….I'm the world's worst person.'* In this passage Jane provides some insight into the issues discussed previously regarding her narrowed view of the world whilst in crisis, which, once the crisis has subsided she viewed as selfish behaviour. She judges herself by imagining how she must look in others eyes because of her self-harm. She sees herself this way due to the fact that, had she killed herself, she would have added another bereavement to the family who are still recovering from the last one.

To some extent this sentiment is shared by Alan who states he was '*just sitting here hating myself*', and again he notes that '*at the time, all you do is think about yourself and yourself only*'. Jim expressed shame and embarrassment about his self-harm: *'You've got people who are in a bad way and then you get someone who, like me, who…and then it's got 'self-inflicted'…….it felt about, like, like embarrassing for, for what I, what I'd done.'* This embarrassment was made more acute by the thought that others around him, as he was bed-bound at the time of assessment, would know that what he had done was by his own hand.

Feelings of guilt and shame are known to be strong factors in preventing people seeking help when in distress. The fact that these participants were clearly feeling ashamed is likely to have added another barrier to their ability to ask for help and to feel worthy of receiving and accepting help when offered.

5.5.1.4 LOT 1d: Re-living Trauma – 'I'd already told'.

This fourth LOT concerns the issue of having to revisit distressing, disturbing or traumatic memories from personal history or of the recent triggering events that led to the self-harm. Two participants ended their interviews early as their pain (physical and/or emotional) was too great to continue. There were real concerns about becoming enmeshed in recent events, feeling the urge to self-harm again and having to revisit memories of abuse or loss. This fear is well founded as the assessment process (outlined in 1.7.7) requires this contextual information in order to help the mental health practitioner understand the full picture and offer appropriate options for moving forward, so the likelihood is that this fear would be met. Reluctance to re-visit previous experience would be likely to create an additional barrier to getting help. This is clearly demonstrated by Alex when she states: *'I don't like reliving the past….problems in the past with the family I don't like talking about …*' Indicating that for her she believed that: *'repeating things just goes in my book of, repeating yourself to two, three different people, and it confuses situations, it upsets people, and it makes emotions run high.'* She stated that she was glad when being assessed by someone who knew her and knew her history, very unusual in this context, as: *'it makes the patient feel more at ease about seeing them, it really does.'* Thus preventing the need to revisit negative events from her childhood which she found distressing.

Dave indicates this fear in his opening sentence:

'It was scary. Um, obviously when you're not in the right frame of mind to be in a confrontational issue, having people asking what was going through your head, what you were thinking of, why you did it, scares you and at the same time makes you re-think about everything that made you do that, 'cos to give them a straight answer you've got to think about … think the way you were thinking at the time.'

So he indicates a wish to give the mental health practitioner a straight answer but this is hampered by his fear of going back to thinking how he was at the time he self-harmed. He expands on this a little later when he says:

'What happened was I was reminded of a lot of things that had happened to me recently, and the fact that I, that someone was talking about them to get

me into a situation like that, having to re-live that in my own mind, it did feel quite uncomfortable and, and in some ways kind of regretting that more damage wasn't done.'

Here he indicates a further concern that on reviewing these 'things' he is left feelings that he regrets his self-harm wasn't more catastrophic suggesting perhaps that he wishes he had died. He is clearly showing that the experience is uncomfortable and scary. Reassuringly he goes on to indicate that:

'in the same sense you, you've got to strike a balance, you've got to try and find the right frame of mind to understand that you've got a strike a balance between knowing what is right, what's wrong; so basically knowing that you want to do more damage but they've got to know what was going through your mind for the right assessment and understanding of your frame of mind then.'

Here he indicates that he is aware that professionals need this information and appears willing to take the risk to allow for the right assessment.

Ann often, during interview, noted times where she was expected to repeat herself over and over again; *'the last thing I wanted to do was actually to have to repeat everything again, again and again.'* Interpreted to mean that this was experienced as an unreasonable expectation. *'need to go through it for probably the fourth time, 'cos I'd already told the receptionist; I'd already then told the triage nurse; I'd already told her, and I'd already told the consultant that I'd seen. So I didn't really want to have to go through all the events which had led up to it yet again.'* This situation is common throughout healthcare. Similarly to Alex she felt relieved if she was to see someone she knew already: *'I actually get very distressed when I see somebody new…. It was mainly repeating stuff'.* She talks about the effects of this when she says: *'it would obviously bring back lots and lots of thoughts and lots of emotions.'* These excerpts demonstrate the amount of times a patient might be expected to repeat themselves in one admission and the effect of doing so.

Fred was angry throughout his interview when recounting his experience and reported reacting very angrily when asked to explore issues from the past during his assessment: *'then we started talking about my Dad, his dementia, um, and a load of other fucking crap.'* This anger was, in part, due to the lack of relationship between him and the mental health practitioner who were

assessing him, it came across as a liberty that they should expect him to share painful memories when they hadn't even bothered (in his view) to create a basic relationship with him. *'I don't trust them, I'm sorry'.* However, during the research interview he quite willingly went into the issues that had led him to self-harm in the first place without any clear indication of distress and indeed without being asked. This may suggest that as he was leading the disclosure at a time he was happy to, and because he trusted me in a way he didn't trust the mental health practitioner whose task it was to assess him at the time. This may have reduced the distress caused by revisiting difficult trauma or experiences. This would suggest that recounting trauma is not always a negative thing, if the relationship between those sharing the interaction is good and the timing of the request aligns with readiness to share.

This idea, regarding timing and readiness to share, gains some credibility when considering Alan's experience of being assessed as he immediately trusted his practitioner and states revisiting issues made him feel: *'happy and not emotional like I had been.'* It helped him move away from thoughts of suicide, from: *'thinking about what I could do to make things go away, which was also exactly what I did yesterday.'* To a place where he felt more positive with an active plan to live: *'I'm going to go back to my sisters or, wherever, get my stuff, go and…it's not worth you taking a life really, I know that now.'* Indicating that he had moved away from suicidal thinking.

Jane found revisiting memories and events difficult even before there was any intervention from mental health services: *'everything is going round, and round and round in your head, and it's just going to be 110 times worse.'* Here she is indicating that she is already revisiting everything in her head and it is making things worse, a situation clearly echoed by Ann when she says: *'thoughts were going through my mind, and that they were going more and more through my mind and I didn't feel safe'*

Having to revisit trauma then is perhaps a mixed experience. It is perceived as something which is a necessary endeavour, in terms of information sharing to elicit help, but at the same time it can be a distressing event which may leave the person recounting events at risk of further trauma. The suggestion from this LOT is that it can be a barrier to getting help if the relationship with the practitioner is not developed enough and timing of the request for revisiting is

out of sync with the person's readiness to share. It appears to be something that participants were willing to do however in the hope of getting help and when the practitioner was able to facilitate this it was a more positive event.

5.5.2 SOT 2: The Business of Being Human

This second super-ordinate theme refers to some of the myriad factors that affect the shared humanity of the contact between mental health practitioner and patient. Participants generally wanted to be seen as a whole person and to feel that they were connecting with a human being not judged or stigmatised. This SOT is informed by three LOTs; 'A person looking after another person'; Stigma – 'An aberration?'; and Standing in judgement.

5.5.2.1 LOT 2a: 'A Person Looking After Another Person'

This LOT considers qualities that the participant either witnessed, experienced or wished for in the mental health practitioner. It incorporates attitude, professional but caring behaviour and, most importantly, being humane, recognising that the practitioner is a person albeit one who is caring for another person. Participants clearly desired not only to be seen as a whole person but to have a human being to interact with, not just someone who was officious and clearly driven by the needs of the service above the needs of the patient. Some participants reported officious practice with other participants having an overall negative experience of contact with mental health services. Some participants had overall positive experiences and the remaining participant expressed a mix of positive and negative.

Dave states early in the interview that the person carrying out his assessment was: *'I hate to say it but they seemed quite….. I don't want to say bossy or strict but they seemed quite straight to the point, um, and sort of… they seemed kind of down.'* He compares this business like impression with the demeanour of his counsellor: *'I see her, she's always happy, she's always friendly'* He goes on to demonstrate how the practitioner could have done things more effectively for him: *'…I think I would have felt better if she had reassured me'* This comment suggests that his mental health practitioner was perhaps not as sensitive as she could have been to Dave's feelings and the fact that he was in crisis. Thus Dave appears to experience his practitioner as a rather more business like professional then a human being.

Fran had a similarly difficult time with her mental health practitioner, from the very beginning of the interview she explains how the mental health practitioner came across: '*The lady there I saw, she, she came across as quite un-empathetic, um and not very compassionate'* Her experiences cause her to question the humanity of the mental health practitioner, demonstrated when she states: *'do you actually even have any idea what people go through?'* She hypothesised many reasons as to why this practitioner might behave this way but ultimately decides that she just doesn't care: *'she didn't care, she wasn't bothered'.* Fran is quite angry about this reception from her mental health practitioner and goes on to state how she could have done things differently: *'if you're not gonna care and you're not gonna do your job, then don't, don't, don't even bother…..she could have been exactly the way that she was but shown an interest……actually shown a real human interest'.* Unfortunately this interaction had a very negative impact on her mental state: *'it made me feel that I was right, that nobody really cares about..and er, I really am just a waste of time….that I'm better off dead like I wanted to be.'* This statement demonstrates how a cold officious response can be experienced and in a vulnerable patient group, some of whom would have had suicidal ideation, as Fran did, this kind of response could be catastrophic.

Fran carries on her consideration of how the mental health practitioner could have done things better when she says: *'if I had 30 seconds, in those 30 seconds I would give my all of me to that person, and I would……I would make them feel they actually did matter and their problems, as ridiculous as they might seem to you and me, or as small, for that person they are HUGE'.* She sums this up when she says: *'you are a person caring for another person, you can still do your job showing that you care.'* Indicating that she believes there is a more compassionate way of dealing with people then the individual dealing with her on this occasion had.

Jane talks about this humanity when discussing the treatment her parents received from mental health services, practitioners who: *'thinks they're god, they treat their patients like they're a piece of dirt on the end of their shoe, treat them like two year old kids'.* However she cites her own experience on this occasion as rather more positive with her practitioners: *'they just made me feel like I was a normal person and I was just going through a lot of crap, basically and it just got too much to deal with.'* Indicating here that they had

been able to see her as a person not just as someone who had self-harmed. Again she has advice for healthcare practitioners as to how they could do things better: *'What they really need to do is to listen to the patient, the patient is the one that deals with the disease every day, we're the one that lives with it, we're the one that lives with what's going on inside our head – they should open their ears more and listen to us and they might find they might actually make better doctors because of it, and nurses.'* Here indicating that she thinks professionals need to listen to the patient more and take what they say seriously especially when it is about their own bodies and experiences.

The practitioner Seth encountered appeared to be unable to see the human being behind the presenting behaviour. Seth reported being predominantly 'annoyed' with his experiences of being assessed by mental health services due to their inability to see beyond his drinking behaviours and outlined what he felt he would like in an ideal assessment: *'someone would sit down, ask you what our problems are, um go through 'em with yer'.* He states that his practitioner was: *'helpful towards, about me, me stop drinking but…she didn't really, she didn't really ask me too many questions about why I'm like depressed or anything like that.'* This quote perhaps illustrating the service driven agenda of abstinence over the patient driven agenda of addressing his problems.

Fred's experience of his practitioners was extremely negative and he was still quite angry about the experience of being assessed when he was interviewed. He repeatedly stated that they were: *'a waste of space'* and other similar comments such as*: 'about as much use as a chocolate fucking fireguard'.* He felt they had it wrong from the beginning when they didn't have the basic courtesy of introducing themselves in a manner he was expecting: *'Good morning would have been a good start'* suggesting to him a basic lack of politeness. He notes that it is not necessarily a question of liking them either, suggesting that they can be just as effective even if they are not liked if they are professional in their demeanour which echoes somewhat Fran's experience above. *'I don't like any of them but, I mean it's not a matter of liking someone'.* Fred talks about a previous experience he had where he fared rather better and outlines why: *'he was absolutely fantastic, as soon as I met him I knew that I could trust him, cos the first thing he did is shook my hand properly.'* Here

indicating the importance of basic communication rituals in setting the scene for a more complex and personal communication to occur.

Some participants (n=4) reported a good rapport with their mental health practitioner as demonstrated here. Alex had an overall positive report of the way her mental health practitioner came across: *'the way the attitude came across, it was quite positive'.* May was also pleased with her practitioner; *'the lady I spoke to, she was really really nice, she couldn't have been more helpful'.* May applied an assumption that healthcare staff are always caring, demonstrated when she says: *'because ladies like you understand'.* This statement demonstrating positive transference and the belief that understanding is a fundamental part of her practitioner's humanity. Alan was very clear that his practitioner was on his side, he states: *'she looked at you when you were talking, straight into your eyes, you knew she was listening to you and she knew, or you knew she wanted to help.'* He wasn't quite sure, beyond this, what the qualities were that made him feel comfortable: *'there is just something about her, she walked in and I just knew straight away I could talk to her.'* And *'she made me feel good about myself.'* He also went on to talk about her being respectful and courteous and listening attentively to him.

Ann had mixed reviews of her practitioner stating that: *'the nurse that came was supportive she did listen to what I had to say, she did given me time to actually talk about it, she did give me time to actually be upset and she did validate everything that I'd actually been saying.'* Then later on finding her a little less helpful when she was unwilling to make a decision regarding her care, and having listened to Ann's opinions about what should happen next, did not act on them. '*I did actually sort of question her sort of clinical skills, if she wasn't able to make her own decision about what the best thing to happen would be.'* Although one could argue here that the practitioner was indeed being very human in that she was scared to make the wrong decision about discharge and therefore opted not to make one.

The data presented here indicates some of the qualities experienced as negative from the practitioner, such as being too business like or impolite, and those experienced as more human, such as attentive listening and positive attitude. The importance of the practitioner being basically kind and respectful

is highlighted as well as recognising that the practitioner is in fact, just 'a person looking after another person'.

5.5.2.2 LOT 2b: Stigma – 'An Aberration?'

This second LOT refers to the stigma experienced from others and the stigma they held for themselves. Self-Stigma is influenced by the knowledge and internalisation of societal stigma. There was evidence of societal, peer and institutional stigma reported and words like '*massive taboo', 'dirty little secret'* were used often along with questioning what constitutes '*normal*'. Interestingly Alex did not mention this as an issue and she was the only one that staff on the ward warned me about before the interview, telling me that she was potentially violent. This indicating to me that she was stigmatised by the staff in the department.

Dave was concerned about the wider impact of being in mental health services clearly indicating he was concerned with societal stigma: *'I was kind of worried about how the situation would affect my life'* He went on to say that he was unable to speak freely because of this worry: *'you're scared of the consequences'* In Fran's case, she was very concerned with societal stigma and the effect this had on her: *'I think mental health has a really long way to go, I think it's a massive taboo, massive stigma that nobody wants to talk about.'* She had a vision of how society could manage this differently and ultimately allow her to be who she is, flaws and all as demonstrated when she says:

'But it's, it's not about deciphering it; it's not about putting it into these little boxes and making it from black to white. It's not black or white, it's not a puzzle that needs deciphering, or putting into the right, proper little boxes, it's just about people accepting it for what it is; it just is what it is, and just people learning to live with it, and I just … you know, it's, it's the same as, as someone being born gay – it's no different; or being born black, or white, or yellow – whatever colour – it's just who you are.'

She talks about what she feels society expects from her: *'there's immense pressure that you have to be a certain way and you have to look a certain way, and you have to be this and you have to be that and you have to be perfect and you have to be normal, but what is perfect, what is normal?'* She has no answer to these questions but is clearly expressing her distress at what she

feels are unrealistic expectations of her. She goes on to very clearly show how this makes her feel and shows how angry she is about it: *'As if it was some dirty little secret. I don't want to be a dirty little secret, I shouldn't have to be a dirty little secret, I'm just a person trying to live.'* A statement that appears to be motivated by the desire to be seen as a person struggling with life rather than someone who needs to be ashamed of being 'ill' or tainted in some way.

Fran was also the most vociferous in terms of self-stigma, clearly seeing herself as somehow tainted and lacking in the qualities that should make her '*normal or perfect*' although she couldn't define what these qualities were. *'I really am just a waste of time and I'm just a waste of resources.'* At the same time as stating this she expressed her anger at having to feel that way, showing how she was aware of the public stigma towards mental health issues but was railing against it whilst at the same time applying it to herself: *'I describe myself as I'm an aberration' She* goes on to wish for a world where we can be who we are: *'Why can't you just live and let live? I don't know, just… there's so much pressure to, to, to be…why can't you just live and let live?'* At the time of interview and on re-listening to the recording there was the distinct feeling here that she was not only speaking to others but to herself, evidencing the internal nature of this stigma. She ends by saying: *'I don't want to label myself but in this case I think I will have to.'* Here suggesting that she has indeed stigmatised herself although she is fighting against it in her protestations against the public stigma she talks about above.

Jim mentioned stigma twice in his interview both times in relation to what he expected others would think once they knew he was in due to his own actions: *'I think it's knowing, other people knowing what you'd done, I mean there are some people, I think they're attitude is, you know, if… you know, if you were going to die you're going to die, I mean natural causes or something, but you know, to take, to take, try and take your own life….and you do get people, you know who would never understand.'* Alluding to the wider public perception he perceives to his actions.

Fred was very aware of the stigma around mental health and demonstrates this by suggesting that a commonly held practice is stigmatising as a result of the effect of societal stigma: *'you can't have the mental health team coming in here because as soon as they've ….all the nurses, or all the patients here know*

you're a mental health patient, all your respect has gone right out the window.' This statement sets up a tension for practitioners as they are expected to be clear about who they are upon approaching the patient however, as Fred points out this is a potentially detrimental practice which is also against the prevailing codes of practice.

In a similar vein to Jim and Fred, Ann was concerned with loss of face and mentions it several times, this excerpt is an example: *'I didn't really want the next family in the next bay finding out exactly what I was talking about'.* She also describes a previous occasion when she was in a different department following a previous episode of self-harm where she was actively discriminated against in the context of keeping her safe:

'the um, other A&E department, who'd actually, um insisted that I actually sit in the middle of A&E, next to the Nurses station on a chair cos they wouldn't leave me in the cubicle on my own……. I was a complete and utter spectacle and that I was being stared at by absolutely everyone and that every move I was…I made was being absolutely watched.'

The environmental issues inherent in this comment are explored further in 5.5.3 and whilst they may have been able to justify this in terms of risk management, it was extremely undignified for Ann who felt like she was on show and was being punished for being naughty. This paternalistic benevolence may have been well meant, and it did prevent her from harming herself in the department on that occasion, but the negative messages that were inherent in such a dehumanising action may have had multiple negative repercussions.

I interpreted Ann's comments above to mean that she was subjected to institutional stigma and Fran provides another example when she says: *'there is no help out there for, for mental health realistically, there's so much for everything else but for mental health there is nothing. It's like there is no importance for it whatsoever.'* Indicating a general lack of funding, interest and importance given to mental health issues in the wider world, a situation which is likely to be affected by levels of stigma surrounding the issue.

Jane was aware of the issue of stigma and reflected how this had affected the care of her parents who both had mental health issues as part of her interview.

Firstly she mentions the effect she has noted suggesting a wider societal impact: *'people, as soon as they find out you've overdosed or you've self-harmed, or you've got a mental health problem, they put you into this stereotypical category that you're completely crazy; but you're not.'* She then makes comments I interpreted to be about institutional stigma when she states that the way her parents were treated by professionals had a negative impact: *'make them feel like they're two inches tall.'* She reflects that they had often said to her that they just wanted to be treated like '*normal*' people but that she had never really understood what her parents meant until this particularly brush with healthcare: *'they always wanted to be treated as a normal person and I never understood what that meant until yesterday.'* Referring to the practitioner seeing her as a person who was struggling rather that someone who was ill (see5.5.2.1).

The stereotypes and attitudes that accompany stigma clearly affect the way the person as a whole is viewed. These participants felt somewhat lessened in importance as an individual, so perhaps felt themselves viewed by others, and viewed themselves at times, as less human and deserving of care. The call to action for professionals from these participants is to see beyond these stereotypes and find the person behind them.

5.5.2.3 LOT 2c: Perceived Judgement

This third LOT, regarding perceived judgement was a theme identified in the data of all the participants however it took slightly different forms. For some the perceived judgement came primarily from the staff or patients around them, for others from society, family and friends. In many cases this perceived judgement had an effect on how the participant believed they were viewed by others and, in some cases, has a very negative impact on their ability to receive care.

Dave mentioned judgement several times during his interview from the very beginning: *'you can't help but think that people are judging you…..you can't help but feel that they're starting to judge you more and more'* This perceived judgement influenced his ability to speak freely about the situation leading up to his self-harm as he felt this would increase the amount of judgement he received. *'if you don't answer how you want them to answer you get judged'.* He was concerned that the mental health practitioner would judge

him and stated that he would have liked some reassurance from the practitioner that: *'we're not here to judge'.* These data were interpreted to mean that Dave was perceiving judgement from others primarily although much of the perception appears to arise from within him which may suggest he was judging himself too, as he couldn't '*help*' but think and feel he was being judged.

In Fran's case she was experiencing judgment from all sides. She felt her mental health practitioner, who she experienced as very cold, judged her as not worthy of much effort: *'she felt that maybe I wasn't as bad or that I needed as much help as everybody else.'* Then she also experienced herself as being judged by society at large as she had mental health issues: *'for some reason if you have a mental illness people think, oh my god! You're a complete freak, you're a weirdo'* .Jane was worried she had been judged before she even entered the Emergency Department: *'you think they'd already based their judgement of you as soon as you walk in.'* This is a situation she was anxious should not happen and indeed this judgement did not materialise in this contact with services, demonstrated when she says: *'there was somebody there and there is somebody there to listen to you and they're not there to judge, you know when you see them there you think, god, they've already made a judgement of me……..but they didn't make me feel like that at all'* Here indicating that her fears had not been met.

Alex did not specifically mention judgement as an issue that she was concerned about apart from noting that she hoped not to be judged in relationships where trust should be present: *'talk to someone that's at the same level as you um, with mental health, that they'll understand, they won't judge you they won't criticise you'.* She noted that her practitioner did not appear to believe her at one point, which she found upsetting: *'the situation and the response were quite upsetting, um, like she couldn't believe what I was saying'.* Feeling herself judged as a liar here meant she had to break off the assessment and go and calm herself down before she could continue, *'I actually have a fake cigarette in my bag which I can use in hospitals, um so I just have a couple of puffs of that outside and it calms my nerves, calms me down.'* This statement clearly shows the emotional impact feeling judged can have on the individual.

Jim expected judgement and he was worried about being overheard as he felt that he would be judged due to lack of understanding: *'you know, to take, to take, try and take your own life…..and you do get people, you know, who would never understand.'* He did not experience this judgement from mental health practitioners as he says: *'you know, like the job you're in, and the chap who come in and see me, I mean they're understanding of what's going on.'* Whereas Seth can't get past being seen as a drinker so he feels he is pre-judged before he is even in the department and his mental health issues are overlooked: *''it does annoy me that they say to people that, you know, cut, you can't get help 'cos, 'cos you've been drinking'* He feels this is really holding up any chance he has of getting well, demonstrated when he says: *'if I got help when needed from depression and that, then maybe I might stop drinking.'* So the judgements of staff regarding him being a drinker, is clearly affecting the care he receives.

Fred was convinced from the beginning that his mental health practitioners did not care about him; *'they couldn't give a flying fig mate.'* When asked how he would have liked them to be he stated: *'I would like them to look at me not cynically for a start'* this suggests that he felt they had judged him in some way before meeting him. Alan felt that it was more likely that he would be judged by someone he knew than by a stranger because: *'That person can't really judge you by just what you tell them'* Suggesting that those you know make more assumptions about you than those who are not previously known: *'cos people you know don't listen as much as people you don't know'* In a similar way to Dave, Ann was fearful that she would be judged: *'I was scared that they would judge me'* In this extract she was particularly scared that they would judge her based only on her history and not take account of what she needed at that time. She was very worried about the response she might get from her own team when they found out where she was and what she had done:

'I started to get really, really, really, really worried about what um, what response and what feedback I was going to get from um, tsk, my own care team when they found out what had happened.'

With regards to her own mental health practitioner in the Emergency Department on this occasion she states: *'I was worried she'd be judgemental*

and she certainly wasn't, she certainly wasn't judgemental in any way.' Suggesting that she felt this practitioner had got this right on this occasion. However, in light of the rest of her experience with this practitioner, Ann found that she was not happy to base her actions on the information Ann had given her and insisted that she wait many more hours until her own team came on duty to make the decision regarding discharge. Thus, although Ann did not feel actively judged by her, the actions of the practitioner suggest that she was indeed judging Ann to be a risk to herself perhaps even others, despite the assurances Ann gave her, suggesting judgemental attitudes in her actions.

Judgement is one of the ways that stigma from others can be experienced and, as such, this theme is closely linked to the one above (5.5.2.2). It has been considered separately because of the difficulty inherent in having others pre-determine who or how you are. Being perceived as judged appears to diminish the belief that one is being seen as a person. It seems to again move the practitioner away from viewing the patient as a person and considering more the potential risks and behaviours that might happen. This has a clear impact, as described by the participants of restricting their freedom, reducing the effectiveness of the care they need and reducing their perceived value as people.

5.5.3 SOT 3: Traumatising Environment

The effect that the physical environment has on the experience of the patient cannot be overlooked within this data and was identified as a clear SOT for participants. This SOT is informed by three LOTs; Physical space; Systems driven care; and the assessment – helpful or traumatic?. Only May did not mention any factors pertaining to this theme, possibly because she appeared to be completely immersed in her own situation to the exclusion of external issues. The three LOTs reflect first the physical space within which the encounter with mental health services takes place, then the systems that affect the encounter and the interaction itself particularly in terms of the psychosocial assessment which is the interaction that occurs at this time as dictated by NICE (2004, 2011).

5.5.3.1 LOT 3a: Physical Space

This LOT was mainly concerned with the environment, the physical space within which the participants were located at time of the admission and the medical technologies and equipment within it. The main issues were risk items (such as oxygen tubing which could be used for ligaturing) left lying around and lack of privacy which is linked to fear of stigmatisation. Also in evidence here is the effect of the busy environment of the general hospital and the Emergency Department in particular.

Dave mentions how the health and medical technologies of care impacted on his ability to think when being assessed: *'trying to find that frame of mind is quite difficult, 'cos, you know, you've got like, you know, you've got drips, ECGs, you know'* Fran mentions this too but more to suggest that the acute care staff really appeared to know what they were doing: *'the treatment that I needed, the, the, the IV, the drips all the bloods, they're all…the physical side of it, they were, they were very, very good'.* Perhaps suggesting that the medical equipment was reassuring as a result.

Since Jim was bedbound at the time he spoke to the mental health staff he was very aware of the fact that others in the ward would then be aware of what he had done because of the lack of privacy. He demonstrated this by contrasting the way we were doing the interview, in a private room away from the staff: '*I do like, you know, coming in here because no one else can hear, but then I spoke to them out there, everyone else doesn't really know what I've done….yeah, it was in a ward when I saw them, so, well I couldn't get out of bed at that stage.'* This statement implies that he knows that there was a good reason for his having to speak in an environment where there were other people but that he did not really like it. Fred was in agreement with Jim regarding this matter: *'when they come in here it should be in a private room, I don't want everyone knowing my woes and troubles.'* Ann also agreed with this: *'it was just a cubicle surrounded by curtains'* She then went a step further to cite the range of potential risk items available in the cubicle which could be used for further self-harm: *'sitting in a cubicle with oxygen tubing around, lots and lots of um, leads, around, all sorts of things around which just playing onto my urges to actually self-harm further'.* Here indicating the potential for

further harm that could occur due to the environment if someone was unable to overcome the urge to self-harm.

Ann found the overall environment of the Emergency Department on a busy Saturday night very distressing and quite overwhelming: *'it was a Saturday night so there was quite a few screams and there were quite a few drunks around and things so you have to talk loudly to actually be heard.'* When one is already distressed such an environment is hardly likely to be therapeutic, Ann demonstrates this when she says: *'I was getting very distressed by the noise, very distressed by the environment and I needed to go somewhere quiet.'* In the event she was up all night on a chair and did not get the opportunity to rest at all, another factor that could have had quite an impact on her mood and risk of further self-harm.

The lack of private space to conduct sensitive discussion, as is likely to happen after self-harm, is clearly an issue for these participants. They are very clear that privacy impacts on their ability to communicate, their fear of being stigmatised and the distress they feel. Noise levels are also a factor and the general business of the environment which can be very overstimulating and increase distress. For those who are still experiencing the urge to self-harm, the numbers of risk items in the environment present an additional problem and for others the medical equipment serves to interfere with mental processing.

5.5.3.2 LOT3b: Systems Driven Care

It was found that care that appeared to be driven by service need rather than patient need. The predominant issues are; waiting; the division between physical and mental healthcare; the interface between physical and mental health services and dual diagnosis. Particularly of note are instances where participants felt that service needs were being held above patient needs, process over people. The traditional split between physical and mental health care was generally accepted with the exception of Jane who started off appearing happy with the status quo but then increasingly demanded a rethink, stating that there should be mental health staff in the Emergency Department in order to deal with people's distress too. Another prominent theme here is coercion. None of the participants were clearly asked if they would like to see the mental health teams, they were told it would happen so

although there was still the possibility of objection they did not feel able to assert their rights.

Dave picked up this last point when he says:

'I was told in advance and I do think the timing of when I was told was good, they could have told me when I was in the wrong frame of mind and it could have sent me further off the edge but the fact that they waited till I was in, I was in a more of a stable condition did make it easier to understand why they were making me see the mental health team.'

So Dave here demonstrates that he was not given a choice about seeing the mental health team and, in fact, when he suggested he might not, he was threatened with the police. So he felt had no choice, but he notes that they were skilful in choosing when to tell him he had to do this thing, whilst this is a good thing, he is also noting that it could have been a very negative thing potentially raising the risks. He also discussed previous occasions when he has undergone mental health assessments and been concerned that his concerns were not taken seriously: *'I've said "I don't like being on medication, it makes me feel like a zombie," and then they would turn around, "oh, there's a tablet that can fix that," and then it just seems like you're going nowhere and you're just trapped.'* This persistence in the medical model, despite his implied wish to explore other options, led to him feeling trapped and no further forward.

Like Dave, Jim was not offered an assessment but he got one anyway: *'someone came along and told me who he was and I had a chat.'* As previously noted he was bedbound at the time they came to assess him and he didn't like the lack of privacy so perhaps waiting until he was ambulant would have been a good idea for him, he states that he was still quite foggy from the medication he was on: *'well I was just out of it really.'* Approaching him at this time could be considered as ethically questionable as he would not necessarily have had capacity to truly consent nor would he have had clear recall of events or memory of the discussion had with the mental health team, potentially rendering it pointless.

Fran did not experience her interaction with the mental health practitioner as care. She did not recognise the care plan she had been given and was discharged still believing that she would get a care plan. Interestingly, when

asked by her husband, the practitioner also did not note that she had already given Fran a care plan. This is demonstrated when Fran lists the points that would have constituted her care plan: *'oh, here' s a leaflet, here's a couple of numbers, if you find yourself in this same situation, um call these numbers, if it's out of hours the….which was access and um, during the day phone [name] house or your care co-ordinator.' She* then goes on to say: *'he talked to her and basically um, what she said straight up, um, as far as she knew because I was discharged um, even though there was no care plan, um it was no longer her responsibility.'* The use of the phrase 'straight up' suggests that Fran finds this incredulous and she certainly found it undermining. Fran experienced her as cold and uncaring and overly efficient, although she did understand the need to be efficient as demonstrated when she says: *'I understand that you have to be efficient and you have to follow procedures….to follow certain rules'* However, she disputes the need to be uncaring in the process: *'You can tick all the boxes but still do it in a way that you show, um that you care.'* I interpret this case as an example of the process of care as dictated by the system overriding the interpersonal elements of care resulting in Fran feeling dismissed and uncared for.

Jane had a major complaint right from the beginning of her care episode as she was led to believe that there would be someone in the Emergency Department that she could talk to straight away: *'I was told by the paramedics, um, by the triage nurse that it would be quite quick to see them and to have time to talk to them'* Her distress was increased once she found out the amount of time she would actually have to wait to be seen: *'when I was taken round to the minors department I was told that it might take hours and hours and hours and hours and that's…when you're distressed that's not something that you want to hear.'* It is possible that she may have been given differing information by different professionals. For the paramedic it may have been misunderstanding of the systems within the Emergency Department but for the triage nurse one would expect they would understand the processes and not give her misleading information. It may have been that she misunderstood the information given to her however it is clear that the system had quite an impact on her experience of care. *'If you were told you had to wait three hours to see a general medical doctor, and then possibly another three hours on top of that to see somebody from the Mental Health Team, that's six hours you're*

waiting and everything is going round, and round and round in your head, and it's just going to be 110 times worse.' Even once they had been to see her she was expecting to see them again and the lack of information on when they would return was problematic: *'it's just a waiting game.'* This situation appeared unacceptable and was costly personally for Jane.

Like Jane, Ann found the waiting around intolerable: *'That waiting in A&E is probably the worst, the worst experience, and I think it is that, it is after an overdose, it's like waiting to get blood tests back – I don't think anyone appreciates quite what that, what that is actually like.'* Ann found her mental distress was accentuated by the amount of time she was waiting with nothing to do and as previously mentioned, no place to rest.

Due to the time that Ann was referred and the way services in the area are constructed, Ann was assessed by a practitioner who was not based in the hospital but came from the local Crisis Resolution service. She found there were several issues with this, partly there was the delay and difficulty in finding someone who would agree to come out and see her, which left her feeling very unimportant. Additionally, the person that did eventually come was out of place in the department, *'She was very much a visitor that didn't know the staff, wasn't part of the staff, rather than actually being part of their, part of their team.'* The practitioner did not know about Ann and her care needs as she had not read up beforehand and she was risk averse. She avoided making a decision about her care but made Ann wait even longer before getting a decision on her discharge from her own care team when they came on duty the next morning.

'There was a huge great saga getting hold of the Mental Health Team. It was actually the middle of the night and the problem was that because I was actually out of area the [name] Mental Health Team actually refused to come out and see me to start with.'

All of these issues had a knock on effect on Ann's mental states increasing her distress at having to wait, enhancing her existing feelings of being a burden and of guilt and undermining her validity as a person entitled to care.

Jane was insistent that there should be someone there who is able to deal with psychological distress and the system could be different for those whose

presentation to the department was not purely physical in nature: *'this should have some sort of system available that when somebody comes into A&E, especially with mental health problems, that they have somebody on the site that you don't have to go through an A&E doctor, you know?'.* Alex provides some support for this point in the following quote:

*'you don't really see many psychiatric nurses in a hospital, only mental health team, which I suppose for some people could feel quite strange in some ways, um, especially if they have a CPN (*Community Psychiatric Nurse)*, that they've built quite a good bond with. Um they can feel very isolated that that person's not there to talk to'*

She found the idea of seeing a stranger quite frightening partly because of having to repeat traumatic past history (see reliving trauma above) but also fear of the unknown and dislike of inconsistency: *'scary at first, um, cos I thought it would be a stranger, luckily enough I knew the lady so that made it a lot easier…I don't like unconsistency…….it upsets me having unconsistency.'* My interpretation of this data leads me to the point that the system of healthcare that considers only physical health without considering mental health is one that cannot provide the best care for people who self-harm and that a consistent mental health presence in the general hospital would provide some continuity that is currently lacking..

Seth was continually facing one of the most difficult issues in modern mental health practice, that of the use of alcohol and mental health. Despite years of rhetoric of the need to recognise people with Dual Diagnosis as having mental health issues that may be driving the addictive behaviours, there are still very few mental health services that will provide care for someone that is actively abusing substances. *'I know I need help but none of them seem to help me until I stop drinking.'* Seth is '*annoyed*' by this repeatedly, and at the end of the interview he suggests that next time he self-harms he will make sure he is sober so as to get the help he needs. *'Because it's not like I drink every day, you know, I have, I have two or three days a week I don't drink. So basically what they, what I think they're saying is well if you're going to take an overdose take the overdose the day that you're sober and then you'll get some help.'* This suggests that the system in place is in fact encouraging risky

behaviour rather than helping Seth to work towards sobriety and learning to deal with his mental distress.

Fred is very scathing about the mental health system: *'I think the whole mental health team needs to be reassessed from the ground up!'* He gives an example whereby processes have been prioritised over patient care. He states: *'the kitchen staff have done really well, but can you not see that we're slightly busy here? But then it's lunchtime and they don't give a fuck. It's lunchtime, there's your dinner, BANG!'.* There is no human factor here, the kitchen staff have a job to do and they will do it regardless of the patient's readiness to engage with the task. In this instance the system is clearly affecting the patient experience in a negative way.

The data in this theme illustrates the impact some of the systems present in healthcare can have on the experience of a hospital admission. It also highlights the difficulty of having to wait in healthcare environments particularly when in mental distress. Coercive practices, in terms of having an assessment rather than being offered one are also brought forward as an issue. Whilst this was not exactly objected to it does raise ethical issues that need considering and is a clear example of how the system is driving care and could cause further difficulties for the patient.

5.5.3.3 LOT 3c: The Assessment – Helpful or Traumatic?

This third LOT concerns the actual experience of the assessment from the participant perspective. As this is the interaction dictated by the guidance that governs the care of individuals attending the general hospital after self-harm (NICE, 2004, 2011) it is included here as an environmental factor as it is as much part of the experience as the fabric of the building itself. The main issues within it are mental health practitioners being dismissive in some way of the patient experience leading to feelings of invalidation, attitudes that indicate lack of hope for the individual and not listening. In some cases it was assumed that more information was taken from the notes than asked of the patients themselves. This LOT was identified in the data from all of the participants, with five participants stating they had a predominantly positive assessment, four predominantly negative and Ann's experience was mixed.

Dave opened his interview by describing the assessment as: *'it just felt like an interrogation, um, especially so soon after a serious incident like that.'* He understood that the intention was to help but it still felt '*horrible*'. He describes a situation whereby he was sharing something very personal and found that it was not attended to as he had hoped by his mental health practitioner: *'at one point we were talking about, um, about a situation with an ex of mine and the conversation got to quite a serious point and suddenly it was like, so your home address will…so your family members are, like… it was quite a serious conversation at that point…'* He experienced this as quite invalidating: '*just to being dropped like that made, like, made it seem sort of like me and my problems seem quite small and tiny'* He has a suggestion as to how the practitioner could have acted to avoid this situation: *'it wouldn't have hurt to go on, 'how does that problem make you feel?' or 'do you know how you're going to solve the situation?' instead of dropping the conversation completely'* He also describes the effect of this communication breakdown in conjunction with the medication issue mentioned in 5.5.3.2: *'so sort of like they want you to go forward, but they're trying to send you left or right. It just kept on feeling like you were going to hit a dead-end sort of.'* So it appears that rather than finding these interactions helpful he is finding them frustrating and leading him down a path which has no resolution to it as far as he is able to ascertain.

Fran also describes the assessment in dramatic terms, for her it was '*traumatic'*, her mental health practitioner was experienced as uncaring and officious: *'maybe you're like fed up of listening but she didn't listen, she didn't ask me one single question, she didn't care. She wasn't bothered. I know I gave up but..it would have been nice..'* In this excerpt is appears that Fran is alluding to the role of the practitioner of holding the hope for those who have lost their own, something that appears to be particularly important in working with people who self-harm. She goes on to state, *'in hindsight now, um, I think that this was completely not acceptable and completely out of order, and my previous thought that I had at the time when I was speaking to her in that room. I was right, she really didn't care. She had no compassion'* She was clear that she felt this attitude was unnecessary, she was aware that there was a need for being efficient and ticking boxes, as mentioned in 5.5.2.1, but

believed this could still be done at the same time as being caring and compassionate.

Assessment that is unhelpful was a situation experienced by Seth, who is a somewhat divergent case in terms of his needs being a clear dual-diagnosis patient with both mental health and alcohol problems. He experiences the assessment as the '*same old, same old*.' He is caught in the gap between mental health and alcohol services and feels he cannot get the help he needs to stop drinking so is in a vicious cycle: *'maybe if they sent me to talk to someone, or…try and find out what was, was, was wrong with me, then probably if I got better, or started to get better then probably I wouldn't drink.'* This was an unfulfilled need on this occasion though as he demonstrates when he says: *'she was helpful towards, about my, me stop drinking, but… she didn't really, she didn't really ask me too many questions why I'm, like, depressed, or anything like that.'* This would suggest that for Seth the experience of assessment was somewhat pointless, a process he had to endure to be discharged.

In Fred's case he stated the assessment was a waste of time as the mental health practitioners he had were '*a waste of space'*. He was unhappy with the way his assessment was conducted: *'not just to come in here and sit your arse down and talk blatant, couldn't give a flying fuck about me actually: it's all about you getting here, and in the end we had a chat about [name] and his glasses! Hello! What about me? I could not believe it!'* He stated that being asked how he was feeling, in the circumstance of being in hospital after self-harming with suicidal intent, was particularly foolish as perhaps one would assume that if one felt well then the self-harm would not have occurred and admission would not have been necessary. *'are you fine? Er, if I was fine I wouldn't be here. He said to me how are you feeling? And I told him in this current circumstance that is the most stupidest question.'* This appeared to reinforce to Fred the pointlessness of the process for him on this occasion.

Alex gives us another example that the assessment process can be difficult when she describes the process as: *'invasive and personal'* She talked about the importance of reassurance: *'security that …just that bit of a reassurance um, that it's going to be all right.'* Overall though she found the assessment quite positive: *'it helps you sort your head out, sort thoughts out um, and sort*

of puts you on the right track in life again.' suggesting that she hoped the assessment would be something that would assist her in finding a way forward that was more helpful then the one that had led to self-harm.

Jane was shocked when someone appeared at her bed offering to assess her and described the assessment as nerve wracking in her opening sentence: *'At the start nerve-wracking….I didn't know I was going to see them…. They just appeared in the afternoon.'* Despite her initial nerves Jane found the assessment positive overall: *'it just felt like a tiny, not a lot but a tiny bit of weight had been lifted off me shoulders and I could relax a little bit more.'* So the act of talking appears to relieve her of some of her distress. Jim, like Jane, felt a little better for having been given the opportunity to talk: *'it's nice to talk, you know, about what I been through'* Alan opened the interview by saying that the assessment was very positive: *'she was in here for ten minutes and after that interview it's literally like a ton of bricks went off of my head.'* All indicating the positive potential of the encounter.

Ann was out of area, in that she was attending an Emergency Department which was not her local one, she stated this was the reason for this: *'I was treated so appallingly by the local A&E I was too afraid to go the local A&E which is why I'd taken myself down to [name].'*This suggests immediately the importance of getting the assessment right as this is extreme behaviour for someone who does not drive (she mentions using trains later in the interview in order to get home). However, when the practitioner was unable to make a decision after the assessment she states: *'I felt in a way that I'd gone through it all for nothing.'* Despite this she still found it useful to be able to talk to someone about her situation, although she appears to be talking about the Emergency Department nurse rather than the mental health practitioner when she says: *'I did actually find it useful actually being able to um, talk to somebody straight away and actually talk to somebody face to face.'* The mental health practitioner did allow Ann to have time to express her emotions which she also found beneficial, and she did not rush her: *'for a period she just let me cry actually, she didn't pin a whole load of questions on me'.* This quote indicating the value of being given time to express emotion and how the assessment process can be helpful.

The experience of the assessment itself, one which should be offered to all people attending the general hospital with self-harm (NICE, 2004), can be both helpful and traumatic according to the interpretation of the data outlined above. When helpful it appears to be particularly the opportunity to talk, for those that can (see 5.5.1.1), and make sense of experiences that is helpful. When it is traumatic it can lead to invalidation and further distress, which in a situation where someone has already self-harmed is likely to represent a further risk factor rather than helpful care.

5.5.4 SOT 4: Patient Power

This SOT explores the power differential between practitioner and patient, the effect this may have on care and on the experience of the participants in this study. This SOT is informed by three LOTs; 'You don't want to lie to them, yet you don't want to tell them the truth'; 'You scratch my back, I'll scratch yours'; and Expert by experience. The data from all participants contributed to this theme in some way. Although four is a low number for the consideration of a theme becoming a LOT the impact of this theme, in terms of care eliciting and the fact that it echoed an issue raised at the first patient consultation cemented its importance so it was included. As Smith (2009) states themes are not selected purely on the basis of prevalence within the data. These themes are linked to power by the fact that the patient has to decide whether to cooperate, whether the risk of telling is worth taking and if asserting their rights as a person who knows themselves will succeed. The fact that these are risks, in part, points to the power differential that exists between mental health staff and patients due to the power of one group to detain the other. The participants demonstrate that this is an active issue in the interaction that passes between them.

5.5.4.1 LOT 4a: "You don't want to lie to them, yet you don't want to tell them the truth'

This data for this LOT considers the issue of truth telling, deciding what or how much to tell the mental health practitioner. This echoes the feelings of those who were present at the patient consultation who also described the need to give just the right amount of information in order to get the help they needed without prompting an over-reaction. This also leaves people at risk of not

getting enough help when they need it. This theme has important implications for the patient getting the right care at a time when it will be meaningful and effective. If they are not able to tell the truth then staff are not able to really help and so the whole interaction is undermined. This theme indicates the influence that the MHA has on the interactions that ensue between practitioners and patients in mental healthcare where neither staff nor patient are able to be completely honest.

Fred talks about a mask he wears which allows others to think that he is coping when he isn't and this remains in place when he feels unable to be truthful, so although he may not necessarily lie outright he is masking the truth: *'I put a mask on. Sometimes it'll be a titanium mask, normally it's black ebony or…sometimes I've put a crystal mask on so they can see me…acting normal but they don't know that I'm wearing this mask.'* This statement in the context of the interview suggested that he often wore the mask when seeing mental health professionals and when mixing with the public and by extension suggests he was wearing it during his assessment. During the research interview he was at pains to explain: *'yes, my mask, my mask is i…it's down now'* Suggesting that he was telling the truth during the interview and he certainly had the demeanour of one who was passionately relaying a negative experience and it felt honest. The reason for this mask and his inability to tell the truth to mental health practitioners is summarised when he frankly says: *'I don't trust them, I'm sorry.'* The fact that he apologises after this statement suggests that he is aware of an unwritten expectation that healthcare professionals should be automatically trusted and therefore told the truth.

Dave, who already stated that he felt like the assessment was an '*interrogation*', is quite clear that being completely honest is risky: *'you don't want to tell them the truth because you're scared of the consequences.'* However, he is also acutely aware that not doing that might limit the chances of him being understood and therefore given appropriate help: *'That has, like made me miss out on a lot of opportunities in the past to get um, help and support for my mental health'* So he clearly decided in the assessment situation to take the risk and let some of the truth out in the hope of preventing this from happening again;

'You are gonna still have some barriers up that aren't going to let everything out.. not going to tell the full story, but if you can just get some of the points across for, like, a chance of an understanding'

In the event he still felt he was no better off after the assessment so perhaps would have judged the risk to have been pointless. This risk appeared, for Dave, to be particularly around letting the mental health practitioner know about the possibility of future self-harm or suicidal ideation, he demonstrates this when he says:

'you want to turn around and go, honestly, I don't know, I still feel no different, I still want what I planned to do, but don't want them to judge you, so you, you just turn around and go "I don't know" or "who knows what's going to happen tomorrow, or in the future?" and then it feels like you can…it just feels to yourself that you're like avoiding the question which kind of makes you feel bad for not allowing them to do their job.'

Dave had previously stated that he worried how the assessment might affect his future and that, considered alongside this statement above, could indicate fear of detention under the MHA. He is therefore denied the opportunity to discuss his suicidal thoughts and make sense of them, something I interpret he would like from what he says, for fear of the consequences.

Ann mentions a similar difficulty to Dave in that she felt she had to police what she said although her fear was more around the possibility of losing control of herself: *'I had to be very very careful about how I did that because I was scared of actually losing the plot completely'* At one point, when she felt she might just discharge herself and she had been told that the police would be called if she tried to leave she states: *'I wasn't sure on whether to trust in what they said or not.'* Suggesting, seemingly in alliance with Fred here, that the practitioners do not always tell the truth either.

Alex found not being believed by her practitioner put her in a position whereby she felt unable to say any more: *'Made me feel quite uncomfy, didn't want to talk anymore, didn't want to tell her anymore.'* Whilst she asserts she was not lying, she had been suspected of it due to the extreme nature of her story and this may have effectively shut down any possibility of honest answers to future questions from that practitioner.

It would seem from this LOT that the issue of truth telling is far more complex then would appear on the surface. So the patient is in a position where they may well not want to lie but they are not able to tell the truth because the response they receive may be out of line with what they perceive they need. Thus it is necessary to mediate the truth to ensure that an overreaction does not occur. This can create a tension for the patient in that they feel guilty for not telling the truth and they are also aware that they cannot really get the help they actually need, eg talking about suicidal thoughts. Additionally when patients do tell the truth and are then not believed, it also closes down communication further as does the belief that the practitioner is not telling the truth, a situation which is not uncommon in healthcare as will be discussed further in 6.4.1.

5.5.4.2 LOT 4b: 'You Scratch My Back, I'll Scratch Yours'

This second LOT was identified in all participants data and illustrates the way the participants were willing to cooperate in order to elicit some form of caring and compassion. This can be seen as a transactional interaction with each side expecting something from the other. The sharing of personal information was often driven by hopes and expectations of forthcoming help. This was a theme for all of the participants.

The majority of the participants described variations on a transactional view of the world which influenced their ability to speak and listen. This is illustrated by Alex when the balance that this view requires is maintained she is able to cope with a lot of difficulty and adversity. She clearly does not expect life to go smoothly but this transactional nature means that if you are good to her, she will be good to you. She describes how she finds mutual respect essential in communication and this respect is reciprocated as long as she perceives the mental health practitioner as being respectful in their attitude and dealings with her.

'Q - And respect, can you just say a bit about that – what's important about that?

A - I got brought up with the saying from my Grandmother: You scratch my back I'll scratch yours….'

Alex expects that the mental health practitioner will have some knowledge that will help her: *'they will point me in the right direction, set me on the right track'* She found that the assessment she had on this occasion met her expectations in this way as she found she had additional resources to draw on after the event: *'I found it really helpful, um, gave me a lot of information to take in, lots of opinions to take on board and advice.'* This advice was delivered in the correct sort of transactional style for Alex: *'She was very generous, open with me; um…I was open with her and said how I was feeling, she took that into account and tried to help me quite a lot about it, just coming up with different strategies.'* She mentions the importance of the initial disclosure of name and other details that show respect for the individual: *'it makes it easier when you know what's going on, you know who the person is you're talking to, you know their name, you've got their contact details, um just gives you that little bit more reassurance'.* She sums this up in her last sentence when asked if she would use the service again: *I definitely would, 'cos you get the communication out of them; you get the respect out of them; you get the courtesy and you get that balance and it helps you sort your head out, sort thoughts out, um and sort of puts you on the right track in life again.'* These excerpts suggest that initial respect via introductions, kindness and a balanced interpersonal communication results in reassurance and assistance in finding solutions to problems which may enable forward movement in life in a more positive manner.

The importance of basic courtesy in the transaction was also mentioned by Jim: *'He came round and just introduced himself and then had a chat with me'.* Whilst there may appear to be a lack of consent here, the basic courtesy has been noted and possibly moderated the lack of choice. Fred's mental health practitioner ignored the basic courtesies of communication which had an immediate impact on how affective the interaction could be: *'Just professional courtesy. They always should start with, Good Morning. How are you?'* These comments supporting the need for basic communication rituals in the form of introductions and greetings clearly experienced as respectful and validating.

Dave found talking to people hard, so there was a perceived personal risk in him sharing anything, he did however and he explains why he took the chance of trusting the practitioner when he says: *'I was kind of hoping for something um, but I don't think I knew what I was hoping for, I was just hoping that*

something could be done, apart from, like anything apart from medication ' He goes on to say that he justifies it to himself by saying: *'This is a chance to get myself some help, get my life back on track'* In the event, the effort was predominantly one sided for Dave, he could see the practitioner trying to make an effort but missing completely: *'Like they want you to go forward but they're trying to send you left or right.'* This had a negative effect on his view of how he might utilise a similar experience in the future, in his closing sentence he says: *'it didn't feel like a helpful, positive experience for the situation I was in……..if the same was to happen again I do think I would say that I don't want to see them.'* Although bearing in mind the coercive nature of his current experience he may find it difficult to refuse without consequence.

Jane, was reluctant to come to the Emergency Department as her father had died in a similar place just days before. One stated reason she wanted to talk to someone from mental health is because she held the belief that they would have knowledge, wisdom or understandings that she didn't and this would help her: *'they don't know me from Adam but could probably deal with the situation better.'* She experienced not having someone from mental health from the beginning of her admission as negative as she also expected that talking to them would help her manage her emotions: *'not having somebody there, you know to, to calm you down'* Thus demonstrating that she believes the mental health services may have a role in emotion management. When asked if she would use the service again she states: *'if my mental health was bad, yeah, yeah, yeah definitely, if there was some sort of consistency to it, yeah I would….i just wish I hadn't have done what I'd done [overdosed] to the point where I ended up being admitted into a general hospital before I'd seen the mental health team.'* Here she is intimating that either the community mental health services should be more accessible for those in distress or that there should be someone from mental health at the front door of the Emergency Department.

In alignment with Alex and Jane, Jim is expecting something from the mental health practitioner: *'I'd always hoped, you know, that if, if something does happen to someone, there'll be someone there, you know, who you can talk to, you know, so it doesn't happen again.'* He sees the role of the mental health practitioner as partly to be: *'someone to… stop me, you know, if I ever thought about doing it again'* Seth is asking, by his very presence in the Emergency

Department, for a transaction that he is not getting. His self-harm suggests that he had some mental health needs but because of his drinking behaviour this is continually overlooked: *'Maybe if they'd help me and got rid of the depression'* He is caught in this loop and as yet, as not found the way out of it although he hypothesises that those who do it differently will automatically get the help he wants: *'someone might be a constant drinker and then one day can't get any drink, take an overdose, comes in and then he gets the help he needs straight away, 'cos on that one day that he was sober.'* This is unlikely to be what happens in reality but his inability to get the help he needs is leading him to a place where is suggesting he may self-harm again for the sole reason of trying to get help rather than it being driven by alcohol or illness.

May sees the mental health practitioner as an opportunity to get herself back on track: *'some suggestions of how to get myself back on track'* May also described transactions with her mental health practitioner whereby she was told what she would have to do in order to take advantage of the services being offered, suggesting that in the past she may not have used the arrangements that were put in place to help: *'she said it, um , you've got to make choices about how you deal with your money, things like that.'* Suggesting that she agreed the transaction would have longer lasting effect then just whilst being in the department.

Alan has a similar view to Alex, Jane and Jim with regards to the interaction with the mental health practitioner: *'solve how you go about doing things before you get to doing whatever you may do.'* Whereas Ann did not view the practitioner as being someone who knew better she was quite clear that she knew what to do: *'I knew in my heart of hearts what I actually needed and what help and support I actually needed through having been distressed before'* She hoped that by being honest with the practitioner she would be heard and trusted to do the safe thing;

'But she did tell me at the end that she wouldn't actually be able to make any conclusions or any ideas, or anything, because she didn't know me, and that even after talking to her for probably about ¾ of an hour in the end, she just told me that she was going to then make me wait for another three hours in A&E.'

This situation meant the hoped for transaction did not occur, the practitioner did not believe that Ann knew what she needed and did not trust her to go home.

The transactions noted in the data from the participants' highlights the importance of basic communication rituals in setting up a respectful space within which sensitive interactions can take place. It also highlights the expectations from the participants of the type of assistance they are expecting from the practitioners, that is in terms of advice or assistance to find their way in life again and to move forward in a way puts them back into a position of power in their own lives.

5.5.4.3 LOT 4c: Expert By Experience

Expert by experience is a phrase used frequently in modern healthcare to elevate the knowledge that the patient holds about their own history, experience and bodily functioning to a higher level, in an effort to encourage practitioners to listen to it and take it into account in clinical decision making (McLaughlin, 2009). The data in this third LOT explores times when the participant asserted their needs and also looks at the ways in which they had taken action to meet needs in the past and the effect that had had. It considers the way the knowledge the participant held about themselves was respected by their practitioner. For two participants their experiences were so negative that they took nothing from the interaction and felt disempowered by the experience so this was not a theme for them. Another participant, Jim, was still in so much pain that this was affecting him adversely and he did not talk for long enough to raise many themes.

Jane was most vociferous of this theme, she was quite clear that the patient is the one who is experiencing the mental distress on a daily basis and therefore will know more about it then the practitioner despite their qualifications:

'they seem to think 'cos they read out of a text book they know everything about every medical and mental health disease going, but what they really need to listen to is the patient. The patient is the one that deals with the disease every day we're the ones that lives with what's going on inside our head'

She believes that the practitioner being more respectful of the knowledge the patient has would lead to them being better practitioners: *'they should open their ears more and listen to us and they might find they might actually make better doctors because of it….and nurses.'* Stating very clearly here that practitioners need to take note of what the patient says as it would enhance the care they can give.

Alex refers to the need for respect as in the theme above and states that if this is not forthcoming then she does not feel that she is getting the respect she deserves as someone with valid requests and wishes: *'I would have felt like I was being betrayed, um, that they didn't respect me, they didn't respect my wishes'* Alex describes herself as being on a journey suggesting that she has had a lot of experiences that affect where she is now and she is hoping to get some support in her efforts to: *'try to get my life back together on the slow steady upward spiral instead of downward'* Here indicating how her previous experiences can affect her negatively and she needs assistance from the practitioner to find a more positive perspective, assistance she can only accept if it is presented in what she views as a respectful way.

Seth was convinced he knew what he needed but was unable to get anyone from the mental health service to help him: *'I know I need help but none of them seem to help me'* He goes on to describe how he believes he had depression first and uses drink to help him manage it, therefore it may seem logical to him that the mental health issue is what should be treated first, unfortunately for him services do not agree with him: *'the first time I come in – going back a while now – I come in er, I thought I was going to actually get some help, 'cos obviously I've had depression for years, since I was little, but I just hid it away and not told anyone, and then they said that they couldn't help me 'cos I was, I was, I was drunk at the time.'* In this context, no one appears to be taking Seth's mental state seriously hence they are not recognising that he might have some knowledge that is useful in trying to circumvent the vicious cycle he is in.

May did not so much see herself as someone who knew what to do but she knew what not to do and was listening to what others told her to do then telling herself the same things: *'I gotta start…helping myself'* She talks about how she nearly beat her eating disorder on a previous occasion but then fell

into addictive behaviour after the loss of a pet, describing the latter as something she needs to avoid in the future: *'I nearly beat my eating disorder and then when I lost my old dog it just broke my heart so much that I just didn't eat anything and all I did was get drunk'* Part of her, at the time of interview, believed that this admission might be the one that helped her to turn her life around but her negative approach to her own self-belief suggests that this might not be the case. *I gotta start.....helping myself instead of sitting in a room full of squalor looking at the wall, that's all I do is sit and look at the wall.'* These assertions could have given the practitioner a lot of information about Mays thought processes and her readiness to make the changes she stated they were requesting of her. The way she described it, the response she seemed to get was predominantly paternalistic '*they say I've'* and as such may not have represented the most helpful response.

Seeing the mental health practitioner had helped Alan make decisions about what he was going to do next instead of planning on ending his life as he had been prior to the assessment: *'I was … um … thinking about what I could do to make things go away, which was also exactly what I did yesterday. … its not worth you taking a life really, I know that now.'* He describes times in his life when he has managed satisfactorily, albeit differently to the way he has recently, and is able to see the flaws in that way of being when in distress: *' I even went in the Army since I left school to try and change my mental and physical status. Um, I come out absolutely fine, a year later back to my normal self again'* He was determined to make changes in his behaviour following discharge and leaves the interview with this parting advice: *'Just take the information on board really and do something about it'* indicating that he means to act on the information he's been given on this occasion and appearing to feel optimistic about the future. He has clearly experienced an increase in self-awareness during his contact with mental health services on this occasion which may well help facilitate change in his life.

Ann clearly has a lot of experience of dealing with mental health teams and expects the mental health practitioner assessing her to give her some credit for knowing what care she needs. She had, however, misjudged that coming to an Emergency Department out of area would mean they would take her more seriously and she would be discharged once she was medically cleared: *'… I thought it would just be treating it from a medical side of things, and then I*

thought that um, I thought they'd just be happy with me to say that I'd contact somebody the next day, and let me go.' Here Ann clearly believed that she would be taken at her word; believed to be competent to make promises regarding her safety and deemed honest enough to keep her word regarding follow up. In the event she was wrong and her experiences served to undermine rather than strengthen her position as her perspective, despite assurances from the mental health practitioner that it would be, was not valued. *'She did tell me that I obviously knew myself better than she knew me, so I would know what I actually needed.'* When she got to speak to her own team, who dealt with her over the phone rather than coming to the Emergency Department to see her, she did finally get what she had hoped for albeit after a visit to her own team in her home town miles away:

*'In the end, um, I waited until about half past nine in the morning, and in the end I ended up um, I never saw another member of um, the Mental Health Team, I think they dealt with it all by 'phone; ….I'd been up the entire night …I was absolutely shattered, and knew that I was going to have to then get a bus and a train to get me back to [*name] and then drag myself to the other side of [*name]'*

Here Ann has been subjected to a train journey when completely exhausted from a sleepless night of waiting in the Emergency Department. She was not treated as an expert by experience by her practitioner despite the rhetoric.

This LOT has reported the findings from the data regarding the patient as holder of knowledge about themselves and their experiences that the practitioner does not have. It places the patient in a position of power which is often not recognised in practice and indeed, as illustrated here, often met with a paternalistic response which may not have a positive effect.

The experience of people who have contact with mental health services in a general hospital following self-harm is varied. There are initial barriers to be overcome in order to elicit help in the first place, including emotional state; feeling guilt or shame about having self-harmed; having to revisit distressing situations as part of the encounter and the difficulty of the encounter being a talking one for those who do not identify as natural talkers. The issue of being seen as a whole person is another issue alongside that of the practitioner being human too. Both affecting the quality of the interaction. Stigmatising

attitudes that include judgement were raised repeatedly as ways that the personhood of the individually is obscured and this also affects the interaction. Additionally the impact of the environment on the interaction is reported, the physical space itself; the impact of service driven agenda on the interaction and the psychosocial assessment process itself which is demanded by NICE (2004, 2011) as part of the interaction. Finally, power was reported via data on truth telling; the transactional nature of the interaction and the amount of credence that is given to the patient in leading their care. This chapter has reported the data and how it contributes to each of the SOT and LOT, and now the work will consider these themes in light of research literature.

Chapter 6 Discussion

The first part of this discussion chapter considers the findings in the context of wider literature from both health and social care. Some of the literature with which this work dialogues is found in the literature review chapter, however, in line with IPA methodology additional literature searches have been undertaken as a result of the themes arising from the findings (Smith et al, 2009). This work particularly converses with mental health nursing literature, especially Barker (2004) and King (1999); with anti-psychiatry literature particularly Sayce (2016); patient literature particularly Beresford (2015) and Russo and Sweeney (2016). Due to the broad applicability of findings, literature from other professional groups eg. psychoanalytic practitioners, has also been included. The theoretical position that unites the literature used and informs the analysis, is primarily that of a person centred nature, literature that puts the person at the centre of services, therapy and practice. The second part of this discussion chapter, considers the unique contribution to knowledge this thesis provides.

6.1 Internal Barriers to getting the help you need

According to NICE (2004) guidance, every person coming to the general hospital following self-harm is expected to be offered, and preferably receive, a psychosocial needs and risk assessment. The general outline of this talking assessment is described in 1.7.7. Firstly, the issue of being a non-talker in this talking encounter is considered, it outlines the difficulties inherent in this process for people who do not find it easy to confide. Secondly, the effect that the emotional state had on the ability of participants to confide is also considered with a focus on the narrowing of attention that may occur with high emotional states. Thirdly, the effects of guilt and shame are considered and how these perceptions influence the ability of the participants to share the information they needed to in order to get help. Finally, the issue of repetition is considered in terms of the difficulties inherent in having to revisit past trauma and the fear of reawakening emotional states that were distressing at

the time. These barriers arising from the participants inner world influenced them getting the help they needed.

6.1.1 Being a non-talker in a talking encounter

This study found that the expectation of the contact with mental health services, that the patient talk about their issues, was often experienced as a challenge particularly by those who did not find talking easy. The literature on self-harm being a substitute for words is vast (Babiker & Arnold, 1997. Favazza, 2011. Strong, 1999. Lemma, 2010) suggesting that the link between self-harming behaviours (including suicidal actions) and personal expression is strong. Grosz (2013) suggests that there are people who are unable to process events by storytelling and instead find that they tell the story via actions, or 'the story tells them'. It would not be illogical to suspect then, that people who express themselves in this way may indeed find it difficult to express themselves using words and yet services maintain the stance that the situation the patient is in when presenting to services, with some form of self-harm, must be explored using a talking encounter, namely the psychosocial assessment (NICE, 2004 & 2011). Words are only one way of expressing ourselves and for those who have been forced to be silent, through abuse for example, or who have never learnt the language required for self-expression the act of self-harm itself is a form of expression which mental health practitioners have a responsibility to understand (Shaw, 2013). Shaw goes on to say that language is a way of passing on information, of evoking emotions and responses in others, as way of building our identity and of having our needs met. Without the right language we struggle to be understood and metaphor becomes a way of creating our own language, thus self-harm becomes a metaphor for internal pain, a cry for help or whatever the function of the self-harm is for that individual. This point was borne out in the context of Alex's self-harm and the research interview as she used metaphor to help her communicate. In this context it would seem important that staff taking part in this talking encounter have a level of communicatory competence that allows them to be able to read alternative communication strategies.

In Goffman's sociological theory, Forms of Talk, the talking encounter entered into by mental health practitioner and patient is an example of interactional talk, an arrangement whereby people come together, sustaining conversation

and mutual attentiveness that holds them in an intersubjective world (Goffman, 1981). The social setting within which they meet (hospital) sets the scene providing not only context, but also partially determining the structure of the interaction (enquiries required by psychosocial assessment, see 1.7.7 for outline). As Goffman (1981) suggests, in order for a potentially sensitive discussion to take place there are certain conditions that must be fulfilled if the interaction is to succeed and these will be individual to those within the encounter. Previous unsuccessful interactions can provide schema that can be matched to current situations so possible meanings from previous events can be applied to the current one. Thus, early attempts at communication, if unsuccessful, can set the tone for future attempts (Goffman, 1981). This could lead to a disinclination to express oneself as noted by Yousaf et al (2013) particularly in men but also in women who subsequently also went against the gender stereotype and were reluctant to seek help from mental health practitioners (Outram, 2004).

6.1.1.1 Being a non-talker and gender

Pain can be difficult to express (Biro, 2010), language representing an often suboptimal way of trying to describe suffering, however, the consequences of silence in a talking assessment are unacceptable. Findings from this study, confirm that males are more likely to be non-talkers then females. Only one of the six participants mentioning this as a theme was female, suggesting a slight gender bias for this LOT. This is conversant with literature on male help seeking and emotional talk and is the only theme in this study where it was noted that the service may actually favour women, in that generally they find emotional talk easier. McPhedran (2013) states that notions of masculinity impede help seeking, there is much evidence in the literature that supports this assertion (Green, 2010; Emslier, 2005; Scholz, 2014; Rickwood, 2014). Green (2010) found that soldiers often lack a language with which to express distress due to the soldier being the epitome of hegemonic masculinity. Whilst in the services the camaraderie of the environment serves to moderate this somewhat but outside of the military confine it can become problematic.

The language of war is often used within healthcare settings as disease is often seen as the enemy to be fought, however in the instance of Dave, his use of military language could also be attributed to ideas of masculinity which may

have been preventing him from expressing himself emotionally. Ideas of hegemonic masculinity that appear to have sway in this instance include the 'strong and silent' approach to emotional difficulties as highlighted by O'brien et al, (2005), the belief that surviving a suicide act is less preferable to suicide as found by Canetto (1997) and emphasis on control, strength and responsibility to others as highlighted by Emslier (2005) and Rickwood (2014).

Yousaf (2015) found an increased disinclination to express emotions in men and that men are very reluctant to seek formal psychological help (Cusack, Deane, Wilson, & Ciarrochi, 2006; Good & Wood, 1995; Hammer & Vogel, 2010; Johnson, Oliffe, Kelly, Galdas, & Ogrodniczuk, 2012). Possibly influenced by the traditional hegemonic masculine norm that pain should be borne and problems solved by men alone (Jeffries and Grogan, 2010). So, discussing issues becomes problematic.

This theme suggests females may be favoured by the services insistence on a talking encounter as males are more likely to find confiding difficult. This could also be viewed as a societal issue; spoken language has become the primary focus of all communication in the public sphere thus putting those who find talking to others easy at a distinct advantage over those who find talking difficult. It also suggests that language based communication is more important than other forms of communication such as body language or arts based expression. The form of talk being described by the participants here is emotional talk and it is here that it would appear that men may be at a slight disadvantage. Goffman (1981) points out the difficulty in the belief that language is the best form of communication when he clearly demonstrates the issue of interpretation of talk. He states that what is said will be interpreted differently by the listener, to varying degrees, and that there is an assumption of understanding that does not really exist.

6.1.2 'Emotions run high'

This study highlights communication difficulties which may indicate that not only do emotions affect clarity of expression and understanding, but that staff may not be fully equipped to recognise or best support emotional expression. Policy calls for advanced communication skills from mental health practitioners in this area (NICE, 2004, 2011. Hart and Eales, 2004), but this study indicates a

shortfall in communicatory practices within this area. Human beings are always in some sort of emotional state (Leblanc et al, 2014), this emotional state influences perception of the world, memories and decision making. Emotions are often viewed as derailing logic and causing chaos, during an emotional event they have been shown to impair the recall of previously learnt information (Leblanc et al, 2014) however, there is growing recognition that human beings cannot function without emotion (Wider, 2007). One compounding factor about emotion is that cognition can trigger emotion, so thinking about her social problems causes May to become emotionally aroused, but that emotion does not necessarily trigger cognition (Leblanc et al, 2014).

According to arousal models of emotion, emotional arousal (either positive or negative) activates specific areas of the brain (Hamann, 2001) and this can lead to narrowed attention and tunnel vision as that demonstrated by some participants where they were unable to see past their current distress. Additionally Gasper and Clare (2002) found that those in sad mood are more likely to see a limited range of options compared to those in more positive mood. More support for this perspective is forthcoming from Lecblanc et al (2014) who note that if the situation that created the emotions or the emotions themselves are particularly goal orientated, often expressed as anger, this may lead to individuals attending to and remembering only the information that pertains to the active goal.

It could be argued that those patients in mental health crisis, who are likely to be emotional, would fall into the category of those with complex communication needs. They may be further disadvantaged if their complex communication needs are not easily recognisable from observation. Emotional states are not always noticed by others. In some cases though obvious distress and anger may mean that strategies to maximise calm are likely to be required from the professional. If narrowed attention results from emotional arousal it would be logical to imagine that our ability to communicate with others and to interpret their emotional signals could be compromised. If compromised by emotion, there may be an absence of capacity for reading and responding to others emotional states and thereby our sense of self is impaired (Wider, 2007). As Finke et al (2008) point out, effective communication, regardless of practice setting, is essential for good practice. In order for communication to

be effective both the nurse and the patient need to possess the skills and knowledge required for the interaction. Poor communications can lead to increased risk and levels of anxiety and frustration raise, further adding to the emotional burden, which influences recovery rates (Balandin et al, 2007). There is an assumption that emotional talk is good for the self. In the current cultural climate there is a tendency to expressing the self through emotional talk (Ellis and Tucker, 2015) , although the efficacy of this emotional talk is not known. Acceptable emotions are defined by a set of rules or conventions in each culture or sub-culture, which dictate what feelings are allowed by whom, when and where (Rustin, 2009), with conformity being associated with reason, non-conformity with lack of reason. Ellis and Cromby (2012) state that emotional non-expression appears to have a negative affect on psychological processes and increased physiological illness. Bucci (1997) describes the process of organising experience and connecting it to words as 'referential activity'. The three states of this process in expressing highly charged emotional memories are:

1. Symbolic expression – somatic activity such as high pitched vocals and heightened autonomic activity (speech is likely to be incoherent and affectively charged)

2. Symbolised figuratively eg by pointing or drawing

3. Via concrete language, narrative via which further meaning and insight is likely

These stages take time to work through with the third stage being required for talking therapies to be effective. It is also this third stage that people need to be in for the psychosocial assessment to be most effective. Under current working practices it is not always possible to allow the time needed for this stage to be reached so people are often still very emotional, this suggests creative practice may be required eg. Allowing someone to write things down instead of speaking them out loud.

For several of the participants in this study, they appeared to be aware that they needed help but found themselves unable or unwilling to express these needs or seek out help, and found disclosure difficult. Rickwood (2014) suggests that one of the reasons people do not express their distress could be

lack of emotional competence. Indeed, learning the emotional competence required to express the emotional world is a major barrier for boys, who are socialised to seek less help from all sources across early and mid-adolescent years (Green, 2010; Emslier, 2005; Scholz, 2014; Yousaf, 2015). With the added complexity of suicidal thinking Rickwood (2014) also asserts that help seeking decreases as suicidal intent increases raising risks considerably for the individual. Thus the issue of gender could be a factor in the findings of this LOT too, if men find emotional expression more difficult than women they are facing another barrier to getting the help they may need.

6.1.3 Guilt and Shame

In this study, the shame and guilt that those participants in this LOT described was mainly linked to their having been admitted to the hospital via their own actions. The effect of guilt and shame is underrepresented in mental health nursing literature. Rüsch et al, (2007) agree that shame is the most central emotion in Borderline Personality Disorder and the emotion most closely associated with self-harm and suicide. Shame plays a role in many mental health problems and self-harm (Tangey and Dearing, 2002) and Gilbert (1997) describes shame as one of the most powerful, painful and potentially destructive experiences known to human beings. Nelson and Muehlenkamp (2012) found a direct correlation between shame and self-harm. Mitten et al (2016) concur and add that people who self-harm often experience guilt and shame just because they self-harm and are engaging in a socially frowned upon practice. In exploring the role of shame and self-criticism in a mixed clinical population, Gilbert et al (2010) found the self-persecuting function of self-criticism related strongly to self-harm.

Shame leads to both approach and avoidance behaviour (Hooge et al, 2011). Approach is motivated in an attempt to restore the damaged self and avoidance when situational factors make it too risky or difficult to restore. Thus approach behaviours reduce over time as it becomes more important to protect the self. Shame is also implicated as an important factor in personality pathology (Schoenleber and Berenbaum, 2012), it is suggested that people with personality pathology may have elevated shame aversion and this may contribute to maladaptive shame regulation. Negative self-beliefs that elicit shame are very distressing (Schoenleber and Berenbaum, 2012) and result

from attributing information about a specific situation or occurrence to characterological defects. Thus the triggers for shame are carried within the individual and are a constant threat of distress which can be inadvertently triggered by others as well as themselves. Physical clues that someone is experiencing shame are well known eg. cast down eyes, looking away and blushing. Could this be the reason behind Dave's behaviour when he has to look away from the practitioner during his assessment in order to overcome his 'blockades' to enable himself to talk to her and try and elicit some help? Three types of maladaptive shame regulation have been suggested (Schoenleber and Berenbaum, 2012):

- Prevention – eg. by achievement sabotage, dependence, perfectionism
- Escape – eg. by social withdrawal
- Aggression – either directed at others or at the self

They go on to hypothesise that self-harm as a regulator of emotion may have a specific focus for those with personality pathology, on down-regulating shame.

Whilst Gilbert et al (2010) state that an elevated sense of shame has been linked to avoidance of help seeking for emotional difficulties which may lead to self-harm, they also note that internal criticism and put down can be linked to severe negative affect and involuntary subordination. This change in power differential can also be seen when considering the effect of guilt. Hooge et al (2011) suggest that the psychological origins and motivations of shame and guilt are different. Guilt is related to protecting or repairing damaged relationships whereas shame is concerned with protecting the self and so, whilst they may both initiate approach behaviours (eg. coming to receive help in hospital) the reasons behind them are very different. Guilt is felt in situations of interpersonal harm (Zeelenberg and Breugelmans, 2008), is closely associated with suffering and is an integral part of depression (Goldblatt, 2010). It is an emotion that motivates compensatory pro-social behaviour to repair social bonds (Nelisson and Zeelenberg, 2009), when this is not possible then the guilt may provoke self-punishment including thoughts of suicide.

Fantasies of suicide are common (Goldblatt, 2010), whilst they may be a source of masochistic torment, they may also be a source of control, empowering

oneself with omnipotence in one's own fate. Thus the person feels stronger with the fantasy of absolute control whilst also feeling as powerless as a victim of torture. These thoughts of suicide can be a way of soothing disturbing affect and maintaining cohesion (Maltsberger et al, 2010), self-attack can restore a sense of competence and the ability of cope when people feel weak and helpless, so those with unconscious guilt prefer the sense of guilty power to helpless impotence (Goldblatt, 2010). Talk of suicide however, is likely to provoke an over response in services therefore it is likely that these fantasies cannot be explored in the interaction between the person who has self-harmed and the practitioner.

This theme suggests sensitivity is required on the part of the practitioner to the presence of both guilt and shame. It would be reasonable to suggest that a compassionate, non-judgemental response would be required to ensure these feelings are not reinforced in the individual as outlined in humanistic person-centred mental health nursing theories (Peplau,1988 .King, 1999. Barker,2009) . The effects of these emotions on the disclosure needed in order to elicit required help are not fully appreciated in mental health nursing literature or in the training of mental health nurses.

6.1.4 Re-living Trauma – 'I'd already told'.

This study has found that the experience of contact with services characterised by feelings of vulnerability caused by having to revisit difficult memories or trauma was a barrier to sharing, and thus getting help, raised by several participants. Multiple assessments leading to repetition of distressing events was one of the complaints raised during the Better Services for People who Self-Harm project (Palmer et al, 2007), both locally and nationally. Shatell et al (2014) state patients report having to repeat stories around three times even before seeing a mental health professional is at best stressful, and at worst harmful. Peplau (1988) asserts that human behaviour is purposeful and goal seeking, predominantly towards satisfaction of a need and/or in search of security. Blocking or interference of this satisfaction creates great frustration and may lead to aggression. At the point of self-harm it could be assumed that the person has already found themselves frustrated in pursuit of their needs and directed this subsequent aggression towards themselves. In the context of wanting to feel safe and secure, which is a fundamental need as Peplau (1988)

suggests, it is not so surprising that patients are reluctant to revisit traumatic experiences and feelings.

This topic is well discussed in the literature pertaining to trauma focussed therapies, debriefing and Post Traumatic Stress Disorder (PTSD), wherein traumatic or distressing past events are deliberately revisited to facilitate healing (Shearing et al, 2011. Butler et al, 2006, Vincent, 2004), but relatively ignored in the general assessment literature and within the self-harm literature. Shearing et al (2011) describe re-living in Cognitive Behaviour Therapy (CBT) whereby traumatic events are deliberately revisited to treat PTSD. Despite this being a relatively well evidenced therapeutic technique (Butler et al, 2006), therapists are fearful of employing it in case they re-traumatise patients. Some of these fears appear to be well founded as Vincent (2004) states that in trauma focused therapy participants identified difficulties in anticipatory anxiety, reactivating suppressed memories and re-experiencing emotions, pain and exhaustion. One of the reasons participants gave for agreeing to relive is desperation for change (Shearing et al, 2011) which echoes the position of several participants in this study.

Shearing et al (2011) also talk of an increase, albeit temporary, in flashbacks, emotional exhaustion, nightmares and other PTSD related symptoms. This could be particularly relevant for patients who are diagnosed with the controversial Emotionally Unstable or Borderline Personality Disorder (EUPD & BPD), a common diagnosis given when self-harm is a factor. The correlation between this diagnosis and PTSD has often been highlighted (Wright et al, 2007). Over time it appears that the evidence for trauma based therapy is overall positive however, in the context of the Emergency Department, where there may only be one interaction between several different professional team members and patient, expecting patients to relive trauma over and over again is unreasonable and could be further traumatising.

This study suggests that the effect of this repetition could influence the ability of the person to communicate when we consider the effects of emotion on communication (see 6.1.2). Foa et al (2002) found in a minority of patients that reliving traumatic events increased the frequency of intrusive thoughts after the initial session which supports the assertion made above and indicates a fundamental difficulty in the psychosocial assessment. Increased levels of

anxiety induced through imaginal exposure may be construed negatively by patients which may affect therapy or assessment attrition and prevent people accessing help in the first place (Foa et al, 2002). Pitman et al (1991) found that imaginal exposure could have the effect of exacerbating guilt feelings, self-blame and feelings of failure although again they assert that the potential positive benefits of revisiting were tolerated as they might lead to positive change. Speckens et al (2006) cast further light on the subject when they discovered that the patient view of their reactions to the initial trauma had a clear effect on the prospect of having to revisit them. If the person believes that they will, 'fall apart' or 'go mad' if they start thinking about it then they will obviously be reluctant to do so, additionally those who were still very angry about the event found reliving it much less effective as an intervention (ibid).

The experience of re-living trauma is likely to be influenced by the quality of the relationship with the professional concerned. A validating response from the mental health practitioner is likely to minimise any resulting emotional dysregulation (Shenk and Fruzetti, 2011). However, an invalidating response is likely to be met with erratic or extreme responses. Shearing et al (2011) state that having trust in the person who is asking the patient to revisit trauma is very important. Peplau (1988) states that positive outcomes are more likely to be achieved when the nurse provides unconditional acceptance in a sustaining relationship, a position supported by Shattell et al (2014) who highlight the importance of listening and understanding in a crisis situation, which self-harm can be construed as. The theory that damage from revisiting is minimised by a good interpersonal relationship between mental health practitioner and patient is supported within the data in comparing the reaction of Alan to his mental health practitioner, whom he trusted immediately, with Fred who found the whole experience traumatising primarily because he found himself unable to trust the practitioners. Fred indicated many times during his interview that the mental health practitioners who had assessed him had not succeeded in creating a good relationship with him suggesting therefore that he did not feel safe to revisit old wounds. This finding offering additional support to the importance of humanistic, person-centred care in mental health nursing.

In exploring disclosure of traumatic experiences Marriott et al (2015) state that many people reported to them that they disclosed because they thought it

would make them feel better, although in the event only half of them did feel better for it. They note that in different levels of trauma, particularly high betrayal trauma (characterised by being violated in some way by someone in a position of caring authority), disclosure is often delayed and there is a clear correlation between levels of depression, anxiety and dissociation within this group. They also assert the importance of the relationship between the discloser and the hearer of the disclosure as being key to how supportive the discloser finds the experience. Those who experience high betrayal require a more intimate and interpersonal disclosure process (Foynes and Freyd, 2013) in order to minimise any negative impact of sharing. Considering this then, asking people to revisit trauma in an assessment and not responding in an empathic or supportive way is likely to be adding to the trauma burden for that person. It could also be considered an example of high betrayal trauma. It is critical to ensure an empathic and supportive response to disclosure, whether it be for the first time or subsequent sharing, in order to enhance the benefits of disclosing (Marriot et al, 2015).

Despite all these points which highlight the complexity and risk inherent in asking people to revisit trauma the fact remains that, in the psychosocial assessment practitioners are expected to ask trauma and abuse related questions (NICE 2004 & 2011) of people who self-harm. This recognises the fact that exposure to trauma has been shown to be a risk factor in completed suicide (Putnam, 2003). The experience of the participants in this study was mixed with regards to this issue, which may be partially explained by the timing of the questions with some of them being more ready to answer than others and was also affected by the relationship that the participant had with their assessing clinician. It is important to consider ethical implications inherent in asking others to revisit unhappy experiences and the need for the relationship between the clinician and patient to be positive. As Foynes and Freyd (2012) point out recovery from stressful life events often involves telling others what happened and the supportive reception of these disclosures has been shown to have positive outcomes for the individual concerned. A positive relationship between practitioner and patient has been shown to be a strong indicator of the perception of supportive disclosure reception. In a therapy situation, whether it be trauma focused or not, much effort is invested in building the therapeutic relationship whereas in the busy general hospital

environment, where speed and efficiency are currently prized above relationships (see Traumatic environments,6.3 for more discussion of this issue) taking the time to build a good relationship is more challenging.

6.1.5 Conclusion

Findings suggest that the current service model, based on a talking encounter, may favour women as men may find it more difficult to engage in emotional talk. Emotional state also affected the ability of the participants to talk and share the information required for them to get the help they needed and findings suggest that practitioners need enhanced communication skills in order to overcome complex communication needs. The guilt and shame that often accompanies admission to hospital for a 'self-inflicted' injury is easily made worse if the response from the mental health practitioners is not empathic and compassionate. This suggesting that the practitioner needs to be able to respond in a non-judgemental and respectful way. Although the trauma or events leading to distress are external to the individual, the expectation that patients repeat them several times is unreasonable and creates an internal barrier within the individual who may wish to protect themselves from more distress. Steps need to be taken to reduce the amount of times people are expected to repeat themselves or at the very least, if they have to then it must be ensured that actions taken or responses to this information make that effort worthwhile. All of these factors are influenced by the quality of the relationship the patient has with the participant and findings clearly show that further distress can be minimised if the person trusts the practitioner, feels listened to and respected and finds it easier to talk, even when they do not identify as a person who talks easily.

This SOT has considered the aspects the participants found influenced their ability to seek help. These barriers arose from within but were easily exacerbated by the response they received to their initial help elicitation behaviour. Discussion of this theme is often missing from mental health nursing Literature and these findings add to this body of work. The influence of emotions, particularly guilt and shame on disclosure and the highlighted need for humanistic and person-centred approaches is important in moving the field forward. It will be necessary to consider more creative ways of working in

order to overcome communication difficulties and this work could also contribute to research in the field of creative practice.

6.2 The Business of Being Human

Standardised psychosocial assessment, as used by mental health services, potentially obscures the unique personhood of the individual. In exploring how the assessment process influences the experience of the treatment of adolescents, Binder et al (2013) found that it was the relational quality of the interaction between practitioner and patient that could ensure the assessment, despite being standardised to some extent, was still a positive and hope enhancing encounter. As Todres (a psychodynamic phenomenologist) states, when someone is considered as a diagnosis, statistic or label, people are dehumanised, their inherent uniqueness is lost and this can deeply influence the person's sense of self (Todres et al, 2009). Additionally, receiving a diagnosis, and stigma held both by others and the self, have an impact on belief in one's uniqueness. Assessment contains the potential for recognition of the 'me' in the patient and can strengthen the patients identity and sense of self. Experience of illness rekindles awareness of our unique personhood and fundamental aloneness (Kissane, 2012) by highlighting individual issues and shortcomings that can threaten our sense of self and the way others view us. Whilst findings from this SOT continue to support the humanistic, person-centred approach advocated for in policy and mental health nursing literature, it is clear from this study that the rhetoric does not necessarily match the experience.

Human beings are complex and regardless of membership of certain groups and larger contexts we maintain a uniqueness in space and time that characterises our individuality (Todres et al, 2009). Taylor et al (2009) suggest that health can be regarded broadly as a certain amount of freedom from the constraints of identity imposing systems (diagnosis, psychiatry) allowing movement towards an enhancement of identity and self-hood. If this point is accepted then the importance of practitioners seeing patients as more than just a diagnosis or behaviour is clear. So whilst the psychosocial assessment does not rely on diagnostic criteria, this information is gathered as part of the process and inevitably, the announcement of any pre-existing diagnosis will carry with it preconceptions, stereotypes and potentially provoke assumptions

on the part of the practitioner. Currently services are provided based around diagnosis, so the potential for losing the person in interactions between patient and practitioner are many.

In this study participants noted times when they felt were not viewed as people but rather, were judged, stereotyped, seen cynically or stigmatised in ways that reduced their humanity. They also noted times when the practitioner before them appeared to be less then human in their interactions, often leading to a somewhat negative experience.

6.2.1 'A Person Looking After Another Person'

The findings from this LOT are consistent with the literature from humanist, person-centred nursing, counselling and psychology, which stress the importance of therapeutic rapport and compassion. The issue of common humanity has been shown as being essential in the recovery process (Wright et al, 2007) and, in describing recovery alliance theory, Shanley and Jubb-Shanley, (2007) state that individuals are social beings and share a common humanity which, via interaction with others, helps us to develop as individuals. In her personal account of self-harm, LeFevre (1996) describes multiple occasions of de-humanising behaviour, stating that professionals behave as exactly that and not as human beings, this she associates to the 'risk' of being attached to someone who self-harms as being seen as too great but this social rejection and professional distance merely serves to increase the need to self-harm.

Human beings care about meaning (Todres et al, 2009), narrative truth can feel far more meaningful than statistical truth and when we are forced into standardised frameworks (such as psychosocial assessment) it may make logical sense but doesn't necessarily feel like care. It could be that this professionalism occurs precisely because the mental health practitioner is human. Menzies Lyth (1959) describes task orientated behaviour as a means of anxiety management, a position aligned to Tomlinson (2016) who clearly outlines the issue of anxiety in healthcare practitioners in the uncertain world of healthcare and the steps taken to alleviate it. So following this line of argument, the mental health practitioner was being human in the case

although not necessarily humane in terms of empathy, understanding or caring.

It is clear that the therapeutic relationship is an important tool in improving patient outcomes (Taylor et al, 2009. Harper et al, 2014. Leibman & Burnette, 2013. Shedler, 2010) and Palmer et al (2009) raise the point that the patient narratives that exist around self-harm clearly state that the main improvement that can be made in self-harm services is that care staff be more compassionate. The importance of this for people who self-harm is demonstrated by Tate (2010) who reports that when accessing services following self-harm being talked to as an equal, or another human being, allowed her to open up, leading to a more positive outcome for both her and the service. In a study exploring effective care in patients with mental health issues in the community, Erikson et al (2013) show that acknowledgement of humanity is essential. Compassion to self and others has an important role in helping people manage their mental state (Crawford & Hallawell, 2011) although, whilst supporting this, Gilbert et al (2011) also point out that whilst there is evidence that helping people develop compassion for themselves and others has a powerful effect on negative affect, there are some who find compassion so difficult they avoid it totally. Smith and Cashwell (2011) talk about the concept of social distance, with low social distance meaning a feeling of commonality, or belonging to a group, based on the idea of shared experiences. Their research showed that mental health practitioners had similar desires to the public for high social distance from people with mental health problems, a desire they feel is based in stigmatising attitudes and beliefs. Taking these issues together it begins to become clear why a mental health practitioner may be so cold and dismissive during assessment as several participants experienced. This has serious implications for mental health nurse training.

Healthcare practitioners of all professional groups have been found to provide less compassionate care to people with self-harm who are often viewed as less deserving (Patterson et al, 2007.Wright et al, 2007. McAllister et al, 2002). Indeed Palmer et al (2007) in their exploration of patient experiences of using services after self-harm found that 30% of mental health practitioner attitudes were rated as poor or very poor towards people who self-harmed. Barker and Buchanan-Barker (2004) point out that professionals are encouraged to write in

the third person, ignoring or minimising the subjective element (human element) which will inevitably be there. They go on to say that in order to understand anything about human nature we must examine the lived experience although they point out that, in the very doing of this, we shape, change and influence the experience. Following this logic the process of assessment can change, shape and influence the lived experience of the person who has self-harmed.

When dealing with sensitive subjects, such as self-harm, it is likely some emotions and reactions will be triggered in the mental health practitioner, if utilised correctly this experience can be useful in helping aid the process of understanding (Gemignani, 2011) and the principles of managing countertransference (CT) may be usefully considered. CT is the internal and external reactions to a patient that are influenced by the mental health practitioners personal vulnerabilities and conflicts (Hayes et al, 2010) and regular projections from patients. In a study by Liebman and Burnette (2013) which explored the advent of CT with patients with BPD, self-harm was identified as being a challenging diagnostic characteristic which may trigger CT. If this CT is unaddressed and the self-harm subject to unhelpful stereotypes, eg. being about attention seeking, then this has potential consequences for risk management, patient safety and invalidation. If practitioners can use the reactions in order to deepen their understanding of the individual who self-harm, this is likely to improve the outcome for both the patient, in terms of therapeutic encounter, and the practitioner in terms of reduced burnout. Poor CT management can lead to poor patient outcomes (Liebman & Burnette, 2013). Self-insight, empathy and anxiety management in the mental health practitioner are key in addressing CT. Empathy is highly validating (Elliott et al, 2010), the ability to see through the patients eyes as far as possible and understand the patients' feelings, thoughts and point of view is essential in a context of authentic caring.

In exploring counsellors perceptions of people who self-harm and the impact they experience in terms of personal challenge, Fleet and Mintz (2013), found that clinicians reported powerlessness, confusion and frustration amongst other strong emotional reactions. The complexity of self-harm exacerbates anxiety and creates tensions within the practitioner that are difficult to resolve as the potentially creative aspect of using self-harm as a coping mechanism in

order to stay alive is diametrically opposed to the wish for the patient to cease self-harm. Additionally it is difficult for practitioners to envisage a destructive act as being positive in any way. Favazza (1992) points out that self-harm is one of the most difficult patient behaviours to understand and treat. Richards et al (2010) show that mental health practitioners are susceptible to impairment in their professional lives that can undermine their therapeutic effectiveness, so self-care is important and can be considered to include self-awareness. Self-awareness is a somewhat reified concept, varying from simple awareness of one's thoughts and emotions to more complex constructs such as self-consciousness and insight (Richards et al, 2010). It appears that having a good level of self-awareness guards against the vulnerability that may be triggered in CT (Hayes et al, 2010) and protects against burnout (Demerouti et al, 2010) leading to more emotionally competent practitioners more able to facilitate better patient outcomes. In her reflection on promoting self-awareness in practice Billington (2013) points out that her thought processes were her biggest challenge in terms of self-doubt and lack of confidence albeit triggered, at times, by interactions with patients. Using techniques such as reflection, mindfulness and self-care became essential in maintaining good professional health.

Cutcliffe et al (2006) assert that a key psychosocial problem in dealing with suicidal people is re-connecting them with humanity and suggest a three stage healing process with the first stage being 'reflecting an image of humanity'. Participants in this study echoed the views of Cutcliffe et al's (2006) participants in that they did not want to be treated mechanically but rather form a close human relationship with the mental health practitioner. This relationship does not have to be long but needs to be meaningful (Crawford & Brown, 2011). In order to reflect an image of humanity the mental health practitioner needs to be able to facilitate a warm, care based human to human contact that nurtures insight and understanding (second stage - guide back to humanity) before sending the person back out into the world to the third stage, 'learn to live again' (Cutcliffe et al. 2006).

6.2.2 Stigma – 'An Aberration?'

The effect of stigma on the experience of care is not well considered in mental health nursing literature so these findings add to this. The main body of work

relating to this topic, with which this section converses, is from contemporary anti-psychiatry and patient accounts, thus grey literature. Participant concerns with being identified as a person with mental health difficulties are well supported in the literature. In his book on stigma, Goffman (1963) states that the term originated to mean bodily signs which were designated to expose something unusual and bad about the moral status of the person assigned the mark. Whilst the term has changed its significance slightly over the years it is used in close to its original meaning today although, in mental health, the term is applied to labels, replete with stereotypes, rather than bodily signs. Mitten et al (2016) define stigma as an overarching term that refers to problems in attitude, behaviour and knowledge that is experienced as prejudice, ignorance and discrimination, a process that is generally a harmful process and result in negative outcomes for the individual such as reducing the success of treatments and marginalisation. Stuart et al (2012) anticipated that between 40 and 70% of people with mental illness would face stigma and discrimination on a daily basis, however Corry (2008) in a Time to Change survey found that nearly 9 out of 10 (87%) of their respondents reported experiencing stigma related to their mental illness, and that these rates were higher for women and those with an additional minority status related, for example, to race or sexual orientation.

Borneo and Pinfold (2007) state that stigma is a dehumanising process that labels and stereotypes and this prevents people accessing help; impairs recovery; isolates; excludes them from day to day activities and stops people getting jobs (Corry, 2008). A position supported by Moses (2009) who states that stigma is a complex social and psychological phenomenon that has significant implications for the individual living with mental illness.

There is ample evidence of stigmatising attitudes within mental healthcare (Mitten et al, 2016) and, as Farrelly et al (2015) point out, mental illness related discrimination correlates positively to suicidality, can increase feelings of hopelessness and increase social isolation. Thus it may not be such a surprise that Henderson and Thornicroft (2013) state that discrimination by mental health services is a key reason why people who are in crisis eg. Suicidal, may not come forward and ask for help. Mitten et al (2016) found that the participants in their study perceived healthcare practitioners as making assumptions, minimising and belittling their problems although they reported

a more empathic level of care from mental health professionals then from Emergency Departments when accessing them for self-harm. Curry (2008) identified all healthcare practitioners, in particular psychiatrists, as targets for anti-stigma work as their attitudes are crucial in reducing stigma across the board.

Therapeutic interventions (and the psychosocial assessment, can be therapeutic in nature) are not therapeutic if the person carrying them out holds damaging representations of the people receiving the intervention (Wright et al, 2007). This is one of the most important issues that Tate (2010) notes in her description of positive contact with services following self-harm. Staff perceptions of the amount of control that the person had about the events that led to self-harm and the way it was carried out also appear to affect their attitudes to those who self-harm (McHale & Felton, 2010). Those who are envisaged as having had choice over their decisions are viewed less favourably in terms of manipulative motives and therefore may warrant a less caring attitude from the professional.

The process of being treated differently from others is a source of significant stress and influences how one feels about oneself (ibid, Mitten et al, 2016). As labelling or categories do not hold over large numbers of people, it is likely that moving away from labelling would be a positive step, particularly the inexact and bias driven, categorisation of diagnosis (Sayce, 2016). The issue of labelling is a difficult one as, although it is stigmatising, many also desire a label as it may allow access to certain services or provides some validation for their experiences (Mitten et al, 2016). Indeed, the best aftercare provision, that remains non means tested, in mental healthcare is Section 117 aftercare, which can only be accessed by those meeting certain criteria after being sectioned under the MHA.

In their report looking at various anti-stigma approached in New-Zealand and Australia, Case Consulting (2005) found that education had a positive effect on stigma but was not sufficient on its own to bring about long term change. They conclude that the most effective form of anti-stigma approach is one that involves contact. Considering this then mental health staff, Emergency Department staff and those who often have contact with people who self-harm or are in mental health crisis could be expected to be much more

understanding of the individual in crisis and less stigmatising? Since literature suggests this is not the case they further explored the literature to ascertain why this might be and suggest that there are five conditions that need to apply before the anti-stigmatising effect can be seen (ibid). They are thus: Both parties (stigmatised and stigmatising) need to have equal status; they need time to get to know one another; the stigmatised needs to provide information or experience that challenges the stereotype held; they need to actively cooperate and be in pursuit of a mutual goal.

So, whilst in healthcare it may be possible to demonstrate times where all these criteria are met, in mental healthcare there are extra challenges because, at no time does the patient have the same power as the practitioner due to the MHA. Time to Change (a national anti-stigma organisation) are realistic when they note that it will take years to break the stigma related to mental illness down (Curry, 2008) but they have not, as yet really considered the impact of the MHA and until they do 'People are being denied opportunities to be people.'(ibid) and practitioners will not be able to fully realise the fact that they are *'just a person looking after another person'.* Ethics of care, a normative ethical theory developed in the field of dementia care that considers what makes actions morally right or wrong, provides an epistemological alternative to understanding multiple moral voices (Barnes et al, 2015). It can give voice and credence to joint experiences including openness about resource issues that provides a sense of relief for those interacting and a pragmatic honesty which will enable creative problem solving in endeavouring to find solutions to the problems facing individuals. In the same way the ethics of care perspective considers dependency as inherent in the life course, thus eliminating the need for ageism. If we apply this perspective to mental health in terms of a spectrum across which we will all experience varying degrees of distress at different times, then the need to think of those in emotional distress as 'other' also diminishes. Thus the ethics of care approach promotes the reduction of stigma and increases the ability for both the professional and the patient to have open and honest discussion.

Self-stigma can be defined as an individual's response to perceived stigma (Brohan et al, 2011), in this case resulting from their self-harm or mental illness, which leads to self-discrimination (Corrigan et al, 2012). Corrigan et al (2012) suggest it is an hierarchical process beginning with an awareness of the

stereotype that is similar to the perceived stigma that might be directed toward them by others; agreement with it; applications of this stereotype to themselves and then the resultant damage to self-esteem which effects future behaviour, a position upheld by Oliveira et al (2015). Graham et al (2013) noted how self-stigma effected people's ability to lead healthy lives alongside managing a mental health problem, and Brohan et al (2011) also report multiple negative effects resulting from self-stigma including lower self-esteem, increased depression, reduction in treatment seeking behaviour and reduced quality of life particularly in those with a diagnosis of bi-polar disorder or depression. Corrigan et al (2012) state that this self-stigma can result in a 'why try' effect whereby people affected by self-stigma limit their opportunities to engage in social, work and health related activity, thereby potentially compounding the problems that are inherent in mental illness such as social isolation. Brohan et al (2011) state that self-stigma can be considered a marker of the burden of illness, a recovery barrier and a factor that could benefit from intervention but note that, whilst there is evidence that around half of people diagnosed with schizophrenia suffer with regards to this (Brohan et al, 2011), there is still limited evidence regarding the degree of self-stigma experienced by people with common mental illness. Internalised stigma impedes personality and identity development (Lysaker et al, 2008) and suicidal ideation in those with schizophrenia is linked to helplessness leading to negative self-evaluation.

Self-stigma can lead to the individual holding the view that they are socially unacceptable (Vogel et al, 2013a). People partly appraise their own value by the group of people they feel they belong to (Major and O'brien, 2005) thus by identifying oneself as 'someone with mental illness' is likely to be linked to held beliefs about that particular diagnostic group (Lysaker et al, 2008). This belief can lead to a general sense that one does not belong in the social world of others (Ritsher and Phelan, 2004).

The effect all three types of stigma have on the individual who has self-harmed is apparent in this study. Public and internalised, so self, stigma clearly influence the way the person sees themselves and their own value as human beings. Institutional and public stigma is likely to affect the way that the individual who self-harms is perceived by the practitioner and may affect the quality of their care. If they are seen as less deserving patients then care may

not be optimal. This work contributes to the minimal work in mental health nursing on the wider effects of sigma on care and supports the more anti-psychiatry argument regarding problems with labelling. It also begins to highlight the influence the MHA has on the experience of care in the mental health service.

6.2.3 Perceived Judgement

One of the effects of stigma, given importance over others by participants in this study, was the discriminatory action of judgement. Despite repeated policies asserting the need to be non-judgemental in practice (DoH, CQC, 2015) making judgements is a key role of mental health practice (Barker, 2009). The very process of the psychosocial assessment requires mental health practitioners to make judgements about many aspects of the person including risk, needs and, it could be argued, taking positions regarding the persons worth and value. Thus it may be no wonder that people feel judged, however it does appear that this issue is not as simple as that. The participants, describe the feeling of judgement in fairly vague terms and so it is difficult to judge exactly how this experience manifests. It will be useful to consider judgement in more general terms before trying to make sense of the data.

The NMC (nd) Field Specific Competencies state the mental health nurse will:

'Acts professionally to ensure that personal judgements, prejudices, values, attitudes and beliefs do not compromise care.'

CC3, 4.

Peplau (1988) supports Barker (2009) in stating that the making of judgements in practice is basic to problem solving, healthcare professionals are often in a position where something needs to be done and she states that judgement occurs when one makes a choice that is dependent on deliberation of the 'facts'. She is at pains to state that each judgement made regarding an individual patient should be just that, individual, and not then generally applied to others. In these cases they are discussing 'clinical judgement' which, for the purposes of this topic is separate to, although influenced by, personal judgements which have a decidedly more moral flavour. A fundamental issue to consider here is that the principles underpinning any practitioner will be

variable and influenced by factors such as codes of practice; law; service values and, most importantly here, personal values. Any one of these factors may be at odds with the person being 'judged' and as such create a negative effect.

In 2002 McAllister et al noted that cynicism and judgement were mentioned as attitudes met by people who self-harm when seeking care and in 2015 the situation does not appear to have improved greatly with participants in the crisis survey done by the CQC stating that the Emergency Department in particular was the place 52% of those in mental health crisis felt they would be judged, despite much effort to make things better in intervening years (Palmer et al, 2007). In this study judgement appears to have been experienced as being treated with a lack of compassion, care and respect (CQC,2015). Patterson et al (2007) found that moral judgement was a feature of the attitude that the nurse participants had in their study and they state that empathy can only be achieved by setting aside personal judgements and preconceptions. Goffman (1959) states that when someone appears before others they consciously and unwittingly project a definition of the situation, in this case the self-harm, and the conception and projection of self is an important facet of this. If an event occurs eg. Feeling judged or discriminated against, that is incompatible with the fostered impression then significant consequences are felt including embarrassment, potential cessation of the interaction and even disruption of self-identity.

This assertion has merit when one considers the many stereotypes and assumptions that surround the issue of self-harm both in the public and healthcare arena. Many of these stereotypes have a basis in reality eg. Some may well self-harm in order to draw attention, however it is when the practitioner stops at the judgements made on the basis of these assumptions that problems ensue. To illustrate, if a person who has self-harm is judged as 'attention seeking' then this closes off many avenues of consideration for care. It may well be the case that the individual wishes attention, it may not. If it is then what is the reason for the need for attention, beyond it being a human need that we all share? The point is that standing in judgement over a person we are caring for is a dismissive and power centric act which devalues them as individuals and reduces the level of 'care' they receive. Marriott (2011) draws attention to another common stereotype when she discusses the issue of the assumption that self-harm and BPD are linked, she states that this is generally

unhelpful and means that the stigma and stereotypes often applied to the controversial diagnosis may be considered as pertinent without evidence that they actually influence the individual concerned.

The NMC code (2015) states clearly that all nurses must treat people as individuals, uphold their dignity and avoid making assumptions. Additionally in view of the findings of McAllister et al (2002) who found that people who self-harm are more likely to leave the Emergency Department without assessment if they feel judged then this would appear to be an important issue to address. Shattel et al (2006) assert that people in crisis want to be connected to another human being and not judged so it is important to consider how this position might be improved. Heyman et al (2012) argue that if mental health practitioners view self-harm as a legitimate form of coping activity they may well be perceived to be less judgemental. A position adopted by Schappman et al (2007) as well, who suggest that self-harm be viewed as a form of self-care which is appropriate for some. Whilst this reframing may well have a positive effect in the way they assert and is a more positive starting point, there are some concerns with adopting such a position. Firstly, and most simply, the function of self-harm for the individual may not, in fact, be about coping or self-care it may have an altogether different function so we have returned to a position where we would be in danger of making assumptions that could have catastrophic affects, particularly if the function of the self-harm was to end life. This position also negates the potential of the longer term, likely unintended, consequences of using self-harm as a coping strategy, such as a reduction in the efficacy of the act of self-harm resulting in a need to escalate harm; the social isolation resulting from hiding the behaviour long-term and the exhaustion that living with unresolved emotional problems that self-harm allows one to postpone engagement with (Heyman et al, 2012).

When participants in this study felt themselves judged they believed their humanity was being diminished in some way. Being considered as a risk or a diagnosis in this reductionist way may have the paradoxical impact of raising the risk of repeated self-harm or suicide due to the reduced quality of the interaction between patient and practitioner. The participants in the cohort were predominantly suicidal at the time of their self-harm (n=9) and several voiced difficulty in being truthful about their remaining nihilistic feelings, so these were not discussed. In exploring her experiences of use of mental health

services following self-harm Shaw (2016) asserts that whilst in the presence of self-harm you are certainly in the presence of distress, you may also be in the presence of someone who is fighting to stay alive. She supports the view that in engaging with death we also engage in life.

Having well developed views on self-harm may be helpful and ensuring that the person is not lost in the interaction, but their needs and context kept uppermost so that any assistance required is commensurate with their situation not based on assumptions or judgements made from stereotypes. This call for a non-judgemental approach from participants clearly supports the policy; mental health practice literature on the subject; is one of the basic tenets of mental health nursing and upholds the assertion that person centred and humanistic approaches are most effective.

6.2.4 Conclusion

Shared humanity is an important factor in a therapeutic relationship, it helps support compassionate and empathic responses to distress. It must be recognised that part of the difficulty inherent in this approach is the emotional capital that it demands of the practitioner. Thus those working in this field need to be able to manage this demand whilst maintaining the human qualities mentioned by the participants. These qualities were predominantly basic human and validating approaches such as listening and understanding but they also included more professional aspects such as non-judgemental and polite, respectful approaches. Public, institutional and self-stigma all have an influence of the perceived humanity of people in mental distress. In self-harm the addition of the 'self-inflicted' element is likely to compound matters. Steps to reduce stigma are still required in this field and a clear acknowledgement of the role the MHA plays in legalising the discrimination that occurs may be influential in improving care for this group of people. Being perceived as judged by others can diminish feelings of humanness thus compounding self-stigma. Practitioners need to have education to ensure they have well developed understanding of the varied functions of self-harm and ensure that they hold the person who has self-harmed at the centre of the interaction. Personalising the interaction, meeting the person where they are is essential in facilitating this. This SOT provides more evidence that person-centred humanistic mental healthcare is most likely to be effective for this cohort in

crisis. It also highlights some of the difficulties inherent in facilitating the close human relationship requested by the participants in the findings which will be a useful addition to the discussions on facilitating therapeutic relationships in mental health nursing.

6.3 Traumatising Environment

One dehumanising factor of healthcare is the lack of appropriate spaces in which to conduct interactions such as psychosocial assessment (Todres etal, 2009). This assertion is clearly at odds with what Peplau (1988) states when she says that hospital wards are a social context wherein the patient should be aided to 'grow in the direction of health'. Crawford et al (2013) point out that in recent years, NHS focus has changed from a caring core to a focus on non-clinical management bureaucracy, the aim of which was to improve efficiency and quality of care. In the event there is much evidence to suggest it has had the opposite effect (Leys & Player, 2011) of reducing standards and creating care environments where there is less time for patient care. As Cooper (2009) suggests, systematic interventions, such as policy processes, inevitably generate unpredictable consequences that can negatively affect pre-existing efforts to achieve pre-established goals, such as compassionate care.

There has been increased use of the Emergency Department since the 1970s for mental distress (Wright et al, 2003) with 10 to 15% of all visits being for mental health related reasons (Clarke et at, 2014) and patients often access the department when they are acutely ill or in crisis. The fast paced and often chaotic environment can make it more difficult to intervene and provide appropriate care and may exacerbate symptoms (ibid). Thus the physical environment, and the processes imposed by the system, have a major impact on the experience of the patient and their subsequent contact with professionals within it.

6.3.1 Physical Space

Six participants noted the hospital space as a theme at interview, in particular the effect this had on privacy, the risk of being overheard, noise levels and items being left around that could be used to self-harm. The built environment has a direct and indirect effect on mental health (Evans, 2003). Direct effects

include overcrowding, noise and light levels; indirect effects can be noted where the design of the building reduces personal control, as in the lack of private rooms in which to conduct psychosocial assessments resulting in reduced privacy. Policy documentation makes some recommendations regarding the physical environment of the area in which the patient with mental health issues should be cared for in the general hospital, but the Emergency Department in particular. The Psychiatric Liaison Accreditation Network (Palmer et al, 2014) state that an assessment room should look comfortable and inviting and that it should be private. It very clearly states that:

'The use of a curtain around a patient's bed does not ensure privacy and should only be used rarely, and as a last resort, i.e. if there is significant risk and no safe alternative room, or if it is not physically possible for the patient to be moved to a more private setting.'

(Palmer et al, 2014. P11)

Respect for patients privacy and confidentiality has long been an expectation of healthcare practitioners (Moskopp et al, 2004). They point out that upholding this expectation in the Emergency Department is a challenge as the open nature of many Emergency Department environments does not support this and many are overcrowded and busy. They alert us to the fact that many people go to the Emergency Department with highly sensitive and private issues, self-harm being one such issue, and this means that patients are at higher risk from the effects of disclosure, particularly in this case from stigma and shame. Confidentiality is a word that is commonly used in place of the word privacy. Both privacy and confidentiality are necessary preconditions for personal autonomy, if privacy is upheld patients are more likely to share fully and truthfully (ibid), thus this issue could have a bearing on barriers to getting help and truth telling.

Privacy was one of the main barriers to effective suicide assessment according to staff included in Petrik et al's (2015) study; they believed that the lack of privacy undermined the validity of the assessment as patients were less likely to be honest if they felt their privacy to be compromised. Weiland et al's (2011) study concurs and found environmental factors scored highly as a barrier to effective treatment and management of mental health patients citing lack of

privacy even in the psychiatric safe room, noise and high levels of activity as barriers. They also mention the numerous risk items that were lying around easily accessible in the department although there was little literature on this matter.

In a survey of patients' perspectives about their stay in the Emergency Department, Gilligan et al (2007) state that overcrowding in Emergency Departments compromises their critical function and patient safety. It was found that nearly a quarter of the patients in that study felt their privacy was violated. If effective staff patient relationships are to be formed then privacy is essential to allow the patient to share sensitive information without fear of being overheard. Olsen and Sabin (2003) agree that Emergency Departments are chaotic and that curtained rooms allow conversations to be easily overheard. In another study Olsen et al (2007) point out that the Emergency Department setting is unique and often an old, undersized space where patients are in close proximity with each other, and this is certainly the case in Emergency Departments located in cities close to the geographical area of this study. They also note that there are often very sensitive reasons for presentation at the Emergency Department in the first place (in this case self-harm or suicidal ideation) which mean that privacy and the resulting confidentiality, are even more important in this patient group. Privacy in mental healthcare alludes to access to personal information and personal space (Barker, 2004), it allows for the expression of information that would not ordinarily be revealed eg. reasons for self-harm.

Emergency Departments are obvious places for those in psychiatric distress or crisis to seek help, certainly in the absence of a viable alternative, but mental health presentations do not usually fit the treatment norm of most Emergency Departments (Clarke et al, 2007). In a series of eight focus groups held in Canada they found participants reported that lack of privacy, particularly at triage, worsened their distress. Crowley (1999) highlights the differing cultures between the Emergency Department and mental health services and asserts that the initial interview after self-harm is crucial, they go on to say that to facilitate this interview and development of good rapport between clinician and patient, private rooms are preferable to cubicles. In Australia, which in terms of mental healthcare Britnell (2015) cites as world leading in his search for the perfect health system, as in the UK, Emergency Departments are the main

place patients with mental health problems go to access acute mental healthcare. 5-15% of presentations being mental health related (Morphet et al, 2012, Clarke et al, 2014) and management of them in the Emergency Department is a complex process. The participants in their study recommended single rooms for mental health patients, Hinkulow (2014) would agree with this and goes on to state that noise is a pollutant that distracts patients from their recovery. Since the smooth clinical surfaces often found in hospitals will serve to create reverberations that will directly amplify the noise levels, this is an environmental factor that needs consideration.

One of the main issues in maintaining privacy in the Emergency Department is 'noise creep' (Broadbent et al, 2014) whereby the noise levels, which are already high, grow as people have to raise their voices to be heard, this decreases the ability of patients and practitioners to have private conversations. Brown et al (2015) suggest that excess unwanted noise is detrimental to health and recovery and although it does not have a causative role in mental illness it is widely accepted as an environmental stressor which negatively affects psychological and physiological wellbeing (Evans, 2003). Gardner et al (2009) notes that noise is a significant barrier to sleep in the acute hospital and that sleep is essential for good physical and mental health (Richardson et al, 2008). The modern acute hospital is usually busy and noisy and the patient is subjected to a constant barrage of voices, movement, alarms and equipment sounds whilst admitted which, as Heyland et al (2013) assert, may exacerbate mental health symptoms with multiple unsettling stimuli.

Where mental health patients are concerned, whilst it is clear that not everyone is affected by noise in the same way, it is likely that those least able to cope are the most likely to be affected (Brown et al, 2015). Mental health patients in the Emergency Department are vulnerable because; a) they generally have to wait longer for treatment (Broadbent et al, 2014) in the noisy environment so are generally trapped within it, sometimes on section; b) sensitivity to noise may be a predisposing factor to mental illness; c) there is a correlation between noise and psychopathology whereby noise elicits more stress or arousal behaviour in those with psychological or psychiatric vulnerabilities(Brown et al, 2015). The concept of 'soundscapes' has been posited by Brown et al (2015) which refers to the noise as potentially having social meaning as well as just being a physical stimulus. Familiar sounds can

have a calming effect and generate feelings such as that of belonging, whereas unfamiliar, harsh, disturbing noises may generate feelings of anxiety and fear thus making the person hearing them feel unsafe.

Data from the participants in this study supports calls for a quiet, non-stimulating environment, as has been found ideal for those with mental health issues (Morphet et al, 2012) although the busy nature of the Emergency Department makes limiting such stimuli a challenge. Additionally, Olsen et al (2007) found that there was a significant reduction in overheard private conversations when their Emergency Department was enlarged and private rooms created instead of curtained bays. Participants involved in a study exploring their experiences of an alternative community based facility in the USA, The Living Room, (Shattell et al, 2014) state that the way the environment is designed including furniture and space promoted and conveyed a sense of progress, hope and healing. Their reported experiences of the Emergency Department, in contrast, were characterised by feelings of loneliness, insecurity, intimidation, discomfort and fear.

Mental health assessment and triage remain a challenge for Emergency Department staff due to the noisy and public environment in which it is often undertaken (Innes et al, 2013), staff identified busy noisy departments as an issue when caring for patients with mental health issues. Wright et al's (2003) study suggests improving the work climate may improve staff attitude to caring for people in mental distress as they assert that the organisational climate affects staff attitude. Thus knowing in advance that there is a lack of compassionate space within which to see a person with mental health issues may mean the staff are already feeling a sense of frustration and discomfort at having to provide care for them in an unsatisfactory space, which will inevitably influence the care the patient subsequently receives. This suggesting that improving the environment might actually improve care. Attention to the physical environment including sound needs to be considered more closely in recovery and humanist mental healthcare literature.

6.3.2 Systems Driven Care

A 'production line' expectation in healthcare where neglectful, perfunctory or unemotional exchanges can leave people feeling isolated and ignored is

becoming more prevalent according to Brown & Crawford (2003). In this current climate of fast healthcare the norm is task driven, time is money and interpersonal communications become a luxury (Crawford & Brown, 2011). Part of the drive towards this 'fast' way of working has come from the introduction of targets since the early 2000s (DoH, 2000). Mannion and Braithwaite (2011) cite this drive for increased productivity as being caused by increased patient demand and reduced resource and they found twenty unintended dysfunctional consequences of performance measurement in the NHS. For the purposes of this work, and mental health services generally, the most damaging are:

- Tunnel vision – whereby the focus on dimensions of performance displace other important but unmeasured aspects eg. compassion
- Myopia – a focus on immediate and short term issues at the expense of long term issues which, in a slow moving world of recovery as is found in mental health, puts the whole service at a disadvantage
- Quantification privilege - preoccupation with reducing complex social phenomena to numbers moves attention away from appreciation of the more qualitative aspects of care, which are arguably more important in mental healthcare.

A systematic review carried out by Jones and Schimanski (2010) found no consistent improvement in care and multiple evidence of dysfunctional behaviour on the part of trusts desperate to meet the targets and attain the remunerative rewards for doing so. Menzies (1959) suggests that much of the tick box mentality in healthcare has developed, in part, as a way of those working within the system to defend themselves from the anxiety of working in a complex system. This socially structured defence mechanism reduces the patient to a list of tasks and helps the practitioner avoid guilt by shifting the blame for incomplete work in directions away from the individual. This effect is a manifestation of what Mears (2014) calls encouraging organisations to 'face the wrong way, putting targets and service drivers above patients. This suggests that services are being delivered in a less humanistic and person-centred way contrary to much policy literature. this is likely to have a detrimental effect on the experience of patients who self-harm using the service, an assertion supported by the findings of this study.

Although originally considering criminology Gelsthorpe (2009) suggests that since the 1950s there has been a decline in rehabilitation, a re-emergence of punitive sanctions, all pervasive managerialism and what appears to be a constant state of crisis in healthcare. These issues all culminate in a culture of control and parallels can easily be drawn with mental healthcare. As Brown and Clarke (2014) state one of the few certainties of healthcare is uncertainty. Mental health presentations can be a particular challenge to Emergency Departments as they carry an inherent level of risk, eg the fact that self-harm is the best predictor of completed suicide. Systems in the Emergency Department are not set up for the care of these individuals as it is primarily set up to assess and treat physical illness and trauma.

According to the CQC (2015) patients experience of crisis services varies with some positive but some of the more negative ones have been noted to contribute to an escalation of the crisis. They note that when the crisis is social or emotional in nature and not clearly driven by mental illness there is no clear service to go to. So the obvious place to attend is the Emergency Department but this can result in staff feeling frustrated and annoyed that they are there (ibid). In the same document they also state that the Emergency Department is historically not a place of compassion, empathy or warmth for those in mental health crisis, they state that people should be able to expect that Emergency Departments can provide immediate care and that liaison services are an essential part of this service delivery.

One subject frequently raised by participants in this study is waiting, eg for triage, for test results or to see mental health services. The distress caused by this was extreme in some cases, eg. overdosing as in the case of Jane. Shattell et al (2014) state that long waits in the Emergency Department are detrimental to those in emotional distress as do many other studies (Morphet et al, 2012. Gilligan et al, 2007. Broadbent et al, 2010. Brown and Clarke, 2014). The CQC (2015) notes this in its crisis document stating that people with mental health issues are twice as likely to wait more than four hours before being examined. Brown and Clarke (2014) suggest that one reason for this could be variations in skill levels of triage staff suggesting staff who feel less confident working with mental health patients may delay seeing them. Clarke et al (2007) acknowledge that waits in the Emergency Department are still very long and there are no places to lie down for those waiting many hours. Wellstood et al (2005)

suggest three main determinants of patient satisfaction with Emergency Department care; the interaction between the clinician and patient; information and communication between clinician and patient; and waiting times. As waiting times go up then dissatisfaction with the service also rises. Gilligan et al (2007) also found in their survey of patient perspectives about their stay in the Emergency Department that waiting was the top rated worst aspect of their stay. This study provides additional evidence that waiting can cause distress and exacerbate risk in mental health terms.

6.3.2.1 Working together ethically

As port of this LOT, issues of interdisciplinary working are raised; mental health and physical health services; mental health and substance misuse services; and mental health and patients. In line with the participant experience of this study, better integration of services has been widely called for in this field and nowhere is this more obvious than in the case of dual-diagnosis. In this context, dual-diagnosis refers to the presence of both mental ill health and co-occurring substance misuse issues whether drugs, alcohol or both. Mental Illness and substance-misuse co-occur at a high rate, sometimes as in the case of Seth, as a form of self-medication to mediate mental illness symptoms (Buckley, 2007). After decades of separation (Drake & Bond, 2010), both services have developed completely different modes of operation which has led to a noted service gap in provision of services for those with dual-diagnosis (Edward & Munro, 2009). Neither substance-misuse nor mental health services are currently providing comprehensive care for this group of patients (ibid), an unacceptable position particularly as there is a strong evidence base for integrated working to ensure appropriate screening, assessment and treatment (Buckley, 2007).

Despite plenty of evidence of the requirement to work together on this issue services continue to be slow to modify their practices despite the enormous rates of overlap that exist between mental health and substance-misuse issues (Drake & Bond, 2010). Green et al (2015) state that people with mental ill health are more likely to have substance related problems with over half of this population affected (Morse et al, 2008). This results in these individuals having more complex recovery trajectories (Green et al, 2015) and incurring significantly higher treatment costs than those patients with mental health

issues alone (Morse et al, 2008). In the UK we operate a predominantly 'parallel treatment' system whereby patients go to one service for their mental health needs and another for their substance misuse needs (ibid), an approach that has yielded consistently poor outcomes for this patient group (Drake et al, 2001). Green et al (2015) do point out the importance however of quitting substances in mental health recovery. Ending or limiting use take extreme effort and often multiple attempts, and whilst substance misuse services may be adjusted to such circumstance, mental health services find this more difficult to facilitate. It is also important to note that evidence suggests that this patient group can successfully engage with treatment and therapy and that this has been seen to have a positive impact on mental illness symptomology (Munro & Edward, 2008) and an increase in abstinent days from drug and alcohol use (Baker et al, 2006).

All people who have self-harmed should be 'offered' an assessment prior to leaving the hospital (NICE, 2004, 2011). In practice this should be an offer that can be refused by the individual assuming they have capacity. In the event, all participants described the 'offer' of the assessment as more of a fait accomplis, they were expected to see the mental health team. This could be argued to be systems driven coercion, albeit passively done. However, the situation Dave and Ann describe, whereby they are threatened with the police should they leave and the issue of not being given the choice to see the mental health team could be regarded as explicitly coercive.

The tension between self-determination and coercion is explored by Davis (2002) and acknowledges that, with the presence of the MHA, it is a constant source of difficulty. With the adoption of a more recovery focussed philosophy in mental healthcare the concept of treatment of symptoms has broadened to include managing existential concerns, care is now meant to be patient driven rather than clinician driven and there is a move away from the biological conceptions of cause (ibid). Bowers et al (2014) agree that measures intended to keep patients safe often contain coercion, they also found that, in their study, self-harm and suicidal behaviours were considered one of the most problematic behaviours and more likely to lead to coercion and containment. Staff report finding that coercion is the only thing they think will help in certain situations (Looi et al, 2015).

So there is no clear cut right or wrong in the situation outlined by Dave and Ann and in fact, if considered from differing ethical perspectives, it could be more or less justified. From a utilitarian view it could be considered that threatening the patient with the police when they are intending to leave without assessment following self-harm may protect others from an unknown risk. Therefore the coercion is justifiable as more will benefit if a potential incident is avoided. It could also be argued, from the same viewpoint that as it would possibly only harm Dave and Ann if they missed out on accessing help they may need, then it would be more utilitarian to let them go and carry on caring for other patients who may have more urgent needs. Deontologists might cite the nurses 'duty of care' in insisting that they coerce Dave and Ann into staying as it is their duty to make sure they get optimum care, however, they should also be upholding the right of the individual to be self-autonomous whenever possible and be an agent in their own lives making decisions. In this instance Dave and Ann's capacity to make what the staff would probably consider a poor decision could be brought into question, so this latter outcome is perhaps less likely. Tension is also noted when considering the situation from the perspective of bio-medical ethics as their autonomy is clearly restricted in this case and this goes against principles of least restriction and upholding patients' autonomy.

Even this seemingly fairly straightforward situation is clearly very complex and cannot be judged right or wrong except by viewing it from the consequentialist perspective, whereby it is the outcome of the situation which provides the judgement of the decision. So in the case of the lack of choice in the assessment and the threat to inform the police should they self-discharge it could be viewed as the right decision from the perspective of the service as they both had their assessments as per the policies and guidance that exists, and nothing untoward happened. From the perspective of Dave and Ann though they were not so happy with the decisions, but even here they could see why it might be done, particularly in view of the link between self-harm and suicide already discussed. This complex matter is also discussed by Looi et al (2015) where their participants (ex-patients who had experienced physical coercion as well) felt that there are exceptional circumstances whereby coercion is acceptable. The main issue with this perspective, and it is a perennial problem in mental healthcare, is that the judgement of when it is

acceptable is entirely subjective and the decision usually rests with the clinician who will view the world very differently from the patient, by the very nature of our being human.

6.3.3 The Assessment – Helpful or Traumatic?

The main issues within this LOT are mental health practitioners being dismissive in some way of the patient experience leading to feelings of invalidation; attitudes that indicate lack of hope for the individual; and not listening. Patient literature is of most use in considering this subject.

Many participants used combative words to describe their feelings going into or beginning the contact with mental health services, '*interrogation'*, '*invasive*', '*nerve wracking'* and '*traumatic*' invoking images of a battle about to be commenced or underway, even a form of torture to be endured. Using this terminology when going into what should be a therapeutic encounter is of concern. Having this expectation may impact the interaction and indeed to some extent predict the outcome. If one views this combative viewpoint as part of the general struggle experienced whilst going through life, it could be seen as expected, the person is potentially undergoing an existential struggle which may well feel like a battle underway. It could also be viewed from the perspective of the NHS being an increasingly difficult place to get your health needs met due to competing priorities within the service regarding targets, resources and funding (as discussed in Systems 6.3.2). Pembroke (2009) describes attending the Emergency Department being traumatic due to fear of the response she would get, so much so that she would not always attend for help following self-harm often putting herself at risk. So battle is on in more ways than one, that is without considering the standpoint of the mental health practitioner on the day and how vulnerable they may be to their own life battles at the time which will also impact on the interaction between patient and practitioner. Using the participant's experience as a guide the following pictorial depiction of the assessment manoeuvre, as understood via the interviews, was created (see fig 4).

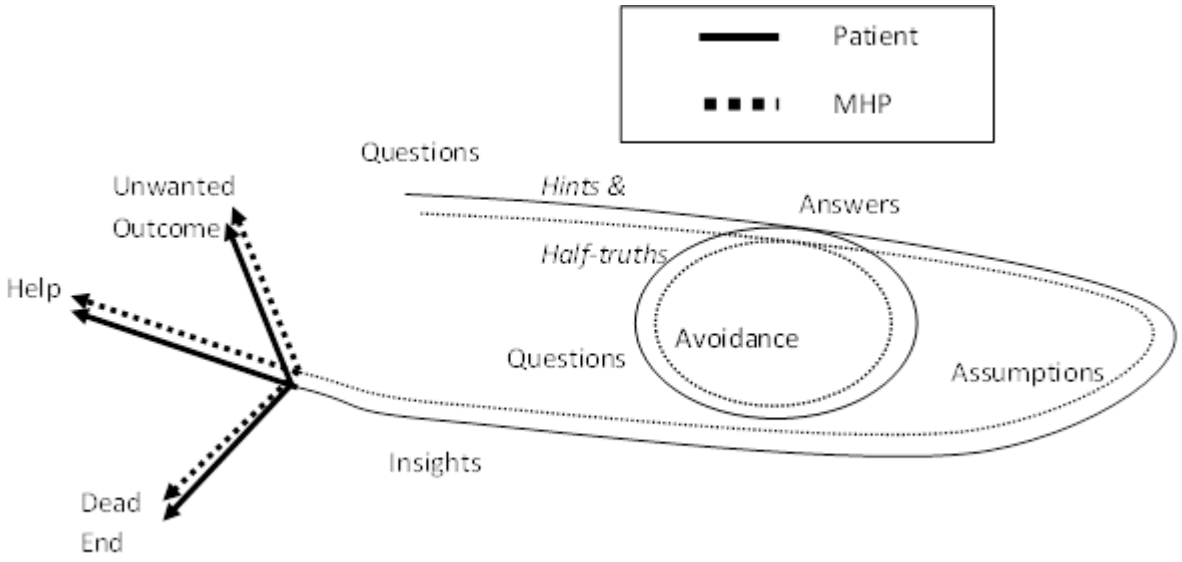


Fig 4 The Assessment – Strategic Manoeuvres

This diagram helps to depict the fact that, although those in this interaction may have the same intention, in terms to helping the person who has self-harmed move out of crisis, the issues that beset them as part of the process create difficulties that can lead to unwanted outcomes and no help or dead ends, as well as getting the help required. So those in the interaction are moving in the same direction but they are not on the same path. At times of poor communication, assumption making, prejudicial thinking and non-truth telling paths may cross and diverge leading potentially to a position whereby the mental health practitioner believes they have helped the person, but the person who self-harms may find they have hit a dead-end. This could leave those who have taken drastic action in order to get help, finding the help they get not actually being helpful from their perspective.

There is evidence from the interviews that the practitioner focus was often process driven rather than person centred. This finding converges with Taylor et al (2009) who found that the psychosocial assessment was felt by patients to be more about service need then their needs. Paul and Hill (2013) found that staff were often policy and process driven in responding to self-harm, the most obvious example of this occurred when Dave's mental health practitioner changed the subject mid conversation to ask demographic questions which were completely unrelated to the discussion they were having. Perhaps the mental health practitioner at this point felt she had enough information

regarding his problem and needed to clarify the family situation, or perhaps it touched a nerve within her own psyche making her vulnerable psychologically. Whatever the reason, this change of step meant that rather than manoeuvring together they found they were in fact crossing paths in a manner that was extremely unhelpful for Dave. Professionals who are process driven or who see their agenda as more important than that of the patient are often seen as cold or disinterested (Borg & Kristiansen, 2004).

Professionals can remove the opportunity for a balanced sharing interaction by being indifferent, not understanding or by setting an agenda that the patient doesn't recognise (Erikson et al, 2012). Egan et al (2012) found staff perceptions of effectiveness in dealing with people who had self-harmed was directly influenced by knowledge and confidence and higher levels of these helped staff to practice more effectively. Despite many efforts to improve services over the years (RCP,2009 & 2014) Cooper et al (2011) found that many patients still have a very negative experience of care following self-harm and that this is very often linked to staff-attitude, an assertion supported by this study. This is reinforced by Urquhart Law et al (2009) who found that the view of people who self-harm as manipulative and attention seeking is a longstanding one and particularly prevalent amongst male care staff and medical staff. This view has been shown to lead to a reduction in care quality (Urquhart Law et al, 2009. Emerson, 2010).

Expectations of assessment and understanding of self-harm can be very different for healthcare practitioners and patients (McHale and Felton, 2010) which means that those in the assessment are not starting from the same place and must ultimately always be slightly out of step. This differing focus need not, in itself, cause problems if the ultimate goal of helping the person move onward and out of danger is held by both parties. Good communication and involving the patient in decisions and discussions regarding care is essential to help them remain in step (Taylor et al, 2009).

Underlying assumptions are fundamental in influencing the paths the patient and practitioner are on during the assessment. Self-harm can be seen as a sign of hope, an attempt to preserve life and an act that can be looking for understanding in a caring environment (Motz, 2010), describing it as 'a communication that contains within it the hope that there will be a response.'

The service response is the psychosocial assessment. This viewpoint is demonstrated in several interviews. Although Dave, Fran, Jim, Fred, Alan and Ann had serious suicidal intent at the time of their self-harm, so it could not necessarily be seen as a sign of hope at the time, following the act they expected responses in the way that Motz (2010) suggests and in the cases of Jane and Alex their self-harm was much more about communication in the way described. The function of the self-harm is essential to discover as part of the assessment process as it is fundamental to informing risk management (Walker, 2013. Walker et al, 2013) however there is potential for an inherent tension in the initial viewpoint between patient and practitioner in this area. Both patient and mental health practitioners usually agree that moving toward cessation is an ultimate goal, however during that period self-harm is likely to continue (Fleet & Mintz, 2013). The assumption, on the mental health practitioners part, should not be that ending self-harm is the goal for the patient, although due to the risky nature of the behaviour and the links to suicide, services have no option but to hold this as the ultimate goal. Kool et al (2014) point out that these differing perspectives of self-harm can cause a struggle between patient and care staff, leading to communication problems.

From the data and the discussion here it is possible to see how the strategic manoeuvres of both the practitioner and patient can be, and often are, out of step in the encounter of the assessment. When the process goes well validation may occur, the person may feel cared for and regain hope for the future. When it does not go well, the potential for further trauma and distress is high. Getting this interaction right is essential in a group of people who are already undergoing some kind of existential struggle.

6.3.4 Conclusion

The effect of the environment both physical and systemic have a strong influence on the experience of contact with mental health services during an admission to a general hospital following self-harm. Despite policy initiatives aimed at improving the physical environment participant experiences were still marred by lack of privacy, noise and risk posed by the paraphernalia of care available in the departments. Several participants had their encounters with mental health professionals at the bedside, something that should no longer be happening. A quiet, more restful environment, free of medical

paraphernalia, with private areas for sensitive conversations is likely to be required for this cohort of patients. The detrimental impact of waiting for interventions in hospital is also clearly demonstrated in the study, alongside the lack of mental health input in the general hospital. The interface between physical services and mental health services, as well as substance misuse services and MH services is raised as problematic. Again despite years of work and initiatives to try to improve this situation. Additionally, the ethical implications of passively coercive healthcare practices, such as pre-ordained mental health assessment, is raised, practices that appear to have more to do with protecting the system itself then the patients it cares for. The assessment, the encounter the system itself demands of patients who self-harm can be life affirming and validating when it goes well and can further compound the individual's mental distress if it goes badly. The evidence from this study adds further weight to the assertion that those working with this group of individuals require advanced communication skills although data from this study indicate a lack of some very basic communication skills which will need to be dressed first. This work will also further inform theories on physical healthcare environments and strengthen calls for inter-professional working between physical and mental healthcare.

6.4 Patient Power

Much focus in modern healthcare is on giving power back to patients and challenging the paternalistic position that historically predominates. Despite years of rhetoric on the importance of empowerment of patients, within policy and guidance literature (DoH, 2000,2005, 2008, 2009, 2010, 2011, 2012, 2014., NICE 2004, 2011), patient involvement remains a challenge within healthcare. This theme explores the power differential between practitioner and patient, the effect this may have on care and on the experience of the participants in this study.

6.4.1 'You don't want to lie to them, yet you don't want to tell them the truth'

This LOT was present in the data of four participants and is considered as it is so important in caring for the patient and ensuring people get the help they need. Dave, Alex, Fred and Ann (for whom this lower order theme was noted)

all had prior experience of services. Alan, immediately trusted his mental health practitioner and cited good eye contact as one of the reason he felt she was trustworthy. Sitton and Griffin (1981) carried out a study that clearly showed that this commonly held belief, that direct gaze is linked to truthfulness, is a myth and that, in fact, those who are attempting to deceive increase their levels of eye contact rather than decrease them. So to avoid telling the truth but also to avoid lying Dave adopts a non-committal stance, both verbally and physically, avoiding direct answers and leaving it open to interpretation. In another field of healthcare, Dickson et al (2007) found that de-legitimation on behalf of GPs led to deception on the part of patients with Chronic Fatigue Syndrome, a condition also commonly noted as being frequently invalidated in a similar way to the experiences and feelings of mental health patients. Dickson et al (2007) define de-legitimation as the experience of having one's definition or perception of the condition disconfirmed particularly with regards to the healthcare practitioner perception of the cause of symptoms.

Truthful communication is important in patient care as it affects patient satisfaction, knowledge and behaviour (Rastam et al, 1992). In a study exploring patient perceptions of treatment in a forensic unit, Livingston et al (2013) found one of the participant themes was whether to trust or not to trust the practitioners. They state openness and honesty is seen by patients as an important vehicle for risk management, an assertion that would appear to be sensible. If patients are not telling mental health practitioners the truth then any risk assessment cannot be accurate. In that study they cited the dual role of staff ie. care vs control; information held about them or disclosed being used to reduce liberties; and fear of negative consequences as being some of the barriers to them being honest (ibid).

There are two strong influences in the assessment situation and truthful communication in healthcare, the medical model and the MHA. Taking the medical model first, there is ample literature on whether patients should be told the truth (Fossey et al,2012. Wells, 2012) . This primarily relates to issues about death and dying; expected symptoms within diagnosis, risks of surgery and side-effects of medication. Not only does this bring the notion of informed consent into view it has clear implications within the predominant field of ethics in healthcare, namely bio-medical ethics and raises the question if

healthcare practitioners don't tell the truth, why should patients be expected to? There is a clear discrepancy here between the wish to maintain patient autonomy and doing no harm.

Patients report that they perceived less need for medications than their doctors did and they believed that the doctor would withhold information about the medicines, about mental illness and about treatments (Fossey et al, 2012). The difficulty for the patients in that study, and indeed in mental health in general, may have been that their protestations or views can be dismissed as symptoms, such as paranoia, due to the nature of their illness. This institutional discrimination, or diagnostic overshadowing, may be influenced, as previously discussed, by the MHA. So genuine concerns from an adult about the future state of their health may be dismissed. Thus the patient remains sick, in the view of the medical model, partly because of the resulting lack of belief in their ability to make decisions, to be truthful or autonomous. This means their illness is confirmed in a virtuous loop, reinforcing both the medical model and the patient status at the same time. It is not hard to see who is benefitting in this scenario and there is an enormous amount of sunk cost bias to contend with when trying to change practice to protect patients from this conundrum.

Taking Dave's experience to illustrate this further, he states he is not going to let everything out, not going to tell the full story, however he hopes that by letting some of the points out he will have the chance of getting some help. Why not tell the whole story? He knows the mental health practitioner cannot do her job properly if he doesn't tell her the truth and feels bad for this yet still doesn't take the risk of showing the whole picture. Perhaps a combination of other factors apparent in the interview, his frame of mind; fear of reliving the incident and finding himself back there; fear of judgement and not being a natural talker so finding things difficult to put into words all influence the decision to hold things back and the perceived consequences of telling the whole story are too great. It is also possible, as he was the youngest of the participants and still in his teens, that the secrecy and guardedness of youth in people experiencing mental health issues could be due to a sense of privacy (Moses, 2009). He also realises that not being more open risks not getting the help he needs, and in the event this is what happens. He doesn't want to lie but also doesn't want to tell the truth for fear of consequences – explicitly

medication and judgement but implicitly he could also be referring to use of the MHA especially as he mentions at one point wishing that the self-harm had done more damage. Had he mentioned this to the practitioner, his likelihood of being admitted to a psychiatric unit would have been much higher, a level of intervention he may not have wanted.

So, to the MHA, the politicians funding mental health services and providing the legal framework within which it operates, could be argued, albeit perhaps unintentionally, to implicitly sanction discriminatory behaviour towards mental health patients (Sayce, 2016). The agents of this power are psychiatrists, Social Workers and mental health nurses (the latter two acting as Approved Mental Health Practitioners). Therefore telling these people the truth will inevitably incur risk of detention. This knowledge may not be held by those new to the system, who may still be operating under the assumption that the law is there to protect the vulnerable, however, those who have been in the system before, as nine of the participants had, are likely to be influenced by this knowledge. The intrusion of this law into healthcare renders both the patient and the professional untrustworthy making truth telling less likely (Vassilev & Pilgrim, 2007). Onken et al (2002) agree stating that the discrimination leading from stigma often manifests in those with mental illness being automatically viewed as untruthful by mental health practitioners, family and others. Lucas, (2003) points out that mental healthcare is delivered against the constant presence of the MHA and patients knowledge that they may be coerced at any time, leads to a need to be perceived as being a 'good' patient. To do otherwise could have direct consequences on the decision about whether they remain free of MHA restrictions. This implicitly coercive power is an ever present force in all relationships and interactions between mental health practitioners and patients. This situation is not newly recognised, Chamberlain (1999) states clearly that she learned to be a good patient in order to regain her freedom on more than one occasion and actively lied in order to get out of psychiatric hospital.

At one point Dave stated that he shouted to staff that he knows that he can self-discharge, an assertion which, whilst accurate, met with the response of a promise of a call to the police. Indicating clearly that this 'option' was not without the consequences of social control. Ann has a similar experience when she announced she might just discharge herself and was told that the police

would be called if she tried to leave. She wasn't sure whether the staff would carry out their threat clearly showing that she did not trust the staff. Not an unreasonable position to take considering Wells (2012) assertion that due to the nocebo effect (fears that side effects will be experienced purely because of expectation) telling patients the truth can actually do them harm. This 'benevolence', which is also apparent in other areas of healthcare, eg. Deciding whether to tell patients they are dying (Fossey et al, 2012), could be considered from a medical perspective as ethically justifiable but it also calls into question the notion of consent and how people can consent to care when they are not really clear on the possible consequences of consenting. In mental healthcare this is extremely important as the consequences of many of the treatments and interventions couched as care can be extremely negative. Even Peplau (1988), as person centred as she was in her approach wonders how much patients should be told about their condition rather than advocating information sharing to enable informed consent.

This theme supports the literature on truth telling in healthcare and indicates that telling the truth in mental healthcare situations is not straightforward. There are issues with truth telling for both the patient and the practitioner in the context of contact following self-harm. There is also power on both sides. The patient has some power here in that they can decide what they do or don't talk about depending on how they have judged the risks to be of doing so. In the context of being in serious mental distress it seems rather unfair that the patient has to make these complex decisions at a time when they may feel quite psychologically exhausted due to their predicament. Should they not be able to trust the practitioner and be sure that the responses they give will be clearly explored and understood in the context of their life situation? These participants show this is not the case and as such it is not really possible to ensure that they receive the help they need.

6.4.2 'You Scratch My Back, I'll Scratch Yours'

The interaction between professional and patient as a dyadic encounter which is defined by asymmetries of power, that is the negotiation between rational and authoritative knowledge and private, proximal relations (May, 2007). In the encounter between the mental health practitioner and the person who has self-harmed, there are two people with knowledge that the other needs. The

clinician needs personal information about the patient in order to facilitate care and the patient, as outlined by several of the participants in this study, needs information they perceive the clinician as having with regards, for example to ideas on managing distress and as the gatekeepers to resources that may be a source of resolution of their problems.

As has been previously mentioned in this thesis however, the playing field on which both these protagonists are engaged in dialogue is not an even one. Even putting aside the ability of one party to detain the other, there are contextual factors (discussed in more detail in Traumatising Environment 6.3) that complicate matters further. As May (2007) further asserts the increased importance of gathering corporate data has reframed the clinical encounter into a corporate rather than a private time and space, resulting in a reduction in the amount of time for the personal. This position is further reinforced when considering Cooper (2009) who states that the reality of emotions is routinely sanitised by policy discourse, this dominance of the rational over the emotional results in a kind of personal and social alienation that actually damages social processes. Rational thinking need not be abandoned, but in complex systems such as those apparent in healthcare, recognition of the messiness, recalcitrance and complexity of the social world is required. So in this context we have a person hopeful of help and a professional who needs information to fulfil strategic goals. The main transaction that needs to occur here is; in order for the person who has self-harmed to trust the practitioner there is a need for the practitioner to regain the personal element of the transaction in order that therapeutic effect can occur.

The initial negotiation that must occur is a basic one, courtesy. King (1999) states that entering a nurse/patient relationship implies respect for the patient as a human being of equal worth with values, and states that all individuals should be treated this way. Peplau (1988) agrees and further states that the interaction between nurse and patient is most likely to be fruitful when communication that identifies and uses common meaning is employed during the interaction. Respect is powerful, by valuing the words the person uses we value the person (Barker, 2009). Rituals in conversation are important and there can be significant breakdowns in communication if they are not upheld (Goffman, 1981). Dewa (2011) upholds this view and states that effective communication can be achieved as a result of a complementary match between

interpersonal styles of those in the dialogue. As it is clear that the quality of mental healthcare is largely dependent on patient/clinician communication (Priebe and McCabe, 2008) and relationship, it is important to get it right. By showing courtesy and respect for the individual, practitioners are indicating that they see the patient as a valid member of the interaction which gives the patient some power in what might be an essentially diminishing environment.

This encounter though differs somewhat from the early notions of transactional care and could be considered more interactional. This is demonstrated well in table 8 below.

Transactional Care and Interactional Care		
Component	Transactional Care	Interactional Care
Information	**Information exchange** Knowing about the patient Understanding the illness Information based on typical needs Focus on information provision More information is better Removing affective components of information	**Shared knowledge** Knowing the patient-as-person Understanding illness-in-context Information tailored to individual need Focus on relevance, comprehension, and meaning Quantity of information depends on patient needs Acknowledging and adjusting for affective components of information
Deliberation	**Negotiation** Elicitation of preferences Negotiation and compromise Contractual relationship Removing affective influences Focus on quantification of risk	**Shared deliberation** Mutual discovery of preferences Collaborative cognition Collaborative "medical friendship" Affective engagement Use of gut feelings and risk quantification
Decision	**Individual choice** Focus on individual autonomy Obtaining consent Delivering care	**Shared mind** Focus on relational autonomy Articulating and confirming consensus Engaging in care

Table 8 (Epstein & Street, 2011)

This table demonstrates how interactional care highlights the more personal elements of the encounter but stops short of being reciprocal, although there are times when it is entirely likely that the practitioner may be taking as much

from the process as the patient, there is no expectation that the patient need actively facilitate this. Transaction is a key step in King's Theory of Goal Attainment (King, 1999) these steps being, self, perception, communication, interaction, transaction, role, stress, growth and development, time, and space. Self – referring to what makes an individual who they are; Perception – the exchange that occurs between the individual and the environment; Communication – the vehicle that establishes relationship, both verbal and non-verbal and ties individuals together; Interaction – the process of individuals communicating with one another on which perceptions that drive action and judgements are based; Role – social systems influence from preconceived notions of how each role should be; Stress – internal and external factors that add additional complexity; Growth and Development – recognition that humans are evolving and developing beings and the environment influences this; Time and Space – resources required to develop an environment ripe for goal attainment and the recognition that change is inevitable(adapted from Caceres, 2015). Action is always involved when two people meet in any given situation and in order for it to be a human action choice and knowledge must be involved.

"Action is a sequence of behaviours of interacting persons which includes (1) recognition of presenting conditions; (2) operations or activities related to the condition or situation; and (3) motivation to exert some control over the events to achieve goals. For example, a nurse may recognize overt needs and also become aware of 'felt needs' of patients. When the nurse and patient have established mutual understanding of events, mutually set goals to be achieved by the patient and agree on means to achieve the goal, a transaction occurs"

(King, 1971, pp. 90-91 . cited in King, 1999)).

If the help offered by services is to be truly helpful then this transaction needs to occur in the most respectful way possible. That is, the patient needs to be given the power to lead the practitioner to the answers that will work for them as individuals in solving their problems and the practitioner needs to be skilful enough to be able to spot the solutions when they are presented and the patient is struggling to notice them. The participants in this study experienced situations where this power was missing and the inherent value they had as contributors to the encounter with the mental health practitioner was not

always noted. This notion and the way this thesis extends King's model of goal attainment is discussed further in the second part of this chapter.

6.4.3 Expert by Experience

This lower order theme puts the emphasis on the person as active agent in their own healthcare, reinforcing the call for empowerment (Taylor et al, 2009. Tate, 2010. Adler, 2012). This theme was a feature for seven of the participants. In analysing the social factors that could contribute to mental health difficulties Tew (2011) found underlying themes of powerlessness and injustice, these experiences can be exacerbated by paternalistic service responses which further undermine peoples sense of agency (Hughes et al, 2009). In a qualitative study Mancini (2007) found that transformation from illness-dominated identity to an identity of agency and competence was central to recovery in mental health. The patient holds the key to their recovery, when one person encounters another a potentially creative exchange follows, both having unique insights to offer (Barker and Buchanan-Barker, 2004), the encounter with mental health services following self-harm is an ideal opportunity for this to occur.

The recovery model is still considered a positive advance toward increasing patient empowerment, self-determination and independence (Walker, 2006). Taking control and responsibility for one's life thus recovering a sense of autonomy are common themes within the model (Higgins & McBennett, 2007). The recovery model is however, weighed down by the use of pathologising, deficit based medical and psychiatric vocabulary, which supports old paternalistic roles (Walker, 2006). So although recovery orientated services are patient centred and use words such as self-determination, independence, community integration and so on, there continues to be a sub-text, related to context, which clearly says 'you are different to the rest of society due to your pathology and we are the experts with the knowledge to help you overcome this pathology'. This position was demonstrated by Jane when she stated that she feels like an '*aberration*' and societal expectations are that you have to be '*normal'* although no one defines what that is. As long as this is the case, no matter how many patient centred and advanced participation models are applied, the power dynamic will remain with the professional. Often very understandable reactions to circumstances get identified as symptoms,

supporting diagnoses, so strengths and skills go unnoticed in the individual (ibid). When someone is diagnosed with a mental illness a reality is created in which human beings are transformed into the mental illness, thus finding themselves trapped in a hermeneutic circle whereby everything is interpreted to reinforce the conceptual system (ibid). In this paradigm, patients who assert themselves are labelled resistant, under the effects of transference, manipulative and so on. A situation Dave found himself in when, despite stating that he wanted to try other approaches then medication to address his issues, partly because of side effects, he was then offered another pill and felt he had hit a '*dead end'.* This negative hermeneutic circle prevents the professional from seeing the perspective of or hearing the voices of the very people they are supposed to be helping. Despite this, the recovery model is hopeful as it represents the humanitarian impulse that prevails despite the power of medical and psychiatric dogma (ibid) although even the recovery model is just rhetoric if the patients' position as expert by experience is continually undermined.

In the late 1990s McDermott (1998) and Valmaki & Leiner-Kilpi (1998) found that service users felt their opinions regarding care planning and decision making were less valued that those of their relatives and healthcare practitioners, and this study suggests there is evidence for that still being the case. Anthony and Crawford (2000) suggest that professional autonomy is threatened by service user empowerment a position that finds some support in Menzies-Lyth's (1990) considerations of anxiety driven processes in healthcare (see Systems 6.3.2). Some of the factors that have been cited as barriers to increased patient involvement are belief in debilitating mental state; negative staff attitudes and limited resources, particularly time, due to a chaotic environment (Anthony and Crawford, 2000). Nurses in that study were clear that they valued patient involvement in the care planning process but felt there were times when it was inappropriate to involve them and that their wishes needed overriding at times, an attitude that clearly shows how difficult true inclusion is when having the experience of mental illness devalues the person. The issue of stigma and discrimination is under recognised in mental health nursing literature and yet it clearly influences even the most person centred approaches. This study is beginning to illuminate the all-pervading impact of mental health legislation on care.

In their study exploring patient perspectives on psychosocial assessment following self-harm, Hunter et al (2013) highlight the fight of patients to be heard and believed during the assessment, particularly if psychosis is a factor. This can lead to increased distress and hopelessness possibly increasing the risk of completed suicide or repeated self-harm. The results of the current study align with this finding. Furthermore, in discussions of lived experience in their recovery approach, Roberts et al (2011) state their desired outcome is not empowerment but people who are able and hopeful about getting on with their lives on their own terms with or without mental health services. They state that recovery training from lived experience experts provides opportunities for those staff without lived experience to 'walk the walk' with a realism that cannot be acquired from text books. In work with people with PTSD Stephens et al (2013) found a paradigm of disempowerment and deferred responsibility which contributed to considerable break downs in care and resulted in readmissions which may have been avoided. As an example they cite the fact that patients complained that the system of care was difficult to navigate but rather than simplify process services blamed the patients for being non-compliant. In Tysons (2013) study they found that most staff agreed that patient involvement in care planning was difficult although they were not clear why that was. They found some correlation between different staff beliefs and outcomes. Thus those staff with a biological rather than social belief of mental distress were more likely to coerce, to encourage medication and had more negative attitudes regarding patient ability.

Since the 1980s there have been groups of patients and ex-patients who refer to themselves as 'survivors' of a system they see as wholly flawed and they promoted increased 'self-advocacy' (Cresswell, 2005). Pembroke (1994) states that the system creates an environment whereby the socialisation and abuse equation, from previous experiences, is reproduced as treatment. Thus, in self-harm, survivor knowledge can be viewed as surviving double violation, firstly from childhood experiences such as physical or sexual abuse and secondly medical modes of intervention such as forced medication and restraint, which is couched as treatment.

'A growing number of women are choosing to call themselves ''survivors'' because they are driven to self-harm by a society that violates them as children

and adults, ignores their personal experiences, then compounds the violation within an ostensibly helping system that actually harms them.'

(Cresswell, 2005 adapted from Pembroke, 1994)

Although they do not express it in such extreme terms, there is some resonance here with the experiences of Fran, Ann and Jane who clearly state that they feel they are surviving despite difficulties in society and invalidating experiences in care, plus reactions to coercion or perceived untruths from healthcare practitioners. In exploring if the use of coercion is worth the threat to autonomy, Galon & Wineman (2011) found that being included in decision making is essential in procedural justice and is likely to contribute to quality of life. This sentiment is reflected in the guidance presented in DoH (2012) 'No decision about us without us' where there is further support for a correlation between quality of life and empowerment.

In exploring methods for increased patient centred mental healthcare, Latvala (2002) found that patients want a more active role in their care but at the same time found the need to empower patients to be a significant challenge. They provide a useful table to summarise the differences in authoritarian to more patient centred care (see table 9 below)

Summary of authoritarian to patient-oriented mental health care

Type of care	Basis of nursing	Co-operation in patient's care	Patient's attitude to their own care	Patient's participation in their own care
Authoritarian care	Authority	Authoritarian co-operation	Passive attitude to care	Passive recipient
Professional-oriented care	Professional orientation	Professional-oriented co-operation	Professional-dependent attitude to care	Responsible recipient
Patient-oriented care	Patient orientation	Patient-oriented co-operation	Active attitude to care	Responsible participant

Table 9 Latvala 2002

Patient involvement is not dismissive of practitioner expertise (Repper & Perkins, 2003) rather; it is an acknowledgment that professionals do not have the monopoly on wisdom. So practitioners can offer their expertise to enable the patients to use it to make decisions themselves, thus upholding more meaningful patient involvement. Patient involvement in treatment and administration decisions was one of the most important aspects affecting satisfaction of hospital care in a study by Taylor et al (2009). Individuals suggested that a more positive risk management approach where staff give

patients more responsibility for preventing their self-harm would help counteract feelings of loss of control on admission to psychiatric hospital. A qualitative exploration of patient experiences of participation in mental health services in Australia in delivery and evaluation of services (Lammas & Happell, 2003) highlights a need for services to value the contribution that patients can make as a result of their own experience. It is by hearing and using these experiences that services will be able to develop effective strategies for and promote genuine partnerships between providers and patients. This echoes the view of Menzies-Lyth (1990) that learned patients may be more able to collaborate as new patients may ask what to do about a problem but a more experienced patient knows that they must take some responsibility and work out what do for themselves. In a qualitative study exploring shared decision making in mental health treatment, patients particularly highlighted the need for respect of their expertise in knowing themselves and saw trauma from past coercive treatment as a significant factor. They were well aware that if the practitioner disagreed with their view they would get the treatment anyway (Mahone et al, 2011). Overall though, shared decision making was welcomed by patients and families although they also expressed some difficulties in seeing the patient and service as equals. Patients continue to want services to recognise their strengths and talents, but in order for this to occur, services need to allow mental health patients to take responsibility seeing them as adults and treating them accordingly.

6.4.4 Conclusion

The findings from this study suggest that the patient holds some significant power within the interaction with mental health services following self-harm but that efforts to assert that power will be likely to be overridden by the more powerful practitioner power. The patient in the interaction knows what the situation is in terms of their mental health but may feel unable to be truthful about it to the practitioner for fear of the consequences. This closes down potentially important avenues of conversation eg. talking about death. Not being able to tell the truth disadvantages everyone in the interaction, so whilst the patient, in many ways, holds the power here the power the practitioner has prevents the patient from using it effectively thus undermining the encounter entirely. This means that the transaction that should occur in terms of truth

telling to elicit care cannot happen and the knowledge that the patient has may remain hidden. When it is forthcoming, the practitioner does not always acknowledge the value of the information shared or believe it, so basic communication fails. That patients are expert in their own experiences is still a subject that services consistently fail to acknowledge. This study suggests that the impact of stigma and discrimination affects the power of the mental health patient in a way that is unprecedented in healthcare generally and that until this issue is addressed care will continue to be sub-optimal for the patient. Within mental health nursing literature this issue is not addressed or even fully acknowledged, this study will help to bring the issues into the foreground and promote further discussion on how this power imbalance can begin to be addressed.

6.5 Unique Contribution of Knowledge - New Ways of Thinking About the Psychosocial Assessment

This work explored the experience of ten participants who had had contact with mental health services whilst in a general hospital following self-harm. Whilst it has been known for some time that self-harm in all its forms is a complex act with functions that vary depending on the individual, what is clear from this research study is that it is very easy to inadvertently increase the distress of this group which may well increase rather than decrease risk of further self-harm or suicide. All the participants criticised the service they received in some way, and most of them had helpful suggestions as to how contact could have been improved. This research contributes to an increasing body of evidence that suggests that, if mental health services want to improve and be effective and efficient as policy suggests, then there is much work to be done to realise improvements to actualise this. What follows is a discussion regarding the potential implications of this study for practice, theory and policy from both an individual and service level, although the two are intricately interlaced and affect each other. The rest of this chapter converses primarily with contemporary anti-psychiatry literature and has an essentially anti-psychiatry stance. This stance is held alongside a pragmatic view regarding the current state of service delivery which must be considered if any recommendations are to be effective in bringing about successful improvements.

The findings of this study suggest a transformation is required in mental health services when dealing with those who have self-harmed or are at risk of doing so. If one considers mental health problems as a combination of bio-psycho-social factors, influenced by problems with living, often generating or accompanied by an existential crisis and less as illness, whether endogenous or exogenous, the human being behind the symptoms comes into view. So the prominent view needs to shift away from the traditionally biological paradigm and towards a more bio-psychosocial paradigm in action and not just in rhetoric. The potential transformation suggested by the results of this study are considered from an individual practitioner and service perspective in what follows. These findings argue for:

- a humanistic and person centred approach which posits positive relational aspects of the interaction between the person who has self-harmed and the practitioner as being the most significant in providing an interaction that is most likely to be experienced as care.
- the training needs of practitioners working in this area must include special attention on complex interpersonal and communication skills as well as an enhanced understanding of the experience of being seen by mental health practitioners in this setting.
- increased exploration of the affect the MHA has on the experience of care in mental health.

Prior to this study there was a clear gap in the knowledge about the experience of contact with mental health services in a general hospital following self-harm. Whilst much of that which was discovered echoes previous research on patient experience, apart from Hunter et al (2013) for whom the focus was slightly different, this provides unique information from this particular context. Hunter et al (2013) did not consider the effect of the environment on the encounter, the need to talk about death for some, or consider the use of the arts to aid communication. There is now an increased understanding of some of the factors that create barriers to communication both emanating from within the patient and created by the context within which the encounter takes place. Whilst not a direct finding it has been impossible to ignore the impact of the MHA on this cohort of participants, and the influence it has on mental healthcare, including some of the ethical issues it raises within this context. Thus the study has increased insights into a previously poorly understood phenomenon.

In answering the secondary research question posed in 4.1.3.6:

'To what extent is the provision of a psychosocial assessment in the acute hospital, following admission for self-harm, justified by patient experience?'

The psychosocial assessment appears warranted in the encounter with mental health services following self-harm from the patients perspective. It provides an opportunity to talk, to gain assistance, to find hope and consider choices possibly previously unnoticed. All of the participants could see a value in the encounter but only if it was done in a human way. The quality of the interaction really matters. It also highlighted the general hospital as being an imperfect place for this encounter to occur whilst at the same time, the Emergency Department in particular, remains the most sensible place for people in acute mental distress to go as self-referral to mental health services in the UK remains impossible. Policy (DoH, 2000,2005, 2008, 2009, 2010, 2011, 2012, 2014., NICE 2004, 2011) and practice theory (Barker,2009. Peplau, 1988, King,1999) support humanistic and person centred approaches but despite the volume of this guidance services are still delivered in ways that have changed very little over the years (Walker, 2006, Sayce, 2009. Russo, 2016), This theoretical thinking and guidance, alongside the findings from this study, if aimed at mental health nurses who are students or in practice, might act as a call to action for those working with the cohort and facilitate actual change.

6.5.1 Individual Practitioner Implications

In order to facilitate this transformation, the implications for individual practitioners arising from this study are now considered. Although these findings have arisen from a cohort of people who have self-harmed, they are applicable to practitioners working in the field of general mental health as well as those working specifically with this cohort.

Themes	Individual Implications	
	Current State	Proposed
Internal Barriers to getting the help you need	• Difficulty managing emotions • Psychosocial assessment – a talking encounter • Patient asked to repeat painful experiences repeatedly with no recognition of the difficulties inherent in doing so. • Lack of understanding of patient experience of contact with MH services after SH.	• Training to increase practitioner ability to tolerate high expressed emotion. • Use of alternative approaches eg. writing to allow other forms of communication during assessment • Better usage of prior records. • Training in communication strategies to decrease distress when revisiting traumatic events is necessary. • Information of the results of this study regarding the experience of being assessed following SH.
The business of being human	• Patient seen as being 'different' due to the nature of MH issues, Institutional stigma • Non-judgemental practice demanded but often falls short. • Professional role creating emotional distance.	• Patient seen as resourceful, holding the key to the resolution of their problems. • Recognition of judgement as part of the role, explore this as part of the process with the patient. • Training regarding retaining the human element, so deciding where staff personal boundaries lie prior to entering into an assessment situation.
Traumatising environment	• Service driven agenda	• Patient driven agenda.
Patient power	• Patient seen as wanting in moral fibre and competence. • Professional opinion seen as more valid. • Truth withheld from patient eg. regarding the use of the MHA.	• Patient seen as human recovering from trauma and having resources that can be utilised to help recovery. • Patient experience and self knowledge valued. • Be truthful

Table 10: Individual Implications

One clear implication highlighted from these findings is the need for the practitioner to have advanced interpersonal and communication skills due to the complex nature of the interaction that needs to occur after self-harm.

This study suggests that strategies to help practitioners manage high expressed emotion, to maximise calm and reduce emotional blinkering are also important. Mental health services are particularly poor at managing people's emotions with the first recourse of management often being medication to eliminate or reduce distress. Distress is a natural part of life and of growth. There is a growing body of evidence that suggests that experiencing adversity is necessary for the development of resilience (Grych et al, 2015). Validation techniques, such as active listening and acknowledging distress, are most likely to be useful in this case but it must be recognised that dealing with people in distress requires emotional capital from the practitioner, so it is important that this is recognised in order to reduce burnout or bruising (Radcliffe, 2015) in those providing care. Promoting staff efficacy at managing emotions and allowing room for the expression of emotion within the encounter between staff and patient have implications for mental health nurse training.

Another issue in terms of the humanity of mental health practitioners is that they need to be both self-aware and be able, in dealing with people who self-harm, to acknowledge thoughts of death and discuss them, this means they need to be at terms with their own mortality. This high demand on personal capital when dealing with people who self-harm may be part of the reason working with people who self-harm is so challenging.

Reflexive log note: Difficult topics – June 2016

The emotion made this interview hard. Fortunately she spoke quite freely and my questioning was around clarification at first. There was a point where I deliberately moved the questioning away from the emotion to process. This was in response to danger, I felt, of losing her to the emotion and having to stop the interview. It felt safer to move to less emotive ground. She had also said something dramatic that felt like a full stop. There was an ethical perspective here too, I felt she could be re-traumatised by continuing on that path. I wonder but am not sure, how much I was motivated by avoiding my own emotional reaction to her plight. This reaction has made me think a lot about the actual assessment process itself when undertaken in practice. How much do practitioners avoid things that make them feel strong emotions?

Barker (2004) states that working with people who are suicidal can present grave threats to the psychic welfare of the nurse. Where the assessment of a suicidal person is concerned, nurses have an opportunity to confront their deepest fears. The person who is suicidal may offer the nurse their own 'tragic gift', they may help practitioners appreciate something of (both) the inestimable value and futility of life (ibid). The fact is people have the option of ending their lives on a daily basis but for most, most of the time the scales tip in favour of staying alive. Paradoxically, in looking closely at death people predominantly choose life but by denying or avoiding thoughts or discussions about death practitioners block an avenue of wider life experience which is, in itself, a risky endeavour, one which may deny the existential crisis being experienced by the patient. Self-harm and suicidal acts are sometimes undertaken because death is the required outcome and yet, discussions about death are not considered in the training of people undertaking such a role.

Mental health nurse training needs to incorporate the issue of having discussion about death without over-reacting to ideas of risk.

6.5.1.1 Role for Health Humanities

Considering all these points alongside the, now rarely contested, fact that self-harm often occurs when there is an absence of words to express the life events or inner world of the individual (Wider 2007. Shaw,2013. McPhedran & De Leo, 2013), a consideration for alternative communication strategies is required. It could be very beneficial to use art or music, indeed any form of alternative media, to help the person describe how they are feeling, to help them to express their distress in a way that is less threatening than having to find words for or utilise words that directly feed the distressing events themselves. Whilst it is perhaps unrealistic to expect that practitioners be furnished with the time and space for artistic creation with patients in an acute hospital, it would a minor matter for them to take copies of already created artworks, perhaps in the form of postcards, which could act as a conduit for discussion of trauma and distress. It would be little difficulty to ask the patient to be seen next to consider writing or drawing about how they are feeling whilst they wait for the practitioner to come and engage them in the assessment. This would fill time, addressing the difficulty of having to wait long periods of time for interventions, and create a piece that could be used as a focus of discussion in the assessment. In this way, those who find themselves non-talkers could be given an advantage and the opportunity to get the same level of help as someone who is very articulate. It could remove a significant barrier to getting the help they need whilst providing a moderating distance from the distress they may feel at having to revisit trauma.

6.5.1.2 Therapeutic Relationships

The relationship between the patient and the mental health practitioner appears to be of paramount importance (Barker, 2009). To the patient it is more important to have a meaningful interaction than it is to be assessed for 'risk' or managed in a process driven way. The requirement for the information gathered in the psychosocial risk assessment is acknowledged by all as being important, however concentration on building the rapport and relationship will enhance the possibility of honest responses to questions regarding risk and influence the possibility of positive outcomes in terms of recovery and risk

management. Many services working with those who are in hospital who have self-harmed refuse to take referrals until the person is medically fit for discharge (NICE, 2004. Aitken, 2007). Whilst there are reasonable, service led, factors that influence this it is a direct problem in allowing time to create a therapeutic relationship, instead expecting the patient to launch straight into talking about very personal events with someone they may just have met. Findings from this study suggest that this is an unacceptable practice and that time to build the relationship and trust is an essential element that needs to be reintroduced.

All the above require training to alert the practitioners to the inner blockades and barriers that this study has highlighted already exist within the individual, that make the job of sensitive and meaningful assessment more difficult. It also supports the need for an individualised assessment as each person's barriers will be different. One resource which is recognised within the policy literature for mental health liaison is the need for time to carry out this process (Aitken, 2007), this is at odds with the fast paced care culture of the acute hospital and creates its own difficulties as discussed previously. Further training is required for practitioners working in this area, designed to cover these main points:

- To ensure they understand the importance of the therapeutic relationship; in mental health nursing the concept of the psychosocial assessment has been primarily viewed as an information gathering exercise that benefits the service more than the individual it is meant to serve. This is a missed opportunity.
- To explore ways of building a therapeutic relationship quickly and effectively
- To develop ways of maintaining personal integrity whilst working with people who self-harm
- To explore difficulties inherent in discussing issues related to death
- To ensure staff are aware of the need for, and have access to, adequate supervision/support to enable their own personal development
- How to inspire hope and the importance of validation

- A deeper and more nuanced understanding of the role of the MHA
- To explore ways of providing optimal care despite the impact of imperfect practice spaces.

Although much work has been done in recent years to improve services for people who self-harm (Palmer et al, 2007, RCP, 2014)) there is still much work to do particularly in the continual fight against stigma and poor attitudes within healthcare.

6.5.1.3 Extending King's model of Goal Attainment

This study has highlighted the complexity of the interaction between mental health practitioner and patient and this encounter has been considered in a more nuanced way than is usual in mental health nursing, so providing an advanced understanding of what happens in an assessment scenario.

The Theory of Goal attainment has been suggested as a framework that is congruent with international and multicultural nursing and that use of the theory prevents stereotypes (Fawcett, 2001). In the increasingly complex healthcare arena there is more responsibility than ever on the practitioner to practice truly participative decision making (King, 1999). One of the assumptions underpinning King's theory is that nurse and patient interactions are characterised by both verbal and non-verbal communications in which information is exchanged and interpreted by transactions wherein values, needs and wants of each member of the dyad are shared (ibid). This model offers a less illness centric and fully holistic, as in both of those present in the interaction not just the patient, approach. It has not been adopted in the UK as yet. King's holistic view of both nurse and patient in the interaction is fundamentally correct and the concept of goal attainment a useful one to consider in the assessment process. As was demonstrated in the strategic manoeuvres diagram in 6.3.3 the reality of the interaction is much more complex than Kings model suggests.

King's conceptual framework for nursing (Sieloff Evans, 1991) suggests a dynamic interacting system comprised of three main elements; personal, interpersonal and social. Personal consists of individual concerns influenced by past present and perceived future goals. Interpersonal concerns groups

including dyads, communication, interaction roles and transactions are key concepts here. This is the place where King asserts that the nursing process primarily occurs. Social consists of a boundary system of social roles, behaviours and practices designed to promote common goals and interests. The healthcare setting is an example of a social system. Many common characteristics exist across social groups but key concepts are authority, decision making, organisational power and status. A core underpinning assumption of this framework is that the focus of nursing is human beings interacting within their environment in such a way as to lead to individual health which allows fulfilment of social roles (ibid).

Purposeful interaction involves nurse and patient openly sharing information (ibid) however in the mental health context, as has been demonstrated by this study, the patients' ability to share openly is compromised by the power imbalance that exists between the dyad and for some the exclusive utilisation of a talking encounter can cause problems. The ability to clearly establish patient goals is undermined by this affect. The importance of understanding the person requesting help and correctly perceiving the internal barriers that exist in complicating attempts to elicit help are also important and underestimated.

King's model neglects the effect of environment on the individual and this study has clearly shown the impact of the environment of the general hospital on the experience of contact with mental health. The system demands have also increased since Kings model was conceived and at times, healthcare focusses more on the demands of the system then on person centred care eg. concerns regarding risk if someone admits to suicidal thoughts. The effect of this is to essentially shut down avenues of conversation that must occur if truly meaningful goal attainment is to occur.

Kings model is essentially over simple for interactions more complex than tasks such as washing or medicine dispensing. This work emphasises the complexity of the seemingly simple interaction that is the psychosocial assessment and therefore extends Kings model to make it more suitable for use in a mental health setting.

6.5.2 Service Alternatives

In order to further realise the transformation required in service provision, table 11 shows the changes implicated by this research.

Themes	Service Implications	
	Current State	Proposed
Internal Barriers to getting the help you need	• Speed of assessment prized over quality • No specific training available in psychosocial assessments • Personal relationships undermined despite evidence that good quality relationships have therapeutic effect • Face to face talking encounter offered	• Time to conduct lengthy personal assessments • Time to build relationships with individuals to increase the likelihood of a positive experience • Use of alternative approaches eg. drawing or writing as additional communication tools
The business of being human	• Institutional Stigma • Public stigma • Primarily see people who are in crisis and this becomes steady state	• Continue to address via media campaigns • Training to include reflection on own attitudes • Increased contact with people who have utilised MH services and recovered.
Traumatising environment	• Lack of private spaces for interview • Liaison services underfunded and increasingly closing nationally • Professional driven focus on managing risk • Non MH staff have a lack of MH know how	• Provision of private space • In house MH staff in the ED and acute trusts • Emotional Emergency Centres
Patient power	• Increasing use of the MHA	• Increased tolerance of 'other' • Increased efforts made to understand behaviour that is unintelligible eg. open dialogue • Use of peers in provision of care

Table 11 – Service Implications

Work on the health service with regards to being person centred rather than service centric is required in order to create the compassionate spaces that the type of holistic practice described above is able to flourish in. It is clear from the study that a different approach is required from a service perspective in addition if there is to be real impact on quality of service for individuals who self-harm or are considering suicide. The first point to consider is whether or not the Emergency Department is the best place for those in emotional distress. Pragmatically it would be very expensive initially to create new services but there are likely to be savings to be made in the long term, and lives to be saved by doing things differently.

This move towards integrated services was alluded to by several of the participants in this study and is well supported by research, as outlined below. The NHS confederation (2012) state that failure to deal with mental health and physical health at the same time leads to poorer outcomes for patients and is

costly, they also recommend in house liaison services. Broadbent et al (2010) add their voice to this argument stating that there should be a mental health practitioner in the Emergency Department at all times it is operational and that mental health services should be integrated into the Emergency Department, the rationale for this also being partly that liaison services bridge the gap between mental health and physical health services and allow for more holistic care (CQC, 2015). Broadbent et al (2010) also state that having a mental health practitioner present is a practical way of ensuring that mental health patients receive equitable care to those with medical conditions, Morphet et al (2012) also found that the confidence of other staff was increased in dealing with mental health patients when there are designated mental health staff in the department. Clarke et al (2007) also recommend mental health staff being present in the Emergency Department , as does the DoH (2014) who state that mental health and physical health services need to be better integrated, as part of this they recommend ensuring that there are adequate liaison services. Parsonage et al (2012) assert that the case for liaison services is stronger on grounds of cost-effectiveness as clinical outcomes are so difficult to measure in this area but still assert that every general and acute hospital should have a dedicated liaison service.

The literature is replete with calls to strengthen the interface between physical and mental healthcare (Hardy & Thomas, 2012), particularly as intersection of emergency medicine and mental health provides an opportunity for clinicians and researchers to develop effective interventions, policies, education and treatment programmes for this vulnerable patient group (Larkin et al, 2009). Emergency Department Staff and patients report feeling better supported by the presence of a mental health practitioner both because they provided a link between mental health services, GPs, community organisations and medical services and because their presence had an impact on waiting times for patients (Wand & Fisher, 2006). In that study it was found that the mental health practitioner was able to see 75% of the patients with mental health issues within an hour of triage. This impact on waiting times was also noted by Smart et al (1999) when they developed a triage tool for use in Australian Emergency Departments. It is predominantly devised to ensure that mental health patients are squeezed into the required format for traditional Emergency Department style services and as such does not represent person

centred care. It is also borderline prejudicial in terms of labelling mental health patients as violent, it does however note that raised confidence of the triage staff in appropriately triaging mental health patients meant that they got referred to the correct place more quickly and so their wait time and resultant distress was reduced (ibid). Broadbent et al (2014), in a study exploring collaborative working posit the concept of 'collegiate presence', this is defined as a connection between two or more professional groups or individuals, who have a common work goal and are aware of their cultural differences. They found that there were three major benefits to this concept:

1. Improved communication – healthcare environments are complex and fast moving, effective communication is a fundament element of teamwork.

2. Social conversations – this is a central element of collegiate presence and influences the quality of the relationship between the differing groups or individuals.

3. Physical presence – actually being in the department and limiting the less personal media of conversations eg, telephone allows for longer, more comprehensive and clearer communication.

This adds weight to the assertion that mental health staff should be present in the Emergency Department at all times and it becomes clear that this could be a key change that could address the current difficulties, particularly waiting and dual diagnosis, in service for this group.

6.5.2.1 Peer Led Services

The participants in this study were clear that they needed to be met with understanding; compassion and a non-judgemental attitude and it may be that a move towards more peer led services could be part of the answer. Beresford (2010) states that peer groups provide the opportunity for people to have safe discussions with others who have similar experiences without fear of judgment or the assumption that they may be mad. In their description of the 'Living Room', a recovery-orientated alternative to the Emergency Department, Shattell et al (2014) stated that their guests valued that they could be themselves, they felt they were more likely to be honest and believed themselves to be effectively helped in a judgement free, open and honest environment largely delivered by service users themselves. They stated that the peer aspect

enhances the human to human nature of the approach. This is a feature also experienced in the 'Clubhouse' system which has many centres worldwide whereby much of the care within the system is delivered by service users to enable them to function (Macias et al, 2001). Clubhouse communities are a network of peers and staff who assist people in leading productive, community orientated lives by encouraging skill development (Pernice-Duga & Onaga, 2009). They state that there are 29 countries within which the Clubhouse model is practiced. Started over 60 years ago by a group of people who had supported each other whilst in patients of psychiatric services, it was not based on theoretical foundations but on their experiences and wishes to do things more effectively (Phillips, 2012). Their users are referred to as 'members' and members can utilise the service voluntarily and there is no time limit (ICCD, 2015). As there are few staff members in these clubhouses, it is intended to run on a predominantly egalitarian basis as it would be difficult to operate the clubhouse if this were not the case. This means the members take an active role in the day to day running of the service with the aim being that they further develop a sense of meaning, increase confidence and nurture a sense of purpose. These clubhouses appear to replace rehabilitation services and are predominantly aimed at people with severe and enduring MH problems. Whilst it is unlikely that this sort of service would be immediately accepted within the UK as an alternative to Emergency Department care, an Emotional Emergency Centre, a phrase coined by Chamberlain (1999), based on similar principles is possible (discussed later in this chapter). Despite a plethora of evidence stating the effectiveness of these alternative services (Phillips, 2012. Briggs et al, 2012) these models have not become established, perhaps because they challenge the current bio-medical model which maintains the status quo in healthcare.

Peer support principles are laid out very clearly by Bassett et al (2010) as being thus:

- Mutuality
- Solidarity
- Synergy
- Sharing with safety and trust
- Companionship
- Hopefulness

- Focus on strengths and potential
- Equality and empowerment
- Being yourself
- Independence
- Reduction of stigma
- Respect and inclusiveness

Many of which qualities have much in common with those asked for from the participants in this study; validating; interested; non-judgemental; respectful; accepting; reassuring; open; optimistic and compassionate. There is interest currently in peer led services and away from formal services (Sayce,2016) . One such service in the UK is Maytree, a suicide crisis service based in London. Maytree is primarily staffed by volunteers (many of whom have lived experience of mental health issues), it is a four bed residential style facility which takes people who are actively considering suicide for a maximum five day admission during which time focussed work on the problems seen most important by the person themselves are worked on in a collegiate way. Admissions are voluntary and there is an underlying assumption that the 'guest' will commit to working hard to improve their situation whilst there. A recent study into the impact of the service was carried out by Briggs et al (2012) and they found two main key points. Firstly that the service was transformational for many guests. This was hypothesised to be because the guests experienced Maytree as an unusual setting, with staff and volunteers who created an atmosphere of interest in the guest, a benign and 'normalising' group setting, and a place for talking through issues and difficulties in order to discover meaning, promote self-reflection and strengthen the capacity to contend with adversities. Secondly that suicidal thoughts, feelings and behaviours reduced whilst staying at Maytree and that improvement was continued following leaving the facility. This is a once in a lifetime service, i.e. it can only be accessed once per person, and some taking part in the preliminary telephone assessment process prior to admission found that this support was enough to help them move away from suicide and 'save' their potential admission for a time when they may feel worse in the future, thus suggesting that this service, by its very existence, could be having a preventative effect.

This peer led service discussion sets up a conflict between that stated earlier, that practitioners working with those who self-harm or are suicidal should be highly trained. This conflict reduces however, when one considers the types of qualities called for which are, one could argue, basic human qualities which do not have to be and possibly cannot be acquired by professional training alone such as compassion, empathy and active listening skills. There is a suggestion that the human qualities mentioned are un-learned as part of the professional training programme (Tischler, 2010. Rogers & Pilgrim, 2014) for medicine and nursing. This does pose a rather larger question of the need for 'specialist' knowledge in mental health work versus the need for life experience and compassion towards others.

In work exploring the impact peer work could have on mental health services, Beresford (2016) draws a distinction between expert knowledge and experiential knowledge. Having an in-depth knowledge of mental health issues (assuming they are seen as manifestations of difficulty coping with life challenges rather than illness) can be very useful as can a deeper general understanding of patterns of behaviour in response to life difficulties/existential crises. It is, however, the experiential knowledge of the practitioner that is required to be advanced. What is required, and this is supported by the participants in this study, is a truly humane service, one where a person is simply supporting another person to navigate difficult circumstance (ibid). Knowledge of philosophy may be more useful alongside practical life skills to aid in the deciphering of what are often metaphorical manifestations of distress. The disease model is unhelpful and, at worst, damaging in the human endeavour (ibid). In recounting her experiences of service use, Shaw (2016) describes how her experience of good care after self-harm came from two support staff, so professional knowledge was not the reason she found them helpful. It was basic human qualities that made the positive difference, interest in her; time spent with her leading to her feeling cared for and valued as a person. In such a service one could argue that the place for current roles, psychiatrist, psychologist and mental health nurse, is quite limited. This may indicate another reason why these peer centric models have not been realised.

6.5.2.2 Emotional Emergency Centres

It has been suggested that there are two main problems in the efforts of services to prevent suicide (Webb, 2016). One is the discrimination that results from mental health legislation (discussed earlier in this chapter) that permits medical violence (eg restraint, forced medication). The second is medicalisation. If self-harm and suicide are deemed to be due to illness then the discussion that could occur as to the underlying reason for the decision to self-harm or end life is effectively closed. If this goes unexplored then we get no closer to ideas about why people act. Having sensible discussions about self-harm and suicide is essential in a mentally healthy community (ibid). Whilst this is the case, people who need services most may actively avoid them (ibid). Webb (2016) goes on to suggest eight elements that he thinks should be present for a suitable suicide prevention service, the first six of these calls are clearly supported by the participants in this study:

1. Prohibit psychiatric violence – stop beating us up
2. De-medicalise suicide
3. Rethink suicide as a crisis of the self
4. Mentally healthy communities
5. Safe spaces for suicidal people
6. Social mode of madness
7. Survivors as researchers
8. Funding – stop wasting money on what we know does not work

Chamberlain (1999) states that patients often have very good reasons for wanting to avoid formal mental health services and for refusing to tell the truth to professionals. She supports creation of 'Emotional Emergency Centres' which are fully led by people who have experience of mental health problems. Places where people are not considered sick or well, but are seen as individuals coping with their lives as best they can. Within this environment people receive care when they need it and when more able give care to others, the definition of need emanating from the individual rather than the professional. She explores three models (Chamberlain, 1999):

1. Partnership Model – professionals and non-professionals work together to provide services but demarcation of helpers and helped is still clearly defined.

2. Supportive Model – membership is open to all who want to use the service for mutual support. Ex and non-patients run the service with the view that everyone has problems at some time or other. Professionals are excluded from this model.

3. Separatist model – ex-patients provide services for one another and run the service, both professionals and non-patients are excluded.

None of these models recognise that both patient and staff are human beings, as referred to by the participants in this study, who will have varying levels of mental distress at different points in life. Therefore by excluding any one group of people the demarcation of groups is reinforced and stigma and prejudice continue. There is also little scope in the above models for those who have been patients and choose to train to become professionals, thus excluding those people means knowledge and skills from people with a good understanding of all aspects of the topic is not accessible. It also excludes those who are professionals who have experience of mental distress and have been patients. The findings from this study could be instrumental in informing the creation of such a service. This is underway already via discussions with a local NHS trust and City Council who are working at improving their provision for emergency mental health. By ensuring that the principles of good communication, enhanced knowledge of mental distress, how to allow expression of emotion safely and the impact of the MHA on interactions within mental health services are shared and understood then any resultant service is likely to be more effective for those that may use it.

6.5.2.3 Open Dialogue

One approach that would be certain to bear fruit in view of both more holistic services delivery and increasing peer led services as above is that of open dialogue. Open dialogue is based on Bakhtinian philosophy which states that people bring their respective social 'baggage' and narrative histories together creating joint language, meaning and understanding (Mac Gabhann et al, 2012). This communicative space creates the opportunity of change in

narratives both historical and projected and can result in actions that can have real life consequence, thus, as a process of communication, open dialogue is viewed as more than just a conversation. It is an open conversation that in itself is a transformation or an action that is and can bring about change (ibid). This approach has been utilised in Finland for most of the 21st century with some transformational effects on MH care provision (Seikkula et al, 2011) with studies suggesting that 81% of those treated this way had no residual psychotic features, 84% returned to employment or studies, use of neuroleptic medication had reduced and the early intervention nature of this method meant that problems were prevented quickly and thus more severe cases were less likely to develop.

The main principles of Open Dialogue (OD) are:

1. Immediate help. The teams arrange the first meeting within 24 hours of the first contact, made either by the patient, a relative, or a referral agency. In addition to this, a 24-hour crisis service is set-up.

2. Social network perspective. The patients, their families, and other key members of their social network are always invited to the first meetings to mobilise support for the patient and the family. Other key members may be other authorities, including employment agencies and health insurance agencies in support of vocational rehabilitation, fellow workers, or the head of the patient´s work place, neighbours, or friends.

3. Flexibility and mobility. These are guaranteed by means of adapting the treatment response to the specific and changing needs of each case, using the most appropriate therapeutic methods. The first meeting is most often organized at the patient's home.

4. Responsibility. Whoever (staff) is first contacted is responsible for organizing the first meeting in which the treatment decision is made. The team takes charge of the entire treatment process.

5. Psychological continuity. The team takes responsibility for the treatment for as long a time as needed in both outpatient and inpatient setting.

6. Tolerance of uncertainty. This is strengthened by means of building up a safe enough setting for the joint process. In psychotic crises, for an

adequate sense of security to be generated means meeting every day, at least for the first 10–12 days. In this way premature conclusions and treatment decisions are avoided.

7. Dialogism. The focus is primarily on promoting dialogue, and secondarily on inducing change in the patient or in the family. All issues are discussed openly while everyone is present.

(Seikkula et al, 2001)

Considering this treatment method with the qualities the participants in this study raised as important, strengths appear to be; that the patient remains in the driving seat with regards to care direction, it is clearly person centred; flexibility of delivery to suit the patient both in terms of treatment and environment of care; being heard and responded to as soon as help requested; involving the social network in the treatment process; striving for psychotherapeutic understanding of the patient perspective and problems; and consistency of delivery. Utilising this egalitarian treatment method also allows for the professionals involved to be more human, it is fully recognised that they have no knowledge of the person concerned and they are reliant on him/her to educate them, use of personal experience from both sides is encouraged and increasingly peers are becoming part of the workforce as they bring additional personal experience that enhances understanding and helps the person in crisis to feel that they are not alone.

The similarity of Open Dialogue to the CPA approach, introduced in UK mental healthcare in the early 1990s, particularly in terms of monitoring and co-ordination by a named keyworker (consistency); Involvement of users and carers in planning and provision of care (person centred); Inter-professional and inter-agency collaboration is apparent. The failure of the CPA process to deliver transformation of mental healthcare is multifactorial and is, in part, due to the continued inability of services to view persons with mental illness as competent and increasingly risk averse practices within services (Simpson et al, 2003). So whilst the open dialogue method is not new per se, it is another effort to reintroduce the humanity of care back into mental health services and, if carried out effectively, could literally transform healthcare.

This transformation is likely to be difficult. There are several challenges discussed above and as Russo (2016) suggests in his work on reclaiming 'mad' studies, the biomedical model is one of the worlds ruling ideologies, a position strengthened by the might of the corporate pharmacological industry. In the light of the MHA influence, the power differential clearly demonstrated within this study and the strength of the status quo it is likely to be many years before this transformation is manifest.

6.5.3 The Elephant in the Room – The MHA

The state interest in having control over those considered mentally disordered began in the early 1800s (Rogers and Pilgrim, 2014) with decisions regarding which behaviours were regarded as mentally abnormal being made first by judges then increasingly by medics. This requirement, deemed necessary by those in power, to exert control over those whose behaviour was less acceptable than those considered 'normal' sends a very strong message regarding the inherent quality and moral standing of the individuals concerned. This institutionally formed bias still influences mental health care today via the public stigma that continues to thrive regarding mental health problems and the various examples of structural stigma whereby rules, policies and procedures are created to restrict the rights and opportunities of a stigmatised group (Graham et al, 2013), in this case specifically the MHA.

What this study has highlighted, completely unexpectedly, is the direct influence of this legislation on the delivery of care to individuals deemed to be mentally unwell. It was first hinted at during the initial service user consultation when they talked about being ill enough to receive help but not so ill you got 'help' in the form of undesired consequences. Participants in the study were subject to direct coercion on two occasions; described several times when their opinions and views were ignored; found themselves unable to tell the truth particularly around suicidal feelings; felt stigmatised and judged by those around them, both professionals and others and subjected themselves to particularly harsh judgement due, in part, to the internalisation of public stigma. Although the issue of the MHA was not raised specifically by the participants, the combination of experiences outlined above and in the themes point or hint towards the issue of detainment. The patient consultations both inferred the same problem particularly in terms of how truthful people can be

about their experiences. The literature regarding mental healthcare, particularly that with a more critical realist standpoint and my own experience on reflecting on 20+ years of practice in mental health all combine to raise the Act as a fundamental influence. There is an inherent understanding within the cultural context of mental health care, that the MHA is always an option. It has become a taboo subject, something that is not clearly spoken about unless the patients behaviour or symptoms are perceived, by the practitioner, to warrant intervention for the purposes of social control ie. prevention of harm to self or others.

Reflexive Log Note – MHA- June 2016

I get so so angry writing about this, part of this is anger towards myself. How can I have been duped so by this legislation? I wonder now how many people walked away from an assessment with me feeling like they hadn't had the help they needed. How many couldn't tell me the truth because they were worried how I might react in terms of detention. They can't have known that I was always determined to manage without the MHA and that I very rarely had recourse to it. I was also unaware that I had a comfortable knowledge that, if things got too difficult, I can always blame their incomprehensible behaviour and get them assessed under the MHA. I feel almost ashamed. So even if I had reassured them at the beginning that this was the very very last resort, it still was a course of action open to me. This cannot continue. It does not feel ethical.

Mental health services, and as such staff operating within such services, are agents of social control (Vassilev & Pilgrim, 2007) and the MHA gives staff explicit power over those deemed mentally unwell. Thus the repeated mantra of policy and of service user literature that staff should view patients as equals to themselves is a challenge when one group has the ability to detain the other. This is a power imbalance that is consistently ignored within research and literature into care failures and difficulties within mental healthcare. Until relatively recently I believed, in line with my nursing education and background, that the MHA existed to protect vulnerable people when they were unable to protect themselves adequately due to decreased mental capacity as a result of mental illness. This view is still widely held within services both from

the perspective of staff and patients. Indeed Owen et al (2009) found that 83% of their study cohort approved of their involuntary treatment once they regained capacity, although even within this study they state the possibility that some of the cohort may have expressed this view in order to hope to reduce the length of stay of their continuing admission to hospital! As Pilgrim (2012) points out in his exploration of lessons learnt from the final report of the MHA commission in 2009, truly voluntary involvement in mental health care is an elusive thing when a background threat of compulsion exists and the report suggests that mental healthcare has become less therapeutic and more coercive since the early 90s when the old asylums were closed down (ibid). Two poles exist, those that advocate state paternalism and those more civil libertarian thinkers who support the view that, unless criminal laws are broken people should only be helped in a truly voluntary way. Previous lobbies for the abolition of mental health law have been unsuccessful or actively blocked (Richardson, 2001) and patient narratives have long called for a total embargo on forced interventions (Chamberlain, 1999. Dhanda & Narayan, 2007).

The MHA is often found to be at conflict with the Human Rights Act (HRA). In considering the impact of the HRA 1998 on mental healthcare Richardson (2006) states that treatment administration in the absence of consent potentially breaches articles 3 (to not be subject to inhuman treatment) and 8 (right to privacy). However, she goes on to state that this treatment can be justified when it can be shown to be medically necessary. Reading Thomas and Thomas (2004) could suggest that the HRA is a better vehicle for protecting the rights of those with mental health issues, especially in view of the issue of continued stigmatisation. The legal framework of the MHA exists to 'protect' the interests of people with mental illness but they also reinforce the social stigma towards that group (Dhanda & Narayan, 2007). Psychiatrists are empowered by law to deprive patients of their liberty and impose treatment without consent even when some patients have the capacity to make their own decisions. The MHA is a 'status' law which hinges on risk to self or others, capacity to decide is not central (Owen & Kanaan, 2008), this inevitably leads to stigmatisation of those subject to the act as public protection is an explicit aim. The fact that there had been a 3% annual decrease in the number of people with MI committing homicide between 1957 and 1999 (Simpson et al,

2003), and there is statistically more chance of being killed by someone who is deemed to have capacity and no mental illness, is not widely publicised.

As Richardson (2012) points out having separate legislation for people with mental disorder (as defined by law) is inherently discriminatory however, it would be justifiable if those people were in fact different from others in some clearly defined way and if the imposed treatments actually improved the situation. Just considering this last sentence in terms of this study it can be seen that the participants were not in fact different in any clear capacity from other human beings and they asserted the need to be treated as whole human beings who were more than their diagnoses (SOT - the business of being human n=10). They reported instances where previous experiences with and the current care experience had made things worse (n=4),rather than better (n=1, mixed positive and negative n=5) and they all recognised that although they had 'voluntarily' agreed to having a mental health assessment they did not really feel this was a choice but rather something that would happen regardless. The two participants who threatened to leave prior to assessment were offered further social consequences, in the form of police intervention, in an effort to help them to decide to stay voluntarily. That services behave this way is understandable with the current focus on risk in society but how services imagine that people will be able to recover from mental distress in this context is a mystery.

Dhanda & Narayan (2007) call for support networks for human distress outside of the medical establishment and for clinicians to re-examine the implications for such a legislation on clinical decision making and practice. This is a call the findings from this study contributes to, practitioners in mental healthcare need to become aware of the impact the MHA has on creating a power differential between them and the people they are caring for. They need to be aware of the potential impact the legislation has on their views of the individual in mental distress, to recognise when they are not taking what the patient says seriously, or dismissing it as a symptom of illness. Practitioners need to be aware that the patient may be very wary of telling them the truth, a clear training need, because of this power imbalance and that this is not paranoia but a very real potentiality if they share the 'difference' of their internal world with professionals. Therefore, extra efforts to promote trust and see the person before them as equal in value and humanity are required. A deeper and more

nuanced understanding of the role of the MHA in providing an implicit threat behind all actions of mental health practitioners is required in order to help facilitate genuine consent and to understand how this legislation creates an atmosphere of distrust and stigmatisation by its very existence. This issue should form a vital part of training of mental health staff generally.

6.6 Consultation 2

This consultation took place after data collection and analysis had taken place and the attendees were different people from the previous consultation event. The process of this consultation was as for the initial consultation except for engagement. Where contact details were known for the original attendees they were invited again; the breakfast group that I had attended previously was no longer running; the university social services group was still running and I contacted them again; and the event was shared via the Good Mental Health Cooperative mailing list and the local MIND notice board. The aim of this event was to find out what they thought about the themes and to ask them who they felt needed to know the results of the research study. I outlined the project with a short PowerPoint presentation, firstly sharing what I had done as a result of the previous consultation event. Then the themes were outlined as they had arisen from the data. Present at this consultation were three women, two other expected attendees cancelled on the day due to ill health. Those who cancelled were two of the original consultation group members. One factor that may have influenced the reduced number of attendees at this event was that the Service User Involvement worker that was employed by the trust and assisted with gathering attendees at the previous event was no longer in place due to cut backs. The event was held in a community business centre affiliated to a church, refreshments were provided and the atmosphere was informal throughout. The people attending did not know each other. Two had experience of self-harm and one was a carer of someone who self-harms. The invitation for the event was for people who had experience of self-harm and using services as a result of this, carers were not explicitly invited. The advertisement did not actively prohibit them attending though and as she had arrived I felt it unreasonable to turn her away. All had experience of using general hospital services. None of the women attending this event were

present at the first consultation event although, where I had contact details, these people were invited again.

6.6.1 Do the themes have resonance for you?

Generally the themes appeared to have many resonances with the attending women with the following points being most salient.

The importance of being seen as a whole person who is attempting, with varying levels of success, to lead a positive life was seen as important. The group generally agreed that physical healthcare is seen as being much more important than mental health care which creates many problems. The carer attendee cited an occasion whereby she was prejudiced against by staff on the ward her mother was being cared for, as her mother had mental health issues which had been exacerbated by not receiving mental health medication whilst in hospital. The group reported a kind of silo thinking from staff whereby they seem to believe that life did not exist before the person came into hospital and the 'pull your socks up' attitude was still very prevalent in both physical and mental health services. They did not feel they were always treated as fully functioning adults.

The group reported feelings of unworthiness, with regards to being a patient, due to the nature of attendance as a result of intentional actions rather than as a victim of illness or accident. This attitude is prevalent within staff groups (Curry, 2008), the public (Stuart et al, 2012) and towards the self (Brohan et al, 2011). Self-stigma affects the way one receives care and the group emphasised that when ill it is not always possible to react normally and everything appears to be a mess. These views are evident in the literature too (eg. McHale & Felton, 2010), the public perception is that it is your fault, as you have done this to yourself, but it is an indication of a person in distress with a difficult inner world. One group member was under twenty and reported that in young people there was more sharing of depression via social media and therefore understanding appears to be increasing for this condition and stigma appears to be reducing although this does not apply to all mental health disorders as yet in her experience.

The group reinforced how important it is to get the encounter right, including that at the front door at triage. The interaction with the Emergency Department

nurse can set the tone for the whole event and influences how one views all staff during that admission, a viewpoint echoed in Palmer (2007). Overall this group had very good experiences of general hospital staff and the group unanimously felt that mental health nurses should be part of the team working in the Emergency Department particularly. The environment of the general hospital was not ideal all agreed, particularly with regards to privacy and dignity which are essential factors to consider.

Communication was a theme for this group, they stated that feeling that you are listened to goes a long way and honesty, on the part of the practitioner, even when needs cannot be met due for example to resource issues, was really important. It was felt that trust was needed in the practitioner before you could feel comfortable enough to tell the truth and that trust took time to develop. This point is upheld by Binder et al (2013) who agree that the relational aspect of the interaction is the most essential to get right. Using the Mental Health Act (MHA) as a threat, which two in the group had experienced, was not conducive to honesty. They also questioned the concept of confidentiality, questioning if it was real and stated that, in the situation of repeated assessments, if nothing useful has resulted from assessment then the patient may not be forthcoming in the current assessment as what is the point? The feeling was that patients are not given the whole story so why should they give the whole story, something noted in Corrigan et al (2012).

The group reported often feeling that they had to battle the system and that the key issues here were; coercion, influenced by the power invested in staff via the Mental Health Act (MHA); fear of losing children and power imbalances that exist between staff and patients especially if behaviour does not comply with that expected. One attendee stated it does not feel as if services respond in a very grown up way to self-harm a position echoed by Beresford (2010). Staff say they are acting to protect but are rarely clear with the individual what the risks are that they are responding to. They also stated that if a patient is likely to be discharged then it can take six months to get back into the system so people don't tell the truth when they are well for fear of needing services if they become unwell again. Preventative care is rarely available, only the most extreme cases get care because there is not enough resource to go round, this can lead to escalating behaviour in order to get care which is not a real representation of the persons health status.

Additionally the group liked the title 'Business of Being Human' and pointed out that although this research aims to strengthen the patient voice, all the actions that are needed to improve services as a result of the study need to be carried out by staff or others groups not patients. The carer member of the group asked if the inclusion of carers/partners had been cited as an issue in this work, which it hadn't been although I informed her that one participant had been interviewed at their request, with their partner.

6.6.2 Who needs to know?

It was felt that the following groups needed to be informed of the outcomes of this study in addition to staff working in mental health teams in general hospitals and mental health establishments, such as Paramedics , Police and Patient journals and service user conferences. There was a feeling that the results needed to be circulated via the wider media in an effort to address some of the pressures and stigma that are inherent in social and other media. Social media is an important place to share these findings as this will target the younger generation. Dissemination is discussed further in chapter 7.

It was important to me to carry out these consultations as involvement of patients in all aspects of care research, planning and delivery is something I hold as essential to ethical practice. As I such I consider all patients to be experts in their own experience and endeavour to involve them as much as possible in all aspects of my work, research, education or clinical practice. This position was upheld during the upgrade process which was very helpful in encouraging me to think more broadly around the impact of patient involvement in research particularly. Considering the importance of patient knowledge, involving them in decisions around their care and in co-producing care packages, services and research has also been shown to have a beneficial impact on wellbeing for the individual concerned (Weinstein, 2010). The issue of patient involvement is now considered more fully in the context of mental healthcare along with the resulting empowerment that should ensue from such practices.

Chapter 7 Conclusions and Recommendations

This chapter concludes the thesis and considers dissemination, strengths and limitations of the study and finally recommendations for further research.

7.1 Proposed Dissemination Strategy

Research projects alone do not change practice it is only in sharing the findings that positive change can be facilitated or considered. The mental health team from the hospital where the participants were recruited and the associated ED have both requested that I come back and do training sessions in order for them to be able to implement any changes required to improve care for those who self-harm. The Emergency Department where I was once a Liaison Team manager have made a similar request. The findings will be shared via the Royal College of Psychiatrists as a continuation of their 'Better Services for People who self-harm' initiative, which I was part of at the time it happened (Palmer et al, 2014). I presented the initial findings at an international qualitative research conference on mental health in Crete in 2014 and at the next conference in 2016 to discuss the final findings. Alongside this I will also present at other conferences that appear to be appropriate. In particular I intend to present on new ways of thinking about the psychosocial assessment and the influence of the MHA of mental health care.

The initial thinking involved in this research process has already resulted in a book chapter (Walker, 2013), exploring the self-harm spectrum, and I have co-written a book on Mental Health assessment (Walker et al, 2013) both of which have had excellent reviews and are aimed at learner mental health practitioners. A publication schedule is written for further dissemination of the findings by publications. I regularly teach healthcare practitioner students of many different disciplines on the subject of self-harm and psychosocial assessment. My findings have and will continue to influence my teaching meaning that the practitioners of tomorrow at my university will be directly affected by the outcomes of this project as I incorporate my findings into the

training I deliver on self-harm and suicide management to mental health nurses. Additionally every participant, bar two, has requested a short report version of the findings.

7.2 Study Strengths and Limitations

The voices of people in mental health crisis utilising general hospital services following self-harm are seldom heard and this is an under-researched area (see Chapter 3 literature review), therefore an in-depth exploration of this phenomenon was appropriate and one of the strengths of this study is the origin of the data ie. from people in, or recently out of, crisis. It could also be argued that this is a possible limitation as interviewing only people in or recently out of, crisis could present bias. A follow up interview once the participant was out of crisis may have been ideal however the ethical implications inherent in doing this were prohibitive and the fact that one of the LOT was trauma due to having to recount events again it subsequently appears this may have been a correct decision to make. The methodology (IPA) allowed for deep immersion in the experiences of the participants and the data was rich in information which has provided new insights into the experience of contact with mental health services for this cohort.

The study design was actively influenced by the voices and experiences of others who had used similar general hospital services following self-harm, including choice of methodology, question schedule formulation and choice of participant group. This meant that the resulting clinical impact of this study is likely to be greater than may be necessarily expected for a PhD study. The second consultation has provided suggestions regarding dissemination which will hopefully influence the study having wider impact.

My own role as researcher adds both a strength and a limitation to the study. The knowledge, experience and understanding that I have of the role of the clinician in the type of mental health services offered in general hospitals has added complexity to the interpretation of the data. This has resulted in richness whilst at the same time represented a risk to my interpreting data from this perspective rather than from that of the patient. At the beginning of this PhD journey my perspective was more that of a mental health nurse, but this changed gradually as analysis occurred. The reflexivity practiced

throughout the study aimed to minimise the likelihood of moving away from their experiences and getting lost in my own. Alongside this, my experience as a patient has, at times, influenced a rather polemic viewpoint whereby I was in danger of being overly influenced by anti-psychiatry literature. There were several occasions when I had to take time to calm before I could write more objectively again, in order to balance the personal and academic voice. This same passion has been a strength in that it has provided much motivation to remain as true to the voice of my participants as possible.

In IPA terms ten participants is a reasonable sample size for a study of this kind and the knowledge generated applies to this group and may not be generalisable. The knowledge developed through this study is not presented as an absolute truth, rather an interpretation of the experiences of the participants, developed using a recognised framework. The data relied on participants' recall of interactions with the mental health services concerned and memory and perception can be faulty and are inevitably influenced by the passage of time. The participants were fairly homogenous as they all met the inclusion criteria and came from the same general hospital in the South of England. They were from different demographic groups, however, with limited cultural diversity which means that findings are not necessarily transferable. This is not one of the explicit aims, however, of qualitative research and this study does provide new insights into the experience of this cohort.

One limitation is presented by the experience of the cohort as all but one of them stating they were suicidal at the time of their self-harm. Self-harm is also frequently used, as mentioned in chapter 1, as a coping strategy and as such is often more concerned with keeping the person alive rather than ending their lives. Therefore the data are from a particular group who were suicidal and does not necessarily represent the experience of those who may use such services after self-harming for coping purposes.

To my knowledge this work is one of only two studies in the UK currently looking at the patient experience following self-harm in the general hospital. The other study (Hunter et al, 2013) uses IPA to explore the patient perspective on the psychosocial assessment following self-harm and its impact on further help seeking. It differs from this study in its focus on the assessment rather than the overall experience of contact with mental health services and

considers further help-seeking. The Hunter et al (2013) study comprised thirteen participants who were interviewed three months post incident and seven follow up interviews. Their findings support the outcome of the patient consultation carried out for this study in that the function of the psychosocial assessment is unclear to the patient. Other findings complement some of those found in this study, particularly with regards to feeling judged and the realisation that a poor assessment can be damaging. As such, more research is required into making sure we are providing what is required for this at risk group in order to be sure we are impacting as much as possible on the likelihood of future self-harm and suicide.

7.3 Recommendations for further research

The following recommendations for research have arisen from the findings of this research project:

- Training has long been shown to make a difference to attitudes, skill levels and enhancement of practice and the training outlined as required in this study should be developed, delivered and the effects of this evaluated in terms of impact on the mental health practitioners themselves and improved care from the patient perspective.
- Alternative approaches to care delivery focusing particularly on peer led services are required in order explore ways of helping those in emotional crisis
- More research into the effects of the MHA on care delivery and the impact on stigmatisation of those designated as mentally ill.
- Those who use mental health services need to be involved far more in the development of research projects and, in view of the request for more peer led interaction, user-led research for those in crisis should be increased
- Utilising artistic interventions, such as reflective writing and artworks in helping those with limited ability to share difficult emotions using words.

7.4 Conclusion

This research study aimed to address the question:

How do patients who have self-harmed, experience contact with mental health services in a general hospital?

It is clear from the study that there is much that needs to be improved in terms of service delivery; societal changes in terms of stigma; legislative changes to aid in reduction of stigma and reduce the infringements of human rights for those of us labelled as mentally ill; and individual training requirements for those dealing with people in the severe emotional crises that often lead to self-harm. Within the study most of the positive experience shared was linked to individual relationships with the practitioners concerned rather than the service itself which was generally considered very flawed. Efforts to re-introduce the humanity in mental health care are required in order that services are indeed able to protect those most vulnerable in times of crisis.

Appendices

Appendix A The Self-Harm Spectrum – A personal journey

‘It’s your artistic personality!’ the nun said as she dragged me back from the first floor window I was half way through, having screamed my intention at the top of my lungs before throwing myself dramatically outwards. I was 15 or 16, in full adolescent flow, approaching exams in a boarding school where I was known for being sensible and musical with literary tendencies. That this behaviour was extremely out of character for me was not acknowledged, no one was told, my parents only found out 20 years later and were horrified they hadn‘t been informed at the time. Was this response the right one? I don’t know, but it was a nice excuse for them to be able to brush it under the carpet and pretend it didn’t happen. A cry for help? Maybe, but it felt more like a rage of frustration and anger over the lack of control I felt I had at the time. It didn’t work as a cry for help anyway because no one offered me any but the crisis diminished and nothing catastrophic happened.

Some years later I began training to be a mental health nurse and one of the tutors was a psychosexual counsellor. To say this man saved my life is not too much of an exaggeration, at the time I was using drugs of all sorts, in a seriously dysfunctional relationship and experiencing flashbacks from childhood abuse. By the time I realised I was pregnant I was beginning to reach a place where I could begin to build some self-esteem, so this combined with the counselling helped me straighten out. Then the post natal depression hit, after the birth of my second son and with this came the cutting. It didn’t help me in the way of making me feel better as some report, but it was a release of the emotional turmoil and I didn’t know what else to do when my distress became

unmanageable. I was a community patient at this time and was generously offered the diagnosis of ‘personality disorder’. I was a junior nurse by then and although the diagnosis had not reached the height of its popularity I was well aware of the damage a diagnosis like that could do to me in future years so I chose to stop attending my appointments and was discharged by default. Not before losing my nursing job because of my mental health problems though and there was no attempt at follow up by the service I was attending. I remember looking ahead of me shortly after my first daughter was born and thinking I have two paths to choose. I either carry on like this and end up a serial patient or I get out of the situation I’m in and start again. I chose the latter, I was lucky that I could see the choices, some are not so lucky.

Once I managed to get back to work years later, I did well. I developed a fascination with self-harm, unsurprisingly, and got a job working in an Emergency Department (ED) managing a team of mental health practitioners providing assessments for people in the acute hospital with mental health issues. The majority of the people we saw had self-harmed. I was aware at the time of the attitude of many of the staff in the department and along with the team, provided training about self-harm in order to try and improve the reception that people who had self-harmed got when attending the ED. The longer I worked there, it was about 6 years in all, the more varied the people, the more varied the types and functions of self-harm. I did my degree part time, my dissertation topic was around self-harm and I was discovering that the majority of the literature I was reading did not appear to understand self-harm as a concept in itself but saw it as a suicidal behaviour. Things have begun to change now but we are still in a position where much of the research that has

been done into self-harm has come about as an accident of it turning out to be one of the most common factors present in completed suicide (Duffy & Ryan, 2004; Coyle, 2001;Barr et al, 2005).

When I began my journey towards a doctorate in 2009 still focussing on self-harm, I became aware of the vast amount of differences in literature regarding a sensible and suitable definition for self-harm. The National Institute for Clinical Excellence (2004, 2011) who provide clinical guidance for services delivering care for people who self-harm, Favazza (1992) and McAllister (2002) have examples of definitions which appear to be attempting to move away from linking self-harm to suicide but this then leave out those people who have variable intent or are motivated by a wish to die. Richardson (2004) provides a short definition 'Deliberately inflicting injury on oneself.' This allows for any intent and avoids any judgement being made about intention beyond the word 'deliberate', but does not prompt asking why the self-harm happened. I needed a good definition for my research and was unhappy with the way that intent was not explicitly mentioned in many so devised this one:

'Any act intended to cause physical harm to the self.'

This definition encompasses all forms of self-harm and draws attention to the need to discover the intent which will be different and variable for each individual. It also allows for the fact that although physical harm may result from the actions there can be a psychological benefit from this same action.

Policy documents have serious trouble separating suicide and self-harm and the literature is littered with articles which bounce from self-harm as a coping mechanism to self-harm as a suicidal act within them. The research indicates

that the two are interlinked whether we like it or not, the fact remains that some will self-harm with no intention of ending or even risking their lives, others will self-harm with the intention of ending it all and there is a huge range of other possibilities so it is impossible to pigeonhole everyone into one category. Is there a danger of us becoming embroiled in the issue of separating the two (Self-harm and suicide) and is this becoming a way of distracting us from the real issues? In order to make more sense of this and to use in the training I regularly delivered, I created a self-harm spectrum (Fig. 1) in order to crystallise my thinking. The spectrum incorporates both self-harm and suicide, accepting that they are interlinked and the tool that helps decide if they apply or not is the person's intent. Favazza (1992) was an eye opener for me, his book helped me confirm something I had become aware of in my role in the ED which is that there is a whole spectrum of behaviours that could be regarded as being self-harm, many of which were culturally sanctioned. (Fig 1 goes here)

The negativism shown regarding self-harm is indicative of the ignorance that surrounds it. Considering the spectrum, it becomes easier to explore how ordinary every day behaviours such as nail biting because you're nervous has a correlation with cutting to release emotion. Where is the line that tells us when a behaviour is self-harm and when it can be considered acceptable? My assertion is that the intent that lies behind the act is the most important factor. If someone drives at 100mph, crashes into the central barrier on the motorway and dies, this is a tragedy. If the driver enjoyed driving at high speeds and was fully aware of the dangers this clearly differentiates him from the driver who has had enough and deliberately hit the barrier in order to kill himself. The intent is key here, but the outcome is the same. In this instance we would only be able to

guess at the intent but in many cases we have the opportunity to look beyond the act to the person behind, to connect with them and enter their world.

There is much room to manoeuvre within the spectrum, by this I mean there may be differing levels of intent that make the same aspects of the spectrum more or less acceptable. To illustrate, consider a person base jumping for pleasure who has no intention of dying and another who wishes to die and attempts to jump from a high building. It is the intent of these people that decides if their behaviour is one that should cause society concern. If they are a consenting adult with full capacity, the activities they engage in for fun should be no concern of ours. If they are suicidal it would be acceptable to intervene and assist if possible in helping the person find ways of making life worth living again. Consider also the person with Chronic Obstructive Pulmonary Disorder (CoPD), who can barely walk 100yds without becoming very breathless, has a zest for life and happy personality but smokes like a chimney, fully aware that they are killing themselves. This scenario is slightly clouded by the issue of addiction, but why is this person more acceptable socially than the one who cuts their arms in order to cope with the stress of their job?

At what point does plastic surgery become destructive? When the silicone from the implants leaks? When the rat poison injected into the face prevents an expression? When the fat injections make the lips look like a fish pout? This brings up the issue of personal values too, I would consider injecting poison into myself completely unacceptable but I have had plastic surgery to correct the damage done to my stomach following childbirth. What is or is not acceptable varies for person to person, culture to culture and completely depends on time, context and intent. We can only comprehend these things if we are able to talk

about them and take an interest in the person rather than judging actions or behaviours.

Understanding that self-harm has been present in our society for centuries if not longer (Favazza, 1992), practices we may consider culturally unacceptable now were common place at other points in history eg. self-flagellation for atonement of sins, puts things into a wider perspective where the hysteria surrounding self-harm begins to seem a little unnecessary. The idea that self-harm can be a creative behaviour may be difficult to swallow, but those who have successfully used cutting or burning to help them stay alive may disagree.

I have always liked tattoos. Using the skin as a blank canvas for expression makes perfect sense to me. Having been through a traumatic relationship breakdown, in 2010 I felt it was time to get the tattoo I had been promising myself for 5 years. I knew what I wanted, so made the appointment and gave the studio my design. On the day I was nervous, I knew I wasn't good with pain and wondered how it would all go. There was a feeling of rebellion as I sat in the chair, my ex was anti women having tattoos so there was a feeling that I was giving him the finger just by being there. The transfer was on, it looked great, I knew it was going to be good and I steeled myself for the first needle prick. The outline was not as bad as I had expected, but the shading of the colours, with needles going back and forward over already damaged skin, was agony. I was resisting the urge to pull away all the time, I was allowing myself to be harmed. There was a conflict there. I talked to the artist about his experiences and about my research and he said he had tattooed many people who he felt used tattooing and piercing as a legitimate way to harm themselves. The pain was intense for nearly an hour but the experience of resisting the urge

to pull away and coping despite the pain was a very powerful one. Once it was done I felt elated, it looked (and still looks) beautiful and I knew I had made the right decision. I felt I had turned over a new leaf in the chapter of my life and the tattoo expressed this. Whenever I see it I feel good about myself, it is a representation of the struggles I have overcome over the years and a celebration of the person I am now, despite the pain. I was struck by the commonalities here with the way some people who self-harm talk about it as a physical representation of their emotional pain, a coping strategy, a way of staying alive and the way scars can remind them of the pain they have survived and journey they have made (Tantum & Huband, 2009). The tattoo provided a powerful release of emotional pain and a rite of passage for me, it is a fine line between harm and healing.

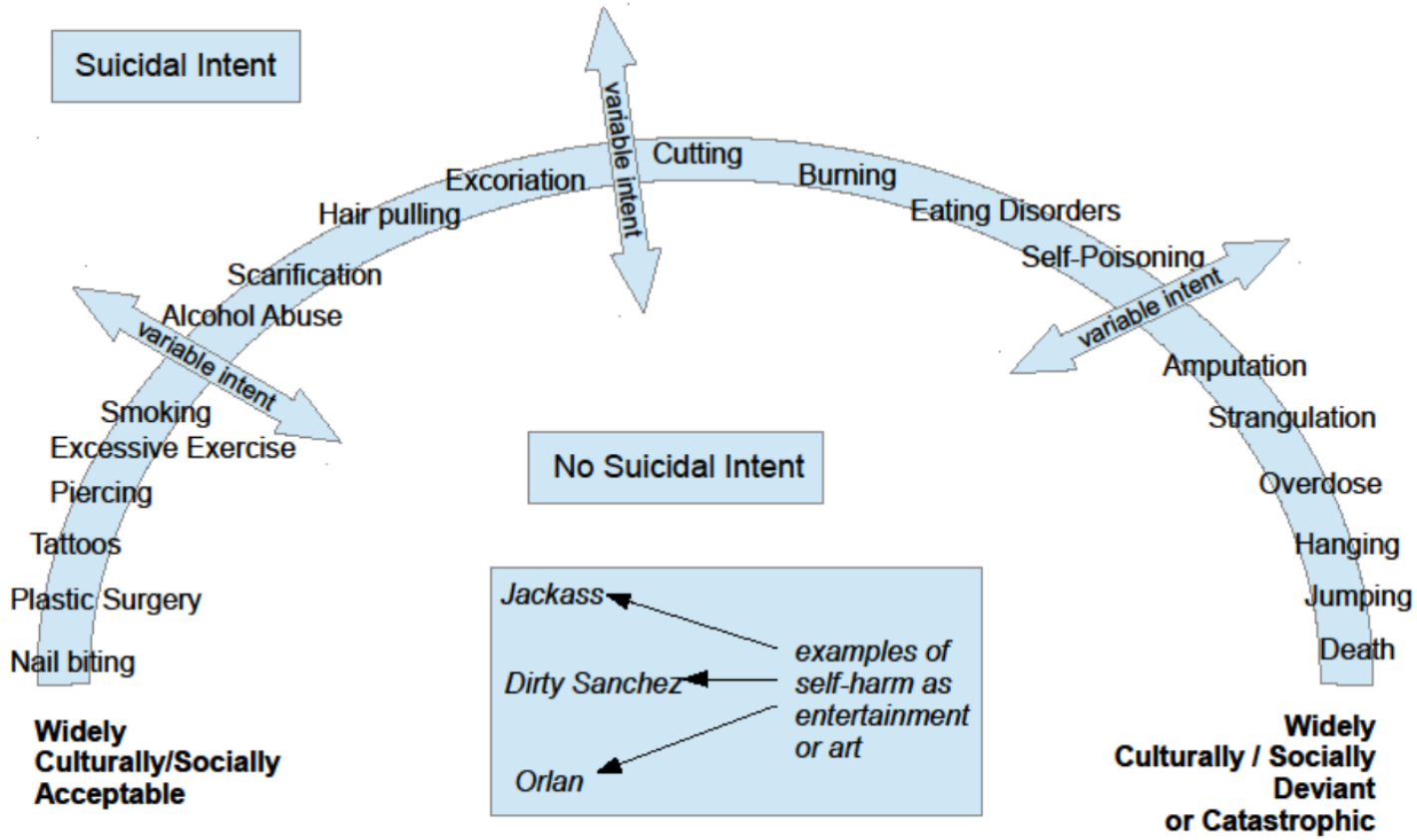
When I set out to write this chapter I wasn't entirely sure what my aims were, having written it, one aim is clearly to broaden the thinking around self-harm from being dysfunctional to being something that has actually been part of our culture for as long as we have and that this link to culture may hold the key to reducing stigma and increasing understanding. Primarily though, I want to encourage all to look behind the act to the person behind it and discover more about them. It is my contention that self-harm is becoming and will continue to become more socially acceptable and recognised as a legitimate coping mechanism. If this is the case, then harm minimisation strategies, such as those suggested by Pembroke (2007) will become essential in order to avoid unnecessary disability. Pathologising every behaviour our society finds disturbing is an expensive and unnecessary route to go down. Only by finding out about the person do we discover what they need, what the self-harm means

for them and if intervention is required or not. The emotional distance of diagnosis and stigmatisation of self-harm only keep the uneducated in a state of ignorant bliss. The challenge to us all is to connect with each other and accept that we are as gloriously different in our modes of expression as we are in our dress sense!

2346 words - main text only.

(Walker, 2013)

Appendix B Self-Harm Spectrum Diagram



Self-Harm Spectrum (Fig.1)

NB. This list is for illustrative purposes and non-exhaustive

Appendix C Consultation ethics email

Re: Consultation presentation
NAME Removed
To:
Cameron S.C. (NB this was my married name at the time now reverted to maiden name)

15 February 2010 10:24

Dear Sandra
you are right, as this stands no ethical review is necessary - it's an example of good practice ie involving clients in research design - which reminds me, you might want to take a look at the INVOLVE website. Of course, you will need ethical review before undertaking the actual study
best wishes
Name removed

>>> "Cameron S.C." <scc2g09@soton.ac.uk> 14/02/2010 22:01 >>>

Dear Name Removed ,
Having written this now I am pretty sure it will be ok to do this without ethical approval but would be very grateful if you could cast a quick eye over it to make sure. It is only 6 slides long and bullet pointed as I can't stand too much info on the wall and like to use it rather like large prompt cards, but the essence is there.
I have been invited to the service user's own meeting that they have every month and should be attending in May. I shall encourage feedback live during the presentation but will also provide post-its to put on large papers with headings of question, study outline, outcomes and patient engagement so that those who do not want to speak in front of the crowd can do so that way. I shall also hang about afterwards to allow 1:1 conversation and there will be the email method for those who have gone away and thought about it and may have something to add.
I will also have details of services they can use should anyone indicate that they are feeling a bit ropey as a result of the subject matter, although as you can see I do not intend to go into that in any detail really just to talk about approaching people who are in crisis and the best way to do that.
Thanks so much for your time I really appreciate it
best wishes
Sandra Cameron

Appendix D Involving People who Self-Harm in Research Design

The Journal of Nursing Research

Involving People who Self-Harm in Research Design

--Manuscript Draft--

Manuscript Number: JNR-D-15-00177

Full Title: Involving People who Self-Harm in Research Design

Article Type: Brief Report

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Title: Involving People who Self-Harm in Research Design

Abstract

Background (背景) and Purpose (目的)

In the UK, the expectation is that service users be involved in mental health research. This report outlines the process involved in exploring with a group of service users a proposed research project being carried out as part of a doctoral pathway into the experiences people admitted with self-harm had of contact with mental health services whilst in a general hospital.

Methods (方法)

A consultation event was held where the researcher outlined the proposed format of the project, the expected aims and outcomes. The group were asked

to consider validity of the question being asked and to consider questions they felt needed to be asked as part of the process.

Results (結果),

The research question was amended in light of the consultation and the research methodology was influenced by the process. Some interesting linguistic points were noted as part of the consultation which has not been previously expected.

Conclusions / Implications for Practice (結論/實務應用)

Although the process was time consuming in terms of set up, it was immeasurably valuable in adding real world value to the project and ensuring that the research outcomes would be more likely to be meaningful to both service users and professionals alike.

Introduction

Service User (SU) involvement is increasingly recognised as being central to health and social care policy and practice (DoH, 2005), education (Speers & Lathlean, 2015) and research (Lieba, 2010). Wallcraft (40 2012) points out that historically, mental health research has mainly ignored the views of the recipients of care and that the SU's subjective experience is often transformed into some kind of quantitative measure of observed behaviour. This is supported by Speers & Lathlean (2015) who add that SUs have invaluable insights to offer into both the conditions they have and their experience of using services. Involve (2012) assert that SUs offer different perspectives and priorities which can enhance the validity of the research and that they are often empowered by taking part in the process. Beresford (2005) defines a SU as a person who is 'on the receiving end or eligible to receive health and social care services.' Leiba (2010) states that it is essential to involve SUs as early as possible in the design and planning of research as they can have a real impact on the direction of the research and ensure that it remains valid from a SU perspective. In view of this and the discussion above, as part of the research design, a SU consultation was carried out. It was ascertained, via an email to

the head of the local regional ethics committee prior to this event, that ethical approval was not required to carry out this consultation.

Methods

The group was comprised of 8 current and ex SUs (2 male and 6 female) who had all had experience of self-harm and psychosocial assessment whilst in a general hospital. Volunteers for the consultation were recruited via the local SU Involvement Worker, via regular local SU meetings and via posters, email and word of mouth. The reason for the consultation was to do the following:

- Explore whether the research question was valid and worth asking
- Ascertain what questions they felt were important to ask the research participants

It was hoped that this consultation would ascertain if the group felt the research idea was valid from their perspective. The research idea was presented to them via a short PowerPoint presentation during which they were invited to interrupt and ask questions at any point. Tea and coffee was provided and the atmosphere was informal throughout. The meeting took place in a local community centre in a room regularly used for SU events, in this setting an informal discussion regarding the research and their views took place. The group were also provided with the opportunity to respond via suggestion slips and email in case they were unhappy to speak in front of others. No one required this and in the event all were happy to speak.

The short PowerPoint presentation shared the proposed research question; the study outline as seen at this time; potential outcomes; requests being made of the volunteers and the researcher contact details to enable further communication should it be required.

Results

Prior to the consultation the research question was as follows:

How do adult SUs, admitted following self-harm, and clinicians experience the psychosocial assessment in a general hospital setting?

The term psychosocial assessment is used extensively throughout nursing and social sciences literature and guidance without any clear definition (NICE,

2011, Hawton et al 2006), it appears to be an umbrella term used to describe an information gathering exercise which may or may not have therapeutic intention. As part of this process the term was explored since the intention was to include it in the question schedule.

'What does psychosocial assessment mean to you?'

One of the main findings of the consultation was that the term 'psychosocial assessment' meant nothing to the group and required explanation before any further conversation could usefully continue. On exploring this further, it emerged that the word 'psychosocial' was dismissed as meaningless. They had no preconceptions of what this was, therefore did not have any strong feelings. They asked for an explanation of the term and in discussing this it became clear that the processes they had experienced that were labelled psychosocial were very different depending on where they had been seen.

The most surprising outcome of the consultation was discovering that the term 'assessment', in contrast to the dismissal of the word psychosocial, had many different and complex meanings for the group. The general consensus was that the term 'assessed' meant being judged with regard to whether the person is 'good enough', 'mad' or 'needing hospital', and being 'tested'. The word was universally disliked but no one could think of a better word to use. This group were of the general opinion that the assessment is primarily service driven and has little to do with SU need.

Having to explain and clarify terms during the research interview could influence participant views and potentially weaken the SU perspective, so the term 'Psychosocial Assessment' was removed from the question and participant information paperwork.

It was considered by the group, and is supported by literature (Mackay & Barrowclough, 2005. McHale & Felton, 2010.), that the views of practitioners in this context had often been sought and therefore there was little reason to repeat this. The group could see no valid reason for inclusion of staff perspectives in this research but clearly stated that they felt that the views of SUs in crisis were vastly underrepresented. In light of this the question was changed to its final form:

How do people who have self-harmed, experience contact with mental health services in a general hospital?

'What should I ask the research participants?'

The group were also asked to consider questions they thought it would be pertinent to ask of the research participants. During this discussion several points were raised, the importance of good communication and the relationship between practitioner and SU were discussed in some detail. The group felt it was essential that the practitioner endeavoured to see the situation from the SUs perspective and stated that the process of assessment was transactional. They described the experience of assessment as often invalidating, particularly if the assessor is unable to stop their own values impacting on the outcome of the assessment and they felt that it was important that questions were framed positively. They suggested the question 'Would you seek help here again?' the implication being that a positive experience would be most likely to generate an affirmative response, so this was added to the question schedule as a prompt to use if the participant was struggling to create narrative without prompting.

Discussion

From the discussions above it became clear that the group felt the need for the issue of SU perspective during assessment to be important. This position is echoed throughout policy literature nationally (DoH, 2001, 2005) in all aspects of mental health recovery, service delivery and research. At the stage of the consultation the research methodology had not been decided, but this emphasis on the perspective and experience of the individual was instrumental in the decision to use Interpretative Phenomenological Analysis (IPA) as the framework for this project.

Reid et al (2005) state that one of the key elements of IPA is that it is an inductive approach that aims to discover and then explore the meanings assigned to experiences by the participant. This approach is now increasingly used in health and social sciences (Smith et al, 2009). Group members were clear that each person views the world from their own perspective and so judges others experiences and could come to conclusions that would be valid for them but not valid for others. This happens in a reciprocal way in the

assessment process however, the group pointed out that the clinician has a responsibility, in an assessment scenario, to 'enter into' the world of the SU so as to be able to assist them in finding solutions that would be valid for the SU. They described this as a highly validating experience. This description of the ideal assessment scenario is echoed by the principles of IPA and as such this methodological paradigm was adopted.

Summary

A summary of issues that demonstrate the impact of this consultation on this proposed research is as follows:

1. It influenced the methodology – Interpretive Phenomenological Analysis (IPA) – this was guided by the desire to see the situation from the SU perspective

2. The original intention to include clinician's views was dropped

3. The question was reformulated

4. Suggested question to be included in the interview schedule when written

This report has described the process of a SU consultation carried out to inform the development of a research project exploring the experiences people who self-harm have of contact with mental health services within a general hospital. Whilst the exercise of setting up the consultation was time consuming, the overall effect was considerable and valuable both to the validity of the project and to the methodological decision making that form an essential part of the research process.

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Appendix E Search Terms

Search Terms Used
Self-Harm
Self-Mutilation
Suicide
Psychosocial assessment
Mental Health Services
User Experience
Patient experience

NB: The term Self-Injurious-behaviour was not used as this term is almost exclusively used in Learning Disability Services and as such the research would fall outside of the remit of this study.

Boolean operator ‘or’ and wild cards were used to explore additional versions of search terms and ‘and’ to combine search terms and narrow the field.

Appendix F Critique table

Number	Year & area of study	Author(s) & Title	Study description, sample, methods	Key findings
1	2013 (UK)	Hunter et al SU perspectives on psychosocial assessment following SH and its impact on further help-seeking: A qualitative study	Qualitative study IPA of semi-structured interviews 13 SU participants ≤3months post incident QSR NVivo7 analysis software 198 invited to participate only 13 interviewed Adults only 7 follow up interviews also conducted	Function of psychosocial assessment unclear Seen as a routine part of hospital care +ve aspects of assessment; legitimation of distress; someone to talk to with alleviates distress and aids recovery of self-worth; inspiring hope for change -ve aspects of assessment; felt shamed and judged; cycle of referral increased hopelessness; struggled to be heard or believed Unclear follow up arrangements Stagnation – little or no change following assessment Interactions with staff shape help-seeking intentions
2	2001 (Aus)	Pirkis et al Self reported need for care among persons who have suicidal ideation or	Quantitative study Survey Data taken from the Australian National survey of MH and wellbeing Clustered probability sampling	Suicidal individuals have a range of needs Those with suicidal ideation had more perceived needs that non-suicidal individual Some who had attempted suicide perceived no needs More than half the respondents who attempted

		who have attempted suicide	245n of which 37 attempted suicide Analysed using SUDAAN7.5.3	suicide or had suicidal ideation had not had their needs met by the service
3	2006 (UK)	Eales et al SUs and other stakeholders' evaluation of a liaison MHS in an A&E department and a general hospital setting	Qualitative study 47 semi-structured interviews 17 Sus & 30 staff Random sampling People with experience of inpatient and A&E care Used NUD*IST software Thematic content analysis Study design extremely unclear would be difficult to replicate	SU themes – Practicalities – Waiting times; Environment; 1st experience of MHSs; another perspective, advice and other ideas Staff themes – Need for MH training; Receiving the service allowed an opportunity to talk Most SUs reported negative experiences of assessment due to brevity and lack of questions regarding background information Outcome – people wanted more information regarding local services and follow up.
4	2002 (UK)	Smith SE Perceptions of service provision for clients who self-injure in the absence of	Qualitative study Thematic content analysis Unstructured interviews View of staff main focus of study (n13) SU participants (n3 all female) with experience of self-injury	SU results – Talking helps; no one asked about the reason for the SH; restrictive ward environments increased desire to SH; Believed they were seen as failures and 'naughty children' Staff results – treatment of people who SH depends on attitude of person caring; generally view people

		expressed suicidal intent		who SH negatively; Not knowing what to do for them; Anxiety regarding SH act; wanted more training; Not knowing what to do to help so distance selves Dynamics of Government directives and service interact catching the patient in the middle
5	2011 (UK)	Cooper et al 'Well it's like someone at the other end cares about you.' A qualitative study exploring the views of users and providers of care of contact-based interventions following SH	Qualitative Study Purposive sampling Semi-structured interviews with SUs Focus groups with staff plus some interviews Thematic Analysis 11 SU interviews Focus group 8 staff 2 staff interviews Data coding used NVivo 7	Proactive, early and genuine intervention most helpful, genuine and sincere Results focus on provision of a letter as a form of support.

6	2002 (UK)	Warm et al Who helps? Supporting people who SH	Quantitative study Internet Survey 243 responses from people who SH 205 Female, 34 male, 4 not specified Chi-square analysis Forced choice responses to questionnaire Questions formulated from contemporaneous extant medical literature Responses from US (133), UK (50), Aus (20), Can (16), other (19)	Medical professionals and nurses rated as least satisfactory in responding to SH SH specialists provided most support 73.3% of respondents had sought help from professionals Recommended training for professionals
7	2009 (UK)	Taylor et al Attitudes towards clinical services among people who SH: A systematic review	Systematic review of mixed quantitative and qualitative research 31 studies included	Despite country of origin, needs of people who SH were remarkably similar Lack of staff knowledge regarding SH Poor communication between staff/patient PA needs improving Access to aftercare often poor Patient involvement in treatment and aftercare rated highly as important Many individuals still not receiving PA and when they do it is often superficial and rushed

8	2007 (UK)	Hume & Platt Appropriate interventions for the prevention and management of SH: a qualitative exploration of service- users' views	Qualitative study Semi structured interviews Grounded theory, thematic analysis 14 patients who had SH Adults 8 male and 6 female Quota sampling 17 asked, 14 interviewed	Heterogenity in the sample was noted, the needs of the individual are important in the management of SH Interventions were preferred where the patient retained some control, including repeating SH Community based care was preferred Those with alcohol problems in addition to SH appeared to be more dissatisfied overall Study did not ask about PA
9	2007 (UK)	Palmer et al Better Services for People who Self-Harm: Key Findings from 2 Baseline Audits. London: Royal College of Psychiatrists' Research and Training Unit. 2007.	National improvement programme audit hosted by the Royal College of Psychiatrists	Pts were involved in designing, bid writing, steering, carrying out the project, advising, consulting and working with and training staff ¾ of teams classified pt involvement as very helpful Sharing of power is necessary and success of project often depended on this. Improvements were not always made or sustained.
10	2005 (UK)	Sinclair & Green Understanding resolution of deliberate SH: qualitative interview study of patients' experience	Qualitative study 20 participants, 8 male 12 female Purposive sampling QSR NVivo software used In depth interviews Thematic and narrative analysis	Resolution of SH was related to: resolution of adolescent crisis; regaining some control in the family situation; leaving home where invalidating experiences were found. Participants described wanting someone to hear and validate their distress They found engaging with a potentially helpful but

				new relationship in the assessment difficult Assessment was seen as something that had to be agreed to in order to be allowed home and often did not match their needs at the time Alcohol was a factor in the SH for many SH was seen as a consequence of illness and once the illness had gone SH stopped SH was the trigger for getting help in this cohort
11	2004 (Finland)	Suominen et al Patients' evaluation of their psychiatric consultation after attempted suicide	Quantitative study Systematic sample of consecutive cases 114 age 15 upwards Comprehensive interview of 424 questions Included Becks suicidal intention scale; hopelessness scale and depression inventory 73 of the 114 had received psychiatric consultation 52 evaluated it using a structured schedule, Only answers available were yes, no, don't know Multiple statistical models applied and compared	Most had positive attitudes to psychiatric consultation Only point of contention from the study was that it was felt that the consultations took place too soon after the event
12	2004 (UK)	National collaborating Centre for Mental Health	Guidelines Policy document Covers the period 48 hours after SH Tokenistic inclusion of pts on the development	Very clearly states all patient should be offered a full PA following SH States that users experience of care is often unsatisfactory

		SH: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care	panel User experience of care guidance based only on good practice points not robust research Age 8 upwards	Calls for high levels of communication skills and for staff to have regular clinical supervision Suggests the use of patient narrative Individualised care and Involving patients in decision making.
13	2011 (UK)	National collaborating Centre for Mental Health SH: Longer term management	Guidelines Policy Document Included several first-hand accounts More meaningful patient involvement Clear outline of the process of research analysis and critique	Guidance regarding assessment content unchanged from 2004 No longer recommending use of risk assessment tools routinely Information about professional attitudes to people who SH and users experience of services has not been updated
14	2006 (US)	Cerel et al Consumer and family experience in the ED following a suicide attempt	Mixed methods Anonymous web-based survey, Adults 465n 49 questions yes/no and 1 open ended question 'what was helpful or hurtful' about the ED experience Non-specific statistical analysis software used Free text thematically analysed iteratively and by consensus	47 positive comments mainly around being emotionally comforting, 15 neutral comments 490 negative comments. Main themes: Unprofessional behaviour; Being unvalued as a person; Feeling lonely or ignored; Suicidal feelings not taken seriously; Waiting times too long.

Appendix G Participant Information Sheet

Project Title: How do patients who have self-harmed, experience contact with mental health services in a general hospital?

Ethics Submission No: 13/SC/0446 this study has been reviewed and approved by the Hampshire B Research Ethics Committee.

My name is Sandra Walker and I am a PhD student at Southampton University carrying out a research project as part of my studies. I have been a mental health nurse for over 24 years and now work at the University of Southampton as a lecturer in mental health.

You are being invited to take part in this research study. Before you decide if you would like to take part it is important that you understand why the research is being done and what it will involve. Please read the following information and discuss it with others if you wish. If anything is not clear and you would like more information please contact the researcher whose details are at the end of this leaflet.

Thank you for reading this.

What is the purpose of the study?

The purpose of this study is to find out what contact with Mental Health services is like for people who have self-harmed. The National Institute of Clinical Evidence provided guidance in 2004 that told services that all patients that come to the Emergency Department following self-harm should have contact with Mental Health Services. This decision was based on expert opinion and not on research evidence, so we do not know how good an idea it was.

Why have I been invited to take part?

You have been invited as you have attended the Emergency Department following self-harm and have been seen by a Mental Health Team within the last 3 months.

Appendix G

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. However, you will still be free to withdraw at any time and without giving a reason. A decision to withdraw or not to take part will not affect any care you have been offered or are receiving in any way.

What will happen to me if I take part?

If you decide to take part your contact details will be shared with me (the researcher) and I will arrange an appointment with you at a time convenient to you. This appointment will take the form of an interview where I will ask you about your experience of contact with mental health services. The interview will take place in a private room, either at the hospital or at the university, according to your preference. Before the interview, I will go through this leaflet with you and if you are happy to take part you will be asked to sign 2 copies of the consent form. You will keep one copy and the other is for our records. The interview is likely to last about 1 hour but could be longer than that and will be recorded.

What do I have to do?

You do not have to do anything except attend the interview and talk about your experience of contact with the mental health team who saw you.

What are the possible disadvantages and risks of taking part?

There are very few disadvantages to taking part. As stated the interview will be recorded to help with the analysis. If you are unhappy with this then you should not agree to take part. If you say anything to the researcher that indicates you might need further medical help, the researcher may have to pass this information to your GP. In the unlikely event that you become distressed and need to take a break at any point of the interview that will be possible. It must also be stressed that the intention of the research is to investigate your experience of the assessment and not to revisit the events that led up to your being in hospital at the time.

What are the possible benefits of taking part?

There is no intended benefit to you from taking part in this study. We plan to use information to develop and improve the care we offer to patients who have self-harmed and subsequently attend the Emergency Department, so your input may benefit other patients.

What happens when the study stops?

The study will be complete within 18 months of the date of commencement ……. The results of the study will be analysed and written up.

What if something goes wrong?

If you agree we will phone you two weeks post interview to follow up and to check if you have noted any issues following interview. Regardless of this, if you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you. This study does not involve any treatment so the risk of anything going wrong is extremely small.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it. You GP will be informed by letter that you have agreed to take part in the research study but will not be told any details about it. If any information is shared that is criminal or indicates serious risk to you or others I am bound, under the Nursing and Midwifery Council Code of Conduct (2008) to disclose this.

What will happen to the results of the research study?

When all the data are analysed the study will be written up for publication in a number of health service research journals. It will not be possible to identify you from these written reports. If you are interested in receiving a copy of the final report please let me know and it will be sent to you. Your data will be stored in a secure place and will be destroyed after writing up has taken place. We will also use the data to review and change the services we provide. This

study forms part of the work I am carrying out to gain a Doctorate in Clinical Practice so the results will be written up to form my thesis.

Who is organising and funding the research?

This research has being jointly funded by Solent Healthcare NHS Trust and Southampton University. The researcher is currently employed by Southampton University.

Can I claim travel expenses?

We will pay for travel expenses to and from the venue if you take part in the study.

Who has reviewed the study?

This study has been peer reviewed by senior academics at the university and approved by the Hampshire B Research Ethics Committee.

Contact Details

Investigator: Sandra Walker
PhD Student
Direct tel: +44 (0)23 80597897
email: scc2g09@soton.ac.uk

Lead Supervisor: Dr Joanne Brown
Senior Lecturer
Direct tel: +44 (0)23 80598304
email: j.c.Brown@soton.ac.uk

Southern Health Research lead : Dr Martina Prude
Address Building 37, room 4055
University of Southampton
University Road, Southampton
Post Code SO17 1BJ
Email: M.A.Prude@soton.ac.uk
Telephone 02382595058
Fax 02380595781

Appendix H Gatekeeper Information

NB. This form is to be read in conjunction with the Participant information leaflet and the Recruitment flow chart which are attached.

You are inviting patients to take part in a research study. This study is called:

How do patients who have self-harmed, experience contact with mental health services in a general hospital?

Your main roles are to:

Identifies potential participants who have had contact with mental health services following self-harm

Assesses capacity for consent and interview as per normal ED procedure

Give recruitment paperwork and administer consent form

Copies of paperwork to be kept on file

Email Sandra Walker scw1y10@soton.ac.uk to alert to the potential participant.

Sandra will then attend the department and collect the information in person.

These are the inclusion and exclusion criteria to help you decide who to invite to take part in the study.

Inclusion	Exclusion
Male and Female Over 18s Patients who have self-harmed (Using the criteria outlined by NICE, 2011) Patients who have undergone a 'psychosocial assessment' during their admission carried out by a mental health team Patients able to give informed consent	Children and young people under 18 Patients who are sectioned under the mental health act after being recruited but prior to the interviews will be excluded due to capacity issues Patients with organic brain disorders. Patients who are acutely psychotic when attending for interview Patients unable to give informed consent

If you need any further information please contact Sandra Walker 02380597897 or email me on the above address.

Appendix I Consent to share details form

Centre Number:

Study Number:

Patient Identification Number for this trial:

Gatekeeper CONSENT FORM

Title of Project: How do patients who have self-harmed, experience contact with mental health services in a general hospital?

Name of Researcher: **Sandra Walker**

Please initial all boxes

I agree to the researcher being given my contact details and understand that they will contact me as soon as possible. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

I confirm that I have been given the Participant Information Sheet [V4] and understand that the researcher will explain this to me in full and answer any questions when we meet. ☐

Participant details.

Name: _____

Address: _____

Telephone: _____

Email:_____

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Gatekeeper	Date	Signature

Appendix J Main Consent Form

Centre Number:

Study Number:

Patient Identification Number for this trial:

CONSENT FORM

Title of Project: How do patients who have self-harmed, experience contact with mental health services in a general hospital?

Name of Researcher: **Sandra Walker**

Please initial all boxes

I confirm that I have read and understand the information sheet dated 20/04/2013 (version 4) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

I understand that the interview will be recorded and transcribed for analysis . ☐

I agree to my GP being informed of my participation in the study. ☐

I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent.	Date	Signature

Appendix K Themes for Participant 1

Theme	Key cross references (Paragraph)	Indicative Quotes	Notes
Barriers *	2,9,10,11,12,17,21,22,23,24,34	'builds up that barrier' – P9 'Mental Blockade' P10 & P34 'Shields just went up' – P11 'Mental block and shields up' P21 'bit of a mental blockage' – P22 'break down those barriers' P22	*Many of the other themes in this interview could fit under this heading. There were barriers on both sides (from his description). Most of his imagery was used around this subject
*Being Judged**	2,11,12,17,29,32,34	'People are judging you' P2 'reassure me that they weren't judging me' P12 'going to get judged' P32 'you feel like a bit of judgement is coming in.' – P32 'Don't want them to judge you' P34 'You may not think it majorly' P29	Last one is an example of him judging others P29
*Reliving the state of mind	1,4,5,8,10,15,22,26,29,32,34	'makes you rethink about everything' – P1 'the way you were thinking at the time' – P1 'Remember what frame of mind you're in' –P8 'trying to find that frame of mind is quite difficult' –P5 'A bit of fear that a similar situation could happen again' – P26 'Same frame of mind when you do what I did' – P34	There was a clear fear that revisiting his state of mind could lead to a repeat of the situation (SH)

*Not being listened to/heard leading to invalidation **	6,7,8,9,28,29,30,31	'asked a question; I would answer it and then it felt like they got side-tracked into a different part they wanted to explore' – P6 'Completely dropping the conversation' – P8 'I've answered all their questions, and just come away with nothing new.' – P28 Medication eg in P33	Related to not telling the full story Left him feeling worse than he had before the interaction
**Answering questions Truthfully ** **	3,24,32,33,34	'An interrogation' – P3 'Not going to let everything out' – P24 'Not allowing them to do their job' – P34 'you don't want to tell them the truth because you're scared of the consequences.' – P32 'You're going nowhere and you're just trapped.' – P33 'Avoiding the question' – P34	**This is affected by many other themes He realises the limitations of this course of action wrt getting the help he needs
*Identity – Not being a natural talker	2,11,21,22	personally I found it quite awkward' – P2 'The only people I would really talk to would be' – P11 'I don't usually like to talk to people.' – P21 'I don't usually go into, like, a talkative, emotional …' – P22	This felt like a big risk for him, to talk to someone so the resulting lack of help and understanding would have been more damaging.
*Attitude of MHPs**	9,11,12,23	'quite straight to the point' – P9 'seemed kind of down' – P9 'their mood, or something, at the time just didn't sit well with me.' – P11 'an interrogation or an interview' – P23	Not just restricted to talking about his current experiences here Compares this MHP to the counsellor he sees in the community – P9

*Past experiences **	9,17,24,28,33	'worried how this situation would affect my life' – P17 'Better than sitting there not saying anything, and not getting the help that you need' – P24 'I've had like a lot of experiences with mental health teams where I've gone there um, I've answered all their questions and just come away with nothing new.' – P28	As already has counsellor and psychologist Suggests he has done this before. ?Self-fulfilling prophecy

Appendix L Extract from Reflexive Dairy

interview this phone call was unnecessary. He said he'd had no ill effects from the interview + would like to see the accessible summary once the research is finished

1st hearing 19/6/14

Wish for transformation/personal experience slow measured speech, really thinking deeply about what he said + seemed to be choosing his words carefully. Does this echo with his description of answering the question re being likely to sit again? Pg 15. It's like he's assessing the likely outcome a response his words may get before saying them. Rewriting his thoughts before saying them aloud.

Post coding (P+I) thoughts. 20/7/14

I am feeling somewhat overwhelmed by the amount of information I have to work through from just this one interview. I feel really stressed out! Don't know where to start writing it up/down. I think I need a plan to help:-

Briefly notes on: - Patterns/themes
- Conflicts
- Essence
- Images + metaphor.

List key themes - table
- ID data extracts

Name themes

Take home message for each theme

Appendix M Draft GP letter

Faculty of Health Sciences

Southampton University
Building 67
University Road
Southampton
SO17 1BJ

GP address
GP address
GP address

Date

Dear Dr [name],

Ref: Pt name and Dob

I write to inform you that ********* has been interviewed as part of a research study the details of which are as follows.

Ethics Ref. No :

Centre Number:

Study Number:

Title of Project: How do patients who have self-harmed, experience contact with mental health services in a general hospital?

Name of Researcher: Sandra Walker

Yours sincerely

Sandra Walker
Researcher
Mental Health Team
Faculty of Health Sciences
Southampton University

Appendix N R&D Permission Letter

Southern Health NHS
NHS Foundation Trust

Research and Development Department
Moorgreen Hospital
Tom Rudd Unit
West End
SOUTHAMPTON
SO30 3JB

Tel: 023 8047 5373
Fax: 023 8047 5188

www.southernhealthft.nhs.uk

20 November 2013

Sandra Walker
12 Elson Lane
Gosport
Hants PO12 4ET

Dear Sandra

Study Title	**How do patients who have self-harmed experience contact with mental health services in a general hospital?**		
REC Reference	**13/SC/0446**	**Trust Project N°**	**SHT102**
Protocol N°	**Version 9 dated 6 October 2013**		

This letter provides the formal Southern Health NHS Foundation Trust approval required for your project to commence. Details of information that the R & D Office will require during the period of your research can be found within the enclosed researchers pack. Your project is now registered on the R&D database with identification number **SHT102.** It would be helpful if you could use this number on all correspondence with the R & D Office.

Please note that this trust approval (and your ethics approval) only applies to the current protocol. Any changes to the protocol can only be initiated following further approval from the ethics committee via a protocol amendment; the R&D office should be informed of these changes.

This approval is conditional on members of the research team either being substantively employed by the Trust or having appropriate Honorary Research contracts in place before they start data collection. Please contact the R&D Department to confirm requirements for any new members of the research team.

This letter confirms that University of Southampton will act as Research Sponsor and will provide indemnity under arrangements for potential liability of harm to participants arising from the design and management of the research.

In the event that this study is adopted to the UKCRN Clinical Research Portfolio, may we take this opportunity to remind you of your responsibility for uploading accrual data for the research site. If you have any difficulty with this process please let us know.

We would like to remind you that as Principal Investigator you are responsible for ensuring that the study is conducted within the Research Governance Framework (RGF) and we encourage you to become fully conversant with the RGF Health and Social Care document. Any breaches of the RGF constitute non-compliance with the RGF and as a result Trust approval may be withdrawn and the project suspended until such issues are resolved

It is the responsibility of the R&D office to monitor all research taking place within Southern Health NHS Foundation Trust. Please visit the Trust website to ensure that you are familiar with our policies and procedures.
http://www.southernhealth.nhs.uk/research/conducting-in-research/

Please do not hesitate to contact us should you require any additional information or support. May I also take this opportunity to wish you every success with your research.
With best wishes

Yours sincerely

Director of Research & Development

INVESTOR IN PEOPLE

Trust Headquarters, Sterne 7, Sterne Road, Tatchbury Mount, Calmore, Southampton SO40 2RZ

Appendix O Ethics Approval Letter

NHS
Health Research Authority

NRES Committee South Central - Hampshire B
Bristol REC Centre
Level 3 Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT
Telephone: 0117 342 1384
Facsimile: 0117 342 0445

15 October 2013

Ms Sandra C. Walker
Senior Teaching Fellow
Southampton University
B67, Faculty of Health Sciences
Southampton University, University Road
Southampton, Hants
SO17 1BJ

Dear Ms Walker

Study title: **How do patients who have self-harmed, experience contact with mental health services in a general hospital?**
REC reference: **13/SC/0446**
Protocol number: **4909**
IRAS project ID: **124390**

Thank you for your letter of 14 October 2013. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 01 October 2013

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Evidence of insurance or indemnity		05 August 2013
Participant Consent Form	4	06 October 2013
Participant Consent Form: Consent to Contact	4	06 October 2013
Participant Information Sheet	6	06 October 2013
Protocol	9	06 October 2013

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Evidence of insurance or indemnity		30 July 2012
Evidence of insurance or indemnity		05 August 2013

A Research Ethics Committee established by the Health Research Authority

Appendix O

NHS
Health Research Authority

GP/Consultant Information Sheets	3	06 August 2013
Investigator CV	Sandra Walker	
Investigator CV	Joanne Brown	09 January 2013
Investigator CV	Ruth Bartlett	
Participant Consent Form	4	06 October 2013
Participant Consent Form: Consent to Contact	4	06 October 2013
Participant Information Sheet	6	06 October 2013
Protocol	9	06 October 2013
REC application	124390	06 August 2013
Referees or other scientific critique report		12 November 2012

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

13/SC/0446 **Please quote this number on all correspondence**

Yours sincerely

Libby Watson
REC Manager

E-mail: nrescommittee.southcentral-hampshireb@nhs.net

Copy to: *Martina Prude, University of Southampton*
Ms Penny Bartlett, Southern Health NHS

A Research Ethics Committee established by the Health Research Authority

Appendix P Annotated Analysis note –Participant 1

Felt she needed support at home. Someone to be there if the thoughts + urges to sh came back. Needed someone – to talk to – to go to.

Panicked. Asked husband to intervene. Discharged. No longer her responsibility.

Unacceptable. This reinforced the belief that she didn't care – No compassion – No empathy. Increased risk.

Talking to her MHP felt she'd given up on her. Why do the job if you don't care. Why bother? Expectations.

but I didn't really felt that I was ready to be on my own in the world, alone, and in a sense I now … and it's … not explaining myself quite well, but I felt like I needed some support while I was all, I was at home, and I needed someone to be there to … in case if I felt … I had those thoughts and urges to do something else like that again, and I needed somebody to talk to and somebody to go to.

And when I was told that um, there really wasn't a care plan I, I panicked and I didn't know what to do, and… and then I … tsk, I asked my husband if he could um, talk to the, to the doctor and talk to this lady, and um, he talked to her and basically um, what she said straight up, um, as far as she knew, because I was discharged um, even though there was no care plan, um, it was no longer her responsibility.

And I, I … in hindsight now, um, I think that this was completely not acceptable, and completely out of order, and my previous thought that I had at the time when I was speaking to her in that room, I was right – she really didn't care; she had no compassion and she was just like, Oh here's this leaflet, here's a couple of numbers, go on your way. I was 100% right. And I thought, Do you actually even have any idea what people um, go through? Are you human?

Yeah, I understand maybe you're like fed up of listening, but she didn't listen; she didn't ask me one single question; she didn't care; she wasn't bothered. I know I gave up, but … it would have been nice … I mean if, if that service is there then maybe … I mean if you, if you're not gonna care and you're not gonna do your job, then don't, don't, don't even bothering that service, just, just forget about it, you know, just, just leave it, don't worry.

'On my own in the world' leading up we're alone. Can't trust herself. Needed another to help moderate her thoughts + urges.

Expectation on not – the care plan wasn't recognised = fear. Passivity with powerful husband. The MHP didn't assess or recognise the CP? washed hands of her.

looking back unacceptable at the time wasn't accepted? Can't the MHP walk in other shoes? SH is not lightly done people are in distress. Anger.

MHP job to not give up on those who may have given up. Hold the hope. Pointless having a service there if it isn't caring about the people it serves.

INTERVIEW - 2. 20.05.14 3

Appendix Q Integrative Analysis of SOT

SOT / Participant	Internal Barriers to getting the help you need				The Business of being Human			Traumatising Environment			Patient Power		
LOT	Being a Non-Talker in a talking encounter	'Emotions run high'	Guilt & shame	Re-living trauma – 'I'd already told'	'A person looking after another person'	Stigma – 'An aberration?'	Perceived Judgement	Physical Space	Systems Driven Care	The Assessment – Helpful or Traumatic?	You scratch my back, I'll scratch yours	Expert by Experience	'You don't want to lie to them yet you don't want to tell them the truth .'
Dave	x	x		x	x	x	x	x	x	x	x		x
Fran		x	x	x	x	x	x	x	x	x	x		
Jane		x	x	x	x	x	x	x	x	x	x	x	
Alex	x	x		x	x		x		x	x	x	x	x
Jim	x	x	x			x	x	x	x	x	x		
Seth	x	x		x	x		x		x	x	x	x	
May		x	x		x					x	x	x	
Fred	x	x		x	x	x	x	x	x	x	x	x	x
Alan	x	x	x	x	x		x			x	x	x	
Ann		x	x	x	x	x	x	x	x	x	x	x	x

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