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**EXPLORING THE KNOWLEDGE AND
SKILLS OF EMERGENCY DEPARTMENT
ADVANCED CLINICAL PRACTITIONERS
WHO ASSESS AND TREAT CHILDREN
PRESENTING WITH SELF-HARM**

A PHENOMENOLOGICAL STUDY

JANET YOUD

**A THESIS SUBMITTED TO THE UNIVERSITY OF
HUDDERSFIELD IN PARTIAL FULFILMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF NURSING**

THE UNIVERSITY OF HUDDERSFIELD

SUBMISSION DATE: MAY 2019

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Abstract

Self-harm is an increasingly prevalent occurrence amongst young people, with rising numbers presenting to emergency departments (EDs) each year. Due to medical workforce challenges, growing numbers of Advanced Clinical Practitioners (ACPs) are now assessing and treating these young people, yet the educational requirements necessary to prepare them for this undertaking are not defined.

The purpose of this study was to explore the experience of ACPs, to determine the specific knowledge and skills they use in their practice. Employing a hermeneutic phenomenological approach, in-depth interviews were conducted with a purposive sample of eight clinicians from three English NHS Trusts. Participants included: ACPs, Paediatric Emergency Medicine (PEM) Consultants, a Paediatric Emergency Nurse Consultant and a specialist Child and Adolescent Mental Health Service (CAMHS) practitioner; all of whom had experience of seeing children with self-harm.

Template analysis of the transcripts resulted in the finding of two important integrative themes: Engagement, and Risk Assessment. The knowledge and skills associated with these themes were deemed pivotal to the effective care of children who have self-harmed. They enabled the assessment, and directed interventions pertinent to five elements of practice: 'Looking for Injuries or Potential Poisoning'; 'Pursuing Safeguarding and Social Concerns'; 'Interpreting Emotional State'; 'Identifying Suicidal Intent'; and 'Deliberating Professional Practice Issues'.

Congruent with existing literature, all clinicians reported a lack of formal training specific to the care of children who have self-harmed. This lack of training was attributed to the participants' varying opinions about elements of the risk assessment, particularly regarding the impact of a child's maturity on their risk. It was also attributed to practitioners being unaware of the need to use a validated alcohol screening tool with this client group.

Despite the lack of training, the experience of participants resulted in their pursuit of a range of safeguarding concerns, assessment of mood, and overt enquiry about suicidal ideation, in the assessment of young people. These practices were well supported by the literature. However, the ED clinicians were unaware of child psychological development principles, such as attachment theory; the knowledge of this was deemed important for the assessment of parental support and family relationships, which influence further influence risk.

There was a universal perception that a young person's engagement in the clinical consultation represented a lower risk of immediate harm. Conversely, young people who were unable or unwilling to engage, were perceived to be at higher risk. No evidence was found to confirm or refute this opinion.

Further analysis of the data revealed an emotional impact on clinicians who engage with these young people and their families. Therefore, opportunities to debrief and regular access to clinical supervision are recommended, to facilitate learning from incidents and protect emotional well-being.

Whilst most previous studies have recommended 'training' per se for ED clinicians who assess and treat young people who self-harm, this study has resulted in specific recommendations for ACP education, based on the knowledge and skills required to initiate engagement and conduct an overall risk assessment of a young person. These should be considered when any curricula are developed or revised for these health professionals, and be subject to further scrutiny in order to evaluate any clinical or professional benefit.

Acknowledgements

Firstly, acknowledgement must go to the participants of this study who willingly gave their time to share their experiences. Without them there would be no study.

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My gratitude also goes to my fellow students, colleagues and friends, for understanding when times were tough, and always being there for support. You know who you are.

Finally, I dedicate this work to my amazing family, for tolerating days (and weeks) of my disappearance. I could not have done this without you.

To Catherine and Henrietta, you will be pleased to know mummy will now be there for you, in both mind and body, not merely in the house on the computer.

To Chris, thank you for the times you have been both mum and dad to our girls, for the fine meals you have provided, and for encouraging me all the way. Hopefully you will be pleased to have your wife back.

<u>Contents</u>	<u>Page</u>
List of Figures	14
List of Tables	15
List of Abbreviations	16
Glossary of Terms	19
Chapter One: Introduction and Background	22
1.1 Introduction	22
1.2 Advanced Clinical Practice in Emergency Departments	23
1.2.1 Emergency Department Pressures	23
1.2.2 Advanced Clinical Practitioners as a Solution to Workforce Pressures	23
1.2.3 The History of Advanced Clinical Practitioner Development in English Emergency Departments	24
1.2.4 The Work of Advanced Clinical Practitioners in Emergency Departments	29
1.2.5 Focus on Competence	29
1.3 Adolescent Self-harm Presentations to the Emergency Department	31
1.4 The Development of the Study Focus	33

Chapter Two: The Literature Review	35
2.1 The Literature Search Strategy	35
2.1.1 Inclusion and Exclusion Criteria	36
2.1.2 Summary of the Literature Search Results	37
2.2 The Literature Search Results	38
2.2.1 Professionals' Attitudes	38
2.2.2 Patient Experience	48
2.2.3 Staff Education	50
2.2.4 Clinical Management	53
2.3 Identification of the Knowledge Gap	56
Chapter Three: Developing the Research Question and Methodology	58
3.1 Developing the Research Question	58
3.1.1 The Final Research Questions	58
3.1.2 Intended Purpose of the Study	59
3.2 Methodology	59
3.2.1 Ethnography	59
3.2.2 Grounded Theory	60
3.2.3 Phenomenology	61

3.2.4	Epistemological Position	63
3.3	Reflexivity 1	64
3.4	Ethical Considerations	65
3.4.1	Informed Consent	66
3.4.2	Protection of Participants	66
3.4.3	Confidentiality and Anonymity	67
3.4.4	Researcher Safety	67
Chapter Four: The Research Design		68
4.1	The Research Method	68
4.1.1	Interviews as a Research Method	68
4.1.2	Other Methods of Data Capture Considered	70
4.1.3	The Sample Selection	70
4.1.4	Planning the Interviews	74
4.1.5	Interview Transcription	75
4.1.1	The Pilot	75
4.2	Quality Assurance	77
4.3	Data Collection	79

Chapter Five: Data Analysis Method	81
5.1 Template Analysis	83
5.1.1 Developing the Template	84
5.1.2 A Priori Themes	84
5.1.3 Summary of Analytical Interventions to Develop the Final Template	85
5.1.4 The Initial Template	86
5.1.5 The Second Template	88
5.1.6 The Final Template	90
Chapter Six: Findings	92
6.1 Ordered Themes	93
6.1.1 Looking for Injuries or Potential Poisoning	93
6.1.1.1 Wound Management	93
6.1.1.2 Overdose Management	94
6.1.2 Pursuing Safeguarding and Social Concerns	95
6.1.2.1 Child Sexual Abuse and Exploitation	96
6.1.2.1.1 Alcohol and Substance Misuse	98
6.1.2.2 Bullying	99
6.1.2.2.1 Social Media	99

6.1.1.2.2	School	100
6.1.1.3	Support	101
6.1.2.3.1	'Should Parents Stay or Should They Go?'	102
6.1.2.3.2	Looked-After Children	103
6.1.2.3.3	Attachment Theory	104
6.1.2.4	Boyfriend/Girlfriend Issues	105
6.1.3	Interpreting Emotional State	105
6.1.3.1	Mood Assessment	107
6.1.3.1.1	Cooling-Off Period	107
6.1.3.2	Maturity Assessment	108
6.1.3.2.1	Child Development Theory	109
6.1.3.3	Physical Appearance	110
6.1.3.3.1	Body Language and Behaviour	110
6.1.3.4	Environment of Assessment	112
6.1.4	Identification of Suicidal Intent	113
6.1.4.1	Repeat Attendance	114
6.1.4.2	Planning, Method and Preparedness	115
6.1.4.2.1	'Help Seeking' Behaviour	116

6.1.5	Deliberating Professional Practice Issues	116
6.1.5.1	Scope of Practice	117
6.1.5.1.1	Personal Scope of Practice	117
6.1.5.1.2	Role Specific Scope of Practice	118
6.1.5.1.3	Service Provision	119
6.1.5.2	Lack of Formal Training	122
6.1.5.2.1	Reflection and Emotional and Clinical Supervision	124
6.1.5.3	Maturity of the Clinician	125
6.1.5.4	Gender of the Clinician	126
6.1.5.5	Time Pressure	126
6.1.5.6	Identification of the Cause of Self-harm	129
6.2.5.6.1	Information gathering	129
6.2	Integrative Themes	130
6.2.1	Risk Assessment	130
6.2.2	Engagement	132
6.3	Summary of the Findings	137

Chapter Seven: Implications of the Findings and Discussion	140
7.1 Discussion Related to the Integrative Themes	140
7.1.1 Exploring the Concept of Engagement	141
7.1.1.1 Definition of Engagement	142
7.1.1.2 Attributes of Engagement	142
7.1.1.3 The Use of Engagement in the Context of the Study	143
7.1.1.4 Antecedents and Consequences of Engagement	144
7.1.1.4.1 Antecedents	144
7.1.1.4.2 Consequences	145
7.1.1.5 Concepts Related to Engagement	146
7.1.1.6 The Implications of Engagement for the Study	147
7.1.2 Exploring the Concept of Risk Assessment	148
7.1.2.1 Definition of Risk Assessment	148
7.1.2.2 Attributes of Risk Assessment	150
7.1.2.3 The Use of Risk Assessment in the Context of the Study	150
7.1.2.4 Antecedents and Consequences of Risk Assessment	151
7.1.2.5 Concepts Related to Risk Assessment	151
7.1.2.6 The Implications of Risk Assessment for the Study	152

7.2	Discussion related to the Ordered Themes	153
7.2.1	Looking for Injuries or Potential Poisoning	153
7.2.2	Pursuing Safeguarding and Social Concerns	155
7.2.2.1	Child Sexual Abuse and Exploitation	156
7.2.2.2	Bullying	157
7.2.2.3	Alcohol and Substance Misuse	158
7.2.2.4	Parental Support	160
7.2.2.5	Social Media and the Internet	163
7.2.2.6	Looked-after Children	163
7.2.2.7	Safeguarding Interventions	165
7.2.2.8	Summary of Discussion Relating to Pursuing Safeguarding and Social Concerns	166
7.2.3	Recognising Emotional State	166
7.2.3.1	Mood Assessment	167
7.2.3.2	Maturity Assessment	169
7.2.3.3	Physical Appearance	171
7.2.4	Identification of Suicidal Intent	171

7.2.5	Deliberating Professional Practice Issues	173
7.2.5.1	Scope of Practice	174
7.2.5.2	Lack of Formal Training	175
7.3	Limitations	176
7.4	Reflexivity 2	176
7.4.1	Clinical Practice	176
7.4.2	Education	177
7.4.3	Research	177
7.4.4	Leadership	178
	Chapter Eight: Recommendations and Conclusion	179
8.1	Recommendations	179
8.1.1	Recommendations for Policy	179
8.1.2	Recommendations for Education	180
8.1.3	Recommendations for Practice	183
8.1.4	Recommendations for Research	184
8.2	Conclusion	185
8.2.1	Final Reflections on the Study Process	186
	References	188

Appendices	202
Appendix 1. Details of Literature Identified through Search Process	202
Appendix 2. Indicative Interview Guide and Questions	206
Appendix 3. Background Information Sheet	208
Appendix 4. Consent Form	210
Appendix 5. Health Research Authority Decision Document	211
Appendix 6. Evidence of School Research Ethics Panel Approval	212
Appendix 7. Evidence for Thematic Identification	213
Total Word Count: 49953	

List of Figures

Figure 1. Page 85. Summary of Analytical Interventions from Identification of A Priori Themes to Production of the Final Template.

List of Tables

Page

Table 1. Summary of Literature Search Outcomes	37
Table 2. A Priori Themes	84
Table 3. Initial Template	86
Table 4. The Second Template	88
Table 5. The Final Template	90
Table 6. Recommendations for Policy	179
Table 7. Recommendations for Education	180
Table 8. Recommendations for Practice	183
Table 9. Recommendations for Research	184

List of Abbreviations

ACP	Advanced Clinical Practitioner
ADSHQ	Attitudes towards Self-Harm Questionnaire
ANP	Advanced Nurse Practitioner
AHP	Allied Health Professional
AUDIT	Alcohol Use Disorders Identification Scale
AYP	Attitudes to Young People Scale
AYPSH	Attitudes to Young People who Self-Harm scale
BGS	British Geriatric Society
CAMHS	Child and Adolescent Mental Health Service
CNO	Chief Nursing Officer
CYP-MH SAT	Children and Young People Mental Health Safety Assessment Tool
CSE	Child Sexual Exploitation
ECA	Emergency Care Association
ED	Emergency Department
ENB	English National Board
ENP	Emergency Nurse Practitioner

GP	General Practitioner
HEE	Health Education England
IPA	Interpretative Phenomenological Analysis
IRAS	Integrated Research Application System
MAU	Medical Assessment Unit
MTS	Manchester Triage System
NHS	National Health Service
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
PEM	Paediatric Emergency Medicine
PGD	Patient Group Direction
RCEM	Royal College of Emergency Medicine
RCN	Royal College of Nursing
RCP	Royal College of Physicians
RCS	Royal College of Surgeons
RMN	Registered Mental Health Nurse
RSQ	Risk of Suicide Questionnaire

SAM	Society for Acute Medicine
SHAS	Self-Harm Antipathy Scale
SOQ	Suicide Opinion Questionnaire
SREP	School Research Ethics Panel
UK	United Kingdom
USA	United States of America

Glossary of Terms

Advanced Clinical Practitioners (ACPs): The Royal College of Nursing (RCN) defines the level of practice within which ACPs work as encompassing the following:

- making professionally autonomous decisions, for which they are accountable
- receiving patients with undifferentiated and undiagnosed problems and making an assessment of their health care needs, based on highly-developed nursing knowledge and skills, including skills not usually exercised by nurses, such as physical examination
- screening patients for disease risk factors and early signs of illness
- making differential diagnoses using decision-making and problem-solving skills
- developing with the patient an ongoing nursing care plan for health, with an emphasis on health education and preventative measures
- ordering necessary investigations, and providing treatment and care both individually, as part of a team, and through referral to other agencies
- having a supportive role in helping people to manage and live with illness
- having the authority to admit or discharge patients from their caseload, and refer patients to other health care providers as appropriate
- working collaboratively with other health care professionals and disciplines
- providing a leadership and consultancy function as required

In practice, the term Advanced Nurses Practitioner (ANP) is often used to describe the ACP role when the individual has a professional nursing background as is commonly the case. However, it is recognised that there are many ACPs working in emergency care settings who have a paramedic or other allied health professional base registration, hence the generic term ACP will be used throughout this thesis.

Children/Child: Young People aged below 18yrs of age.

Clinician: For the purposes of this study, this term refers to any health professional who has an autonomous, diagnostic role, and is able to prescribe management plans and treatment for patients. This includes ACPs, ANPs, doctors and other specialist practitioners, but excludes general nurses or emergency nurses who are not ACPs or ANPs.

Knowledge: Facts and information acquired through experience or education; the theoretical or practical understanding of a subject (Oxford Dictionary, 2012).

Looked-After Children: Children who are subject to local authority care. Often these children have been removed from the parental home and are living in foster care or a local authority care home.

Skills: Capacity to accomplish successfully something requiring special knowledge or ability; a technique acquired through training or experience (Reader's Digest 1984). It is recognised there are other definitions of 'skills' in more reputable dictionaries. However, this definition most accurately reflects the use of the term in the context of this study.

SADPERSONS (risk assessment tool): This is a risk assessment tool that was widely used in emergency departments for use with adults who have presented with self-harm conditions. It is an acronym of the criteria which are thought to be correlated with increased risk of future self-harm or suicide, and subsequently assigned a score from which a total risk score can be quantitatively calculated:

- Sex (Males 1, Females 0)
- Age (15-25 or 59+ score 1)
- Depression or Hopelessness (Score 2)
- Previous Suicide Attempts or Psychiatric Care (Score 1)
- Excessive Alcohol or Drug use (Score 1)
- Rational Thinking Loss (score 2)
- Single, Widowed, or Divorced (Score 1)
- Organised or Serious Attempt (Score 2)
- No Social Support (Score 1)
- Stated Future Intent to harm? (Score 2)

Evidence has demonstrated this tool is neither sensitive nor specific in identifying people who are risk of future self-harm or suicide and should not be used in clinical practice (Katz et al., 2017).

Self-harm: Deliberate self-poisoning or self-injury, irrespective of the apparent purpose of the act (excluding body piercing, tattooing or repetitive injuries from activities such as head banging by young people with learning disabilities) (National Institute for Health and Clinical Excellence, 2004).

Chapter One: Introduction and Background

1.1 Introduction

This study originated from my interest in both the professional nursing development of advanced clinical practitioners (ACPs) in emergency care, and the clinical topic of adolescent self-harm. I have worked as a nurse, registered to work with both adults and children, in emergency care settings for over twenty five years, and been employed as an Emergency Nurse Consultant in a North of England district general hospital for sixteen years.

From clinical experience, the increasing prevalence of self-harm amongst teenagers presenting to the emergency department (ED) had become apparent. Through discussion with colleagues, and my role as Chair of the Royal College of Nursing (RCN) Emergency Care Association (ECA), I became increasingly aware of the challenges this client group can bring to nursing professionals in the ED.

Having completed an MSc in advanced clinical practice in 2006, I chose to undertake a professional doctorate in 2012 to further my professional academic development. During the taught element of the course I refined the focus of the study by exploring strategic policy drivers, alongside a concept analysis into suicide risk assessment. I also used the work to contribute to the National Institute for Health and Care Excellence (NICE) Quality Standard for Self-Harm as a topic expert (National Institute for Health and Care Excellence, 2013).

This thesis is the culmination of that professional doctorate journey and chronicles the processes of the study design, execution and outcomes. In order to demonstrate the extent of personal growth, investment and integration in the study, the text has been written in the first person where appropriate.

1.2 Advanced Clinical Practice in Emergency Departments

1.2.1 Emergency Department Pressures

The National Health Service (NHS) was a significant campaign focus in the United Kingdom general elections of both 2015 and 2017, as well as the referendum on membership of the European Union in 2016. In addition, the so called “crisis” in emergency care has received much political and media attention, both as part of these campaigns and subsequently (Blunt, Merry, & Edwards, 2015; Campbell, Morris, & Marsh, 2017; Cordery, 2014; Donnelly, 2017; The King's Fund, 2017). The four-hour emergency care standard (Boyle, 2016) often described as the ‘Four-Hour A&E target’, has been used as a barometer of pressure in the entire health and social care system (Campbell, 2017; The King's Fund, 2017).

During 2017, the NHS witnessed the worst performance against this standard in a decade (The King's Fund, 2017). The government determined that the majority of NHS trusts would return to achieving this standard by 2018 (NHS England, 2017). At the time of writing, this has not yet been achieved; January 2018 saw performance fall further than that of winter 2016/17, with the national average for patients being admitted or discharged within four hours below seventy five percent (NHS England, 2018).

1.2.2 Advanced Clinical Practitioners as a Solution to Workforce Pressures

One reason cited for EDs failing to achieve the standard, was the absence of sufficient senior clinical decision-makers to see patients in a timely manner (House of Commons Health Committee, 2013). Traditionally senior decision-makers were doctors on specialist emergency medicine training programmes, or emergency medicine consultants. In 2015, the College of Emergency Medicine reported that in some regions, up to fifty percent of training posts, and up to nine percent of consultant posts were vacant (The College of Emergency Medicine, 2015). This resulted in a reliance on locum medical personnel, particularly out of hours and

at weekends. The use of locum and agency staff present huge clinical safety risks for patients and financial risks for NHS trusts (Cordery, 2014; Donnelly, 2015; Hughes, 2014).

One suggested solution to the medical workforce shortage is the employment of ACPs in EDs, to function in roles traditionally undertaken by doctors (Calkin, 2012; The College of Emergency Medicine, 2015).

1.2.3 The History of Advanced Clinical Practitioner Development in English Emergency Departments

Through the 1990s, ED nurses began to expand their roles beyond that of traditional nursing, both as a response to meeting clinical needs of patients, and as a way of career progression. Initially the expansion was very much skills based, focusing on tasks such as suturing, that were traditionally the domain of doctors.

The next development, in the mid-1990s, saw the introduction of nurses requesting investigations, such as x-rays, for patients prior to being seen by medical staff in order to expedite their journey through the department.

Further development took place with the introduction of the Emergency Nurse Practitioner (ENP) role. These nurses predominantly saw patients with minor injuries, and for the first time had diagnosis as part of their role; albeit that treatment relied on the use of Patient Group Directions (PGDs), since legislation did not allow for independent nurse-prescribing at the time. These nurses often worked to strict protocols, with specific inclusion and exclusion criteria dictating which patients they were permitted to see. The detail of the protocols varied by department, as did training provision; some nurses had a two-week, in-house education, others were educated to degree, and some to Master's level through higher education institutes.

In an attempt to standardise education and practice, the English National Board for Nursing (ENB) developed a course specifically for emergency nurse practitioners; the A33 Autonomous Practice Course. As the ENP title was not regulated, there was no mandate for hospital trusts to adopt the course, and huge variation in education and job descriptions continued. This standard course ceased to exist with the abolition of the ENB in 2002. Despite this, the expansion of the nursing role in emergency care continued and was given credit for significantly reducing waiting times in EDs (Alberti, 2004).

The title Advanced Nurse Practitioner (ANP) started to appear in emergency care in the early 2000s. More recently the title Advanced Clinical Practitioner (ACP) is used to represent both nurses and other Allied Health Professionals (AHPs) working in roles traditionally undertaken by doctors (Royal College of Emergency Medicine, 2015).

Over the past decade, interest has increased both nationally, and internationally, in the role of the ACP in emergency care (Considine et al., 2012; Griffin & McDevitt, 2016; Hoyt et al., 2010; Smyth & McCabe, 2017; Wolf, Delao, Perhats, Moon, & Carman, 2017). As the international context of advanced clinical practice is very different to that of England, with the majority of countries having legally defined boundaries of practice and regulation of the title, the literature reviewed in relation to the ACP role was mostly confined to British publications for the purposes of this thesis.

A study by Griffin and Melby (2006) argued the role lacked clarity, giving rise to confusion about titles, role boundaries, clinical accountability and educational requirements. However, their study concluded that attitudes of both medical and nursing staff were positive towards development of the role.

In 2010 the Department of Health (2010) defined advanced nursing practice to clarify the advanced practitioner role: "A registered nurse who has command of an expert knowledge base and clinical competence, is able to make complex clinical decisions using expert clinical

judgement; s/he is an essential member of an interdependent health care team and his/her role is determined by the context in which s/he practices". It was this definition that was used when this study began in 2012.

Despite the Department of Health's (2010) advanced practice definition the preceding year, McMurray (2011), demonstrated that little progress had been made in clarifying the confusion cited by Griffin and Melby (2006). He attributed this to the fact that, in England, the title is unprotected in legal terms, leaving the task of defining what it is that advanced nurses 'do', in terms of health care, to individual nurses, who must attest to their own training, practice scope and competence.

McMurray observed advanced practitioners to be a sub-set of the nursing profession moving in clinical terms to be equivalent to that of doctors, crossing the '*cherished jurisdictional boundary of the right to diagnose*' (McMurray, 2011, p. 808), but in professional terms to be of unequal status, remaining sub-ordinate; arguing that their development is 'permitted' by the medical profession purely due to lack of capacity of doctors to respond to the clinical demand, despite having often attained a higher academic level of education (Master of Science), than their medical counterparts (Bachelor of Medicine).

In 2012, the RCN (Royal College of Nursing, 2012) produced a guide for ANPs, endorsing the Department of Health (2010) definition. Whilst this guide was not specific to those nurses working in EDs, it enabled higher education institutes to have advanced practice programmes accredited with the RCN, although individual accreditation was still not possible.

In 2014, Adkins, Trivedy, and Stanhope (2014) surveyed the clinical leads (all doctors) of the Major Trauma Centres of England to establish whether ACPs formed part of the Major Trauma Team in their departments, and if so, in what capacity. Their results revealed that the majority (76%) thought ACPs should be part of the team, but their role within the team varied widely, with only 50% using ACPs for clinical assessment, the remainder using them for traditional

nursing roles. Of the clinical leads, 35% felt that the barriers to inclusion on the major trauma teams included rota capacity, whilst 68% thought clinical ability and training was a barrier. Only 55% of respondents felt they fully understood the role of the ACP. This survey corroborated the findings of previous studies, signalling continuing confusion about the role, and medical dominance of its implementation (McMurray, 2011).

Despite the continuing confusion and uncertainty, the ACP role was endorsed by both RCEM and Health Education England (HEE) in 2015, when a Curriculum and Competency Framework for Advanced Clinical Practitioners in Emergency Care (Royal College of Emergency Medicine, 2015) was produced.

The employment of ACPs in EDs over the past four years has begun to proliferate. My own department has had an increase in employed ACPs from two to eight. In 2017, a publication by NHS Improvement (NHSI) (2017), which was designed to improve acute hospital patient flow, specifically stated: *"The deployment of advanced clinical practitioners in emergency departments is strongly encouraged (they may come from a range of professional backgrounds including nurses and allied health professionals – for example, paramedics and physiotherapists)"* (NHS Improvement, 2017, p. 27). This publication was produced in collaboration with, and endorsed by, The Royal College of Physicians (RCP), The Royal College of Surgeons (RCS), The Royal College of Emergency Medicine (RCEM), The Society for Acute Medicine (SAM), and The British Geriatric Society (BGS), but surprisingly not the Royal College of Nursing (RCN). Yet nursing remains the largest base profession of ACPs. Evidence suggests ACPs make safe clinical decisions, using both analytical and intuitive decision-making techniques in determining clinical care (Smyth & McCabe, 2017).

HEE produced an updated definition of advanced practice (Health Education England, 2017) to supersede the previous one from the Department of Health (2010), and reflect the multi-professional nature of advanced practitioners. They state: *"Advanced Clinical Practice is delivered*

by experienced registered healthcare practitioners. It is a level of practice characterised by a high level of autonomy and complex decision-making. This is underpinned by a Masters level award or equivalent that encompasses the four pillars of clinical practice, management and leadership, education and research, with demonstration of core and area specific clinical competence. Advanced Clinical Practice embodies the ability to manage complete clinical care in partnership with patients/carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance patient experience and improve outcomes.” (Health Education England, 2017, p8). It is this new definition that is referred to throughout this thesis when the term Advanced Clinical Practice is used.

Whilst the title remains unregulated, the RCEM, (one of the first medical royal colleges to include other professionals in its membership, albeit as associates), began credentialing nurses who had successfully completed their curriculum in 2015. This was followed by the RCN in 2017. Nurses who demonstrate that they work to an advanced level, incorporating the four pillars of practice into their work: clinical expertise, leadership, education, audit and research, are able to be credentialed (Royal College of Nursing, 2017). They state that advanced practice is characterised by the following principles:

- Autonomous practice
- Critical thinking
- High levels of decision-making and problem-solving
- Values-based care
- Improving practice

Whilst the ACP role has undoubtedly developed during the progress of this study, it remains to be seen whether the latest RCN (2017) and HEE (2017) guidance has any influence on the confusion surrounding this role, or whether the title ever becomes regulated, and if so by whom. However, strategic publications (Health Education England, 2017; NHS Improvement, 2017) would suggest the role is likely to expand in EDs, and thus warrants further research.

1.2.4 The Work of Advanced Clinical Practitioners in Emergency Departments

ACPs in emergency care are able to look after patients with a wide range of pathologies from the self-limiting to the life-threatening:

- They are able to identify the critically ill and injured, providing safe and effective immediate care.
- They have expertise in resuscitation and are skilled in the practical procedures needed.
- They establish the diagnosis and differential diagnoses rapidly, and initiate or plan for definitive care.
- They work with all the in-patient specialties as well as primary care and pre-hospital services.
- They are able to correctly identify who needs admission and who can be safely sent home.

(Royal College of Emergency Medicine, 2015).

In my emergency nurse consultant role, I have worked to the advanced clinical practice standard since completing my Master's Degree, which included the qualification for independent prescribing, in 2006. I thus have personal insight into the challenges and rewards it can bring. I also bring my personal experience to this study.

1.2.5 Focus on Competence

Alongside the development of ACP roles, there has been increased focus on the competence of clinical staff in England, resulting from the publication of the Francis Inquiry into the serious failings at Mid Staffordshire NHS Trust (Francis, 2013). Furthermore, as an immediate prelude to the publication of the Francis Inquiry, the Chief Nursing Officer (CNO) for England published a strategy for nursing, known as the '6Cs' (Cummings & Bennett, 2012). This strategy explicitly named 'Competence' as one of the six vital components of nursing practice.

The concept of competence is defined as having 'adequate skill or ability' (Oxford Dictionary, 2012). I would argue that skill alone is insufficient for ACPs to be competent in their autonomous roles. They need to be evidence-informed practitioners or 'knowledgeable doers' (McSherry, Simmons, & Abbott, 2002), in order to appreciate when to apply the skills, and when those skills may need modification.

A Master's level education is required for credentialing of ACPs, (Royal College of Emergency Medicine, 2015; Royal College of Nursing, 2017) . Many university Advanced Practice Master's programmes focus on the competence of physical examination techniques and interpretation of the findings (e.g. cardiovascular system or neurological system). However, mental health assessment is not mandatory for completion of the programmes, or for credentialing as an ACP with the RCN. Therefore, the majority of ACPs, like myself, have not had the opportunity to be trained in mental health assessment, as it was not included in the Master's programme. Furthermore, at the time of writing, there was no regulatory requirement to demonstrate competence in either the care of children, or care of patients with mental health problems, to undertake ACP roles in EDs. However, the new NMC standards of proficiency for registered nurses (Nursing and Midwifery Council, 2018) states in standard 3:10 (p15) "...demonstrate the skills and abilities required to recognise and assess people who show signs of self-harm and/or suicidal ideation". This should ensure new nursing registrants from 2022 will have this competence. However, the ACP workforce also comprises allied health professionals to whom these standards do not apply.

Whilst the Nursing and Midwifery Council (NMC) previously published a consultation document on the regulation of ANPs (Scott, 2005), this has yet to be established in the United Kingdom. Even with regulation of the title, the diversity of practice for clinicians in these roles would mean that detailed specification of the clinical content of training is unlikely. Therefore, specialty specific training requirements are likely to continue to be recommended by the specialist royal colleges rather than be subject to statutory requirements.

1.3 Adolescent Self-Harm Presentations to the Emergency

Department

Self-Harm has been described as 'self-poisoning or self-injury, irrespective of the apparent purpose of the act' (National Institute for Health and Care Excellence, 2013). It is an expression of personal distress. Typical self-harm acts include cutting, and ingestion of medication in excess of the therapeutic dose.

The prevalence of self-harm behaviours amongst young people appears to have increased over the past eighteen years. In 2000, Meltzer et al. (2000), suggested between 4.6% and 6.6% of the population had self-harmed. Morgan et al. (2017) reported a 68% increase (from 2011) occurring amongst girls aged thirteen to sixteen years. It is now estimated that self-harm affects between 10-15% of the population in England (Hawton, Bergen, et al., 2012; Morey, Mellon, Dailami, Verne, & Tapp, 2017; Stallard, Spears, Montgomery, Phillips, & Sayal, 2013). Whilst exact numbers of ED attendances for self-harm are unknown, Clements et al. (2016) suggest there could be as many as 205,000 people attending EDs in the United Kingdom (UK) each year following a self-harm episode, with at least 25,000 of those being under the age of 18 years.

It is unclear whether the prevalence is truly increasing, or whether there is improved recognition and reporting of the condition, alongside increased occurrence of young people seeking professional help. These factors may account for the increase in ED attendances, due to public awareness campaigns and strategies to reduce the stigma of the condition by charities such as Mind, whose Royal Family endorsement has increased public awareness of mental health issues (Mind, 2016). Furthermore, true prevalence of self-harm is difficult to assess as studies which examine prevalence rates base their statistics on varied measures; some include use of alcohol or substance misuse as behaviours which constitute self-harm, whilst others do not (Cleaver, 2007).

Despite the uncertainties about accurate ED prevalence of self-harm, there is strong evidence demonstrating a clear link between deliberate self-harm episodes and subsequent completed suicide (Department of Health, 2012; Newton et al., 2010; Victor, Styer, & Washburn, 2015; Westefeld et al., 2010). Cooper et al. (2005) demonstrated that 20-25% of people who died from suicide had a self-harm episode in the year before their death. The latest statistics reveal suicide is now the leading cause of death in the UK for people aged 20-34 years, and the second leading cause of death in children aged 5-19 years (Office for National Statistics, 2015). Thus, appropriate care of young people who self-harm is an important aspect of the current National Suicide Prevention Strategy (Department of Health, 2012).

The first time a young person seeks professional help for self-harm behaviours is often following a crisis when they attend an ED (Olfson, Gameroff, Marcus, Greenberg, & Shaffer, 2005). If the response that young person receives is inappropriate, it can have a lasting negative impact on their future experiences with health professionals, and be detrimental to their recovery from self-harm behaviours (McCann, Clark, McConnachie, & Harvey, 2006).

In July 2013, I was selected to represent emergency nursing on the topic expert reference group for the National Institute for Health and Care Excellence (NICE), who published quality standards for the care of persons over the age of eight years who self-harm (National Institute for Health and Care Excellence, 2013). This group reviewed the evidence available in order to determine care quality standards for this client group. Whilst these standards outline the processes that should be conducted, for example suicide risk assessment, and the environment in which they should occur, they do not specifically state the knowledge and skills required to undertake the processes, as there was absence of evidence to support any such statements.

My experience with this client group has revealed that they can be challenging to care for. They frequently have had more than one previous attendance, which can influence the interaction between the young person and the health professional. Reflection on my practice

has led to an opinion that young people, who are troubled and hurting, often display troublesome and hurtful behaviour. They can be verbally and/or physically aggressive, and appear intimidating to staff and other patients. Their presence may cause much disruption to the day to day running of an ED, which may also be crowded with physically sick patients. Should such disruption occur, the return of the same young person may result in staff anticipating a recurrence of the behaviour, and their reception may be less than welcoming. This negative attitude of ED staff is well documented in the literature (Conlon & O'Tuathail, 2012; Saunders, Hawton, Fortune, & Farrell, 2012; Timson, Priest, & Clark-Carter, 2012).

In the emergency setting, there are often heightened emotions from accompanying family members, and both medical and nursing colleagues have informed me that they are often hesitant to intervene, for fear of saying or doing the wrong thing.

This thesis has already documented how ACPs are now participating in activities previously undertaken by medical staff, including the assessment and treatment of young people who have self-harmed. If ACPs, working in emergency care settings, are to be competent to care for young people who have self-harmed, then an in-depth understanding of the knowledge and skills necessary to undertake this duty is required. Only then can appropriate educational preparation be developed.

1.4 The Development of the Study Focus

Having embarked on the Professional Doctorate programme, I wanted to undertake a study that combined the role of the ACP with children's mental health. In 2012, when this study began, the SADPERSON suicide risk assessment score (Khan, 2011) was widely used in EDs to evaluate the risk of adult patients who presented as a result of self-harm, yet there was no equivalent tool for use with children. At that time, I believed that a solution would be to develop a tool for use with children and use the doctorate study to evaluate its validity.

During the first module I quickly realised that this aspiration was neither feasible, due to the time and resources available to me, nor necessarily clinically desirable. The SADPERSON scoring tool was subsequently demonstrated to be of detrimental clinical value, having neither sensitivity nor specificity in practice (Saunders, Brand, Lascelles, & Hawton, 2014).

Having discounted the development of a tool as a study, I decided to focus on the role of the ACP and children who self-harm. In particular, I was interested in the knowledge and skills used by ACPs to complete a clinical consultation with this client group.

Chapter Two: The Literature Review

2.1 Literature Search Strategy

Having decided to study the knowledge and skills used by ACPs to complete a consultation with a child who has presented to an ED as a result of self-harm, I searched the literature to establish what was already known about the topic. The following databases were accessed to identify relevant literature: Medline, CINAHL, Cochrane, and Psych Info. The results of which are summarised in Table 1 (Section 2.1.2). Articles read in depth also had the references scrutinised to identify any further relevant studies. Throughout the study I periodically re-searched the literature and a final search took place in March 2019 prior to submission of the thesis.

In order to limit the search results to relevant items, the Boolean terms 'OR', and 'AND' were used with the following search terms:

#1- 'self-harm' OR 'self-poisoning' OR 'self-injury'

#2- 'emergency department' OR 'A&E' OR 'accident and emergency'

#3- "child" OR "children" OR "young person" OR "adolesc*" OR "teen*" OR "youth" OR "young people"

#4 - "knowledge" OR "understanding" OR "ability" OR "comprehension" OR "skills" OR "expertise" OR "competence" OR "experience"

#5 - 'Advanced Clinical Practitioner' OR 'Advanced Nurse Practitioner'

When all five searches were combined with the Boolean term 'AND', there were zero results identified on all databases. Therefore, the fifth search was removed and searches 1, 2, 3 and

4 were combined with 'AND' to identify literature relevant to the topic of interest, the client group and the place of care, but recognising the absence of Advanced Clinical Practitioners as the health professional group of interest.

2.1.1 Inclusion and Exclusion Criteria

There were no date restrictions placed on the search in order to prevent elimination of any seminal work. Only scholarly and peer reviewed papers, and those written in English, were included.

Title and abstract screening took place of all the initial papers identified. Papers were excluded from further scrutiny if: their focus was not on self-harm; was outside the ED environment; was adult only focussed; the focus was on specific mental health professionals; or the report was exclusively about self-harm prevalence data or epidemiological statistics. Duplicate papers identified in more than one database were also removed.

See Table 1. for summary of numbers of papers identified and selected from each database.

2.1.2 Table 1: Summary of Literature Search Outcomes

Source	Medline	CINAHL	Psych Info	Cochrane
Number Identified from combining searches 1, 2, 3 and 4.	76	37	27	5 Reviews 11 Trials
Not self-harm focussed	28	8	4	2
Not ED Focussed	5	1	2	1
Adult population only	5	6	0	4
Specialist Mental Health Practitioners	0	1	2	7
Epidemiology or Prevalence Report Only	21	7	7	1
Focussed on specific toxicology treatment	4	0	0	0
Not written in English or Focus non-western population	0	4	2	0
Duplicates removed	0	7	9	0
Subject to Further Scrutiny	13	3	1	1
Papers further identified from reference lists	16			
Total papers scrutinized	34			

See Appendix 1 for references of the specific literature identified by this search strategy.

2.2 Literature Search Results

Whilst no studies specifically focussed on the knowledge and skills of ACPs treating self-harming children, the search identified thirty four papers relevant to the topic of children who have self-harmed and their treatment in EDs (see Appendix 1). Following review, it was established that the papers broadly focussed on four themes; Professionals' Attitudes, Patient Experience, Staff Education, and Clinical Management.

2.2.1 Professionals' Attitudes

Seventeen papers had health professional attitudes as the focus of the study, four of which were systematic reviews. Rayner, Blackburn, Edward, Stephenson, and Ousey (2019), conducted a systematic review with meta-analysis of emergency department nurses' attitudes towards patients who self-harm. Their meta-analysis focussed on five studies, two of them used the Self-Harm Antipathy Scale (SHAS) (Conlon & O'Tuathail, 2012; Patterson, Whittington, & Bogg, 2007) and three used the Attitudes towards Deliberate Self-Harm Questionnaire (ADSHQ) (McAllister, Creedy, Moyle, & Farrugia, 2002; McCarthy & Gijbels, 2010; Perboell, Hammer, Oestergaard, & Konradsen, 2015). This rigorous meta-analysis demonstrated limited empathy and negativity towards patients who self-harm. It should be noted that only one of the five studies included in this meta-analysis was based in the UK (Patterson et al., 2007), therefore the results of the studies conducted in Ireland (Conlon & O'Tuathail, 2012; McCarthy & Gijbels, 2010), Australia (McAllister et al., 2002) and Denmark (Perboell et al., 2015), could have been influenced by cultural differences and not necessarily be representative of UK ED nurses' attitudes. Furthermore, none of the included studies specifically focussed on nurses' attitudes towards children who have self-harmed and thus may not be representative of the nurses caring for this client group. None of the staff identified in these studies were ACPs.

Nineteen international studies on staff attitude to self-harm were evaluated by McHale and Felton (2010) of which eight were identified by the search strategy for this study. These studies were limited to studies of mostly adult populations, conducted across a range of health care settings, and not limited to EDs. McHale and Fenton (2010) used an interpretative thematic approach with content mapping to identify six themes, which contributed to both positive and negative attitude:

- *Education and training needs*

McHale and Fenton (2010) concluded that lack of education was the primary rationale for negative attitudes. This appeared in all the studies they reviewed, with education being seen as a vehicle to promote quality care through positive attitudes due to an increased understanding about self-harm. There was no identification or recommendation for the content of the training within McHale and Fenton's (2010) paper.

- *Role expectation and clinical culture*

This theme emerged from studies on acute medical wards, whereby nurses felt their roles were focussed on giving physical treatment rather than "developing therapeutic relationships" (McHale and Fenton 2010 p736). These nurses believed the busy culture on the ward contributed to challenges in being able to deliver care to patients who self-harm, particularly if they displayed challenging behaviour. It could be anticipated that this culture of a busy environment would be similar in an ED.

- *Perceptions of health needs*

Negative attitudes were reported to be linked with professionals' perceptions of a client's ability to control their self-harm, with repeat client presentations increasing negativity (McHale and Fenton 2010).

- *Knowledge of self-harm*

McHale and Fenton (2010, p737) identified that where positive attitudes were identified, the staff tended to be “knowledgeable about self-harm”. This knowledge was attributed to prior training. They do not specify the content of the training, nor the specific knowledge about self-harm possessed by the staff with positive attitudes.

- *Education and training use*

Scarcity of education and training around self-harm was found to be a key theme in McHale and Fenton’s (2010) thematic review. They cite financial restrictions as a cause of reduced educational provision. They argue that appropriate training must be available for health professionals to positively influence their attitude towards patients who self-harm. Again, they are not specific about the content or learning outcomes needed from appropriate training.

- *Dissatisfaction with care*

Some of the studies analysed by McHale and Fenton (2010) included service users’ perceptions of care. None of the studies reported positive attitudes of health professionals by service users, though some appeared ambivalent or at least not negative. Where service users reported dissatisfaction, this was attributed to service users feeling unimportant to staff, or being spoken to in a derogatory manner. They also had the perception staff did not understand them and deemed them ‘failures’ (McHale and Fenton 2010, p738).

It should be acknowledged that despite this review being limited to adult populations, and not including ACPs, these five themes influencing attitudes may be transferrable to ACPs treating children. However, these themes still do not offer details of the knowledge and skills required

in assessing and responding to the needs of children who self-harm in an emergency department setting.

Seventy three studies investigating staff knowledge and attitudes of self-harm were evaluated by Saunders et al. (2012). Nine of these were also identified in the search for this study. (Papers numbered 6,7,8,11,13,14,15,22 and 25 in Appendix 1). The majority of their included studies were not limited to EDs, or to the care of children. Similar to McHale and Fenton (2010), they revealed negative and even hostile attitudes towards patients who self-harm. Additionally, they also found that general hospital staff were more negative in their attitude than psychiatric staff; this being more prevalent in doctors than nurses. They concluded that active training led to consistent improvements in attitudes and knowledge in all groups. This gave reason to believe that training would positively influence the attitudes of ACPs, being largely from a nursing background, but undertaking a traditionally medical role. Interestingly, only one of the studies they reviewed (Lamb & Mullally, 2006) outlined the content of the training they delivered. This was the Skills Training on Risk Management (STORM) programme delivered over two days. This generic risk assessment and safety planning training is not specifically aimed at health professionals, or staff treating children and young people, so it is difficult to evaluate whether this would be adequate for ED ACPs, or whether additional knowledge and skills are also essential.

A literature review conducted by Clarke, Usick, Sanderson, Giles-Smith, and Baker (2014) used systematic methods to synthesize evidence concerning attitudes of ED professional staff towards those who present with issues related to mental health. They included forty-two papers from ten different countries. They did not specifically focus on self-harm as a presenting complaint, but rather grouped together all presentations which might be indicative of mental health problems. They did not isolate children as a distinct client group in relation to professional attitudes. Four themes emerged from their synthesis: *consumer perspectives of attending ED services; ED staff-reported attitudes and associated influences; the environmental climate of the ED; and interventions which have been used to evaluate change*

in attitudes. Consumer perspectives were mostly gathered from qualitative studies. Similar to the previous reviews, Clarke et al. (2014) highlight negative staff attitudes as experienced by patients. Consumers described a range of negative feelings, which included feeling disrespected or embarrassed due to lack of privacy and confidentiality, and felt that they were punished for self-harming or suicidal behaviours by being made to wait, or being told they were wasting time. The few cases where patients reported positive attitudes appeared when they felt they were treated with empathy and given information and support.

The theme of *staff reported attitudes and associated influences* reflects the findings from the systematic reviews by Rayner et al. (2019), McHale and Felton (2010) and Saunders et al. (2012). Based on the literature reviewed, there is no consistently-found correlation between the age of the clinician or length of clinical experience and the presence of positive or negative attitudes, although some authors found that older ED nurses demonstrated more positive attitudes compared to their younger colleagues (McCann et al. 2006), possibly due to increased length and scope of post-registration and life experience (Friedman et al. 2006).

The *environmental climate of the ED* theme was similar to McHale and Fenton's (2010) theme of *role expectation and clinical culture*. The challenges of delivering care in a fast-paced, noisy environment were thought to contribute to staff feeling they had insufficient time to deliver the care needed, resulting in their being perceived as rushed and reluctant to stay and listen to the patient.

Interventions which have been used to evaluate change in attitudes are almost exclusively related to staff education and training. Contrary to Saunders et al. (2012), Clarke et al. (2014) concluded there is little evidence to support the correlation between education and improved staff attitude. They cite Marynowski-Traczyk and Broadbent (2011) who suggest that without supporting non-mental health staff to appreciate their role within the overall process of the recovery of patients with mental health problems, they are likely to maintain negative

attitudes despite having increased knowledge about any pathophysiology of mental health issues.

A mixed methods study examining staff attitudes towards young people who self-harm (Cleaver, Meerabeau, & Maras, 2014) combined a survey of 143 staff members from four EDs and one ambulance service, with semi-structured interviews of twelve nurses and paramedics from the same localities. The survey used two tools to assess attitudes to young people, the Attitudes to Young People (AYP) scale, and the Attitudes to Young People who Self-Harm (AYPSH) scale. Both these scales were adapted for use in Cleaver et al.'s (2014) study and used as a pilot, since they had not been validated. They identified that nurses and paramedics held more positive attitudes to young people who self-harm, than to young people per se. They found that attitudes were even more positive if the child was of a younger age or appeared immature. The rationale given for this was that health professionals believed younger people were not responsible for their self-harming behaviour. This complements McHale and Fenton's (2010) findings that nurses were more negative towards patients whom they believed could control their behaviour. Although Cleaver et al.'s (2014) study did not include ACPs, and the sample of participants were self-selecting, so may not be representative of the larger population of emergency care personnel, their study does specifically address staff attitudes towards young people in the emergency department, the population of interest for this study.

A qualitative study, using a grounded theory approach to explore nurses' and doctors' perceptions of young people who engage in suicidal behaviour was undertaken by Anderson, Standen, and Noon (2003). They interviewed 45 doctors and nurses from the specialties of paediatric medicine, emergency care and psychiatry. No ACPs were interviewed. Their findings were grouped into two main themes: *Experiences of frustration in practice* and *strategies for relating to young people*. Frustration in practice arose from not having enough time and resources to enhance their relationships with young people. Doctors and nurses also felt that the need to provide treatment to other people, often for a clinical emergency,

influenced their interactions with this client group. This theme was not unique to the ED, but crossed all specialty settings. Participants expressed frustrations about not being able to deliver interventions of therapeutic use to a young person, equating the return of a young person with failure of any previous interventions, resulting in frustration at not being able to help. The category *strategies for relating to young people* was established in relation to how the doctors and nurses explored the nature of skills required to work with young people who self-harm. They articulated a lack of training to be able to care for this client group with some admitting a feeling of incompetence, attributing this to a lack of qualification in mental health nursing. Participants in Anderson et al.'s (2003) study recognised the importance of being able to communicate with young people but felt unskilled to do so, being fearful of saying the wrong thing.

Anderson and Standen (2007) conducted a further quantitative study examining attitudes towards suicide amongst nurses and doctors working with children and young people who self-harm. They used the Suicide Opinion Questionnaire (SOQ) which measures attitude to suicide on eight clinical scales. Data was collected from 179 nurses and doctors working in one ED, two children's medical units and two adolescent inpatient units. This study did not measure attitude to young people, but rather the health professional's attitude to suicide as a method of dying. There was strong agreement on the clinical scales for Mental Illness, Cry for Help, Right to Die, Impulsivity, Normality and Aggression scales, and less agreement on the Religion and Moral Evil scale, meaning these staff did not believe suicide was due to a lack of religion or was a morally unacceptable action. There is a clear link between self-harm and subsequent death by suicide (Department of Health, 2012), therefore it would seem relevant to explore the beliefs about suicide amongst staff who are treating potentially suicidal young people, as a belief that it is morally wrong may contribute to a detrimental attitude towards those young people, adding guilt to existing feelings of desperation.

A thematic framework analysis of semi-structured interviews exploring the beliefs and attitudes of ED staff in New Zealand about self-harm behaviour was conducted by Koning,

McNaught, and Tuffin (2018). They specifically chose to include ancillary staff working in the emergency department alongside doctors and nurses. They did not specify whether they questioned staff about attitudes to children or adults. From fifteen interviews, for which there is no identification about numbers from each professional group, they identified five major themes: *causes of harm are multi-factorial; beliefs about harm can change over time; emergency departments should only focus on the physical; self-harm occurs on a spectrum; and the system has failed*. The results suggested that participants felt ill-prepared and were lacking in training to help patients who self-harm. Furthermore staff had little faith in the mental health system, viewing repeated self-harm as a failure of the system, similar to the finding by Anderson et al. (2003), in their description of frustrations by staff in feeling they had failed when a person re-attended. Despite aiming to identify any differences between registered health professionals and ancillary staff, Koning et al. (2018) reported the results from participants as if they were a homogenous group rather than making distinctions between them.

An adapted version of the SOQ was used by McCann et al. (2006) to conduct a quantitative study assessing nurses' attitudes towards patients with self-harm. No ACPs were participants in this study. They concluded that overall, nurses' attitudes were generally positive, with older and more experienced nurses having more positive attitudes to people who self-harm than younger and less experienced nurses. They reported more positive attitudes from nurses who had attended in-service education, although they did not state the nature or content of this. This study did not specifically address attitudes towards children.

A quantitative study investigating attitudes of accident and emergency (A&E) staff towards patients who self-harm through laceration, used an unvalidated questionnaire, developed through focus group methodology (Friedman et al., 2006). As with previous studies scrutinised, they highlight the need for greater staff training, though do not specify the nature or content. Unlike previous studies, this was the only study to reveal that increased length of ED service was correlated with greater negativity and even anger towards this client group.

Mackay and Barrowclough (2005), explored the perceptions of 89 nurses and doctors across four EDs in the north of England using four hypothetical scenarios. They concluded that the greater the attributions of controllability of the event, the greater the negative affect of staff towards the person, and the less the propensity to help. Male staff and medical staff had more negative attitudes, and medical staff saw less need for further training. These results were based on hypothetical scenarios, with limited information to make judgements. Therefore, it could be argued that the interpersonal connection when faced with a real person, who may be emotionally upset, may be completely different to the objective and unemotional responses based on reading a paper-based scenario.

Timson et al. (2012) investigated staff attitude and knowledge about adolescents who self-harm in order to identify training needs. Alongside ED staff, they included the views of English school teachers and CAMHS health professionals. They used self-report questionnaires, developed by Jeffery and Warm (2002) to measure perceived knowledge and effectiveness. They found that CAMHS staff had more knowledge and perceived themselves to be more effective than ED staff or teachers. This would be expected since the CAMHS service are perceived to have expertise in dealing with this client group. They also found CAMHS staff attitude to be more positive than that of ED staff or teachers. They demonstrated an inverse relationship between self-report knowledge and staff negativity, implying that increased knowledge was related to more positive attitude. 98.4% of staff from all the groups who participated indicated that they would benefit from 'further training' (Timson et al 2012 p 1312). They do not specify the content of this further training.

Increasing numbers of paramedics are now becoming ACPs, as such the grounded theory study exploring paramedic perceptions of caring for people who self-harm (Rees, Porter, Rapport, Hughes, & John, 2018) was reviewed. Whilst the study did not specifically focus on children who self-harm, or care in EDs, they generated the theory that factors associated with people who self-harm, such as the challenges of assessing physical versus mental health problems, the role of alcohol and intoxication, and the potential for violence and aggression,

make paramedic care for people who self-harm a 'wicked problem'. They argue that self-harm contradicts the principles of their role as 'preservers of life' (Rees et al. 2018 p12) and recommend urgent training and support for paramedics who treat people who self-harm. Again there is no specification of the content or nature of the training required. Whilst this study does not focus on children who self-harm, it is likely that the complexities of caring for children for whom there is also parental involvement, and complex legal and safeguarding frameworks will make the problem more 'wicked'.

Conlon and O'Tuathail (2012) also used a quantitative design to measure ED nurses' attitudes towards deliberate self-harm in southern Ireland and formed part of Rayner et al.'s (2019) meta-analysis. In this study nurses reported a "lack of mental health knowledge" and were found to lack "the necessary skills to care for self-harming patients" (Conlon & O'Tuathail, 2012, p9). They do not state what the necessary skills are, but recommend that care for self-harming patients may be improved through the "delivery of educational curricula, at both undergraduate and postgraduate level" as it "should improve nurses' attitudes, knowledge and confidence" (Conlon & O'Tuathail, 2012, p11). No justification for this recommendation was made, nor was there any specification about what the curricula should contain.

In summary, there is consensus from the literature that emergency department health professionals can hold both positive and negative attitudes to self-harm, with those having greater knowledge and experience generally possessing a more positive attitude. The vast majority of studies focussing on the attitudes of staff caring for patients who self-harm recommend training to improve attitudes. It is thought that increased knowledge increases confidence and understanding, which in turn may influence the experience of the client in a more positive way. Aside from the STORM training (Lamb & Mullally, 2006), no specific training content or learning outcomes have been evaluated for effectiveness. Furthermore, as Saunders et al. (2012) highlight, the studies that evaluated educational interventions used questionnaires and other self-report measures to assess impact on attitudes. No study has explored the impact of educational interventions on staff behaviour in clinical settings, or on

patient experience, therefore the reported improvements may simply reflect a change in responding about attitude, rather than true underlying beliefs. Indeed, Clarke et al. (2014), citing Marynowski-Traczyk and Broadbent (2011), assert that staff must first appreciate their role in the client's journey of recovery before education will have an impact on their attitude.

2.2.2 Patient Experience

Three papers were identified which focussed on the experience of young people and their carers in emergency departments. Storey, Hurry, Jowitt, Owens, and House (2005) investigated the views of 74 young people (aged 16-22) who had sought help from one of four EDs, 38 of whom who had first begun to self-harm under the age of 16 years. Face to face interviews were used to gather the data. Many of the young people disclosed trying to hide the self-harm behaviour, with many disguising the injuries as accidents. When health service input was received, it was generally as a result of a parent or teacher noticing evidence of self-injury.

The young people described two routes to access services: GP practices and A&E. This highlights the importance of ensuring young people receive appropriate treatment in the ED if this is their experience of health care in response to their self-harm behaviour. One third of these young people had experienced local authority care services and found referral to specialist CAMHS services particularly problematic due to frequent placement moves, often out of area. In response to treatments received, the young people associated the prescription of medications, particularly antidepressants, as being 'fobbed off' (Storey et al. 2005 p73). Young people who had been in touch with counselling services had problems with continuity of service, often due to foster care placement changes. Other therapeutic relationships broke down due to the young person's perception that the therapist was not listening or did not care. Whilst these therapists were not ED staff, these results should be considered carefully because, if a young person feels they are not listened to or fobbed off in the ED, they may

become dismissive of any service they are subsequently referred to before they even get there.

A Canadian study (Cloutier et al., 2010) sought to identify the perceived concerns of care givers and young people who presented to the ED with mental health conditions. The concordance between caregiver and youth perceptions were evaluated and compared with those of clinicians, highlighting five concerns which were similar for both caregivers and young people; self-harm, suicide ideation, depression, anxiety and suicide attempt. Parental expectations in coming to the ED were that: they would get help and guidance in caring for their child; an assessment, evaluation and diagnosis would be made; and that they would be referred to other health care professional resources. Concordance rates between clinician rating of concern and parental rating of concern ranged from 39.4% to 80.6%. Concordance rates between clinician and young people ranged from 11.1% to 59.4%. These results demonstrate that there is clearly a difference of opinion between the concerns of parents and the concerns of clinicians. This difference is greater still between clinicians and young people. These findings may possibly account for the experience of young people feeling 'fobbed off' or not listened to, as reported by Storey et al. (2005).

An American survey of 465 consumers (patients) who had attended ED following a suicide attempt and 254 of their family members, reported that fewer than 40% of patients felt that the ED staff listened to them or took their injuries seriously (Cerel, Currier, & Conwell, 2006). Whilst all the participants were American adults, and thus may not be representative of UK children, these results corroborated those of Storey et al. (2005) who reported that young people did not feel listened to, and Cloutier et al. (2010) who demonstrated significant differences between the concern of young people for their mental health and the concern of ED clinicians.

In summary, young people often report a negative experience when they visit EDs with mental health concerns. This could be explained by professionals' attitudes (see section 2.2.1),

different expectations from the service, and differing opinions about level of concern between young people, their carers and clinicians.

2.2.3 Staff Education

Six papers specifically focussed on the education of health professionals in relation to caring for children who self-harm. As identified previously, many of the studies recommend 'training' as a way of improving professionals' attitudes. Therefore, the papers on staff education were anticipated to be particularly relevant to the topic of knowledge and skills of ACPs in the emergency department who assess and treat children who self-harm.

Giordano and Stichler (2009) used an education programme to increase nurses' knowledge of the factors associated with suicide in an American ED. The purpose was to attempt to reduce both numbers of completed suicides in the city, and the financial implications to the hospital from failure to identify patients at risk, and subsequent litigation. The details of the education programme are not included in the paper, although it is noted that a staff psychiatrist and the director of ED reviewed the content which focussed on the SADPERSONS scale. This scale has subsequently been demonstrated to be of detrimental clinical value (Saunders et al., 2014). The programme was evaluated positively by comparing pre and post-test results, although the test is not included in the paper, making any judgement or replication of it unachievable.

Egan, Sarma, and O'Neill (2012) examined predictors of personal effectiveness in dealing with self-harming patients, as reported by ED staff. A questionnaire design was used with a response rate of 45%, giving rise to the inclusion of twenty eight doctors and ninety seven nurses from five EDs. No ACPs were included in the data. However, the authors identified that "knowledge can enhance staff members' perceived competencies in their work role in addition to decreasing negative biases and cognitions towards certain patients" (Egan et al., 2012,

p1087). They assert that this is likely to impact on the overall experience in the ED, for both staff members and patients. The study concludes by proposing that “*with appropriate training, ED staff can gain the knowledge and confidence required to begin the healing process for individuals who are experiencing emotional distress*” (Egan et al. 2012, p1088). It contains no specific details about the content or the knowledge outcomes of the proposed training.

Holdsworth, Belshaw, and Murray (2001) evaluated a series of 5 half-day workshops delivered to ED and MAU nursing staff by specialist mental health practitioners on the subjects of: suicide risk assessment, responses to repeated self-harm, documentation, and reflection on participants experience of treating people who self-harm. These workshops were designed for nurses caring for adult patients, therefore they did not include the clinical skills and knowledge required of ED ACPs. However, they did evaluate that the workshops decreased work related stress in participants. They presumed the stress reduction was as a result of improved professional coping responses in relation to this client group subsequent to education. Whilst reducing stress for staff is a positive outcome, Holdsworth et al. (2001) did not make any evaluation of the impact of the workshops on behaviour or attitudes towards patients.

Children and young people with experience of self-harm were used to co-produce an e-learning programme for Registered Children’s Nurses as part of a study conducted by (Latif, Carter, Rychwalska-Brown, Wharrad, & Manning, 2017). The nurses identified that they needed education related to: knowledge of self-harm, effective communication and risk management. The children and young people ensured the content of these areas reflected their experiences. This study identified the challenges alongside positive benefits of co-designing educational materials. Following completion of the e-learning, nurses reported being more knowledgeable and more confident in working with children and young people who self-harm, particularly in relation to their ability to communicate with them. The health professional participants of this study were exclusively nurses registered to work with children and young people, and who worked on paediatric in-patient wards. It could be argued that

the training requirements of ACPs, whose clinical role is different, and who are predominantly registered to work with adults, in an emergency department environment may be different to those of Latif et al.'s (2017) study.

An Australian study (McAllister, Zimmer-Gembeck, Moyle, & Billett, 2008) used an education intervention centred on a nursing philosophy known as solution focussed nursing (McAllister, 2003), to develop communication skills for nurses working with clients perceived to be challenging, such as those who self-harm. The intervention, a two-hour discussion about evidence-based treatment techniques, followed by a one-hour discussion on the philosophy of solution focussed nursing, was aimed at moving away from problem-focussed care to "providing interventions which will assist clients to gain strength and resilience" (McAllister et al., 2008. p274). They used pre and post-test questionnaires to measure nursing self-concept and participants' perceptions of nursing skills and purpose. This study did not evaluate the knowledge and skills related to caring for patients who self-harm, but rather evaluated the nurses' professional self-concept, which was not demonstrated quantitatively to have significantly changed following the educational intervention. The qualitative report of this study (McAllister, Moyle, Billett, & Zimmer-Gembeck, 2009) concluded that the intervention resulted in improvements in knowledge and understanding of self-harm, self-belief in nurses' capacity to positively influence clients, and the value of health promotion skills. The paper did not elaborate on the detail of the evidence-based treatments used in the discussion.

Having reviewed these six papers focussing on staff education in relation to caring for people who self-harm, the evidence suggests that educational interventions may improve staff attitudes and confidence to care for this client group. However, there is little evidence to inform the specific educational content of any training required for ACPs working in emergency departments with children who self-harm.

2.2.4 Clinical Management

Eight studies focussed on the clinical management of self-harm (see Appendix 1).

Hawton et al. (2015) conducted a systematic review of interventions for self-harm in children and adolescents. They reviewed eleven clinical trials with a total of 1,126 participants. All trials examined the impact of psychosocial interventions rather than pharmaceutical interventions; nine of which were based in community settings and two in acute hospital settings. Of the two based in acute hospital settings, one (Ougrin et al., 2011) reviewed effectiveness of a therapeutic assessment delivered by CAMHS professionals. They concluded that the therapeutic intervention improved engagement by young people in healthcare services, but did not reduce the number of ED attendances due to self-harm. The other trial based in an acute hospital setting (Spirito, Boergers, Donaldson, Bishop, & Lewander, 2002), was based in America with a psychological intervention being delivered by psychiatric doctors prior to discharge following suicide attempt. In the systematic review by Hawton et al. (2015) there were no trials evaluated which included any clinical intervention by ED staff for this client group. The conclusion to their systematic review was that despite the scale of the problem of self-harm in young people, there is a paucity of evidence of any effective interventions.

A systematic review conducted in Canada (Randall, Colman, & Rowe, 2011) examined the evidence for tools used to assess risk of self-harm in EDs. Twelve studies of mostly adult populations were reviewed, examining sixteen different risk assessment tools. Due to study variance, it was not possible for them to conduct a meta-analysis. They concluded that none of the tools were useful for predicting future self-harm. Six of the scales were deemed useful in their ability to predict the need for admission of patients:

- Violence and Suicide Assessment Form (Feinstein and Plutchick, 1990)
- Modified Sad Persons Scale (Hockberger and Rothstein, 1988)

- Severity of Psychiatric Illness System (Lyons et al., 1997)
- Beck Hopelessness Scale (Cochrane-Brink, Lofchy and Sakinofsky, 2000)
- High Risk Construct Scale (Cochrane- Brink et al., 2000)
- Beck Scale of Suicide Ideation (Cochrane- Brink et al., 2000)

These studies were predominantly adult focussed and historic in their nature. In addition, in-patient psychiatric care, has changed to more community-based care in the UK over the past two decades. Therefore, it is unlikely that these scales would be useful in predicting the need for admission, at the point of assessment in the ED, for children and young people who have self-harmed.

Tishler, Reiss, and Rhodes (2007) conducted a review of the literature to highlight the challenges of assessing suicidal children under the age of twelve years. This American publication suggests factors which influenced decisions for the disposition of a child from the ED to either inpatient, or community based specialist child mental health facilities. As the nature of American healthcare provision is very different to the UK, their decision tools and care pathways are not directly transferrable.

Kennedy, Barraff, Suddath, and Asarnow (2004) focussed on the assessment of suicidal adolescents presenting to an ED in California. They used factors known to correlate with completed suicide to develop a checklist for history taking for ED physicians. As ACPs in England are undertaking roles traditionally conducted by doctors, I initially felt that this publication would be relevant. However, the demographics of those who die by suicide in the USA, are very different to the UK. The leading method of death by suicide in North America is through access to firearms, with mental health problems being more prevalent in the adolescent Hispanic or Native American population (Gould, Greenberg, & Velting, 2003). Consequently, the risk assessment developed by Kennedy et al. (2004) focussed on these factors. Therefore, this study provided interesting information, but was not directly relevant

to the UK context, with relatively low numbers of suicides by firearms, and an extremely low Hispanic or Native American population.

Dieppe, Stanhope, and Rakhra (2009) used focus groups to design a triage tool for use with children who presented to an emergency department in Birmingham, England with self-harm. They incorporated: the Risk of Suicide Questionnaire (RSQ), a four-item tool with sensitivity of 98% developed in Boston, USA (Horowitz et al., 2001), with the CRAFFT questionnaire (Knight, Sherritt, Harris, Gates, & Chang, 2003), another tool developed in Boston, USA which assesses for problems with alcohol or substance misuse. They added some questions recommended by NICE (2004), and some questions designed to identify those who may have life or limb threatening problems as a result of the self-harm, to produce an eighteen item triage tool. This aligned with the colour codes of the national Manchester Triage System (MTS) (Manchester Triage Group, 2008). The purpose was to improve risk assessment at triage, with the aim of improving prioritisation of this client group to be seen by a clinician. No further publications could be found about the validity of the tool Dieppe et al. (2009) created. Furthermore, no recommendations were made for the clinical consultation in the ED beyond triage.

NICE (2004) published guidelines for the management of people who have self-harmed which recommend *"Emergency Department staff should assess risk and emotional, mental and physical state quickly, and try to encourage people to stay for psychosocial assessment"* (National Institute for Health and Care Excellence, 2004. p13). There is no recommendation for how this assessment should be undertaken, although there is a detailed section on medical and surgical management of self-harm injuries and poisoning. With reference to training, section 1.1.2.1 states: *"Clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed"*. No recommendation is made about the content of the 'appropriate training', how it should be delivered, or what knowledge or skills outcomes should be acquired as a result of that training.

The most recent publication identified from the search was that by Manning et al.(2018). They developed and evaluated a tool for use by children's nurses to establish the immediate risk of self-harm and suicide of children admitted to a UK paediatric emergency department and paediatric wards following self-harm acts.

Manning et al. (2018) used a three phase strategy; a scoping review of existing assessment tools, expert consensus Delphi survey to design an assessment tool, followed by robust psychometric testing of the tool. The resulting publication provides a rapid and sensitive 6 item tool (CYP-MH SAT) to identify immediate risk of self-harm and suicidality in children and young people (aged 10-19 years) presenting to acute paediatric care. The copyright for the CYP-MH SAT is held by Nottingham University Hospitals NHS Trust and University of Nottingham. Manning et al.'s subsequent (2019) publication demonstrates that registered children's health care professionals were able to risk stratify children who have self-harmed into low, medium, high and very high risk within the ED environment. Their paper did not identify the care implications following on from this assessment, nor did it identify the full extent of the knowledge and skills required by ACPs to undertake the initial assessment of a child who has self-harmed.

In summary, there is much clinical guidance on the treatment and management of clinical injuries or overdose for children who self-harm. This literature review also identified appropriate tools for assessing immediate risk of self-harm or suicide in this client group. However, there is little evidence to guide the consultation or care delivery beyond triage or initial risk assessment for ACPs.

2.3 Identification of the Knowledge Gap

No research was identified that specifically explored or identified the detail of the knowledge, and equally important, the skills required with knowledge application, in the autonomous care

of children who have self-harmed presenting to an ED. Furthermore, no research could be found which pertained to the experience of ACPs in this context.

In summary, the literature search identified papers which focussed on young self-harm patients in the ED, with specific focus on professionals' attitudes, patient experience, staff education and clinical management, but not the role of the ACP. Many of the papers were internationally based and thus may not be applicable to the UK population. Whilst these papers almost universally recommended training for clinical staff about self-harm, the majority did not elaborate on what the specific content of that training should be, nor the specific expected outcomes. Findings of the study by Holdsworth et al. (2001) would suggest that any specific training should include clinical management and suicide risk assessment knowledge and skills.

Chapter Three: Developing the Research Question and Methodology

3.1 Developing the Research Question

As an Emergency Nurse Consultant with responsibility for designing and delivering education curricula for ACPs, I was interested in establishing what knowledge and skills were required to undertake an initial consultation with a child having presented with self-harm. The concurrent exploration of the philosophical foundations of research in the taught element of the professional doctorate programme, led me to consider whether exploring the experience of ACPs would help identify the knowledge and skills required. Following the literature review in Chapter 2, a knowledge gap was identified in relation to the experience of ACPs treating children who have self-harmed and the knowledge and skills they use.

3.1.1 The Final Research Questions

Two research questions were identified:

- i. What is the experience of ED ACPs in treating children presenting with a self-harm episode?
- ii. What knowledge and skills do ED clinicians, including Advanced Clinical Practitioners, use when assessing and treating children who have self-harmed?

3.1.2 Intended Purpose of the Study

The intention of the study was to help understand the experience of ACPs, and other ED clinicians, treating children who self-harm, and in doing so, establish the knowledge and skills they use in clinical practice. It was believed a better understanding of the knowledge and skills required, could influence future curriculum design for trainee ACPs, and other ED clinicians, to better prepare them for their autonomous role with this client group.

3.2 Methodology

In the absence of previous studies or a hypothesis to test, a qualitative approach was considered most appropriate to explore the experience of managing the emergency care episode of a child who has self-harmed. Qualitative methodologies seek to portray a world in which reality is socially constructed, complex and ever changing (Glesne, 1999). For this study, I was interested in the socially constructed world of the ED which young people enter with complex psychological and physical needs associated with self-harm, and the part ACPs and other ED clinicians, play in that world.

In establishing the final methodological approach, each of the main qualitative approaches were considered: ethnography, grounded theory and phenomenology. These are discussed within this chapter.

3.2.1 Ethnography

Ethnography is '*a branch of human inquiry, associated with anthropology, that focuses on the culture of a group of people, with an effort to understand the world view of those under study*' (Polit & Beck, 2008, p753).

Ethnography was quickly rejected as a methodology, as the purpose of the research was not to study the culture of ACPs in the ED. Immersion in the setting through observation and interviews is key to good ethnography (Holloway & Todres, 2006). The practicalities of observing ACPs undertaking assessments with young people who have self-harmed would have been logistically very challenging for this small doctoral study. It would have been difficult to predict a time when children may be present in each setting, at a time when the ACPs were also on duty. In addition, addressing the ethical implications of observing a potentially emotional situation for a young person, not least obtaining consent, would have been problematic.

3.2.2 Grounded Theory

Grounded theory is '*an approach to collecting and analysing qualitative data that aims to develop theories grounded in real-world observations*' (Polit & Beck, 2008, p755).

The principles of a grounded theory approach were initially very appealing for the study design. It focusses on processes, relationships and meanings (Grbich, 1999). It appeared that the situation under investigation had a process (the care of a child having self-harmed), a relationship (between the child and the ACP), and meaning (the significance appreciated by the ACP). The main purpose of grounded theory is to generate theory from data (Corbin & Strauss, 2008). However, the purpose of this study was not to generate theory, but rather to gain greater understanding about the experience of ACPs, and the knowledge and skills they use in treating children who have self-harmed. Therefore this approach was rejected.

3.2.3 Phenomenology

Phenomenology *'is a qualitative research tradition, with roots in philosophy and psychology, that focuses on the lived experience of humans'* (Polit & Beck, 2008, p761). It can be divided in to two broad classical approaches: descriptive and interpretive (Sloan & Bowe, 2014).

Edmund Husserl (1859-1938) is credited as the founder of descriptive phenomenology, which challenged the Cartesian philosophy which was empirical and positivist. Positivism is the traditional scientific approach, which assumes there is a fixed reality that can be objectively studied (Polit & Beck, 2008). Husserl wanted to develop a science of phenomena that would clarify how objects are experienced and present themselves to human consciousness (Spinelli, 2005). He regarded experience as the fundamental source of knowledge (Dowling, 2007). Husserl believed the purpose of phenomenology is to find insights, or themes, that apply more generally beyond the cases that are studied in order to emphasise what we may have in common as human beings. Husserl called such common themes 'essences' or 'essential structures'. His descriptive, or transcendental phenomenology, was so called because the observer could transcend the phenomena and the meanings being investigated, to take a global view of the essences discovered. This technique of transcending the phenomenon is often referred to as 'bracketing off'. The purpose of this is to establish an objectivisation of the meanings of human experiences (Smith, Flowers, & Larkin, 2009).

Martin Heidegger (1889-1976), a student of Husserl, developed his own strand of the philosophy, existential phenomenology (Spinelli, 2005) or hermeneutic phenomenology, (Smith et al., 2009), which can be viewed as a follow-on from Husserl's descriptive phenomenology (Sloan & Bowe, 2014). Hermeneutics is the interpretation of text or language by an observer, and can be used as a methodology (Web & Pollard, 2006).

Heidegger was of the view that the observer could not remove him or herself from the process of essence identification; that he or she existed with the phenomena and the essences. He or

she would be required to bear that in mind during the phenomenological process, hence the alternative description of 'existential' phenomenology. Heidegger suggested that a philosopher cannot investigate 'things in their appearing' to identify their essences while remaining neutral or detached from the things—that it is not possible to 'bracket off' the way one identifies the essence of a phenomenon (Langridge, 2007). The use of language and the interpretation of a person's 'meaning-making', their attribution of meaning to phenomena are central to Heideggerian phenomenology. This is the interpretive part of 'interpretive phenomenology'. Heidegger purported that knowledge, or knowing, is nothing outside of the knower. Ontology, the study of being, particularly 'Dasein' or existence, should be prioritised over epistemology, the study of knowledge (Mulhall, 2005).

Hans Georg Gadamer followed the works of Husserl and Heidegger, and was a student and colleague of Heidegger's in the mid-1920s. Working with Heidegger, Gadamer wanted to add to hermeneutic phenomenology and developed interpretive phenomenological thought into a philosophy now called Gadamerian hermeneutics. Gadamer, through hermeneutics, concentrated on how language reveals being, with the philosophical stance that all understanding is phenomenological, and that understanding can only come about through language. He saw language, understanding and interpretation as inextricably linked (Langridge, 2007). Gadamer connected language with ontology and, from the influence of Heidegger's work, focused on a mode of being, rather than the epistemological mode of knowing, that was most prevalent in philosophy up until that time.

Of the two classic approaches, I decided that the interpretive phenomenological (hermeneutics) approach most closely aligned to my beliefs, and had the potential to offer the most satisfactory answers to the research questions. It was chosen over Husserl's classic descriptive phenomenology, as I wanted to use my experience of working in EDs with children who self-harm, rather than try to 'bracket' preconceived ideas about the phenomenon. The hermeneutic approach encourages the use of existing preconceptions to sensitise the

researcher to elements that may be different, whilst still pursuing 'fusion of horizons' (rather than essences) (Laverty, 2003).

By exploring the experience of ACPs, and other ED clinicians, undertaking the consultation role with children who have self-harmed, and how that experience is interpreted and subsequently described by them, it was predicted to be possible to explore the knowledge and skills used by them in the role, and thus, answer the research questions (section 3.1.1).

The strength of this hermeneutic approach is that it *"provides both philosophical and methodological support in attempting to capture and express the meaning of significant human experiences in a rigorous manner"* (Gerrish & Lacey, 2010, p234). In this study the significant human experience is that of an ACP undertaking the assessment and making autonomous decisions about the care of a child who has presented to the ED following a self-harm act. It is anticipated that by having a greater understanding of the experience, curriculum designers and educators of ACPs will be better able to prepare them with the necessary knowledge and skills to be competent when they encounter that experience.

It is recognised that the findings from a phenomenological study are not derived from a representative, probability sample, and thus are not designed to be generalisable and correspond to all cases. Rather, it was the pursuit of the knowledge and skills used by ACPs in their lived-experience with young people who self-harm, as 'themes' (Sloan & Bowe, 2014, p. 1295), or 'fusions of horizons' (Laverty, 2003, p25), that was the focus of this study. These should have sufficient coherence to be meaningfully applied in similar situations.

3.2.4 Epistemological Position

Epistemology is the study of what is known, and the relationship of what is known with the knower. Prior to this study, my experience of clinical evidence review and immersion in a culture of evidence-based medical practice, with its hypothetical-deductive reasoning, gave

me a personal preference for the positivist paradigm. I felt comfortable with numerical data, and understood the principles of hypothesis testing in research; using representative samples in pursuit of generalisable results with validity and reliability. I had developed trust in empirical knowledge.

When I considered the research questions, it quickly became evident that with the absence of a theory or hypothesis to test I would need to adopt a qualitative approach. As this approach was unfamiliar, I studied the underpinning philosophies and methodologies before deciding on a specific research design. This required me to challenge my own beliefs about the value of qualitative research, and appreciate the principles of trustworthiness and inductive reasoning, in addition to learning the skills of rigorous qualitative data analysis.

Having already disclosed that I have personal experience of the role of ACP, and of treating young people who self-harm, my epistemological position for this study was rooted in the interpretivist paradigm. An interpretivist researcher enters the field with prior insight of the research context, but assumes that this is insufficient to develop a fixed research design due to the complex, multiple and unpredictable nature of what is perceived as reality (Hudson & Ozanne, 1988). Therefore, the study design must evolve as the research progresses.

This journey with understanding and executing a qualitative study has enabled me to appreciate both the quantitative and qualitative research paradigms. I now believe each are valuable in the pursuit of evidence-based practice.

3.3 Reflexivity 1

When using hermeneutic (interpretive) phenomenology as a methodology, reflexivity, a person's reflection upon, or examination of a situation or experience, can help in interpreting the meanings discovered, or add value to those types of interpretations. Reflexivity describes

the process in which researchers are conscious of, and reflective about the ways in which their questions, methods and subject position might impact on the data produced in a study and the subsequent findings (Sloan & Bowe, 2014).

Reflexivity is paramount in hermeneutic phenomenology. The researcher uses empathy, or relevant prior experience, as an aid to data analysis and/or interpretation of meanings. This is in contrast to descriptive phenomenology where the principle of 'bracketing out' means personal reflection should not influence objective description of the phenomena.

Throughout this study I used a reflective journal to document my own thoughts and feelings on the process, situation and analysis; analysing my own experience of working as a nurse consultant in an ED, as is consistent with the methodology. In pursuit of transparency, I have tried to be explicit about how my own experience has influenced the interpretation of the data, and how I analysed the implications for practice, and hence the recommendations from the results.

3.4 Ethical Considerations

Throughout this study the ethical guidelines for research, as published by the University of Huddersfield (University of Huddersfield, 2011), were followed. In addition, the ethical principles as set out by the World Medical Association in the Declaration of Helsinki (2013), were adhered to. Although it was established that this study did not require formal NHS Research Ethics Committee approval, as demonstrated by the Health Research Authority decision document in Appendix 4, (IRAS Project ID 164560), approval was obtained from both the Huddersfield University School Research Ethics Panel (SREP) (Appendix 5) and the local NHS Trust Research Governance Group prior to approaching participants for inclusion in the study.

Although my role in this study was as a researcher, I am also a registered nurse and adhered to the Nursing and Midwifery Council (NMC) Code at all times (Nursing and Midwifery Council, 2015). The main ethical principles considered were, informed consent, protection of participants, confidentiality and anonymity and researcher safety.

3.4.1 Informed Consent

Access to participants was gained through electronic contact with line managers in the EDs of the three NHS Trusts involved in the study. They sought volunteers from the professional groups required, and gave my contact details to those willing to participate.

In advance of the interviews, participants contacted me and were given verbal information about the study, and were asked if they would like to participate. Following this discussion, email was used to confirm their desire to be included and arrange a suitable time and place for the interview to take place.

Informed consent was obtained prior to interviewing any individual. Participants were given a Background Information Sheet (Appendix 2) to read alone prior to being interviewed, then allowed time for questions at the start of the interview process prior to signing the consent form (Appendix 3).

3.4.2 Protection of Participants

Participants were treated with dignity and respect at all times. As self-harm is thought to affect at least one in twelve young people (Bergan, 2012; Hawton, Saunders, & O'Connor, 2012), and possibly even as many as one in seven (Morey et al., 2017), there was a strong possibility that those being interviewed may themselves have been affected by self-harm. Equally, the interviewee may have had a previous distressing encounter with a young person who had self-harmed. Thus, the interview process may have inadvertently triggered

uncomfortable emotions. Had this occurred, the interviewee would have been asked if they wished for the interview to be terminated, and/or been given information about counselling services available through the occupational health department, or encouraged to speak to their General Practitioner (GP). It was made clear to participants that my relationship with them was as a researcher, and not as a health care professional in a therapeutic relationship.

3.4.3 Confidentiality and Anonymity

Data presented in this thesis is anonymised as far as possible. Each interviewee was described by their professional background as a pseudonym and a number rather than a name. They were informed that verbatim quotes may be used in the final publication of the study, therefore acknowledging that participants may recognise themselves in this document. Each informant had the right to withdraw from the study up until the time of data anonymisation and analysis. A specific date was given to each interviewee, before which time they could contact me should they wish to withdraw. No participant chose to do this.

3.4.4 Researcher Safety

As part of the SREP process, a risk assessment was undertaken to consider any personal safety risks. Interviewing participants on a one-to-one basis could potentially pose a safety risk. However, as all the participants were registered health professionals, and the interviews were held on NHS premises, this risk was perceived to be minimal.

Additional risks identified were those associated with driving to the venues for the interviews. Again these were perceived to be minimal, and not outwith normal daily activity risks. Had adverse weather created additional hazards, interviews would have been rearranged.

Chapter Four: The Research Design

4.1 The Research Method

4.1.1 Interviews as a Research Method

The research design was planned to evolve as the study progressed, as is consistent with the hermeneutic phenomenological approach (Cohen, Kahn, & Steeves, 2000). The initial plan was to use in-depth interviews to gather data from participants. Interviews were chosen as they are a recognised way of gathering rich data to be analysed in a phenomenological study (Gerrish & Lacey, 2010). Research interviews, unlike journalistic interviews, or therapeutic interviews, have the purpose of producing knowledge. It is a professional conversation; an inter-view where knowledge is constructed in the inter-action between the interviewer and the interviewee. Interviews enable the researcher to “get to know other people, learn about their experiences, feelings, attitudes and the world they live in” (Kvale and Brinkman, 2009, p1). As the research aims were about understanding the experience of ACPs in treating children who self-harm, this was deemed the most appropriate way to gather data.

Before committing to interviews as a data collection method, it was important for me to know I had the ability to conduct them competently. Prior to commencing the study, I already possessed some skills in using open-ended questions, deep level listening, and having participant focussed conversations from previous experience and training as a work-place coach. I believed these skills would be of benefit for maximising data quality using the interview technique. However, I had never previously used interviews in a research study. It was therefore important to learn more about the craft of interviewing, as a knowledge producing interaction (Kvale & Brinkman, 2009), and to ensure that my interview technique, including transcription and analysis, was in accordance with the philosophical principles of hermeneutic phenomenology.

As part of the taught doctorate programme, I completed modules on research methodologies within which qualitative methods were discussed. This was the first time I had carefully considered the principles of qualitative research and whilst I understood the practicalities of recording interviews and transcribing the oral language into written language, I found the concept of analysing the text extremely difficult. On reflection this was largely due to my dominant positivist position at the time, and my ignorance of the philosophical underpinnings of hermeneutics which requires interpretation.

Learning more about interviews as a research method (Kvale & Brinkman, 2009) promoted confidence that my experience of being an ACP, and treating children presenting with self-harm, would naturally lead participants to reveal more than they might otherwise (Atkinson, 1998), and give me the necessary prior knowledge of the subject to enable meaningful interpretation in concordance with the study methodology.

Methods of recording interviews for later analysis include audio recording, video recording, note taking and memory (Kvale & Brinkman, 2009). Whilst video recordings offer an opportunity to interpret social interaction and non-verbal communication in addition to the actual language used during the process, many people are very self-conscious in front of a camera, and it was felt that this might inhibit their ability to speak openly about the subject.

Note-taking requires either an extra person in the room to capture the conversation, or the interviewer to try and take notes during the interview. Either process could be very distracting for participants who might inhibit their free speech.

The use of memory alone is fraught with difficulty in ensuring factual recall of the details after the event. In particular, remembering exact phrases and language used, beyond those which resonate at the time, would be almost impossible. This was particularly true for this study, as it was undertaken on a part-time basis, and the data was required to be accessed after a substantial period of time due to competing work priorities.

Having considered the different data capture methods, audio recording of the interviews was finally chosen. This allowed the words, their tone, and other communication such as laughter and pauses to be recorded in a permanent form that is possible to return to for re-listening, transcription and interpretation.

4.1.2 Other Methods of Data Capture Considered

In using a phenomenological approach, other methods of data collection were considered. Observation of interactions between ACPs and children who have self-harmed, was a possible alternative method of gathering the necessary data. However, as previously established in the consideration of ethnography (section 3.2.1), this would be fraught with logistical and ethical difficulties, so was dismissed as an option.

Case-note text review was also dismissed, as it was felt the data captured would not reflect the experience of the ACP, including feelings, thoughts and interactions with the child and family.

The option to conduct a focus group of practitioners was reserved throughout the study, and carefully considered. However, once the planned interviews were concluded and the data was analysed, sufficient findings of significance were evident to establish answers to the research questions. In addition, the estimated time and effort it would have taken to secure further ethical approval, find a mutually convenient time for the group to meet, then transcribe and analyse the discussions of the group was felt to be disproportionate to the anticipated benefit. Therefore, the use of a focus group was not included in this study.

4.1.3 The Sample Selection

The purpose of qualitative research is not to produce results which are generalizable to a wider population, hence representation is not required in the chosen sample. Therefore within

a phenomenological methodology the term sample should not refer to an empirical sample as a subset of a population (Van Manen, 2016), but rather the sample should ensure 'appropriateness' is sought to produce results which will answer the question.

In qualitative research, sample selection has a profound effect on the ultimate quality of the product. The terms purposeful and theoretical sampling are often used to describe sampling strategies in qualitative studies, and are sometimes used synonymously. However, Coyne (1997) argues they have disparate meanings, and if used interchangeably can lead to methodological criticism if the two are confused.

According to Patton (1990) the power of purposeful sampling lies in selecting information-rich cases for in-depth study; those from which a great deal can be learned about the issues central to the importance of the 'purpose' of the research. In this study, the purpose was to understand the phenomenon of a consultation with a child who has self-harmed, as experienced by ACPs, and other ED clinicians. Thus, the sample selected included those believed to give greatest insight into this phenomenon.

This is in contrast with theoretical sampling, in which Glaser (1978) argues the researcher cannot know in advance what to sample for, and where it will lead. Theoretical sampling is central to grounded theory methodology, which seeks to use a highly systematic approach to generate explanatory theory. Glaser (1978, p36) defines theoretical sampling as *'the process of data collection for generating theory, whereby the analyst jointly collects, codes and analyses data, and decides which data to collect next in order to generate the theory as it emerges'*.

Theoretical sampling does appear to involve the purposeful selection of a sample in the initial stages, in that a researcher will access groups believed to maximise the possibilities of obtaining data on their question. The initial sample may lead to further sampling. It refers to a sampling decision made on analytical grounds, developed in the course of the study.

'Theoretical sampling ceases when it is saturated, elaborated and integrated into emerging theory'
(Glaser 1978, p102).

Sandelowski et al. (1993) state that purposeful sampling refers to a decision made prior to beginning a study, to sample subjects according to a preconceived, but reasonable set of criteria. Becker (1993) supports this distinction by suggesting that selecting a sample prior to the study is not theoretical sampling, as theoretical sampling is determined by the emerging theory and therefore cannot be predetermined.

Sandelowski et al. (1993) do not state what constitutes 'reasonable'. The Oxford Dictionary (2012, p672) defines '*reasonable*' as '*sensible*' and '*logical*'. My reflection on this was that, without explanation, purposeful sampling could be viewed as subjective, reducing the quality of the research. I therefore felt it was important to explain my rationale for sample selection, in order that others may evaluate whether it was reasonable, sensible and logical.

Purposeful sampling according to Patton (1990) can be undertaken using multiple strategies. Of these, the most relevant to this study was stratified purposeful sampling. Consideration was given to the different ED personnel who might conduct the initial consultation of a child who had self-harmed, and persons were selected from those categories. This would enable capture of the different interpretations of the phenomenon with which to compare ACPs' and my own, to produce the 'fusion of horizons' sought for in hermeneutics phenomenology. Therefore, this sampling strategy was deemed to be 'reasonable'.

The sample initially chosen for invitation to participate in the study were:

- Two ACPs from a Yorkshire and Humber ED, who had less than two years' experience in the role. One of whom was invited to participate in a pilot. I was interested to explore how a novice ACP would interpret their experience.
- Two experienced ACPs from a Central England trust which had a well-established ACP service in a general ED.

- Two experienced Paediatric ACPs from a North West NHS trust with a specialist children's ED.
- One Paediatric Emergency Medicine Consultant from Yorkshire and Humber.
- One Child and Adolescent Mental Health Service (CAMHS) Practitioner from Yorkshire and the Humber.

It was anticipated that these eight interviews would give insight into the phenomenon from a range of perspectives; novice ACP through to experienced ACPs, and specialist children's ACPs. The inclusion of a medical Consultant and CAMHS specialist was intended to allow for comparison of the ACP experience with a nurse functioning in a different context (specialist mental health rather than emergency care), and that of someone from a different profession; the medical consultant was arguably still perceived as having ultimate expertise and clinical dominance of this arena (McMurray, 2011).

During the course of the study this planned sample changed following analytical decisions based on the data collected (section 4.3). The final sample consisted of:

- Two novice ACPs working in a Yorkshire and Humber general ED (Identified as 'Pilot' and 'ACP1').
- Two experienced ACPs working in a Central England general ED (Identified as 'ACP2' and 'ACP3').
- Two PEM Consultants, one working in a general ED, one working in a children's ED, both in Yorkshire and Humber (Identified as 'PEM1' and 'PEM2').
- One CAMHS Practitioner from Yorkshire and Humber (Identified as 'CAMHS').
- One Paediatric Emergency Nurse Consultant working in a children's ED in the North West of England (Identified as 'Paed ACP').

These individuals were specifically chosen for their expertise and experience in their roles.

4.1.4 Planning the Interviews

Kvale and Brinkman (2009) explain how professional phenomenological research interviews have a purpose, and as such should involve a semi-structured approach; neither an open everyday conversation, nor a closed questionnaire. They are conducted according to an interview guide that focuses on the topic of the research.

Consistent with the hermeneutic phenomenological method, I had some idea of the issues that may arise in the interviews, but was mindful that I needed to reduce my bias in relation to this. I therefore designed an initial interview guide (Appendix 2) that would serve to influence the questioning if the interview dried up, and be an aide-memoire to ensure pre-existing assumptions, or a priori themes had been covered (King, 1998). Open questions were planned to allow the participants to elaborate on their experiences as they perceived them to be important, enabling new themes to emerge.

The intention was to interview in a style described by Morse (1991) as *interactive interviews* and by Holstein and Gubrium (1994) as *active interviews*. I planned to go in smart, casual clothes rather than uniform, in an attempt to reduce the power hierarchy (Kvale & Brinkman, 2009) and possible Hawthorne effect. The Hawthorne effect is the phenomenon whereby improved performance in research settings has been observed as a result of the research process itself (Payne & Payne, 2004). If I had attended the interviews in my Nurse Consultant uniform, my overt professional role presence may have influenced participants to tell me things they felt I would like to hear, rather than a true reflection of their experience.

The planned emphasis was on listening as opposed to controlling the conversation; using prompts and questions to elicit greater detail and a rich narrative. Summary statements were used to check for clarity in meaning where there was any ambiguity during the interview. This allowed cognisance of any common or contrasting 'horizons' or 'themes' during the conversation which might warrant further exploration.

Prior to data collection, Cohen et al. (2000) recommend having awareness of how it will be later analysed. This will inform collection, as well as transcription styles. Data analysis is discussed in detail in Chapter Five. At the planning stage, template analysis (King, 1998) was chosen as the method of data interpretation. Template analysis promotes the notion of having 'a priori themes'. These a priori themes influenced the initial interview guide.

It was expected that each interview would last approximately one hour, and be captured digitally. Participants were interviewed in their own workplace in a private room to enable them to feel familiar in their surroundings. Field notes were taken at the end of each interview, to aid recall of my thoughts and feelings for reflexive inclusion in the study.

4.1.5 Interview Transcription

It was initially planned for the interviews to be transcribed verbatim by a professional transcriber into Microsoft Word documents. However, after personally undertaking the transcription process following the pilot interview, I realised I had developed a great affinity for the data. Nuances of meaning were given to words through differences in intonation, pitch and pace; something that is not easily attained through the reading of text. This ability to be immersed in the data in order to find meaning is a key principle of phenomenology (Van Manen, 2016), therefore I decided to transcribe all the interview recordings myself.

4.1.6 Pilot

Prior to commencement of the full data collection, a pilot was conducted with one of the recently qualified ACPs from Yorkshire and Humber in October 2015. This was intended to test my ability to conduct a qualitative research interview, establish whether the proposed time frame of one hour was appropriate, and also test the recording equipment. It was also used to test the proposed interview guide (Appendix 2) for suitability.

This pilot interview, whilst only lasting twenty minutes, generated some rich data which was subsequently used in the final study. Technical knowledge of the recording equipment was also enhanced and errors eradicated.

Following this initial interview, feedback on the process was obtained from the participant. Reflection on this indicated my interviewing style and manner had enabled an easy conversation, with the participant feeling comfortable answering questions. Going in civilian clothing had helped me be perceived as a researcher, rather than a nurse. However, the participant still had in mind that I was an experienced nurse, who understood the context to which the answers were given. This not only affirmed my choice of hermeneutics phenomenology as a research method, but also made me mindful to consider in my analysis that participants may tell me what they thought I wanted to hear, rather than what they actually experienced or believed. I reflected that, whilst not wanting to appear distrusting, I would closely observe body language in future interviews to look for signs of disparity between the spoken word and non-verbal communication.

Subsequent to transcription of the data, template analysis was used to generate the first level themes, on which subsequent interviews were analysed (Chapter 5).

Evaluation of the pilot resulted in the decision to make no changes to the background information sheet (Appendix 3) or consent form (Appendix 4). The proposed interview guide (Appendix 2) was also unchanged at this point, though additional questions were asked in subsequent interviews in reaction to participant responses, as in the accepted nature of a qualitative interactive research interview (Morse, 1991). The analysis from the pilot data was included in overall study findings.

4.2 Quality Assurance

Prejudice and subjectivity are the nemeses of empirical quantitative research, which calls for unequivocal truth and facts. Studies based in the positivist domain espouse validity and reliability as concepts to justify their findings. Even in qualitative research, prejudice and bias are seen as features which reduces its quality. Researchers seek to ensure 'integrity' and 'trustworthiness' as a means of portraying accuracy in findings (Polit & Beck, 2008).

Watson and Girard (2004, p875) proposed that quality standards should be reflective of the research method used and that they must be "*congruent with the philosophical underpinnings supporting the research tradition endorsed*". Like other interpretive methods, the hermeneutic phenomenological approach is not grounded in an epistemology that assumes the existence of facts and object reality in the social world to be like that of the natural world. Any interpretation which takes place includes the researchers own perspective. That is not to say that interpretations in hermeneutic phenomenology should not aim to be accurate, only that accuracy is '*contingent and somewhat tentative*' (Cohen et al., 2000, p86). The goal of the researcher is to be able to report things as they appear to be in the data, rather than as the researcher would have them be. This involves a constant effort to reduce partiality which must permeate all phases of the research.

Cohen et al. (2000) suggest the techniques for improving quality in qualitative research fall into two separate areas. Firstly the researcher should identify personal preconceptions, unstated assumptions and other prejudices that may influence the study. At the outset I identified that my experience as a nurse consultant working in emergency care, with experience of young people who have self-harmed, had generated my own lived experience of the phenomenon. I decided to use this as an advantage, to enable greater insight into the data, actively seeking themes which were in contrast, or similar to my own experience. My close affinity with the study topic also enabled me to identify with the participants, which

facilitated a more relaxed interview experience and promoted freer dialogue, from which rich data was captured. However, I was conscious of how my own experience might influence the conduct of the study process, and made every attempt to be open about this.

I was also conscious of how my relationship with the participants, with the research process, and the research topic evolved as the study progressed, and how that might influence my interpretation and presentation of the results. In addition, I came to realise my female gender, and role as a mother, also had a bearing on how I perceived the nurturing role of caring for adolescents with mental health problems. This influence is discussed in more detail in Chapter Seven (section 7.4).

Reflexivity is discussed in section 3.3 and evidenced throughout the thesis. A necessary self-conscious reflexive stance has been developed. This is in contrast to my initial positivist beliefs which envisaged objective observation, and accounts of the researcher in a third-person position of authority, to be the demonstration of accuracy.

The second area of quality improvement (Cohen et al., 2000) consists of activities a researcher can undertake to expose the study process to outside scrutiny. Exposing or opening up the study in the hermeneutic phenomenological approach refers to efforts that are made to conform to systematic activity. The notion of openness means that the methodological and analytical decisions made are described explicitly to other scientists. It is noted that being explicit about methods, and decision making, can make replication of this study possible. That is not to say that such replication would engineer replicable results, since the philosophy of this approach supports the epistemological position of pluralism. Thus, when the use of 'self as a research instrument' (Kahn, 1993) is changed to a different 'self' the likelihood will be the production of a different interpretation of reality.

Nevertheless, ensuring transparency in process and decision making was viewed as important to enable appropriate scrutiny of the study. In addition, academic supervision was sought

throughout the process, to serve both as a decision-making challenge, and to inform data interpretations.

Ultimately, the findings of any hermeneutic phenomenological study stand alone to be read by others, who begin their own interpretative efforts to understand what the author meant. An author must give a rich enough description to readers so that they might understand the interpretation made, and also give readers enough access to the field text in the form of original data, so that they may make their own interpretations (Cohen et al., 2000). It is with such a product in mind that this thesis was written.

4.3 Data Collection

Following the conduction of the pilot interview, further data collection began with an interview with a Paediatric Emergency Medicine (PEM) Consultant in March 2016. This experienced clinician was chosen in contrast to the newly qualified ACP, as it was expected this interview might produce different themes to those generated in the pilot.

As anticipated, some themes were recurring, whilst new themes emerged (See Chapter 5). This gave rise to the decision to interview a second PEM Consultant, to establish whether these new themes were common in this stratified professional group, or whether they were unique to the individual. It is important to note that the research was not seeking representation of this professional group to enable generalisability of findings, but rather research curiosity deemed it important to establish whether these new themes were unique to the individual, or also experienced by someone else in the same professional group in pursuit of the 'fusion of horizons' (Laverty, 2003).

Whilst this change to the study sample occurred after the study commenced, it was not in relation to theory development, so was not regarded as theoretical sampling (Coyne, 1997),

but still in the domain of stratified purposeful sampling (Patton, 1990). This second PEM Consultant interview, conducted in July 2016, identified more new themes and elaborated on existing ones.

The next interviews were conducted between December 2016 and June 2017. Another qualified ACP was interviewed in a Trust where the role of the ACP had been in place for less than three years. She had been qualified for around eighteen months at the time of interview.

This was followed by interviewing two experienced ACPs from a different NHS Trust where the ACP role had been established for over ten years. This choice of practitioners was in a deliberate attempt to establish an opportunity to identify different themes, from which the template, and subsequent interviews could be developed.

As a contrast to the ED employed professionals, I also interviewed a CAMHS practitioner. This decision was made to explore whether a specialist mental health practitioner would reveal different themes, albeit with regard to their working in a different context. They see children who have previously been reviewed by a clinician in the ED, had any physical needs attended to, and had any requisite cooling-off period. This is in contrast to the ED practitioners who are the first point of contact for the child and their family when emotions are often heightened.

The final interview was with a Paediatric Emergency Nurse Consultant from a third north-west Trust. This individual was chosen for their extensive experience, and qualification as a registered children's nurse, working in a dedicated children's ED. This contrasted with the adult registered nurses, working with children in generic departments. The quantity and quality of the data collected during this interview negated the necessity to interview a second paediatric ACP.

Thus, eight participant interviews were included in the analysis for this study, alongside my own reflections as an Emergency Nurse Consultant.

Chapter Five: Data Analysis Method

Qualitative data analysis can be undertaken in a number of ways in a phenomenological study. Cohen et al. (2000) suggest the use of the hermeneutic circle. This is a metaphor which guides the analytical process on several levels. Analysis begins as parts of the text are understood in relation to the whole text and vice-versa. Then the individual texts are understood in relation to all the texts and vice-versa. In other words, an understanding of the hermeneutic circle requires the investigator to consider the meanings of small units of data in terms of ever increasing units of larger data and vice-versa.

Cohen et al. (2000) suggest a pragmatic series of steps in data analysis as follows:

1. Active listening and thoughts about meaning begin during the interview. For this study, thoughts and initial impressions were captured in field notes immediately after each interview and were available to be referred to throughout the analytical phase of the study.
2. "Immersion" (p76), occurs as the researcher simply reads through the data several times. I found the process of transcribing the data immensely helpful in establishing immersion in the data through having to replay and listen to the actual dialogue many times.
3. Data reduction occurs when decisions are made on which elements of the data are important, and which are not. At this stage decisions were made about whether to remove such phrases as "you know what I mean". During the transcriptions decisions were made about whether such things as lengthy pauses were significant or not. No spoken words were removed at this stage.

4. Once transcribed, the data is subject to line-by-line coding necessary for thematic analysis.

This notion of thematic analysis is one that is commonly used in qualitative studies. Interpretative Phenomenological Analysis (IPA), now a widely recognised research methodology, uses a thematic analysis approach and is concerned with the detailed examination of personal lived experience, the meaning of experience to participants and how participants make sense of that experience (Smith, 2011).

Another particular style of thematic analysis is known as Template Analysis (Brooks, McCluskey, Turley, & King, 2015). The main procedural steps for conducting Template Analysis are:

- Become familiar with the accounts to be analysed.
- Carry out preliminary coding of the data.
- Organize the emerging themes into meaningful clusters, and begin to define how they relate to each other within and between these groupings.
- Define an initial coding template.
- Apply the initial template to further data and modify as necessary.
- Finalise the template and apply it to the full data set.

The key difference between Interpretative Phenomenological Analysis (IPA) and Template Analysis according to Langridge (2007), is that IPA is always highly inductive and is grounded in the data and is part of a specific methodological approach, whilst Template Analysis allows more flexibility with cross-case studies rather than within-case studies. Pre-existing knowledge, or theory, should not be applied to the data set in IPA whereas it can with Template Analysis (Brooks et al., 2015). It has already been established that I had personal knowledge of the phenomenon being investigated prior to the study commencing, therefore

I decided to use Template Analysis, which benefits from employing a priori themes as part analytical process.

Preliminary data analysis began after the pilot interview, and immediately after the transcription of each subsequent interview. The results from these influenced subsequent interview questions. Thus, the study design emerged and was reflected in the time frame for data collection.

Each interview was listened to, and read in its entirety to establish a 'first impression', from which a summary sheet was produced. This included who was involved, the issues covered, relevance to the research question and implications for subsequent data collection.

Each transcription was then analysed for relevant themes and first-level coded. Thematic analysis was then conducted using the pragmatic Template Analysis technique (Brooks & King, 2014), to organise the codes into meaningful relationships. Subsequent data collection was influenced by the initial analysis of previous interviews as the data collection and analysis proceeded in parallel.

5.1 Template Analysis

The Template Analysis technique (Brooks & King, 2014) was chosen for its methodical, yet flexible approach to qualitative data analysis. This was deemed particularly appropriate for the kind of text data which the transcription of the in-depth interviews in this study produced. Prior to commencing any data collection I attended the University of Huddersfield workshops on how to use Template Analysis. This gave me the insight into how I would analyse the data once it was collected.

5.1.1 Developing the Template

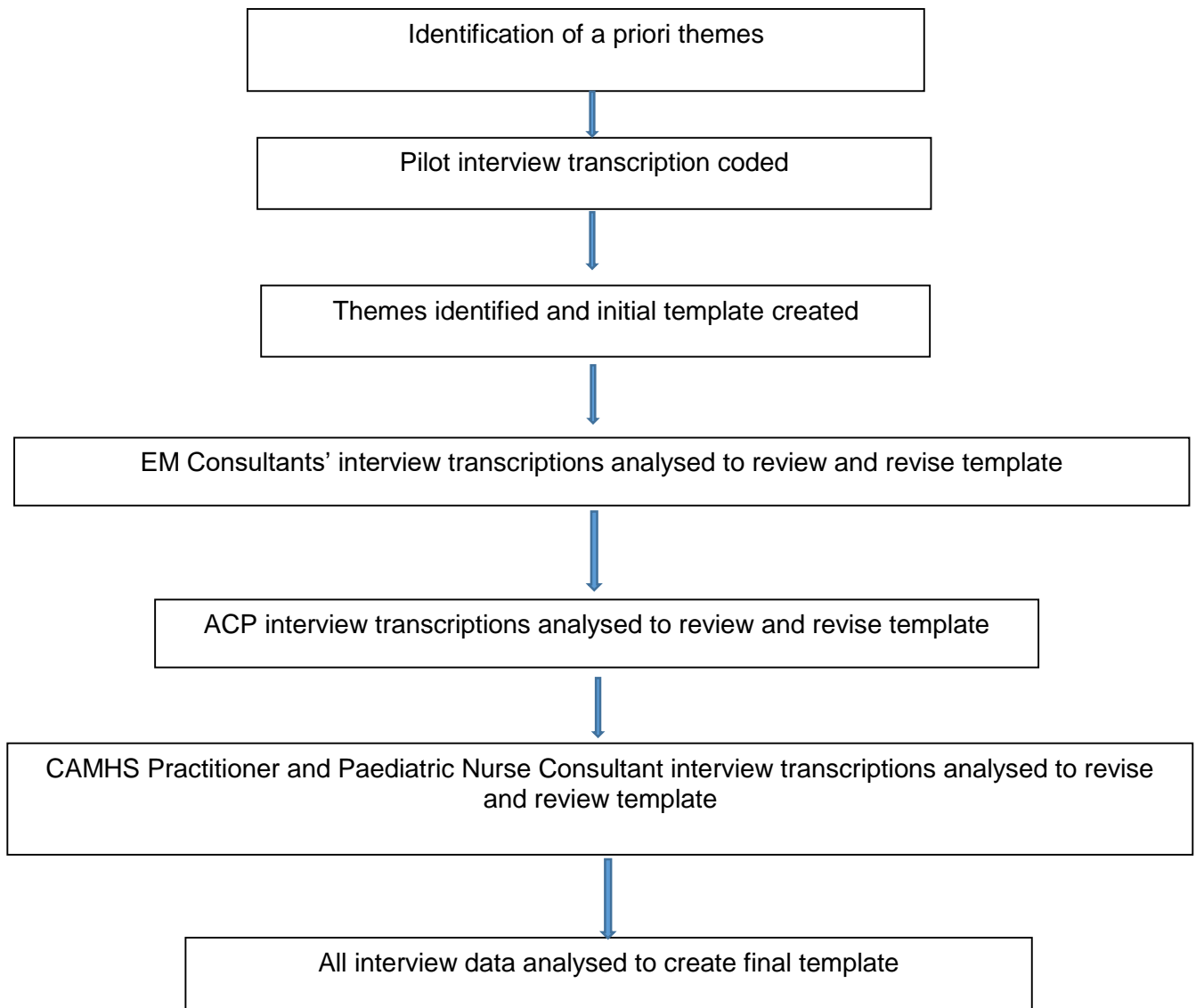
The method of Template Analysis permits the use of a priori themes to allow the definition of some expected themes in advance of the analysis process. Whilst not essential to this analytical method, they can be advantageous in ensuring a key focus on areas particularly relevant to the study (Brooks et al., 2015). A priori themes were identified in this study as outlined in Table 2 below. However, due diligence was observed, to ensure they did not restrict analysis of the data, and there was no reticence in changing the template once the data revealed new themes.

5.1.2 Table 2. A Priori Themes

A priori theme	Description
Knowledge	Includes theory and understanding of self-harm as a mental health issue. Theory or Empirical knowledge used in the consultation process
Skills	Practical measures taken to complete the consultation
Emotion	The experience or expression of emotional feelings during or after the consultation, either by the young person or the clinician
Experience	Previous exposure by the clinician to similar situations (from which learning occurred)

These a priori themes were chosen as a result of personal experience working with this patient group and their presumed applicability to the research question. They were a starting point from which to code the initial data. As will be demonstrated in the findings (Chapter Six), other themes emerged as the study progressed, and the template evolved accordingly. This is consistent with the methodological approach and analysis method. Figure 1 demonstrates the sequence of events leading to the production of the final template.

5.1.3 Figure 1. Summary of Analytical Interventions to Develop the Final Template



Within template analysis it is recommended that a subset of the data is coded before beginning to develop the initial template (King, 2012) . Before beginning the coding, the pilot interview was listened to in its entirety and the field notes reread to recollect initial impressions. Subsequently this pilot data was evaluated to be of sufficient quality to use it for developing the initial template.

The transcript was then coded line by line, highlighting text and marking in the margin any codes relevant to the research. In order to aid clarity for analysis, different coloured text highlights were used for different codes. During coding I was cognisant of the a priori themes, but made a deliberate effort not to adhere solely to them and seek new ones, as it was imperative any identified themes emerged from the data rather than making the data fit the themes. The individual codes were then clustered into themes and combined with the a priori themes to develop the initial template. This is outlined in Table 3.

5.1.4 Table 3. The Initial Template

1st Order Theme	2nd Order Theme	3rd Order Theme	4th Order Theme
Knowledge	Physical Needs	Wound management	
		Overdose Management	
	Suicide Risk Assessment	Physical Appearance	Maturity Assessment
		Method of Self Harm	
		Safeguarding	Drugs and Alcohol
Skills	Suicide Risk Assessment	Repeat attendance	
		Information gathering	
	Communication Skills	Identification of 'cause'	
Emotion	Mood Assessment	Environment	
Experience	Scope of Practice	Cooling-off Period	
	Absence of formal training		

This initial template was discussed with my academic supervisors. It was agreed to continue with the PEM Consultant interview and use the pilot interview as part of the overall data set. The PEM Consultant interview revealed some new themes and it was decided to interview a second PEM Consultant to elicit whether they were indeed profession specific or unique to the individual. Subsequent to these PEM Consultant interviews it was decided to review and amend the template for which a similar process was undertaken to the pilot interview analysis.

The interviews were transcribed, then listened to again in full alongside the field notes and then coded line by line. This was interpreted with the initial template, and a new primary theme of 'time pressure' was included in addition to the second order themes of 'other services', 'mental capacity assessment', 'clinician emotional wellbeing' and 'maturity of clinician'. Several other 3rd and 4th order themes were also added. These are summarised in Table 4.

5.1.5 Table 4. The Second Template

1st Order Theme	2nd Order Theme	3rd Order Theme	4th Order Theme
Knowledge	Physical Needs	Wound management	
		Overdose Management	
	Suicide Risk Assessment	Physical Appearance	Maturity Assessment
		Method of Self Harm	
		Safeguarding	Drugs and Alcohol
			CSE
			Bullying
			Social Media Use
		Repeat attendance	
	'Other' Services		
Skills	Suicide Risk Assessment	Information gathering	
		Identification of 'cause'	
	Communication Skills	Environment	Physical Environment (Food and drink/ feeling comfortable)
			Emotional Environment
		Questioning Technique	
		Listening	
		Body Language	
		Clinician Attitude	
Emotion	Mood Assessment	Cooling-off Period	
	Mental Capacity Assessment		
	Clinician Emotion/Wellbeing	Talking to Colleagues/Debrief	
		Rumination and Reflection	
Experience	Scope of Practice		
	Absence of formal training		
	Maturity of Clinician		
Time Pressure			

Successive interviews with three ACPs, a CAMHS practitioner and a Paediatric Emergency Nurse Consultant were coded in the same way and the template was revisited and refined to produce a final template. These successive interviews afforded significant confirmation of previous findings, in addition to the production of new themes. The final interview revealed no new themes, but gave rich data that expanded the on the previously identified themes. Interrogation of this data enabled further development of the template which was radically revised following reflection and discussion facilitated by academic supervision.

Two integrative themes of risk assessment, and engagement, were identified which influenced each other in a non-hierarchical way and simultaneously were associated with the ordered themes in the template. This is summarised in Table 5 with the integrative themes running along the full length and breadth of the template to represent their amalgamation with the entire template.

5.1.6 Table 5. The Final Template

Risk Assessment	Risk Assessment			Engagement
	1st Order Theme	2 nd Order Theme	3 rd Order Theme	
	Looking for injuries or potential poisoning	Wound Management		
		Overdose Management		
	Pursuing Safeguarding and Social Concerns	Child Sexual Abuse and Exploitation	Alcohol and Substance Misuse	
		Bullying	Social Media	
			School	
		Support	Should Parents Stay or Should They Go?	
			Looked-After Children	
			Attachment theory	
		Boyfriend/Girlfriend Issues		
	Interpreting Emotional State	Mood Assessment	Cooling-off Period	
		Maturity Assessment	Child Development Theory	
		Physical Appearance	Body Language and Behaviour	
		Environment of Assessment		
	Identification of Suicidal Intent	Repeat Attendance		
		Planning, Method and Preparedness	'Help Seeking' Behaviour	
	Deliberating Professional Practice Issues	Scope of Practice	Personal Scope of Practice	
			Role Specific Scope of Practice	
			Service Provision	
		Lack of Formal Training	Reflection and Emotional and Clinical Supervision	
		Maturity of Clinician		
		Gender of clinician		
		Time Pressure		
		Identifying Cause of Self-Harm	Information Gathering	
		Engagement		

Despite there being a stratified sample of different professionals, one final template was developed for the entire data set as it was decided these themes were pertinent to, and represented the experience of all the clinicians who experienced the phenomenon being studied. Template analysis was particularly useful in facilitating this cross-case analysis.

Once the final template was created, the entire data set was revisited to ensure the newly developed template was compatible with the previously identified codes and themes, and that no significant elements had been omitted. The findings from this process are presented in Chapter Six. Details of individual accounts, and how they informed the themes, are used in an attempt to present the experiences of the participants as 'parts' and 'whole', to compliment the phenomenological approach, as discussed in Chapter Three.

Chapter Six: Findings

This chapter provides details of the research findings, which were identified through thematic analysis of the transcripts of interviews with ED clinicians who see and treat children presenting with self-harm episodes. Whilst the a priori themes were used to populate the initial template, the final template was derived from interrogation of the raw data.

It was decided to include integrative themes within the template, as it became apparent during analysis that these elements were fundamental to the entire template rather than hierarchical to any ordered themes. The integrative themes established were Risk Assessment and Engagement.

The five major first order themes identified from the data were: '*Looking for Injuries or Potential Poisoning*'; '*Pursuing Safeguarding and Social Concerns*'; '*Interpreting Emotional State*'; '*Identifying Suicide Intent*'; and '*Deliberating Professional Practice Issues*'. The evidence for these themes is provided in detail throughout this chapter. Appendix 7 facilitates study transparency by aligning direct quotes from the data to the thematic headings. Second and third order themes relevant to these primary themes are established in the associated section, alongside the supporting evidence. The detailed discussion about these thematic findings, and their relevance to the research questions, is provided in Chapter Seven.

6.1 Ordered Themes

6.1.1 Looking for Injuries or Potential Poisoning

In their discussions, every clinician expressed the need to prioritise the identification and management of the physical needs of children over any emotional, mental health or social needs. In particular, the need to provide immediate treatment for the management of potentially life-threatening poisoning resulting from overdose was emphasised by all participants as the first priority for the clinician. This theme of 'Looking for Injuries or Potential Poisoning' in children is also evident in the section describing the theme of 'Deliberating Professional Practice' in section 6.1.5.

The nature of the physical conditions for which practitioners described the assessment and treatment for were divided into two categories: Wound Management and Overdose Management.

6.1.1.1 Wound Management

It is recognised that many children who undertake self-harm activities cut their skin as a method of harm (Paes, 2017). This is reflected in the experience of the ED clinicians who described their role in identifying and treating wounds. They articulated skills used in wound closure using varying methods such as steri-strips or tissue adhesive. When discussing this subject participants appeared relaxed and comfortable. I interpreted this to be because ED clinicians regularly treat patients with wounds, most of which have resulted from accidental injuries, such as occupational injuries with Stanley knives, or cooking related kitchen accidents, and this familiar element of care does not involve any mental health assessment. In addition to treating any obvious wounds, the need to actively search for possible injuries which may not have been initially disclosed by the child was illustrated by the following excerpt:

"Have you looked everywhere? To make sure there is no other wounds." (ACP 2: 596-597). This element of actively searching for wounds as part of the assessment of children who self-harm is different to that of patients with accidental wounds which are generally not concealed.

The treatment of wounds was also used as a distraction to initiate conversations deemed to be of a more sensitive nature about why the child may have self-harmed, or to discuss emotional concerns of the child. *"I might say: "Ok, we'll just give these a bit of a clean" but maybe they don't need closing, or some of them might need steri-strips, but I can start a conversation about other things while I'm doing that."* (ACP 3: 112-114).

In this way clinicians used wound treatment as one way of establishing 'engagement' (integrative theme section 6.2.2.1) of the child in conversation. Focussing on the physical treatment allows for a less intimidating conversation than direct face to face contact or questioning. Interestingly, I reflected that my own children often initiate sensitive conversations when we are in the car and I'm driving. This situation also enables discussion without face to face contact, which may feel less confrontational.

6.1.1.2 Overdose Management

The identification and management of self-poisoning, or overdose, was also seen as a priority by all clinicians. Indeed, one medical clinician was clear that identifying potential life-threatening problems was the most important aspect of their role in treating young people who self-harm, above all other elements: *"Is there something I need to treat first? Particularly from the overdose point of view. And then think about the other side of things when they're fit and well."* (PEM 1: 98-101). Again I perceived clinicians to be comfortable in their discussion about identifying and treating any pathophysiology associated with self-poisoning from overdose of medication. The knowledge and skills associated with this element of the consultation are not dissimilar to those used in the clinical examination of patients who present with other physiological

symptoms requiring physical examination: *"...make sure the liver's not tender from paracetamol overdose or something."* (ACP 3: 118). Paracetamol was identified frequently, but was the only drug named by clinicians in relation to children who present having taken an overdose. It was, however, seen as crucial to start treatment if needed: *"so if they've taken 80 paracetamol tablets, in which case you need to get on with it and start Parvolex. So that would be the very first thing"* (ACP 3:164-165).

In contrast to the ED clinicians, the CAMHS practitioner was less confident in being able to provide this immediate clinical treatment to young people, believing this to be the role of the ED: *"I guess we work on the fact that what we're relying on our colleagues in the emergency department to make a decision to say whether that person needs any treatment"* (CAMHS line 79-80).

6.1.2 Pursuing Safeguarding and Social Concerns

The theme of 'pursuing safeguarding and social concerns' was prominent in every interview. Initially the terms were categorised as separate themes, but as the data from the interviews evolved it became clear that social issues such as friendships, schooling and home support were thought of as potential sources of safeguarding concern. Likewise safeguarding concerns were also associated with social issues such as being in local authority care or 'looked-after'. Hence the terms were combined to form one theme.

In particular, clinicians felt there was a link between previous or on-going abuse in all its forms, and self-harm. This theme was evident from the pilot interview when the following comments were made:

"...it's a lot about child protection." (Pilot:188). *"...a lot of knowledge comes from a child protection background, as in seeing children that presented with signs and symptoms of abuse."* (Pilot: 300).

All subsequent participants mentioned safeguarding in the context of their assessment of this patient group. Examples of statements which support this finding include:

"...in particular, younger children I suppose you are worried that there's things going on at home. Either with the social group or with family group that might be worrying the child or from an abuse perspective." (Pilot: 135-137).

"...just check that it has been done. Are social services aware? Has safeguarding been done?" (ACP 3: 10-171).

"...because we should all be looking for safeguarding issues" (CAMHS: 376).

This theme was further sub-divided into the separate safeguarding and social issues revealed in the data as:

- Child Sexual Exploitation, for which 'alcohol and substance misuse' was a sub-theme.
- Bullying, for which 'social media' and 'school' were sub-themes.
- Parental Support for which 'Should parents stay or should they go?', 'Looked-after children' and 'Attachment theory' were sub-themes.

6.1.2.1 Child Sexual Abuse and Exploitation

Of particular concern to some participants was the safeguarding issue of sexual abuse and child sexual exploitation (CSE). Recent media coverage (Burns 2012), and an emphasis on mandatory safeguarding training (Her Majesty's Government, 2017), have raised the profile of this particular safeguarding issue in the minds of ED clinicians. This is clearly something they consider could be a factor in children who self-harm: *"More recently, as it has become more publicised, I focus on the issues around child sexual exploitation and sexual abuse and the questions that I now ask are more in depth in terms of use of social media, giving of gifts, access to websites, expectations around, you know, when you can go out, for example."* (PEM 2: 126-130).

This element of questioning has featured more prominently in my own practice when caring for adolescents since my involvement on the panel of a serious case review in 2015. It concerned the care of girl who had been sexually exploited since she was 13 years old, and had also self-harmed on several occasions. My experience has been that, generally, parents and children are willing to answer questions of this nature, especially when there are no concerns.

None of the practitioners in this study articulated any challenges they had experienced when pursuing questioning about potential sexual exploitation, although, one said they had been suspicious about the nature of the relationship of a man accompanying a child and about possible sexual exploitation, but the child was unwilling to divulge any information. They had still reported the incident to social services: *"I examined her and thought "What's going on there?" "I don't quite understand why your mum hasn't come with you, or (a) family member hasn't come with you" "This gentleman has come with you. How exactly do you know him?"... her response was "Oh, he's just a family friend", you know, she wouldn't go into any more detail with me... and I didn't want to piss her off, so I didn't probe anymore, 'cos I'm thinking she's going to be referred anyway."* (ACP 2: 417-424)

Only once have I experienced anger and animosity from a parent when asking about the sexual relationship of a 16 year old who had presented with self-harm. After establishing that the girl had a long-term older boyfriend (aged 22 years), and knowing from her notes that she had had a previous miscarriage, I asked her on her own, "Have you ever had sex when you didn't really want to? Or felt pressurised to have sex with someone?" Later in the consultation when the child's mother had returned to the room, the mother became physically intimidating, standing in my personal space at eye level, and aggressively stating *"You have no right to ask about her sex life. We are here (in the ED) because her (the child's) head needs sorting out. Not because she's been gang banged!"* The level of aggression and wording in the reaction gave me serious concerns about the ability of the parent to provide support for this child, and was

instrumental in me then contacting social services to seek further information on this family, of which there were significant concerns. Whilst this incident did not form part of the participants' data, it did allow me to reflect on the importance of asking questions about possible sexual exploitation, as identified by the study participants, even if this can be challenging, and then interpreting the response as part of the overall risk assessment (integrative theme section 6.2.1).

In addition to the identification of safeguarding concerns, clinicians also articulated the need to act on any safeguarding findings: *"you have to phone through to social services and then send it (the referral form) off to the safeguarding people here, and also the ones from social services. If it's really serious or urgent, I'd phone the Police"* (ACP 2: 394-396). As with 'looking for injuries', the dialogue in relation to safeguarding suggested the ED clinicians actively sought to identify and act on any safeguarding issues, rather than merely responding should they be obvious. Hence the theme title to 'pursue' safeguarding concerns.

6.1.2.1.1 Alcohol and Substance Misuse

Two practitioners (ACP 2 and PEM 1) also stated they would enquire about alcohol or substance misuse as part of a safeguarding concern: *"You think about drugs and alcohol. Have they been abusing that for a while? So you have to think about that as a safeguarding issue as well."* (PEM 1: 135). This topic did not feature in-depth throughout the data, and the comments made were not elaborated on, nor did it feature in any of the other clinicians' accounts.

I consciously made it a sub-theme of CSE due to the close association between alcohol and substance misuse which features in many serious case reviews into CSE (Jay, 2014; Raynes, 2016; Rochdale Safeguarding Children Board, 2013).

The significance of the absence of dialogue about alcohol and substance misuse is detailed in Chapter 7.

6.1.2.2 Bullying

Bullying in young people who self-harm was another area of concern for which practitioners felt they might need to instigate safeguarding measures.

"You're also looking at long term abuse, whether it's bullying or whatever." (CAMHS: 152-153).

In response to questioning about ACP practice, one of the PEM Consultants was very complimentary about ACPs pursuing questions about bullying, qualifying the remark by comparing them to junior doctors who may be less experienced at pursuing safeguarding concerns in relation to bullying when seeing children who have self-harmed.

"... I don't see the juniors (doctors) asking about text bullying. I don't see the juniors asking about Facebook bullying." (PEM2: 235-254).

In relation to 'bullying', practitioners commented on two sources; social media and school. These became third level themes in this category.

6.1.2.2.1 Social Media

An increase in the use of social media and digital communication was seen as a source of bullying leading to self-harm behaviour.

The CAMHS practitioner in particular felt that social media had played a large part in influencing the time of day at which children present to the ED: (cyberbullying)... *"was all completely alien 10, 15 years ago, you didn't have that. It was just, you know, bullying at school. But all part of my assessment is to ask...Is that taken outside of school? Is it (bullying) not just happening at local community? Is it happening on Facebook, on Twitter, on any kind of social media?" (CAMHS 394-399).*

"We see a lot of young people who react to that, social media bullying. So it won't be a planned self-harm..."

they are being texted, or Facebooked... at 12 O'clock at night and coming to A&E... We see a lot of those impulsive acts because of something what's happened on-line." (CAMHS 403-405).

In contrast to being a source of distress, the use of social media and digital communication was also seen as a method of seeking help: *"So it might be, you know, "Do you use social media?" "Have you texted etc. etc. to display these thoughts?"* (PEM 2: 200-201). This describes how children might communicate suicidal ideation in addition to the traditional suicide notes commonly written by adults. (See section 6.1.4 on Identifying Suicidal Intent).

My own experience has corroborated the perception of social media as a source of both provocation and protection in relation to self-harm. In the year following data collection, I saw a young girl who was being blackmailed following her sharing a sexually explicit image she thought had been secure and to a person she trusted. She feared this would be shared more widely, and that her school friends and parents would see it. This resulted in her taking a significant overdose which she thought would end her life. She saw no other way to escape the situation. She became scared and told her friend what she had done via Snapchat. Her friend then told her own mother, who informed the girl's mother, who in turn left work to collect her daughter to bring her to the ED. Thus, social media was her preferred method of seeking help. This clinical example resulted in immediate physical treatment for poisoning (see section 6.1.1) and then further exploration of the social media safeguarding concerns which were then shared with the Police.

6.1.2.2.2 School

School, as a place which may be the cause of safeguarding or social concerns, particularly in relation to bullying leading to self-harm, was discussed by several participants. *"...they might start off and say "Well, I'm having problems at school"* (ACP 2: 360-361).

Compulsory attendance at school is a situation unique to childhood. It is therefore unsurprising that this situation, where young people are forced to share space with others, who may be from different cultures and backgrounds, and have different values and beliefs, can result in the emergence of dominant personalities who seize opportunities to prey on vulnerable individuals. Bullying in school, resulting in self-harm is not a new phenomenon. The CAMHS practitioner identified this by saying: *"part of my assessment is to ask the old fashioned... "are you bullied at school?"* (CAMHS 396-397).

School was also seen as a place where safeguarding protection might be offered. *"Have the school nurses been aware? So we're probably talking to our safeguarding team to contact school nurses and for the school team to know that's been going on, so they can give support."* (PEM 1: 330-332).

As with 'Social media', the sub-theme of 'School' was viewed as both provocative and protective in relation to young-people who self-harm.

6.1.2.3 Support

Participants referred to identifying support for the child as an important part of the risk assessment. More often this was in relation to parental or family support, but it was also in relation to accompanying friends or teachers.

Participants also expressed concern for how the family were coping and their ability to provide support to a young person by putting measures in place to prevent opportunistic self-harm, such as locking up medication: *"And then it's also about how the family or the home environment is protected from increasing that risk of self-harm. So a child who's previously taken overdoses, are the parents doing everything they can to limit the risk? Are they locking up medication or is medication still around? Are they putting in place the plans that have been set out in the risk assessments that have gone on before?"* (Paed ACP: 259-263).

This notion of support and family assessment was seen as a key difference between assessing adults and young people with self-harm by the CAMHS practitioner.

(When you work with adult patients) *"You don't work with families. Families are just somebody who come along. You work with that individual 90% of the time, 99% of the time."* (The difference with working with children) *"is that having to realise that young people live within families, so you're working with the whole system rather than that one individual."* (CAMHS: 348-352).

Understanding and interpreting family interactions was a vital part of the initial assessment, and ultimately informed the overall risk assessment (integrative theme) of the child.

"Looking at the interaction between that young person and who they are with, I've picked up one thing that girl said was "My mum's not important".... I thought that was such a funny thing for her to say... "She's not important" She was quite upset and she didn't want her mum to know, but I just picked up on that one phrase she said to kind of think "There's something else going on here." You know there's more of a kind of family system kind of relationship problem." (CAMHS: 505-510).

The issue of whether the consultation with children should take place with parents present, or not, was raised by several participants. This created the sub-theme in the analysis of 'Should parents stay or should they go?'

6.1.2.3.1 'Should Parents Stay or Should They Go?'

Whilst practitioners identified that assessing the family dynamics, and the family's ability to provide support was important as part of the risk assessment, they also recognised the need to respect the wishes of the child with regards to privacy during the assessment. Having parents present may impair the ability to establish engagement with the child, which in turn may make risk assessment more difficult.

Some practitioners systematically interviewed the child, then parents individually, followed by a joint discussion. *"I like to take a history from the patient. That is the child, first. On their own. Followed by whoever the child is with, on their own. And then, together. (PEM 2 66-68). Others were led by the child's wishes about whether they wanted their parents present.*

"I'd normally go in and ask if they wanted the mum and dad to stay in. Or do they want to talk to me on their own? Or do they want mum and dad to go out?" (ACP 1: 215-216).

One practitioner consciously made a judgement about whether having parents present was conducive to the consultation. *"Normally I would go in and introduce myself and establish who is with the patient and their relationships with the patient, and then I would make a very quick judgement call depending on the level of anxiety of the other individuals." (PEM 2: 63-65).*

There was no consistent guidance or policy about having parents present. One clinician used a standard format of: see the child on their own, then parents on their own, then finally both together. However most clinicians used experience to make a judgement about whether parental presence would help engagement and the risk assessment process, or whether asking them to leave would be more beneficial to the child.

6.1.2.3.2 Looked-after Children

In analysis of the interview transcripts, it became apparent that children in local authority care, or 'looked-after children' as they are often referred to, crucially informed the risk assessment (section 6.2.1) as they were perceived as being at higher risk in relation to self-harm and their need to be protected, often due to a breakdown in family support mechanisms. *"Yeah, they are quite a high risk group (Looked-after children), because a lot of them are very socially isolated. Because they have been in the care system and suddenly they are on their own. Who's actually*

supporting them?" (ACP 2: 477-479). Hence this became a sub-theme of 'Support' under the primary theme of Safeguarding.

Other clinicians (PEM1 and PACP) regarded 'looked-after children' as being of higher risk due to their experience of them absconding, either from the home environment or the ED: " *Then if the child's saying to me "I'm going to run away" which you get with some of the looked-after children in foster care. "I'm still going to run away". Then you've got the whole social side of things to sort.*" (PEM 1: 171-173).

6.1.2.3.3 Attachment Theory

The only practitioner to mention any formal theories they consciously used in assessment of children having self-harmed was the CAMHS practitioner. Whilst some clinicians mentioned social support networks as being important (section 6.1.2.3), the CAMHS practitioner felt that many problems associated with self-harming young people could be understood through the lens of attachment theory.

(Do you use any specific theories in your assessment of young people?) " *Definitely. Definitely attachment theory. Because I would say that most of those one-off impulsive acts come (about) because there is an issue between the person and the carer. And then, interestingly, when you start to think about that attachment, you can see it (the problem)..... So I would definitely think about attachment theory, yeah.*" (CAMHS: 868-880). The CAMHS practitioner did not elaborate on how attachment theory might objectively influence the risk assessment or ability to engage with a young person, but appeared to apply it in a way to understand the family dynamic, which may influence the degree of support for a young person, or explain why children self-harm due to lack of attachment: " *So I think attachment theory and early child development go hand in hand. You know we do get a lot of young people ... who come in with more emotional difficulties which cause them*

to react, and then do what they do (self-harm), and come into A&E. The vast majority we get, you know, it is more about that early development, early child development and attachment theory go hand in hand for me.” (CAMHS: 890-896).

Most participants had never heard of attachment theory. This was attributed to lack of training (see section 6.1.5.2): (Have you come across attachment theory?) *“No, not me. But I don't know if that's because I'm not paediatric trained.” (ACP 2: 485).*

6.1.2.4 Boyfriend/Girlfriend Issues

Two practitioners highlighted that the breakdown of relationships can be associated with self-harm presentations. My analysis of the practitioners' casual remarks about this was that they perceived the risk to be lower if the self-harm was purely due to a relationship break-up, and the practitioners had less concerns than if there were other reasons for the self-harm.

(They might say) *“...I've split up with me girlfriend or whatever.” (ACP 2: 361)*

“Is it just a case of 'I split up with my boyfriend last night'?” (PEM 1: 96-97)

6.1.3 Interpreting Emotional State

In addition to 'looking for any injuries or potential poisoning' and 'pursuing safeguarding and social concerns', all practitioners identified the need to assess the emotional state of the young person. The assessment of emotional state appeared to significantly contribute to the overall risk assessment of the young person and approach to the consultation.

“I think one needs to be mindful about the emotional environment that one is going into. The psychological state.” (PEM 2: 40-41).

This theme was further divided into three sub-themes:

- Mood Assessment, for which 'Cooling-off period' was a sub-theme.
- Maturity Assessment, for which 'Child Development Theory' was a sub-theme.
- Physical Appearance, for which 'body-language and behaviour' was sub-theme.

6.1.3.1 Mood Assessment

Assessing someone's mood was identified as a prominent part of the ED clinician's consultation. The phrase 'low mood' was used five times by the pilot participant. Other words or phrases which were interpreted to be part of the 'mood assessment' theme included; sadness, tearful, depression, low self-worth, and feeling anxious. (Mood assessment)...*"it's if they're tearful, distressed, anxious."* (Pilot: 70-71).

"...or "Actually I've been quite low for a long time..." that would concern me." (PEM 1: 97-98).

The mood of a child had a clear impact on the ability of the clinician to engage with them (section 6.2.2), and heavily influenced the clinician's risk assessment of the child (section 6.2.1). Children with signs of depression or low mood, particularly those who appeared without hope, were perceived by clinicians to be at much greater risk than those who had optimistic plans for the future: *"Their general tone is an indicator, do they sound like they're depressed? ...What's their outlook on life? I suppose if you've got someone who, they're a teenager who's looking forward to going to college ...then it gives you some indication that they have a life plan ahead of them or in place. Rather than a child who maybe says "No, I don't want to be here. I don't want to be here next week. I want to die", would indicate more of a risk."* (Paed ACP: 232-239).

6.1.3.1.1 Cooling-Off Period

Several clinicians referred to an element of time known as the 'Cooling-Off Period'. The facilitation of this time, for children to be separated from the home environment, and to have the ability to reflect and become emotionally less charged, was seen as an important aspect of the child's management. This was a key difference between the management of children versus that of adults who have a full psychosocial assessment without first having a 'cooling-off' period. *"I'm probably a lot more cautious with children in admitting them for their cooling-off period than we are with adults. And I think people under value the cooling off period."* (PEM 1: 231-233).

One acute hospital routinely admitted every child overnight, regardless of the method of self-harm or ED assessment, in order to facilitate the cooling-off period. They then had their full psycho-social assessment by the CAMHS team the next working day. Interestingly, there was no process for recording an objective risk assessment or management plan for in-patient paediatric staff to follow during the cooling-off period. The work of Manning et al. (2019) is likely to be of benefit in addressing this as it becomes more widely recognised.

The length of time required for 'cooling-off' was also debated: *"And the concept of a cooling off period is a very difficult one isn't it because, you know it's slightly opaque as to how long that needs to be."* (PEM 2: 407-408). Whilst the experience of one clinician clearly changed their mind with regards its value: *"It's not that they are not serious but a cooling off period means that the assessment can be done much more thoroughly, in a better way and in a controlled manner, once they've got the anger and aggression and the upset out of their system. And I think, I probably didn't appreciate that when I started out and probably like many of my colleagues who poo-poo the cooling off period as just time-wasting, and taking up beds, actually it's a very important part of the mental health assessment."* (PEM 1: 243-247).

Another clinician was dubious about the need for the cooling-off period for everyone: *"I have my reticence that it (cooling-off period) is required in everybody. ...I can rough guess that probably only half need it, and the other half are engaging and you can get a story and they don't need a cooling off period, but again that's the psychological development of the child and their interaction."* (PEM 2: 413-418).

This demonstrates the differing opinions between senior experienced clinicians in relation to the management of children who self-harm. My personal experience has been that the cooling-off period can be very beneficial for some children, particularly when the child is angry or highly emotional at presentation. There have also been other occasions when I have not admitted children for a cooling-off period, usually due to the time lapse of over 24 hours before attending the ED, or due to my assessment that the issues resulting in the self-harm act by the young person have been resolved, that they are being discharged to an environment of their choice with good parental support, and they are willing to engage further with CAMHS services as an outpatient.

6.1.3.2 Maturity Assessment

Assessment of maturity, sometimes expressed as age, had an impact on both 'Risk Assessment' (section 6.2.1) and 'Deliberating Professional Issues' (section 6.1.5). The majority of participants felt that the younger the child was, the more difficult it was to assess them, and the risk was greater:

... So I tend to see children fourteen or above, but it depends on when I see them if I think they are immature for their age." (Pilot: 73-74).

(Risk assessment depends on) *"Age. First of all if they are very young, that would really concern me. So, I've seen a 6year old who tried to jump out of a moving car before, distraught. Which concerns (me)... huge alarm bells ringing."* (PEM 1: 141-143).

"A mature 16year old's got more street cred. They're more savvy. In some ways you might be less concerned than someone who's quite immature for their age." (PEM 1: 351-352).

Others felt that age or maturity influenced communication style and an ability to establish engagement (section 6.2.2), again with younger or more immature children being more difficult to engage: *"And you know, in the very young child, which for me is more difficult, ... it is much harder because they are so much more young, mentally. I feel that they are more, more of a challenge to converse with."* (PEM 2: 201-204).

The implication regarding the relationship between maturity and risk is discussed in Chapter 7 (section 7.2.3.2).

6.1.3.2.1 Child Development Theory

Whilst no-one other than the CAMHS practitioner mentioned any specific child development theories (see evidence for Attachment Theory, section 6.1.2.3.3), two paediatric practitioners (PEM 2 and Paediatric ACP) articulated that they used knowledge of child development in their assessment of the child. Both these practitioners have had specific training in children's emergency care, whereas the ACPs, who didn't mention child development were all registered adult nurses.

For the purposes of this study, child development was linked to maturity assessment as a sub-theme of interpreting emotional state.

"I think any training package needs to look at the psychological development of the child, and the influence of different stressors on this." (PEM 2: 249-251).

"So assessment of their developmental appropriateness is something that's definitely used. Yeah, absolutely." (Paed ACP: 279-280).

In the context of these interviews I interpreted that these clinicians used knowledge of normal child development, and related this to the child's presentation with respect to their level of maturity and emotional state, which was used to inform the overall risk assessment. Those whose maturity and emotional state were not matched to the expected 'normal' for the child's age were perceived to be at greater risk.

6.1.3.3 Physical Appearance

The physical appearance of a child was mentioned by all participants, both in relation to their body language, which was used to assess mood, and interpreted as part of the overall risk assessment, and how well a child was engaging in the consultation. It was also used in relation to assessment of maturity as described in section 6.1.3.2. The physical appearance of a child was additionally used to determine risk in relation to mental illness such as eating disorders.

"I'd like to be able to know if a child looks underweight and malnourished for example." (Pilot: 241-242).

6.1.3.3.1 Body Language and Behaviour

Body language influenced both integrative themes of risk assessment and engagement and was commented on in depth by all participants.

"As I went to speak to her, (I) sort of observed how her persona was, how she looked physically I suppose. So, she was well dressed and her hair was brushed, and she was sat with her mum and gave reasonable eye contact at that time." (Pilot: 47-49).

This statement was analysed to mean that the participant interpreted the body language (eye contact), and physical appearance (well dressed and hair brushed) in a positive way, to represent a reduced level of risk.

"...so I think more about physical things, physical interaction with you, and how they communicate and eye contact." (Pilot: 75-77).

"...general behaviour or, if they look withdrawn, or if they look pale and they look particularly withdrawn. If there's no eye contact." (ACP 1: 114-115).

Eye contact was a key indicator of establishing whether or not a child was engaging in the consultation. In turn it was also used to assess emotional state as part of the risk assessment. 'Withdrawn' body language and 'no eye-contact' was interpreted as higher risk than good eye contact and confident body language which was interpreted as lower risk.

"I think you read a lot more into the body language of your patients." (ACP 2: 100). "...there are certain things that I look out for that would cause me concern. Like if they are not making eye contact with you. If they are looking down. If they are talking monotone. If they look unkempt. You know, all of those kind of warning signs that you pick up. Not from what they're telling you, just from what you are observing with the person." (ACP 2: 102-105).

"Appearance, general appearances as they come in. Are they smiling? Alert? Happy? Good interaction with parents? Or is this a quiet withdrawn person? Not interacting with parents? Which just makes me concerned." (PEM 1: 143-145).

"But it's also more than that. It's picking up on the none-verbal cues as well. So someone who's non-engaging, someone who's looking nervous. Whereas you've got other children who might be kind of confident in their appearance, somebody who has just taken a one-off overdose after a row with their parents because they didn't get what wanted, who maybe sits there being confident. And er... kind of quite overt rather than someone who's quite within themselves." (Paed ACP: 292-296).

The body language of the clinician was also deemed to be important in trying to establish engagement.

"Because if you go into a cubicle and you stand above and you've got your arms crossed and are very closed... And you are "So why did you take the tablets?" or "Why have you cut yourself?" That could come across as being very defensive. Whereas if you just sit down and say "So come on then, what happened?" (ACP 2: 356-259).

6.1.3.4 Environment of Assessment

Two ED clinicians felt the environment was important in trying to facilitate engagement, including the offering of food and drink.

"...try to get an environment that's comfortable for both of you, so thats all the things about environment. ... (make sure) that the environment's relatively quiet." (Pilot: 86-87).

"Offer them something, food, nourishment, that kind of thing." (PEM 2: 180-181).

It was acknowledged that it can be difficult to facilitate an appropriate private environment in a busy ED.

"Sometimes I think, it's difficult in A&E, as in you know it's a really busy environment and people walk in on conversations." (Pilot: 95-96).

6.1.4 Identification of Suicidal Intent

Suicide was identified as a serious risk for young people who self-harm, and the ability to enquire about suicidal ideation was expressed by all practitioners as an important as part of the risk assessment.

"It (Suicide risk assessment) should be part of the history taking for all self-harm." (PEM 2: 193).

"I ask very openly, and I'm not afraid to say "Do you feel like you're going to kill yourself?" "Have you been thinking about killing yourself?" (ACP 1: 187-188).

"Asking them... "Is it just a cry for help? Or did you really intend to kill yourself?" So you're a lot more concerned if they said "Yes, I still want to kill myself."" (PEM 1: 149-150).

"She wanted to die. That's what she said to me. She wanted to die. She didn't want to be here. She didn't feel like she had any benefit." (Paed ACP: 57-60).

Caring for suicidal children can have a significant emotional impact on the clinician as described by one participant: *"It can almost be almost be like a mini post-traumatic stress event"* (PEM2:352). In my own experience there has been at least one occasion when I have had tears in my eyes whilst hugging the parent of a child who had no hope for the future, and wished they were no longer living. As a mother, I can only imagine how devastating that must feel. My reflection was that by showing empathic emotion whilst maintaining composed professionalism, this family realised that I cared about them and their child.

The issue of suicide risk assessment is discussed further in Chapter 7. (Section 7.2.4)

6.1.4.1 Repeat Attendance

The consideration of children having multiple attendances was articulated by several participants. An example of this is an excerpt from the interview with ACP 1: *"She openly discussed it and told me she'd done it loads of times before."* (ACP 1: 63-64), (Looking at previous attendances) *"...gives you a good indication of the risk."* (Paed ACP: 127).

This factor of repeat self-harm appeared to contribute significantly to the overall risk assessment, with first presentation being viewed as higher risk for some: *"...first presentation is very high risky behaviour, then that automatically sets alarm bells ringing."* (ACP 2: 296). *"My risk assessment starts at the beginning. Looking at the computer to see if they have done it before. So I'm always a bit more wary on the ones that are new."* (PEM 1: 90-91).

For some practitioners the repeat episode was interpreted as a lower risk:

"...but if they have got recurrent episodes and their behaviour hasn't escalated to more risky behaviour, you might not be as concerned if they did leave." (ACP 2: 212-213).

Others expressed the need to be cautious when assessing risk in people with repeated self-harm:

"It's difficult because you might have someone who comes every week with the same thing and you get blasé. When actually this time there might be something different." (PEM 1: 222-223).

"(Repeat attendance)... shouldn't change the way you do the assessment...The day you take your eye off the ball on that, is the day that something bad happens." (CAMHS: 433-436).

The implications of repeat attendance for risk assessment is discussed in Chapter 7.

6.1.4.2 Planning, Method and Preparedness

The detail of the planning, the method of self-harm, and preparation for the act all influenced the assessment of risk. Participants interpreted detailed planning and potentially lethal methods of self-harm, particularly violent methods, as an increased risk for future self-harm or suicide.

"Yeah, or jump from a car, or a train. Something that takes method and planning rather than impulse (Is higher risk behaviour)" (ACP 2: 334-335).

"The mechanisms which they might have thought about (self-harming), so hanging versus cutting, and violent mechanisms would make you concerned." (PEM 1: 151-153).

"She has certainly made some significant attempt to end her life." (Paed ACP: 73) This participant was describing how a 13yr old girl had tried to use a sock as a ligature in a cubicle in the department.

"You know, someone who goes and takes themselves out into a wood with a bit of rope to try and hang themselves is more, in my mind, much more risky behaviour than someone who may have taken two paracetamol and told their mum two minutes later that's what they've done." (ACP 2: 136-139).

Whereas, young people who had impulsive methods with little planning were seen as lower risk:

"I'd want to know if it was a spontaneous thing. Had they just had a fight with their friend? Had it been something they'd planned for a long time so? If it's been planned for a few weeks and they decided that this Saturday night when their mum and dad were out that they were going to do this, then that's obviously a massive alarm bell over somebody who's (said) "Oh I had a fight with my boyfriend and we broke up and I took six paracetamol. "" (ACP 3: 355-359) (see also boyfriend/girlfriend issues section 6.1.2.4).

Children who made plans to self-harm when they thought they would not be discovered were also thought to be higher risk:

"Have they done it when they know nobody is going to be in the house? Or no-one's coming back?" (ACP 2: 340).

6.1.4.2.1 'Help seeking' Behaviour

Seeking help prior to self-harm behaviour, or quickly after a self-harm episode, was interpreted by clinicians as lowering the risk for that person: *"If you've had someone who's threatening, but not actually done anything, ...they've sought help before they've done something. So that's good, because that means they want to interact with you prior to having actually done something and they thought "I need to get treatment for that" (ACP 2: 125-127).*

Whereas a delay in seeking help, or deliberately concealing the self-harm act, was interpreted as an increased risk for the young person:

"I always get worried about young people who don't tell people, who wait a long time until they tell somebody they've taken an overdose." (CAMHS: 94-95).

"Time of delay from presentation. If they hadn't told anybody and mum noticed self-harm marks, or discovered tablets were missing, that's high risky, that raises my level of concern." (ACP 2: 133-135).

6.1.5 Deliberating Professional Practice Issues

All clinicians discussed their scope of professional practice, including boundaries of practice. On analysis this was further categorised as either practice pertinent to the individual, role specific practice, or service specific practice.

6.1.5.1 Scope of Practice

6.1.5.1.1 Personal Scope of Practice

The 'Personal scope of practice' sub-theme reflects the decisions made by individuals about their own clinical practice regardless of profession, role or practice setting. Reference was made to the age of the child, which for some influenced whether the clinician felt they had the competence to see them, and also to the limitations of their mental health knowledge. In general, the younger the child, the less likely that the clinician would deem themselves to have the competence to see them.

"...the younger children I feel less confident with, so tend not to see those within my scope of practice."
(Pilot: 212-213).

"I tend to focus on adults, so, for me, I don't always know...Like I say with the younger end, I don't know what I don't know." (Pilot: 248-249).

Some clinicians found it more difficult to engage with younger children, resulting in difficulties making an informed risk assessment (also see Maturity Assessment section 6.1.3.2).

"...but my scope of practice I tend to stick to the group I feel happy communicating with." (Pilot: 231-232).

Others (ACP3 and PEM1) described limiting their practice to providing necessary physical care and identifying immediate risks to safety, but devolving further care, particularly related to their mental health, to other professionals.

"(I wouldn't do anything)... apart from doing anything immediate in A&E for their safety, and then talking to them and establishing what's happened, and why, and what the risks to them are now. Trying to get as much as I can, so they can tell me as well, so I wouldn't start any (mental health) treatment in A&E." (ACP 3: 386-389).

Conversely, the CAMHS practitioner declared their personal scope of practice would be limited to mental health assessment, having not acquired the skills and knowledge of physical assessment which was seen as a priority for ED clinicians (See section 6.1.1).

"I don't know how they do their assessments, because it's completely alien to me is physical health."
(CAMHS: 372-373).

6.1.5.1.2 Role Specific Scope of Practice

Some comments were made by ACPs who felt their scope of practice as an ACP had enhanced their ability to engage with patients compared to their previous role as a nurse.

"...you get more involved as an ACP than I did as a nurse." (ACP 3: 470).

"Well you are a lot more of a nurse as an ACP, than you are as a nurse. You get to spend loads more time with the patients. Which you do, so I think you get a lot more involved and you form a bigger bond and relationship with the patient than you did as a nurse." (ACP 3: 472-474).

This notion that as an ACP you are 'more of a nurse than you are as a nurse', reinforced my own beliefs that developing into the advanced practice role enhances my professional nursing ability rather than distancing me from nursing to become more like a doctor.

The CAMHS practitioner felt that a detailed understanding of mental illness was not essential to assessing young people who have self-harmed.

"...not knowing about the mental illness side of things doesn't stop you doing a risk assessment. So I don't necessarily think you need to know that. Certainly the social workers in the team wouldn't." (CAMHS 478-480). As a nurse not registered in mental health, this surprised me. Similar to the ED clinicians in this study, I believed the comprehensive assessment of children who have self-

harmed would require knowledge and ability to assess for mental illnesses, and had always perceived this to be a limitation to my scope of practice.

6.1.5.1.3 Service Provision

Some comments were made about the scope of the service in the ED and what should be delivered, and what should be provided by other services. Some believed the ED should focus on the physical emergency treatments and delegate the other elements of care to other healthcare services.

"We're here to deal with the acute emergency issues." (PEM 2: 91).

"Some might argue that the secondary elements (mental health and social issues), other teams can manage, and there's a fine line between just dealing with the immediate stuff and leaving go and referring on." (PEM 2: 103-105).

This understanding of the CAMHS service provision and ability to undertake a mental health risk assessment, appeared to be a source of concern for the CAMHS practitioner, who felt it should be the responsibility of all professionals who come into contact with children and young people. The ED clinicians were perceived to limit their service to physical assessment and treatment and expect the CAMHS service to provide any mental health assessment and treatment.

(When asked whether they thought the ED was concentrating on the physical needs rather than the holistic person) *"Yes. Without a shadow of a doubt, without a shadow of a doubt. It doesn't say "Accident and Emergency for physical conditions only" but that's impression we have."* (CAMHS: 251-254).

In addition to ED clinicians, the CAMHS practitioner also believed other professionals involved with children should be able to speak to children about concerns they may have regarding mental health issues:

"...she'd been seeing the school counsellor. She's been seeing the school nurse. She'd been seeing her GP. No one has got the guts if you like, to (ask) "Why are you so thin?" "Why aren't you eating?" ...Because people think this is a mental health problem. Actually when I asked her, she just told me straight away" (CAMHS: 513-518). "...she hadn't been waiting for an RMN (Registered Mental Health Nurse), or someone from CAMHS to turn up and ask her that question. So why didn't the other professionals ask her? So, I wonder if some of it is "This is a mental health problem and I don't know how to deal with mental health problems." You know it's not a magic formula. You've got to sit down and ask questions to young people." (CAMHS: 523-527).

There was a perception by the CAMHS practitioner that acute hospital clinicians do not want to care for children who are not physically unwell, and believe they should not be in the acute hospital, blaming the CAMHS staff for the admission.

"It's becoming a little bit of an epidemic really about, if a doctor or a nurse is thinking "Why is this person in our hospital?" "Why are they in our A&E department because they are not medically unwell?" "Why have YOU admitted them onto our ward? Because they're not medically unwell?" I've seen it quite a few times and what gets fed back to me as well is that the medical staff say things about that young person to us, and to other doctors and to themselves in front of that young person." (CAMHS: 915-919)

"I can understand the frustrations. I just think sometimes, that child's wellbeing, overall wellbeing, because they're not deemed to be medically unwell, sometimes goes out of the window. And I think, certainly at times during the winter, that's more evident." (CAMHS: 972-976) My reflection on this, was that during the winter months there tends to be more pressure on acute paediatric in-patient beds, due to the seasonal prevalence of acute respiratory illnesses such as Bronchiolitis. Therefore

there is a pressure to discharge anyone who is physically well, to make space for those requiring treatment for acute illness. This reflects the perception of physical illness being more of a priority than mental illness (see section 6.1.1) and could be interpreted as an example of lack of parity of esteem (Mental Health Task Force Strategy 2016).

The CAMHS practitioner also perceived the attitude of acute hospital clinicians to be derogatory to patients without physical health needs:

"And we've had feedback from young people who've said 'I've heard them talking about me' 'I've heard them shouting at you about me'. So, you could be talking about somebody who has problems with their emotions, who has problems with their mood, has problems with their self-esteem and image. And this.., this doctor is, not saying, not particularly using their name or saying bad things about them, but in general is saying 'I do not want them on this ward', so they're getting rejected. 'Get them out of here'. And that young person is in crisis and they are thinking 'Where am I going to go?'" (CAMHS: 1007-1013).

The perception of the CAMHS practitioner regarding lack of understanding by ED clinicians about the assessments and services undertaken by specialist mental health services was corroborated in some of the statements by other participants.

(I don't know) *"...if there are any differences in the way that CAMHS and the RAID team work and function. Because they will be very similar, but if there's any differences in their protocol and the way that they assess. I don't know what an in depth CAMHS mental health assessment would look like."* (ACP 1: 274-277) RAID is the Rapid Access, Intervention and Delivery team who are commissioned to see adult patients who present to the ED in mental health crisis.

"And who are we going to involve to get the best for them. And that is often the most difficult thing, is the other agencies. Who do you involve? When do you involve them?" (PEM 1: 295-296).

"Social Workers, Drug and Alcohol Services, CAMHS or adult services if it's RAID. I don't actually have much knowledge of the different systems that are out there once they leave here (ED). What CAMHS actually do with them, the counselling they get. Do they get CBT? I don't know these things." (PEM 2: 301-304).

"In terms of the finer aspects of what's available, I think it's really difficult. There were so many different kind of groups, and I was finding some of them on the hoof really. I don't really understand what they did, and schools have access to different things as well, that I didn't have knowledge of." (PEM 2: 334-339).

Consideration of professional and litigation risk to the practitioner was a possible explanation provided by the CAMHS practitioner for referral practices and decision making by clinicians.

"But, you know, we think about litigation as well, everyone thinks about litigation in their practice don't they? If I'm not sure, or I'm not willing to take an educated, calculated risk, I have no option but to put somebody on the ward. You can dress that up as a cooling-off period, but I am actually thinking about litigation as well. I don't want to go to court and defend "Why have you let that young person go from A&E and they've killed themselves?" So everybody thinks about that. So I can understand if A&E practitioners are thinking about that (when they refer everyone to CAMHS)." (CAMHS: 664-669).

6.1.5.2 Lack of Formal Training

All clinicians commented about the lack of formal training in preparation for undertaking the role of assessing and treating young people who self-harm: *"I can't think of any training we've had in adolescent mental health."* (PEM 1: 257).

"...in terms of training, there was nothing like that. I think it's quite a big educational need, and there's probably a general awareness that A&E departments, and even paediatric wards, are not that well prepared for children with such significant proper suicidal ideation as she had." (Paed ACP: 87-90).

Even the specialist emergency medicine curriculum has no adolescent mental health included: *"You don't get anything on adolescents and mental health at all (in the RCEM curriculum for doctors in specialist training)"* (PEM 1: 186-187)

Many articulated that they had learned solely from experience: *"I think a lot of it would be I've learned through experience."* (ACP 3: 442). *"...unfortunately you have to do so much on the job learning. Which is quite difficult when you are dealing with risk."* (CAMHS: 364-365). This reinforced my decision to use hermeneutic phenomenology as an approach, as this is founded on the principle of experiential learning.

"I think you do learn from experience in A&E... you've got to go and see the child and then identify things that you don't really know, and seek expert help for that." (Pilot: 250-252).

The lack of formal training resulted in uncertainty in the approach to children, as articulated by ACP 1:

"Well I ... rightly or wrongly (I) treated her in a similar way to an adult presenting with a similar... (problem)." (ACP 1: 55-56).

"And whether I'm doing that correctly or I'm not... from a mental health point of view I'm not 100% sure whether I am or not." (ACP 1: 177-178).

It was also attributed to the absence of commencing treatment for mental health conditions in the ED: *"I think, first of all I'm not a practitioner in mental health, I wouldn't know where to start (to treat someone with mental illness)."* (ACP 3: 376-377).

"I wouldn't start treatment for mental health in A&E." (ACP 3: 381).

One element of training that clinicians thought was particularly lacking, was knowledge and skills of communication with young people. This was deemed essential to establishing

engagement: *"I think, certainly from my perspective at a senior level there's been very little training in terms of how to engage with a young person. So, a lot of what I observe is by watching media resources. Not necessarily around talking to young people, because I don't know what exists."* (PEM 2: 144-146).

"You don't get taught that at university, how to talk to young people." (CAMHS: 220).

Even the specialist CAMHS practitioner expressed a lack of formal training around care of children and, for some of the CAMHS team, mental illness:

"There is no children's training in mental health." (CAMHS: 284).

"The vast majority of our team don't know about mental illness disorders." (CAMHS: 469). Some CAMHS practitioners are from a social work background rather than health professionals.

6.1.5.2.1 Reflection and Emotional and Clinical Supervision

It was recognised that seeing children with self-harm can have an emotional impact on the clinician. The ability to reflect and discuss cases facilitated learning and provided emotional support.

"If there's something you don't feel you've handled very well or dealt with, either talk about it first of all, and if it's something that I might not know much about, then I'll go and investigate it or research it more." (ACP 3: 496-498).

"I think I've learnt over the years to talk about these things to colleagues. But normally I'll only do so after a period of rumination and reflection and you know, depending on what it is, it can almost be almost be like a mini post-traumatic stress event. And I recognise that because I've seen a number of cases in my time where one wakes up and thinks is there anything else one could have done?. Why didn't you do this? Why didn't you do that? So, you know if it really is that bad then I guess I would discuss it with a named

protection specialist, but it rarely comes to that because I think that normally just a discussion amongst colleagues is sufficient, but that's done on an ad-hoc basis, and very often we don't get time to debrief, but you know it's got to be particularly bad to debrief." (PEM 2: 350-358).

"...often it's peer support. Just having that... having the discussion with the colleagues around you on the day about how it's made them feel, and how it's made you feel. So we do kind of try to have a little bit of an informal debrief afterward where people can discuss how it's been." (Paed ACP: 386-389).

6.1.5.3 Maturity of the Clinician

One participant felt quite strongly that the maturity of the clinician had an impact on the ability to establish engagement in the consultation. This could be in a negative way:

"You know, just by virtue of my age, my uniform representing some level of authority may have meant they didn't want to open up." (PEM 2: 163).

"If necessary, pick a younger member of staff to try and engage them." (PEM 2: 179).

It could also be in a positive way:

"...so they come with a more mature psychological approach." (PEM 2, 304-30) The participant was discussing the merits of ACPs who have extensive nursing experience prior to undertaking the ACP role.

"I think equally children or young people with self-harm may engage with a younger person with less knowledge as well, so I don't necessarily think one rule fits all." (PEM 2: 311-312).

6.1.5.4 Gender of the Clinician

Only the paediatric ACP felt gender might have an influence on the ability to engage with a young person, although he was not the only male participant.

"So, ok, I tend to try a bit of a relaxed approach. I'm also mindful that the vast majority of these... children are teenage girls. And I'm not sure how sometimes being a man, kind of, allows them to feel like they can open up. So I do think about whether, and I do ask them whether they'd rather speak to a female. Whether they can develop that relationship slightly more with them." (Paed ACP: 190-194).

"I've seen it work the other way as well. I've seen children who've come in regularly who won't engage with my female colleagues and I've managed to." (Paed ACP: 200-201).

6.1.5.5 Time Pressure

Participants from all professional backgrounds acknowledged the ED environment as being busy, and the pressure to see patients quickly influenced the consultation with a young person who had self-harmed. This particularly influenced the ability to engage.

"You have a very short period of time, and it's hard, you cannot form a relationship deeply with somebody within half an hour or an hour, or whatever you've got in A&E to do that." (ACP 3: 288-289)

"I think that (universal referral to CAMHS) is the right way (to ensure proper risk assessment) because these issues can't be drawn out in a 10 to 15 minute conversation on a tick box checklist in the ED." (PEM 2: 394-395).

"...this is not a criticism, but the chaos you walk into quite a lot, when you go to A&E. It is so busy." (CAMHS: 719-720). *"I wouldn't want to work in A&E under that pressure myself."* (CAMHS: 785).

"I suppose the emergency department is quite a difficult place to develop those relationships. It's a bit different when a child's been sat on the ward for three days and has been looked after by the same clinicians and nurses. You see that little bit of a relationship starting to build, whereas in the emergency department, if you're seeing them you've got to go and see them and decide what to do within four hours. Then you haven't really got much time to find out that much about them and develop the kind of patient relationship that might be more beneficial to them opening up." (Paed ACP: 207-213).

The acuity and volume of patients in the ED, coupled with the stress associated with the pressure to see patients quickly, was also attributed to participants recounting what I interpreted to be negative or dismissive attitudes:

"I think, when you are under a lot of stress and it's busy in the emergency department, sometimes it can just be 'Here's another overdose' and you go in there and you are a bit "Why have you done this?" "Don't you realise how dangerous it is to take Paracetamol? Now you've got to be admitted" and that's not the way you want to be, but you can be at the end of your tether, and that doesn't help them and it doesn't help you. You instantly lose that connection." (PEM 1: 208-213).

6.1.5.6 Identification of the Cause of Self-harm

All practitioners commented on the need to try to identify the cause or the catalyst event leading to the self-harm incident, as part of their role in risk assessment.

"Just to try and find out what the cause of her self-harm was..." (Pilot: 134-135).

"And so I asked her what triggered it (the self-harm) off." (ACP 1: 64).

"Cos to them the big thing might not be what they've actually done to themselves, it's why they've done it." (ACP 2: 359-360).

"...to try and find out why, what had been triggered them to get to this point, or what had led to this point?" (ACP 3: 225-236).

"Was there anything particular today that made you do it?" (PEM 1: 69).

Identifying the cause is clearly not always simple: *"The history can be quite lengthy because usually the precipitating event is not necessarily simple. So there can be one precipitator of why the child has self-harmed, but usually leading up to the precipitator there can be a catalogue of escalating events."* (PEM 2: 81-83).

It can also be traumatic for the child to discuss the cause:

"...the primary drivers for her self-harm were these flashbacks, but also the lack of contact with her siblings who she got on with very well with." (Paed ACP: 67-68).

My rationale for trying to identify a cause of the harm is two-fold. Firstly if something distressing is happening to a child, I would want try to instigate measures to prevent its reoccurrence. This is often in relation to safeguarding measures. Secondly, understanding the trigger may enable me to better empathise and engage with a child, and if needed signpost them to appropriate support services. I believe nurses inherently want to help to make things better. Accepting that there may be no specific 'reason' for self-harm would be really difficult for me to comprehend. However I am cognisant that recalling distressing details every time a child presents with self-harm when they use it as a coping strategy could be detrimental to them. Therefore, having readily available clinical notes can be highly beneficial, as identified by one of the participants: *"If the child has had multiple attendances in the past, there is some merit in looking at the previous attendances to gather information on family background, social workers, whether the child is subject to a child protection plan, or previously known to social services, or previously known to mental health services beforehand. Partly because it's not always easy when a child comes in*

acutely, to gather all that information. A child may not be willing to give that information. They may not want to go through that story again. So I think it helps formulate a mental approach before going to see the child.” (PEM 2: 44-50).

(Also see Information Gathering – next section 6.1.5.6.1)

6.1.5.6.1 Information Gathering

Information gathering was a sub-theme generated from participants describing their experience with children who self-harm. Many of them discussed how they obtained information, which may inform the risk assessment prior to the consultation: *“So I try and get a bit of background to start with, just rather than going in, sometimes I go in with a fresh pair of eyes, but it's always... I like to know a bit of background. So if they come by ambulance I read the ambulance sheet.” (ACP 3: 80-82).*

“I often gather information before I go and see them, so... look at previous attendances, previous attendances with self-harm. It usually flags up if they are known to CAMHS, whether there is an alert on a looked-after child or a child protection register.” (PEM 1: 32-34).

“The first thing that you would do as a clinician is to look at the information, either prior to the child arriving or the information on the A&E card. And that would give you information about time of presentation, it will give you a set of observations, it will give you a basic triage history of what the nurse who has assessed has been told. And one would also look at an ambulance record as well because that would, if the child has come in by ambulance, because that may give a different light to the story.” (PEM 2: 26-31).

Others detailed information they would gather during the consultation, which would inform the risk assessment. Engagement of the young person was required to gather any in-consultation information.

"Just general health history first. Asked her about her medical history and who she lived with, her support systems." (ACP 1: 60-91).

(Risk assessment) *"...is all about context. It's all about gathering information."* (CAMHS: 486).

6.2 Integrative Themes

As highlighted through analysis of the ordered themes, two integrative themes emerged as major findings of the study: Risk Assessment and Engagement. The findings unique to these integrative themes are described below.

6.2.1 Risk Assessment.

Risk assessment featured in all the ordered themes and was a key purpose of the consultation of both ED clinicians and the CAMHS practitioner. *"I think risk assessment is key for me."* (Pilot: 269).

Indeed the CAMHS practitioner highlighted risk assessment should be the sole purpose of their consultation in the ED. *"They (CAMHS practitioners) really are there just to do the risk assessment. 'Is this young person safe to go?' The rest of it we can pick up the day afterwards, if it's during the night. But really we are just there to do that assessment."* (CAMHS: 182-184).

Two specific risk assessment tools were identified by practitioners, although neither were designed or validated to be used with children. The Sainsbury's risk assessment is a tool used

to assess clinical risk, and to support risk management and care planning for adult patients in mental health settings (Stein, 2005): *"We do the risk assessment, we do the Sainsbury's risk assessment.... It's part of the comprehensive assessment, but it's not particularly child friendly..."* (CAMHS: 120- 126).

The other risk assessment tool identified was the SADPERSONS score: *"We have a mental health assessment form that we go through.... It has the SAPERSONS score on it."* (ACP 2: 151-152). This is a risk assessment tool that was widely used in emergency departments for use with adults presenting with self-harm conditions. It is an acronym of the criteria which were thought to be correlated with increased risk of future self-harm or suicide, from which a total risk score can be quantitatively calculated. Evidence has demonstrated this tool is neither sensitive nor specific in identifying people who are at risk of future self-harm or suicide. It is recommended that this tool should not be used in clinical practice (Katz et al., 2017).

The majority of practitioners used their own experience to subjectively assess risk as demonstrated from the following excerpt: *"So I tend to do it (Risk Assessment) informally now. So looking at their methods of which they have harmed themselves. So, the extent of their lacerations to their arms, how frequently they do it, and the reasons for why they do it. So I might think, you know, a child who has superficial(ly) self-harmed after argument. When I ask them, is it a stress release "Do you feel better afterwards?" rather than a child who's tried to hang themselves, or is found on the wrong side of a motorway bridge, kind of enhances that risk for me. So I have no formal scoring tool, it's all very, I suppose, subjective based on the questions and the answers they give really."* (Paed ACP: 165-171).

6.2.2 Engagement

Similar to Risk Assessment, the concept of Engagement was integral to all the ordered themes. In turn, the ability to establish engagement highly influenced the ability to undertake the risk assessment.

This ability to engage with a young person was paramount to the success of the consultation with a child who had self-harmed, and arguably the most significant finding from this study. Engaging with a young person influenced the ability to gather the essential information necessary to formulate a risk assessment.

Conversely, inability to engage with a young person appeared to increase the perception of risk, not merely as a result of an inability to acquire essential risk assessment data, such as safeguarding, but also disengagement in its own right was interpreted as a higher risk: *"But if somebody was very, very quiet and all the information was through the parents and I couldn't really get any further information out of them, then I'd be a bit more concerned."* (ACP 1: 116-118).

All clinicians described techniques they used for trying to establish engagement. Most would try a 'friendly' approach:

(I) *"Just act friendly and open, and try to get them to like you a little bit. Ask about hobbies and what they like to do. What are they into and just try to build up a rapport.... You might have to go through the parents if they are not engaging at all. But I do try and get them to."* (ACP 1: 95-99).

"And then you get the other children, like her, where you can just encourage them by being a little bit friendly and just allowing them to open up." (Paed ACP: 145-146).

Treating the child as an individual and as the focus of attention, rather than parents or accompanying adults, was described as important in establishing engagement: *"And, (I) also found that trying to establish a relationship with them (the child), saying 'Hello, I'm (name), I'm one of the*

advanced clinical practitioners" and asking them (the child) who they've brought with them as opposed to going in and speaking to the parents or the teachers, so you are going in and your relationship is with your patient." (ACP 3: 334-338).

"I think helps as well, because your focus is on them. You're not treating them as a child if they are making these grown up decisions about harming themselves. And taking their own decisions into their lives and treating them like that, as opposed to treating them as their parent's daughter or son. So treating them as an individual." (ACP 3:338-341).

Other methods used by clinicians to facilitate engagement included:

- The sensitive use of humour: *"...it depends on the mood in there, so sometimes, you can bring in humour. You know, if you've got a good interaction with the young person."* (PEM 1: 193-194).
- Identifying familiar topics unrelated to the self-harm: *"I try and find something, particularly for the ones that are known, they might have something that they have been known previously just to start talking about and see if that's a starting point. You know even if it's completely unrelated to, you know,... interests, hobbies, that kind of thing can just trigger that little something that allows them to then open up and build that little bit of a relationship."* (Paed ACP: 203-207).
- The use of distraction: *"Whereas, if you've got distraction and you're feeling someone's abdo (abdomen) to make sure the liver's not tender from paracetamol overdose or something, then you might say "So, what made you take them today?" And they seem a lot better to respond, because what you're doing is examining the abdomen, you happen to have asked them a flippant question, but it seems like... that seems to engage them a bit better because you're distracted."* (ACP 3: 118-124).

- Appropriate body language of the clinician: One clinician articulated in great detail how she had learned through experience to be aware of the need for situational awareness, and to respond with conscious use of body positioning, tone and pace of voice, use of therapeutic touch, and questioning style in order to attempt to establish engagement: *"I think the rules (of engagement) are, you've gotta really have a good degree of situational awareness. And that situational awareness you can develop with maturity and having seen a lot of families and young people in the past. So looking at the position that the clinician, comes in at, and the distance that one stands away from the family is quite important. So, do you take the story standing? Do you take it sitting? And if you sit where do you sit and how far away do you sit? Do you sit next to them? Do you sit a metre away? Do you sit 2 metres away? Do you sit at the end of the room? As far away as possible? And that partly is something one gauges from just looking at the child. Now if the child is bashing its head against the wall, I'd probably stand 2 metres away and try and be as non-threatening, and as not in their immediate field as possible. If the child is extremely tearful, on their own I'd say "Do you want me to sit next to you?" "Do you need a hug?" because some children will quite happily have that, and I don't have a problem giving them a hug and, so it's really very variable. In terms of the pitch and the pace. High pitch and fast pace just doesn't work. I think that is something I've learnt from the past. I've begun to drop my voice. And eye contact..., mostly works depending on who you're giving it to and length of time. It's got to be short in general, but again I don't have any fixed knowledge about that. And open hand signals, if used at all. Sometimes I might not use any hand signals. Open gestures, open hand signals. Drink of water, food, quite often works. And allowing, I allow a lot of space for conversation. So, you know, I may not fire out questions at all. You know, I can sit for 5, 10 minutes and allow people to speak without interrupting them because the first impression that you make is very important in the first 3 to 5 minutes. It just depends how much comes flooding*

out. Sometimes nothing, sometimes you'll get this whole raft of information and you just let them carry on and try and pick out bits that are relevant.” (PEM 2: 271-293).

- Facilitating activities familiar to the young person, such as smoking: *“I think it's being able to talk to someone on their own level, not using medical terms. Get down, and sit down next to them. You know, often assessments where you've taken them outside and they're having a fag whilst you are talking to them, because that builds the rapport with them.” (ACP 2: 345-348).*

In this latter example, I reflected that facilitation of allowing them to smoke portrayed respect for their autonomy, and portrays the message that the young person's immediate emotional health was more important to the clinician at that time than their long term physical health. i.e. Engagement at the time was so crucial, allowing time to smoke and being with them as they did so outweighed the well-established long term physical risks from smoking. I perceived this to be an example of parity of esteem (Mental Health Task Force Strategy 2016).

Being non-judgemental in order to gain trust was another important attribute of engagement:

“...you've got to gain their trust, because that's going to make a big impact on how they are going to relate to psych (psychiatric) services when they come. If you're judgemental with them, or you know, come across as having an attitude..., then they are less likely to engage with the next person who comes along.” (ACP 2: 255-258).

“You always feel a personal responsibility and you form that relationship with them (the child), and they rely on you to try and help” (ACP 3: 478-479).

As well as being a concept used for risk assessment, the act of engagement was also regarded as the start of therapy: *“I guess you are starting treatment aren't you? You are starting to engage*

with a mental health professional, so you're starting, if you want to call it a journey, you're starting on that journey. That journey is just starting with a risk assessment." (CAMHS: 843-845).

It was acknowledged that some children do not want to engage: *"I think (the) ones I find the most difficult are the teenage girls that seem to clam up and don't really want to talk to you."* (ACP 3: 507-508).

The refusal of a child to engage was seen as source of frustration for clinicians: *"You know, there's nothing probably more frustrating as a practitioner than sitting in a room with a patient where you can't engage... Our jobs are all about developing relationships aren't they? And caring. And there's nothing more frustrating or disappointing than sitting in a room with a teenager who doesn't want to be there. Doesn't want to tell you why they've done what they've done, or what's gone on before, or what's caused them to do it. And certainly doesn't want to open up as to why they've harmed themselves. So that's the big communication challenge."* (Paed ACP: 285-292).

I reflected that throughout my nurse training, I was taught my purpose was to help and care for others when they were unable to self-care (Orem 1985). Self-harm could be viewed as the absence of a desire to self-care. I am therefore able to understand why a clinician may be frustrated when the care they want to give appears to be rejected. However, it should also be considered that a child may be unable to engage with the clinician, rather than unwilling. This changes the element of perceived control a child has over the situation. An inability to accept care does not equate to rejected care, but a sign that there is still a self-care deficit, and therefore a purpose for the ACP.

One clinician viewed non-engagement of the child as a potential personal failure: *"There are some occasions where I've blatantly failed to be able to get any answer out of the young person, and that may just be that any technique wouldn't have worked. Or it may have been that somebody else who wasn't*

dressed in a uniform, who was dressed relaxed, was perceived to have been much younger, could have engaged a lot better." (PEM 2: 160-163).

When children did not engage, clinicians described behaviour which may be perceived as authoritative rather than therapeutic: *"It depends on your first initial interaction, some children don't want to speak at all...So you have to take a hard line with the quieter ones that don't want to speak or tell you what they've done."* (PEM 1: 56-58).

"...sometimes if I'm struggling and I need to extract information, I might ask mum and dad to go out for a few minutes" (ACP 1: 216-217). I analysed the notion of extracting information to infer obtaining information against the will of the child. This is the antithesis of engagement.

When engagement was established it was not only perceived as beneficial for the young person, but also offered some reward for the clinician: *"So sometimes you have families that say "You know, you've really taken the time to sit and listen, and understand, and address these issues, and we know that you can't really directly do anything but we thank you for actually taking the time to listen" and that in itself provides satisfaction."* (PEM 2: 111-114).

"You can at least be somebody that they feel confident in opening up to, and, you know, that is part of the reward of trying to help the individuals that come to your service." (PEM 2: 115-117).

6.3 Summary of the Findings

The technique of template analysis resulted in the identification of two significant integrative themes; Risk Assessment and Engagement. The ability to establish engagement influenced the risk assessment related to the five major ordered themes which were identified as:

- **Looking for Injuries or Potential Poisoning.** This involved the identification and treatment of any immediate life-threatening risks resulting from self-poisoning, and seeking any wounds which may require further exploration and/or closure.
- **Pursuing Safeguarding and Social Concerns.** The need to identify and act on any safeguarding or social concerns was articulated by all practitioners. This sometimes gave an explanation for the self-harm, and also informed the risk assessment. The particular safeguarding issues which were actively pursued were:
 - Child sexual abuse and exploitation,
 - Bullying, either through social media or school,
 - Recognition of the specific needs and challenges of Looked-after children.

The level of support available to a young person also informed the risk assessment, with those having greater support being deemed to be of lower risk. Attachment Theory (Bowlby and Holmes, 2005) was offered as a means of assessing familial relationships.

- **Interpreting Emotional State.** This theme influenced both the risk assessment and ability to engage with a child. Sub-themes pertinent to the theme included the assessment of the mood of a child, with low mood being perceived to represent greater risk. The 'cooling-off period' was thought to positively influence subsequent mood and ability to engage with children, and assess them more accurately. Factors used to analyse emotional state included the maturity of the child and their developmental stage, and their physical appearance, including body language.
- **Identifying Suicidal Intent.** Assessing the risk of suicide was an important element in the clinical consultation for all clinicians. Repeat attendance for self-harm had the

effect of reducing the perceived risk for some clinicians. Others were cautious that this perceived risk reduction may be erroneous. The majority of clinicians used their previous experience to subjectively evaluate suicidal intent. Only two clinicians identified the use of specific suicide risk assessment tools: the Sainsbury's tool, and the SADPERSONS tool. Neither of these tools had been validated for use with children.

- **Deliberating Professional Practice Issues.** The professional practice of individual clinicians was influenced by their personal confidence and competence in their ability to undertake a risk assessment of a child who has self-harmed. It was also influenced by the perception of the limitations of the provision of care which should be provided by their service. ED clinicians perceive CAMHS to be the experts in child mental health to which all children who self-harm should be referred. The CAMHS practitioner believed all health professionals should be able to undertake a risk assessment, but perceived the attitude of ED clinicians to be that mental health care is beyond their remit. Time pressure in the ED was regarded as a factor which impeded engagement and therefore accurate risk assessment.

All clinicians, including the CAMHS specialist, articulated lack of formal training to undertake the role of initial assessment of children who have self-harmed. They used experience to learn the skills required for engagement and risk assessment.

Chapter Seven: Implications of the Findings and Discussion

This chapter discusses the findings, identified in Chapter Six, with regard to the purpose of the study to establish the knowledge and skills used by ED Clinicians in their consultations with young people who self-harm (section 3.1.2). It discusses implications for ACP training and practice, as well as future research.

7.1 Discussion Related to the Integrative Themes

The integrative themes of Engagement and Risk Assessment were prominent throughout the findings of this study. In order to fully appreciate the implications of these themes, I decided to explore them in greater detail as concepts. An emphasis on concepts is appropriate, as “concepts play an important role in the development of knowledge” (Rodgers, 1989 p330). Identification of knowledge, through exploration of experience, was a key objective of this study.

Risjord (2009), states that a concept analysis helps make the meaning of a concept explicit. As these integrative themes are fundamental findings of this study, it is important to be explicit about their meaning in order that their application can be researched further and the concepts developed.

I decided to apply the principles of the evolutionary concept analysis method described by Rodgers (2000). This approach is associated with the interpretive paradigm (Weaver & Mitcham, 2008), and views concepts as continually subject to change. Rather than focusing on the concept as a ‘thing’, it focuses on the ‘use’ of a concept within a specific context. Therefore, this method was chosen for its alignment with the interpretive philosophical foundations of the methodology of hermeneutic phenomenology used in this study. The concepts of Engagement and Risk Assessment were explored within the context of ACPs

providing care in the ED for young people who have self-harmed and in relation to the five major themes identified. The method was adapted to facilitate greater clarity of the concepts within the confines of this study, rather than conduct the full concept analyses with regard to their use in other contexts.

Rodgers (2000), describes three distinct influences on concept development: significance, use and application. The concepts of Engagement and Risk Assessment have both been demonstrated to be significant within the findings of this study. The use of a concept, according to Rodgers (2000), is the common manner in which the concept is currently employed. Discussion of how these themes were used within the first order themes form part of the concept analyses.

Application of a concept results in the identification of the scope or range over which the concept is effective. Through the process of application, the concept may be continually refined. As a result, the concept may be enhanced in its explanatory or descriptive power (Rodgers 2000). As previously stated, the purpose for the concept analyses in this study was to clarify the significance and use of both Engagement and Risk Assessment within the context of the study phenomenon, rather than apply them to other contexts. It is acknowledged that others may wish to use this initial concept exploration as a foundation on which to conduct a more complete concept analysis, with a view to developing the concepts further.

7.1.1 Exploring the Concept of Engagement

The word 'engage' was used by several clinicians when describing their consultations with young people who self-harm. Other descriptions were also interpreted and attributed to the theme of 'Engagement' (section 6.2.2).

7.1.1.1 Definition of Engagement

Engagement is the noun derived from the verb to 'engage' (Oxford Dictionary 2012). The definitions of which are given as:

1. Occupy or attract (someone's interest or attention)
 - 1a. Involve someone in (a conversation or discussion)
2. Participate or become involved in.
 - 2a. Establish a meaningful contact or connection with.

The action of engaging or 'Engagement' has other surrogate terms or synonyms. These include:

- Involvement, from the verb involve
- Participation, from the verb participate
- Connection, from the verb connect
- Collaboration, from the verb to collaborate

Findings from this study demonstrate that 'Engagement' with the young person, and their families was paramount in securing the relationship necessary to obtain information required to formulate a risk assessment. From looking at the definition and synonyms, having already become familiar with the data, I reflected that when clinicians use the term 'engagement' they infer the active involvement and participation of the young person which requires a connection and collaboration.

7.1.1.2 Attributes of Engagement

Understanding the features and properties of a concept enables detection of its presence. (Rodgers 1989). Template analysis (King 2012), and the strategy of coding individual data sets, followed by cross-analysis with the whole template, then completing the hermeneutic

circle by applying the final template to the whole data set, enabled detection of the integrated presence of Engagement through representation of the following attributes:

- **Body language and eye contact.** These were both visual cues used to identify whether someone was engaging. Closed body language and absence of eye contact were interpreted as signals that someone was not engaged. This was also used in the assessment of a child's mood (section 7.2.3.1). When children abscond from the department, as described by small number of participants, this also represents absence of engagement.
- **Verbal communication.** The willingness of someone to enter into conversation and offer verbal information, or as a minimum answer questions openly, was taken as a sign of engagement by clinicians within the context of self-harm in the ED. A lack of verbal response, particularly coupled with absence of eye contact and closed body language, was taken as lack of engagement. As with absconsion, any aggressive verbal remarks from a child suggesting that the clinician should leave the consultation may also indicate an absence of engagement.

7.1.1.3 The Use of Engagement in the Context of the Study

Engagement was used to gain information, in order to evaluate the risk for a young person associated with the five major themes: '*Looking for Injuries or Potential Poisoning*'; '*Pursuing Safeguarding Concerns*'; '*Interpreting Emotional State*'; '*Identifying Suicidal Intent*'; and '*Deliberating Professional Practice*'. The extent of the influence of Engagement in relation to Risk Assessment is highlighted in the consequences below. Engagement as a concept was also identified as risk factor in its own right. The presence of Engagement was interpreted to

represent a reduced risk for the young person, whilst absence of Engagement was associated with higher risk.

7.1.1.4 Antecedents and Consequences of Engagement.

7.1.1.4.1 Antecedents

In order for Engagement to occur, a willingness is required by both parties to actively contribute to the consultation process. The words 'connection' and 'collaboration' (see section 7.1.1.1), suggest an equal extent of willingness to contribute to the process and an absence of hierarchical power or authority. Therefore if children are unwilling or unable to contribute to the relationship, the clinician may be required to find persuasive strategies in an attempt to secure engagement.

Strategies used by clinicians to persuade a child to engage revealed in this study included: the assessment of the requirement for personal space, or desire for therapeutic touch; conscious use of open body language and positioning; calm 'friendly' speech; distraction and the offering of food and drink. These strategies were learned through experience rather than taught. All clinicians felt that having better awareness of adolescent communication strategies would enhance their ability to engage with young people. This supports the finding by Manning et al (2019) who found paediatric nurses identified a need to better communicate with young people, and should therefore be reflected in the content of future ACP training.

In addition to this willingness to contribute, there appears to be an element of trust required. The young person must trust the ED clinician and in turn feel trusted. They must believe the clinician is willing and able to help, and trust they will not be ridiculed, chastised or otherwise disrespected in any way. For children to have a positive ED experience following a self-harm event, the literature suggests they need to feel respected and listened to (Storey et al. 2005). Therefore securing engagement and trust could be the antecedents of a positive experience for these young people. Conversely, when they feel they are spoken to in what they perceive

is a derogatory manner, young people report feeling unimportant and dissatisfaction (McHale and Fenton 2010). This further emphasises the importance of the need for clinicians to have knowledge and skills to maximise any opportunity to secure engagement, rather than 'extract information' (ACP 1: 216).

The desire or ability to engage can be very difficult for a young person who may have been brought, possibly against their will, to the department, rather than actively choosing to attend. An example of this was given by the Paed ACP who discussed a child being brought to the department in an angry state by his teacher, and another brought in a suicidal state by the Police. Neither of these children had a willingness to communicate and they did not want to be in the emergency department. They did not trust the clinicians and clearly did not want to engage with them.

The time pressures expressed by the participants in this study were perceived to be a barrier to achieving the antecedents necessary for true engagement. Furthermore, the temporality of the relationship between the ED clinician and young person was thought to impede meaningful engagement, as there was no ability to build trust over a period of time with repeated interactions as there are with hospital in-patients. This reflects findings in the literature (Clarke et al 2014, McHale and Fenton 2010). As the ED clinical environment, with high acuity patients and time pressures is unlikely to change, clinicians must be mindful of the antecedents of engagement and make them a priority for children who self-harm. This would go some way to establishing parity of esteem for people with mental health problems (Mental Health Task Force Strategy 2016).

7.1.1.4.2 Consequences

A consequence of Engagement in this study, was that young people were perceived to be at lower risk of subsequent self-harm if they were engaging in the consultation, or seeking

treatment. This was more likely to result in them being sent home from the emergency department. If the home environment is supportive, then this could be very beneficial for the young person. However, if the home environment is not supportive or even abusive, this could be detrimental to that young person.

A consequence of absence of Engagement was a perceived heightened risk assessment for young people, as expressed by participants in this study. This was likely to result in hospital admission in order to keep the young person safe. No evidence could be found which correlates Engagement with risk in self-harm patients.

The absence of engagement also resulted in feelings of frustration for some clinicians, consistent with the findings of Anderson et al.'s (2003) study. This led them to taking an authoritative approach to obtain information necessary to undertake a risk assessment. I considered that it may be this authoritative approach which makes children perceive that they are unimportant to staff, or being spoken to in a derogatory manner; or indeed that they perceive that staff do not understand them, and deem them 'failures' (McHale and Fenton 2010, p738).

It is likely that authoritative strategies will impede any willing connection and therefore should be avoided wherever possible. Clearly, if there is an immediate risk of harm to the child, clinicians have a duty to protect them and proportionate measures may need to be employed to detain or restrain them. Should this be required, the clinician should be cognisant of the impact which this will have on any future attempts at engaging with that child.

7.1.1.5 Concepts Related to Engagement.

The term engagement should not be confused with the term compliance. A child may be compliant in allowing the clinician to examine them or answering questions with 'yes' and 'no'

responses, but this passive acceptance of the consultation does not equate to the active connection required of engagement.

Another concept closely related to engagement was that of trust. One ACP particularly emphasised that she tried to establish trust with a young person. She felt this not only helped with the consultation in the ED, but also facilitated better interactions with other professionals if trust could be established. Of course, any situation leading to distrust, such as breach of confidence, which may occur for safeguarding interventions, could lead to irretrievable breakdown of engagement in that relationship.

7.1.1.6 The Implications of Engagement for the Study

In the context of an ED consultation with a child who has self-harmed, engagement and its surrogate terms, require the active and willing contribution of both the patient and the clinician. One person cannot engage without the interaction or connection of the other. The implication for practice is that clinicians seeking engagement with young people are required to have the knowledge and skill to establish that connection and be prepared to commit to engaging themselves. This may necessitate relinquishing power inherent in the professional-patient relationship in order for the relationship to be more collaborative than hierarchical. It may also expose the clinician to greater personal emotional experiences due to the nature of engaging themselves. Opportunities for appropriate access to debrief and clinical supervision should be available in order to protect the emotional well-being of these clinicians, and for them to be conscious of any learning from their experiences.

With respect to children who self-harm, some of whom have previously been hurt or abused by a person in whom they placed trust, it is easy to appreciate why they may be reluctant or unable to engage with another adult who is a stranger to them; particularly one who has the potential power to remove control or choice, resulting in imposed hospitalisation and/or

treatment through use of either The Mental Health Act (Her Majesty's Government, 2007), or The Children Act (Her Majesty's Government, 2004). Therefore, education surrounding effective communication, and other strategies to secure engagement with young people at different developmental stages, must be included in the preparation of clinicians for the ACP role. They must also respect non-engagement and evaluate this as part of the risk assessment.

7.1.2 Exploring the Concept of Risk Assessment

Risk Assessment as a term was used by all participants in this study and was demonstrated to be a major integrative theme. As with the concept of engagement, the concept of risk assessment was also explored using a modified version of Rodgers' (2000) approach.

7.1.2.1 Definition of Risk Assessment:

This widely used term comprises the two words; Risk and Assessment.

Risk is defined by the Oxford Dictionary (2012) as:

Noun:

1. The possibility of danger or suffering harm or loss.
2. A person (or thing) representing a source of risk.

Verb: To expose to the chance of injury or loss.

Risk has other surrogate terms and synonyms. These include:

- Threat
- Danger

- Hazard
- Chance or possibility
- To be **at risk** is also a definition of vulnerability.

Assessment is defined by the Oxford Dictionary (2012) as:

Noun:

1. The classification of someone (or something) with respect to its worth
2. The act of judging, or assessing, a person or a situation or event.

Assessment surrogate terms and synonyms include:

- Appraisal
- Evaluation
- Measurement
- Estimation

When the terms 'risk' and 'assessment' are combined, and considered in the context of the this study, it is clear that the term 'risk assessment' for ACPs involves the full evaluation of a child's vulnerability to suffering harm from the various factors identified in the five major themes. It also involves the estimation of potential harm to the clinician, due to professional issues such as lack of training or competence to complete an accurate risk assessment.

The details of the risk assessment implications, as they pertain to the major themes, are discussed in the respective sub-sections in Section 7.2.

7.1.2.2 Attributes of Risk Assessment

Risk assessment, involves a cognitive process that results in a judgement of the probability that a person will come to harm. The outcome of which is often simplified as low, moderate, or high risk (Patel, Harrison, & Bruce-Jones, 2009).

Any quantitative risk assessment requires the calculations of two components of risk(R): the magnitude of the potential loss (L), and the probability (p) that the loss will occur. With self-harm, the magnitude of loss is potentially death or severe injury with life-long consequences for both the individual and their families and friends. With such an enormous potential loss rating (L), even a small probability rating (p) would still give a significant overall risk. Yet, it would be inappropriate to treat everyone in the ED as though they had an immediate high risk of death. Therefore, calculating the probability rating (p) is the most clinically significant variable in the equation. In self-harm risk assessment, there is never zero risk or absolute risk, but the reality lies somewhere on a continuum between the two. Consequently understanding and interpreting the significance of, and having competence to assess for the factors that influence probability is crucial.

7.1.2.3 The Use of Risk Assessment in the Context of this Study

The concept of Risk Assessment was used in relation to physical needs assessment, evaluating potential risk of physical harm from wounds or poisoning. It was also used to identify risks to the child from safeguarding or social concerns. In turn, social factors associated with supportive parenting were interpreted to reduce the risk. Emotional state and psychological development influenced the risk assessment as did the assessment of identifying suicidal intent. Risk assessment was also used in determining the scope of professional practice, particularly with regard to identifying the risk of working beyond the level of personal competence.

7.1.2.4 Antecedents and Consequences of Risk Assessment.

The nature of presenting to the ED with a self-harm condition is the antecedent of risk assessment. Risk assessment begins with the first initial assessment or triage process (Manchester Triage Group, 2013) to identify any immediate life or limb-threatening condition as a result of injury or poisoning.

The consequences of an accurate risk assessment of young people who have self-harmed, are that physical needs, safeguarding and support needs, emotional state and suicide risks will be appropriately identified. Once the overall risk assessment has been completed, this can then be used to inform an appropriate risk management plan.

The consequences of an inaccurate risk assessment of physical harm could lead to serious lasting harm or even death for a young person.

7.1.2.5 Concepts Related to Risk Assessment.

Risk management is a concept that is related to risk assessment. Undertaking a risk assessment is arguably only useful if there is then a subsequent risk management plan. Yet no clinicians in this study used the term risk management. Some inferred strategies of risk management by use of security staff to accompany young people, or use of the Police to return them to the department should they abscond. The use of the cooling-off period could also be considered a risk management strategy. However, the key phrase repeatedly used was risk assessment, with no explicit subsequent consideration of any appropriate management plans based on the risk assessment.

When an analogy is made with other healthcare risks requiring nursing intervention, such as pressure ulcers or falls, it is clear the concept of risk assessment in relation to self-harm is not yet fully developed. For falls and pressure ulcers there are validated risk assessment tools (Flores, 2012; Waterlow, 1995) and subsequent guidance which informs the care required is

based on that assessment. With risk assessment for self-harm, there is not yet an objective, validated risk assessment tool, and consequently no guidance for management of the young person with respect to that level of risk. The study by Manning et al. (2018) contributes to the development of this concept by providing an objective assessment tool. Whilst this objective tool has been validated for the assessment of immediate risk of harm and suicide in emergency departments, it does not provide sufficient information on its own for full evaluation of the risks associated with the other major themes identified in this study. However, serious consideration should be made for adopting this tool to inform part of the overall risk assessment.

7.1.2.6 The Implications of Risk Assessment for the Study

Risk Assessment was identified as a major integrative theme in this study. All clinicians perceived risk assessment to be a key purpose of the consultation of a young person who has self-harmed. This included evaluating risk of serious physical injury from wounds or self-poisoning as well as the other uses identified in section 7.1.2.3.

Whilst risk assessment was demonstrated to be a major theme, all clinicians used a subjective assessment. The only objective tools mentioned (Sainsbury's Risk Assessment (Stein, 2005) and SADPERSONS (Katz et al., 2017)) were developed for use with adults, and thus not necessarily of clinical value with young people. The tool CYP-MH-SAT tool (Manning et al. 2018) had not been published at the time of data collection. Furthermore, with exclusion of the CAMHS professional, none of the ED clinicians had received any formal training in risk assessment of young people who self-harm.

Even so, clinicians were appropriately concerned about the factors which may influence risk for a young person having self-harmed, as identified in the first order themes of this study.

Lack of training meant that they had not been exposed to factors, such as knowledge of attachment theory (Bowlby & Holmes, 2005) or child development which may help them formulate a more accurate risk assessment. Furthermore, this lack of training may have resulted in the inaccurate perception of some clinicians that young people who attended due to repeated self-harm have a lower risk than children making their first attendance. Due to the significance of accurate risk assessment for children who self-harm this concept must feature in the educational preparation of ACPs in EDs.

7.2 Discussion Related to the Identified Ordered Themes

7.2.1 Looking for Injuries or Potential Poisoning

All clinicians in this study articulated the need to prioritise treatment of life-threatening conditions resulting from overdose (section 6.1.1.2). However, further analysis revealed they did not discuss in detail what this meant for their practice. On reflection, this may have been that they assumed I would know this detail, as they knew I was an emergency nurse consultant. This was seen as a strength of the hermeneutics approach. Someone using classical phenomenology, with no knowledge of the subject or professional context, may have probed deeper about the process of overdose management and wound care, as part of the interview process. However, having knowledge of usual ED processes enabled the interview to flow more fluently, without the need for me to interrupt to obtain clarity about these processes.

It was clear that the need to quickly identify and treat any immediate life-threatening physical health threat was a priority for ACPs who see children who self-harm. From my experience I know this requires an ability to assess the severity of any wounds, and manage the appropriate closure of those wounds if required. Clinicians in this study mentioned suturing as a wound closure technique (PEM1) and steri-stripping (ACP3). A working knowledge of

referral pathways should the wound require specialist intervention, for example Plastic Surgery for tendon or vascular repair, is also required.

The ACPs in this study put particular emphasis on the need to quickly identify and treat young people who have an actual, or potentially life-threatening condition as a result of self-poisoning. Again, my experience is that this requires the ability to take a comprehensive history about the nature of any medication taken and also the timings of ingestion.

Paracetamol was the only named medication identified by clinicians in this study, when discussing their experience of self-harm in the ED. This is unsurprising, as paracetamol is the most commonly used medication for overdose self-harm acts. Paracetamol is readily available as an 'over-the-counter' medication, and overdose of this drug is the most common reason for clinicians consulting the UK Poisons Centre (Gupte, 2016). In the 1990s, paracetamol poisoning was the foremost reason for liver transplantation in the UK. Subsequent legislation, limiting the pack size available for sale, has significantly reduced mortality from acute liver failure and the consequent requirement for transplantation has reduced as a result.

Treatment for paracetamol poisoning is determined according to the weight of the patient and paracetamol blood plasma levels. The early administration of intravenous N-acetyl-cysteine (Parvolex) facilitates the metabolism of the hepatotoxic intermediate metabolite N-acetyl-p-benzoquinone imine (NAPQI), and elimination without damage to the liver. Failure to identify the need for treatment, or administer it in a timely manner, may result in potentially lethal liver failure, and thus is associated with significant risk.

Whilst pack size limitation has reduced the amount of paracetamol ingested by those taking an impulsive overdose, children with lower weight require much less paracetamol to create hepatotoxic levels of NAPQI in the blood. Therefore ACPs must have knowledge of the evidence-based treatment guidelines (Gupte, 2016), or where to find them in practice, for both single-dose paracetamol overdose and staggered overdose. They also require the skills

to be able to administer the treatment, including the insertion of an intravenous access device and ability to calculate and draw-up the required amount of N-acetyl-cysteine based on weight for administration.

The fact that all clinicians prioritised the physical needs of children, reflects the knowledge and skill competencies for overdose management detailed in the RCEM ACP curriculum (Royal College of Emergency Medicine, 2015).

7.2.2 Pursuing Safeguarding and Social Concerns

Extensive knowledge about safeguarding and social issues was employed by ACPs in their practice with children and young people who self-harm. Whilst this was not identified as an a priori theme, with hindsight this could have been predicted as safeguarding children has become an increasingly prominent activity in EDs over the past two decades. It is now a key component of the RCN National Curriculum and Competency Framework for Emergency Nurses (2017) as a cross-cutting theme. High profile cases such as those of Victoria Climbié (Laming, 2003) and Baby P. (Haringey Local Safeguarding Children's Board, 2009), in addition to the serious case reviews into CSE in Rochdale (Rochdale Safeguarding Children Board, 2013), Rotherham (Jay, 2014), and others (Myers & Carmi, 2016; Oxfordshire Safeguarding Children Board, 2015), have led to heightened awareness amongst emergency care staff to the signs and symptoms which may reflect issues of safeguarding concern.

The safeguarding factors found to be of particular concern to the participants in this study were: child sexual abuse and exploitation, bullying, alcohol and substance misuse, social media use and being in local authority care (looked-after children). Each of these factors are discussed separately in the following sub-sections.

7.2.2.1 Child Sexual Abuse and Exploitation

Practitioners in this study were clearly concerned about the need to identify any risk of CSE or other sexual abuse in children who have self-harmed (section 6.1.2.1). Whilst not specifically referencing any evidence for this concern, seven out of the eight participants specifically referred to CSE in their interview. Interestingly, the only participant not to mention CSE had the least experience in their ACP role (ACP 1). Despite their having extensive ED nursing experience, I reflected that this may have been because they had not experienced this factor within their ACP role, about which they were interviewed.

This clear concern about CSE and sexual abuse appears to be highly appropriate, as the literature demonstrates that they have significant relevance to self-harm. Witt et al. (2018) conducted a systematic review and meta-analysis of risk factors associated with repetition of self-harm behaviour in young people. They found previous sexual abuse was significantly associated with self-harm repetition, citing an Odds Ratio of 1.52 with a population attributable to this factor of 12.5%. This suggests 12.5% of young people who repeat self-harm will have experienced some form of sexual abuse. This systematic review builds on the large scale European study published by Madge et al. (2011), in which over 30,000 young people, mainly of 15 and 16 years old, were questioned about their thoughts and episodes of self-harm. They identified that 19.1% of young people with self-harm thoughts had experienced physical or sexual abuse. This increased to 31% for those who had a single episode of self-harm, and 38.7% of those with multiple self-harm events.

Therefore, congruent with the experience of the participants in this study, and the evidence in the literature, the knowledge and skills required for identification, and subsequent safeguarding interventions of child sexual abuse and exploitation are deemed essential for any ED clinician seeing children who self-harm.

7.2.2.2 Bullying

Two of the ED practitioners in this study highlighted bullying as a safeguarding concern (PEM 2 and CAMHS). This was conducted either through digital platforms such as texting or social media: "...asking about Facebook bullying" (PEM 2: 254), or through more traditional methods at school: "*part of my assessment is to ask, the old fashioned "are you bullied at school?"*" (CAMHS: 396). Interestingly neither of these individuals were ACPs.

Bullying is a stressful life event associated with self-harm. Madge et al. (2011) found that 35.3% of young people with single self-harm episodes disclosed previous bullying. This rose to 43.9% for those with multiple self-harm episodes. These are even greater numbers than CSE and sexual abuse. A more recent study (Foss, Mari, Lance, Stian, & Mari, 2018), identified bullying in adolescence as a significant factor in the presence of suicide ideation and self-harm in later life.

This study demonstrated that, whilst some clinicians think about bullying when assessing young people who have self-harmed, this was by no means a universal enquiry for all clinicians. Although it cannot be assumed that those who didn't mention it in interview don't consider it in practice, it would appear that CSE is more prominent in the minds of practitioners when discussing safeguarding concerns than bullying.

Given the evidence of correlation to self-harm and suicide ideation (Foss et al., 2018; Madge et al., 2011) the ability to identify and instigate safeguarding procedures for young people who have experienced bullying, should be part of the knowledge and skill set of any ACP who encounters children who have self-harmed as part of their role. Good engagement is clearly required to be able to discuss this sensitive subject.

7.2.2.3 Alcohol and Substance Misuse

Two practitioners (PEM 1 and ACP2), mentioned that they enquire about alcohol consumption as part of their consultation with young people who self-harm (section 6.1.2.1.1). The use of alcohol or other substance misuse was not specifically identified as a correlation factor in either Witt's (2018) systematic review and meta-analysis, or Madge et al.'s (2011) European study. However, alcohol features heavily in the serious case reviews related to CSE (Raynes, 2016), which is known to be correlated with self-harm. Alcohol consumption is also known to reduce the ability to make informed conscious decisions, and leads to impulsive, less thought-through actions which could manifest in self-harm acts (Breet & Bantjes, 2017).

NICE guidance (2011), on the assessment of harmful drinking in patients over 10 years of age by healthcare professionals states that young people who self-harm are a key group who should be targeted specifically for assessment of harmful drinking, using a validated tool, such as the Alcohol Use Disorders Identification Scale (AUDIT) (Young & Mayson, 2010), and should be encouraged to consent to brief intervention strategies.

No clinicians in this study mentioned the use of any tools for alcohol screening, with this patient group, or referral for intervention strategies. Walsh, Haroon, Nirantharakumar, and Bhala (2017) suggest that the use of tools in emergency departments is limited due to time constraints. Whilst time pressure was certainly a feature of this study (section 6.1.5.5) it is unclear whether this was the reason why a validated alcohol screening tool was not identified in the study evidence, or whether the clinicians interviewed were unaware of them. This could be attributed to their lack of formal training (section 7.1.6.2).

Specifically asking about alcohol consumption in relation to both safeguarding concerns, and the self-harm behaviour itself is deemed a relevant intervention for ACPs in EDs, as recommended by NICE (2011). Knowledge of validated screening tools, and of local pathways to facilitate early intervention strategies, is therefore indicated for ACPs who treat children

who self-harm. The adoption of the AUDIT (Young and Mayson 2010), as part of the assessment of children who self-harm should be considered.

It is clear from the findings of this study and the literature, that knowledge of and skill in identifying safeguarding issues with young people who present having self-harmed is a fundamental aspect of the clinical role in seeing and treating young people who self-harm. This is reflected in statutory guidance (Her Majesty's Government, 2017, p. 56) which states *"All staff working in healthcare settings – including those who predominantly treat adults – should receive training to ensure they attain the competences appropriate to their role and follow the relevant professional guidance."*

The professional guidance for ACPs working in emergency departments comes from the RCEM in the curriculum and competency framework (Royal College of Emergency Medicine, 2015). The only reference to safeguarding in the framework is found in the core competencies. 'CC19' states in the knowledge domain: *"Understand the legislative framework within which healthcare is provided in the UK – safeguarding children legislation"* (Royal College of Emergency Medicine 2015, p99). There is no further detail provided. It is simply listed amongst other legal issues such as: 'understanding the role of the coroner', 'data protection legislation' and 'medical risk for driving'. There is no reference to safeguarding knowledge or skill in the paediatric specific presentation competencies for poisoning and self-harm (P-AP2) (Royal College of Emergency Medicine, 2015, p193), which focus purely on the knowledge and skills required to manage overdose or ingestion of poisons (Section 7.2.1). This is perhaps why ED clinicians place so much emphasis on identifying the potential risk of physical harm, and on the instigation of any necessary medical treatment.

7.2.2.4 Parental Support

The contribution of parents was discussed by all participants in this study. They identified with a possible protective factor, but also recognised that parents could be a source of safeguarding concern or potential conflict for a young person. This dichotomy gave rise to the consideration of whether parents should be present at the consultation and the labelling of the consequent sub-theme: 'Should parents stay or should they go?' (Section 6.1.2.3.1).

Most clinicians indicated they would take guidance from the child whether or not they wanted their parents present. One of the ED consultants (PEM 2) described seeing the child on their own, then the parents on their own, then both together. I interpreted this to reflect the need to respect confidentiality of children, certainly those who are deemed 'Gillick' competent (Larner & Carter, 2016), and able to consent for themselves, but being mindful that information from parents may be significant in formulating the risk assessment. Seeing children on their own was also used as a strategy to facilitate engagement (section 7.1.1).

Having access to effective support was perceived by clinicians as a protective factor for children who self-harm. Klemmera, Brooks, Chester, Magnusson, and Spencer (2017) highlight the significance of both 'belonging' and 'connectedness' as important components of protective health assets for young people. Having an easy and open communication style as a parent appears to offer a protective element for young people. The same study demonstrated that good parental support was more protective than peer support for young people who self-harm. However, other than the evidence which correlates actual abuse with self-harm (Stanley, Riordan, & Alaszewski, 2005), no evidence could be found which describes the impact or effect of poor parenting at sub-abuse level, on children who self-harm.

The specialist CAMHS practitioner placed emphasis on the application of their knowledge of attachment theory (Bowlby & Holmes, 2005) in relation to assessing the parent/child relationship: "...you get a sense that there's something just not right, and you're relying on that a lot,

that attachment theory to make you inquisitive. So I would definitely think about attachment theory."
(CAMHS: 876-880).

John Bowlby (1907-1990) showed that the early interactions between an infant and a primary caregiver have a profound impact on a person's social, emotional, and intellectual growth. Children who do not have a secure attachment to a caregiver may experience anxiety and depression; factors which are attributed to self-harm (Lundh, Wangby-Lundh, Paaske, Ingesson, & Bjarehed, 2011). Bowlby's theory has had a direct influence on the care of children in hospital environments. Notably parents are now encouraged to stay with their children in hospital to avoid the negative effects of separation anxiety. This is in contrast to hospital rules of the 1950s and 1960s which had severe restrictions on parent visiting, often only allowing visits for 1-2 hours per day.

Attachment theory is routinely taught as part of child nursing pre-registration undergraduate studies, but is not usually included in adult nurse courses, or medical degrees. Hence it is not surprising that the adult trained ACPs, and ED Consultants did not use this as part of their practice.

As identified by the CAMHS practitioner, having knowledge of attachment theory may be helpful to aid understanding of how family relationships can contribute to the psychological stress of a young person, who may then express that stress through self-harm acts, or use self-harm as a coping mechanism for living with that stress. It is also possible that attachment theory awareness may influence the overall risk assessment of the young person with regards to evaluating the level of parental support for that child. Glazebrook, Townsend, and Sayal (2015) identified that 78% of children in their study who were classified as poorly attached to their mother repeated a self-harm act during the six-month study period, compared with 48% of the comparison group who were classified as securely attached. Whilst caution should be made with to regards generalisability of Glazebrook et al.'s (2015) study due to the small sample size (n=48), they used validated tools for measuring attachment, depression and

anxiety. Their results with respect to correlation of anxiety and depression and self-harm were consistent with other studies (Madge et al., 2011; Witt et al., 2018). Therefore, the results regarding security of attachment, should be given serious consideration.

The CAMHS practitioner was the only participant to have had any formal training for the assessment of children with mental health problems, albeit several years into the role. None of the other clinicians mentioned any theories they use to make assessments of the child/parental interaction. It could be that this lack of formal training (section 7.2.5.2), meant that they simply had never been made aware of attachment theory, or its relevance to this client group, and as such ED clinicians may benefit from having knowledge of this theory to inform their practice.

In summary, ED clinicians made a judgement about whether having parents in the room during the consultation is congruent with the wishes of the child, and important in facilitating parental support for the child, or, whether excluding them from the room facilitated better engagement of the child, who may wish to disclose information they want to keep from their parents. This situation then warrants careful consideration about the requirement to respect confidentiality, versus the possible need to share information, in order to safeguard the child.

Clearly practitioners in this study were exercising these judgements, based on their own experiences of seeing young people who self-harm, although there was no common method for doing so. It could be that, as each case is unique, a standardised approach may not be beneficial to the decision whether or not to include parents in the consultation. However, the variance in approach would suggest that this topic warrants further investigation. In addition, if clinicians had knowledge of attachment theory, they may be better placed to make assessments about the nature of the parent/child relationship which could influence the overall risk assessment.

7.2.2.5 Social Media and the Internet

Whilst internet use and associated bullying via social media was identified by two participants (PEM2 and CAMHS) as something they considered to be potential contributing factors to self-harm (section 6.1.2.2.1), there is growing evidence to suggest that the internet may be a source of support for young people (Marchant et al., 2017). Online support may provide useful information about self-harm facts, and improve knowledge of the associated mental health conditions, as well as facilitating the sign-posting to sources of help and support. The use of social media and the internet may also help young people feel less isolated, and thus reduce this key risk factor for self-harm (Witt et al., 2018).

Burns and Birrell (2014), suggest that the use of digital technology could enhance early engagement with mental health services from young people, by using a communication method with which young people are familiar, and more comfortable with than face-to-face. More recently, Nielsen, Kirtley, and Townsend (2017) reported on a mobile device application (app) which was validated to reduce self-harm behaviour in the short term. Whilst it demonstrated no long term impact on self-harm behaviour, the authors report that the potential for positive-impact apps should not be dismissed.

On reflection, it could be that the generation of ED clinicians in this study, who like me were introduced to social media as adults, and have witnessed the apparent harm from its introduction in society, view social media in a culturally different way to the generation of young people who self-harm, having grown up with its use in their life. Further investigation of this notion was beyond the remit of this study but may be useful to explore in the future.

7.2.2.6 Looked-after Children

Children in local authority care, or 'looked-after children', were viewed by clinicians in this study as high risk in relation to self-harm. One example from the data states: "*They are quite*

a high risk group (Looked-after children), because a lot of them are very socially isolated" (ACP2: 447-448). Their experience is reflected in the literature, as this group of children have demonstrated a high incidence of self-harm behaviour, possibly as high as 45% of cases (Stanley et al., 2005). These high rates of mental health problems were attributed to the experience of being looked-after, particularly those who had disrupted placements, or were in residential care, rather than living in foster care or with family, and the adverse circumstances which lead to children entering the care system.

The circumstances leading to being looked-after often included neglect (section 7.2.2.4), and/or physical or sexual abuse (section 7.2.2.1). Both these circumstances are correlated with self-harm behaviour. Wadman et al. (2017) specifically compared self-harm patterns between children who were in local authority care and those who were not. However, this study only had a small sample, 24 children in the looked-after group and 21 in the contrast group living with biological parents, thus caution should be exercised with regards to generalisability of these findings. Wadman, et al. (2017), were unable to demonstrate any difference between the groups with respect to age of onset of self-harm behaviour, frequency or method. The majority in both groups used cutting as a method of self-harm. Similar numbers in each group (54.2% in the looked after group and 47.6 in the contrast group) had received a diagnosis of mental illness including depression, anxiety and eating disorders. Both groups also identified feelings of depression, sadness, and self-hatred as important factors leading to self-harm. These emotional risk factors are discussed in greater detail in section 7.2.3.

Despite the many similarities in self-harm characteristics between young people who are placed in local authority care, and those who remain in the parental home (Wadman et al., 2017), two key differences were identified. Firstly, looked-after children reported more frequently that they had access to means to hurt themselves. Secondly they reported absence

of fear of dying more often. These factors increased the risk for looked-after children, and the implications of this are discussed the section on Identifying Suicidal Intent (section 7.2.4).

Whilst the clinicians in this study did not specifically refer to any evidence regarding the relationship between looked-after children and self-harm, it was clear they correctly regarded children in local authority care as higher risk. On reflection, Bowlby's attachment theory (2005) could go some way to explain this.

7.2.2.7 Safeguarding Interventions

All participants discussed the need to identify safeguarding and social concerns as part of the risk assessment of young people. They also articulated interventions they would take should a safeguarding concern be identified. These included referring children to local authority social services, or reporting their concerns to the Police.

One clinician talked about 'doing' the safeguarding: *"...and then in A&E, it would also be a case of doing the safeguarding things. So that generally gets done straight from assessment by the nurse anyway. So just check that it has been done. Are social services aware, has safeguarding been done?"* (ACP 3: 170)

My experience has been that making interventions for safeguarding concerns can be emotionally exhausting, which was also the experience of the PaedACP. They recounted their involvement in the care of a girl of primary school age who had been removed from the family home due to sexual abuse from a family member, resulting in the separation of her from her siblings who were placed in a separate care environment. Instigating safeguarding interventions can also be time consuming, requiring extensive contemporaneous records, as well as lengthy and numerous telephone conversations. Time pressures have been identified as a potential barrier to engagement, therefore they could arguably also contribute to failures to detect safeguarding concerns (see section 7.1.4.1).

7.2.2.8 Summary of Discussion Relating to Safeguarding and Social Concerns

It was clear from the findings that the ED clinicians in this study placed great emphasis on pursuing safeguarding and social concerns for children who self-harm. This practice is supported by evidence which correlates self-harm with CSE (Witt et al., 2018), bullying (Madge et al., 2011), and being in local authority care (Wadman et al., 2017).

However, only two of the participants mentioned exploring alcohol consumption by young people (PEM 1 and ACP 2). Yet, review of the literature on this topic suggests practice may be improved by adoption of a validated alcohol screening tool (NICE 2011), for which any potential barriers to implication should be explored (Walsh et al., 2017).

Whilst the use of social media was recognised as a potential contributory factor as part of the risk assessment of young people who self-harm, its potential benefits, other than as a means of personal communication for help, were less evident. The use of web-based support, and social media support for young people who self-harm should be explored for possible inclusion into training for ACPs.

Given the significance of this safeguarding theme as a study finding, any professional guidance on ED ACP curriculum and competencies, should consider inclusion of more specific safeguarding knowledge and skills required for ACPs to undertake their role with this client group. This must also include knowledge and skills required to implement appropriate safeguarding interventions.

7.2.3 Recognition of Emotional State

All practitioners articulated the need to assess the emotional state of young people as part of the overall risk assessment. The data pertaining to this theme was attributed to several sub-themes: Mood Assessment (section 6.1.3.1), Maturity Assessment (section 6.1.3.2) and Physical Appearance (section 6.1.3.3).

7.2.3.1 Mood Assessment

Low mood, described as sadness, depression or low self-worth by various practitioners was attributed to an increased risk for a young person (section 7.1.2). The way the mood was assessed was either by direct report from the young person: *"...child presented without any actual harm but had come in complaining of low self-worth, feeling depressed"* (Pilot:31-32), or by interpreting physical appearance (section 7.1.3.3) and the level of engagement of the young person (section 7.1.1): *"I think you read a lot more into the body language of your patients"* (ACP 2: 100) *"...there are certain things that I look out for that would cause me concern. Like if they are not making eye contact with you. If they are looking down. If they are talking monotone. If they look unkempt. You know, all of those kind of warning signs that you pick up. Not from what they're telling you, just from what you are observing with the person."* (ACP 2: 102-105).

Given the correlation of low mood and depression with self-harm (Wilkinson, Kelvin, Roberts, Dubicka, & Goodyer, 2011), the ability to interpret mood is important for establishing the future risk of self-harm to a young person. As with the other elements of risk assessment associated with the major themes in this study, there is a lack of clarity about management plans which should be put in place when this risk factor is identified. Certainly, the ED practitioners would not consider starting treatment for depression *"...I wouldn't start any (mental health) treatment in A&E"* (ACP 3: 389), and the CAMHS practitioner indicated that they would not make a diagnosis or start treatment: *"I always tell people when I go out "This is not a therapeutic session"* (CAMHS: 170), *"The only people who can make (mental health) diagnoses are doctors"* (CAMHS: 583), *"The vast majority of our team don't know about mental illness disorders"* (CAMHS:649). The CAMHS practitioner indicated that if he thought someone was suffering from a mental illness he would arrange for them to be assessed by a psychiatrist. This would only happen as an emergency if he thought they

were in a state of psychosis, or required detention under the Mental Health Act (Her Majesty's Government 2007) for their safety.

Reflecting on this situation raised my awareness that when a child's mood is evaluated to give cause for concern, there is a prolonged period of time before a diagnosis is made, or any necessary treatment started. This is due to the patient being referred from one practitioner (ED), to another (CAMHS practitioner), then on to another (Psychiatrist), often days later. This reflection gave credence to the findings of the study by Cloutier et al. (2010), which highlighted that care givers and youths had concerns which were not in concordance with those of the ED clinicians. Young people and their parents were concerned about depression and anxiety, and their parents expected that their visit to the ED would result in a diagnosis, and the provision of help and guidance in caring for their child.

I would suggest that multiple referrals, with possible days of delays to seeing a clinician who is able to make a definitive diagnosis and initiate treatment, portrays the message that the clinicians do not perceive the condition be urgent, yet this may be the belief of the child or family. This may further explain the findings by Cereal et al. (2006), whose survey revealed that fewer than 40% of self-harm patients felt that the ED staff took their condition seriously.

It would appear that a better understanding of both the ED and CAMHS service provision (see section 6.1.5.1.3), is required by all clinicians, so they are able to explain likely pathways and outcomes to young people and their families at the outset. This may contribute to an improved experience for young people, despite their not receiving an anticipated mental health diagnosis during the ED visit.

7.2.3.2 Maturity Assessment

Maturity of the child, closely associated with physical appearance (section 7.2.3.3), was a subjective assessment made by several practitioners. Some practitioners interpreted more mature young people to be of lower risk than immature ones: *"A mature 16year old's got more street cred. They're more savvy. In some ways you might be less concerned than someone who's quite immature for their age."* (PEM 1: 351-352).

This finding corroborates the finding of Diggins, Kelley, Cottrell, House, and Owens (2017) who found that 12–14 year olds were more often seen urgently by ED medical staff and offered high intensity mental health aftercare. Whereas older adolescents presented with more severe acts of self-harm, yet received the lowest intensity of assessment and after care.

Whilst this finding of perceived increased risk for younger or immature patients does not necessarily determine that staff displayed a more positive attitude to younger patients, as identified by Cleaver et al. (2014), it does suggest they are perceived to be more vulnerable, which may result in a more empathic attitude due to level of concern.

Interestingly, whilst no evidence could be found in the literature to correlate maturity with self-harm risk, Skoog and Bayram Özdemir (2016) demonstrated that girls who mature earlier are more likely to be exposed to sexual abuse or harassment. Given the correlation of sexual abuse with self-harm behaviours (Witt et al., 2018) (section 6.1.2.1), early maturity could also theoretically, be correlated to increased risk of self-harm. Thus, the assumption of reduced risk for more mature young people may be inaccurate.

Practitioners were also more likely to feel competent in seeing more mature young people as part of their scope of practice (section 7.2.6.1). Practitioners explained that they would assess a more mature young person in the same way they would an adult patient: *"I think an older child is probably easier because it's the same, I'd assume it's the same as you would for an adult.... So I tend to see children fourteen or above, but it depends on when I see them if I think they are immature for*

their age” (Pilot: 70-74). “But if they're communicating openly and appear to be quite mature in their approach then I would approach them in a similar way as an adult” (ACP 1: 81-82).

Whilst young people may have physical maturity of most body systems by the age they are sixteen or seventeen, their brains are not physically mature until approximately twenty-five years of age (Romer, Reyna, & Satterthwaite, 2017). This leads to the physical appearance of adulthood with a psychological immaturity. Thus, whilst they may look like adults, their assessment and management should be based on their psychological developmental stage, which is unlikely to be similar to an adult's at the age of sixteen or seventeen.

Interestingly, with the exception of the Paed ACP participant, all practitioners had their initial training and registration in the adult field of practice. This could be one reason for perceiving younger or more immature children to be higher risk: *“First of all if they are very young, that would really concern me.”* (PEM1: 141). Younger children may also present more of a professional risk, being beyond the scope of initial registration field (Nursing and Midwifery Council, 2015), and therefore, more likely to be regarded as beyond the scope of practice for the practitioner (section 7.2.6.1).

Given the absence of evidence to correlate maturity with risk of self-harm, the subjective measure of maturity, which practitioners in this study associated with reduced risk, should be questioned. Furthermore, assuming young people, who appear mature, to be able to be assessed as adults, may result in false confidence of the practitioner in their competence. Therefore, it is recommended that further research into this concept should be considered in order to provide appropriate care for children, and also establish the boundaries of the professional practice of the clinician (section 7.2.6).

7.2.3.3 Physical Appearance

The physical appearance of young people was used to interpret emotional state, the level of engagement, and thus, risk assessment. In particular, the presence of eye contact was a significant factor for assessment. The absence of eye contact was interpreted as being withdrawn, or indicating lower mood and thus representing higher risk. Conversely good eye-contact was interpreted as representing positive engagement and thus representing a lower risk.

It is recognised that interpreting physical appearance in this way was not formally taught to the clinicians, but something they have learnt by experience over time. For new ACPs in training, it would be useful to have more knowledge and skill about interpreting this non-verbal communication.

7.2.4 Identification of Suicidal Intent

The issue of suicide was considered by all practitioners as part of the assessment of young people presenting with self-harm conditions. This was considered to be highly appropriate given that death by suicide was the leading cause of death in the UK for both boys and girls aged 5-19yrs in 2015 (Public Health England, 2017). Whilst some studies support the theory that an act of self-harm is used as a coping measure for psychological stress (albeit maladaptive), rather than an attempt to end life (Chapman, Gratz, & Brown, 2006; Gurung, 2018), there is an incontestable link between self-harm and increased risk of future death by suicide. A meta-analysis conducted by Carroll, Metcalfe, and Gunnell (2014) concluded that 1 in 25 young people who present to emergency departments with self-harm die by suicide within the subsequent 5 years.

Participants in this study conducted assessment for suicide risk through direct questioning: “*I did ask her directly towards the end of the discussion with her about if she was suicidal or not*” (Pilot, 59-60).

Other than the CAMHS professional, none of the ED clinicians used any specific tools to objectively assess suicide risk. Even the CAMHS professional suggested that their subjective assessment based on experience, appeared more valid than the results of the formal assessment tool “*but it is only a piece of paper, you can use it as REFERENCE, but for me it's only a reference guide because you are drawing out on experience*” (CAMHS: 106-107). Indeed, the Sainsbury’s risk assessment tool (Stein, 2005) that was identified by the CAMHS practitioner was not designed for use with children. Therefore, participants in this study universally calculated suicide risk using their own subjective assessment of the young person.

Due to this absence of validated risk assessment tools, a Nottingham team (Manning et al., 2018), conducted a research study to develop and evaluate a Children and Young People-Mental Health Safety Assessment Tool (CYP-MH SAT). Its purpose was to identify the immediate risk of self-harm and suicide in children and young people (10–19 years) in acute paediatric hospital settings. Whilst the tool was validated for use by registered children’s nurses, rather than adult registered ED professionals, the cohort of children for whom this was designed is the same as this study population. Serious consideration should therefore be given to adopting this tool as part of the overall ED assessment of children who self-harm.

Two clinicians felt that repeated attendance represented a lower suicide risk than the first attendance. “*...(the) first presentation is very high risky behaviour, then that automatically sets alarm bells ringing*”...“*but if they have got recurrent episodes and their behaviour hasn't escalated to more risky behaviour, you might not be as concerned* (ACP 2, :293-296)

"So I'm always a bit more wary on the ones that are new. New presentations, particularly if they are quite young as well." (PEM 1: 91-92)

This perception of lower risk with repeat attendance is inaccurate. Several studies have demonstrated suicide is strongly associated with early repetition of non-fatal self-harm. Indeed, Bennardi, McMahon, Corcoran, Griffin, and Arensman (2016) concluded that repeated self-harm represents the single strongest risk factor for suicide.

As with the other risk assessment elements related to the themes of pursuing safeguarding and social concerns, and interpreting emotional state, participants only briefly discussed risk management strategies they might employ following their assessment of suicide risk.

Intervention strategies described for patients perceived to be at high risk included ringing the Police to bring them back if they absconded, or nursing them with one-to-one supervision. On reflection, these strategies are designed to mitigate any immediate risks that suicide ideation might pose to the physical health of a young person, rather than interventions to influence the feelings of a young person who is considering ending their life. I reflected that this may be further evidence of prioritising the physical needs of a child over their mental health.

7.2.5 Deliberating Professional Practice Issues

The theme of deliberating professional practice issues was sub-divided into the scope of practice of the individual, their role, and the emergency department service. Within this theme the sub-theme of 'Lack of Formal Training' was established, which referred to the absence of any specific training around adolescent self-harm in preparation for the clinicians' role with this patient group.

7.2.5.1 Scope of Practice

Scope of practice as a sub-theme referred to the practitioner's decision making about who they were confident to see and treat, and who they believed were beyond their competence. In the latter case they would either not commence the consultation, or stop the consultation and refer on to someone with the necessary competence. This practice is supported by the NMC. The Code (Nursing and Midwifery Council, 2015), is very clear in section 13.3 that registrants must *"ask for help from a suitably qualified and experienced healthcare professional to carry out any action or procedure that is beyond the limits of your competence"*.

This sub-theme of 'Scope of practice' also included the limitations of the service provision. Many believed the time restrictions in the emergency department, made more pressing by the four-hour standard (Boyle, 2016), influenced the amount of time that could be spent with a young person, and thus limited the level of service that could be provided (Section 6.1.5.5). Ironically, mental health patients are a group who often breach the four-hour standard, and thus spend longest in the department, sometimes even days (Verita, 2018). This perception of having insufficient time to establish engagement, and deliver care beyond that which is essential for physical injuries or poisoning, is congruent with the findings by McHale and Fenton (2010) outlined in Chapter 2.

All participants agreed that meeting the physical needs of the child was a priority (see section 7.2.1). Some then referred all young people to the CAMHS service for a psychological assessment, believing this part of the assessment was beyond the scope of the ED service. This belief about the limitations of the ED service was also shared by the CAMHS practitioner who also revealed the absence of mental health diagnosis in the ED, and delays to starting any necessary treatment (section 7.2.3.1), which this study identified as a possible explanation of the disconnect between the expectations of patients and carers, and the perceived concerns of clinicians, as identified by Cloutier et al. (2010).

7.2.5.2 Lack of Formal Training.

All clinicians, including the CAMHS specialist, highlighted a lack of formal training in relation to assessing and treating children who have self-harmed. This resulted in the knowledge and skills of these practitioners being almost exclusively gained through experiential learning.

ACPs were able to exercise their duty to practice within the boundaries of their knowledge and skills by opting not to see children if they felt they didn't have the competence to do so. However, consultant clinicians and CAMHS practitioners were unable to do this, and thus had to apply their experientially gained knowledge and skills to the best of their ability. Lack of training could therefore lead to a poor experience for a young person, due to the potential lack of ability to facilitate engagement, or potentially erroneous risk assessment decision making. The consequences of this could lead to permanent harm or death of a young person. It may also lead to serious consequences for the clinician should such an error occur.

The RCEM Curriculum (Royal College of Emergency Medicine, 2015, p193) sets out the competencies required for ACPs with respect to children who self-harm. These knowledge and skill competencies are entirely related to the management of overdose and poison ingestion. This study has identified that practitioners also require the knowledge and skills to identify and take appropriate action for any safeguarding concerns, assess the supportiveness of the parent/child relationship for which knowledge of attachment theory may be useful, undertake assessment of a young person's emotional state, and conduct a suicide risk assessment. Any revision of this professional curriculum should consider inclusion of these knowledge and skill requirements.

7.3 Limitations

This study used a hermeneutic phenomenological approach, principally because I had extensive experience of the study topic which I wanted to exploit. Every effort was made to be transparent about my rationale for study decisions, and to limit bias in conducting and analysing the interviews. However, it is inevitable that the interpretation of the findings was influenced by my own experience. Whilst this is not strictly a limitation and is congruent with the methodology, it must be borne in mind when evaluating the study.

This study was intended to be exploratory in its design, and not conducted to test theory or a hypothesis. Therefore its qualitative nature with small purposeful sample means it cannot be regarded as generalisable to the wider population of ED clinicians and ACPs. However, the attention to quality assurance and adherence to methodological processes should enable the reader to be confident that the findings were indeed a true representation of the experience of the clinicians who participated in this study. The cross-sample analysis afforded by the template analysis method (King 2012), revealed themes, or 'fusions of horizons' (Laverty, 2003) which would reasonably apply to similar situations.

7.4 Reflexivity 2

Throughout this study I have reflected on my own practice as an emergency nurse consultant, which comprises four elements:

7.4.1 Clinical Practice

I have extensive clinical experience of treating young people who self-harm. My personal challenges in working with this client group provided impetus for the development of this study. As the study progressed I became mindful of the findings, which have influenced my

day to day clinical practice, not least in relation to the identified ordered themes. I am now very mindful whilst undertaking consultations about the need to engender trust and use a variety of strategies to maximise opportunities for engagement between myself and a child in the consultation. Sometimes these work well and other times they are less successful. If I feel another clinician may connect better with a child, I will try to delegate the consultation to them. At other times I now accept an inability to secure engagement as a sign that the child is either unwilling or unable to engage, which I try to respect, having due consideration for this in assessing their overall risk.

7.4.2 Education

Part of my role as a nurse consultant is the facilitation of education for other practitioners. I regularly teach junior doctors and advanced practitioners. This study has helped structure those teaching sessions and has informed the content, particularly on the principles of engagement and facilitating discussions around strategies employed to facilitate this. I also facilitate training on risk assessment, based on the identified risks associated with this study's major themes. More recently I have become aware, not only of CSE as a safeguarding risk factor, but also the issue of child criminal exploitation (CCE), otherwise known as County Lines. Whilst this did not feature in this study, it is also thought to be associated with self-harm (Home Office 2018) and demonstrates the evolving nature of safeguarding risks to young people and the need for clinicians to remain updated.

7.4.3 Research

Whilst the doctorate programme was a vehicle to facilitate this research study, the production of this thesis has provided direction for future research on this topic. I am particularly interested in further exploring the concept of engagement in a clinical consultation as a post-doctoral study.

7.4.4 Leadership

As Chair of the RCN Emergency Care Association I am in a privileged position to be able to influence both the ACP curriculum through my close links with the RCEM, as well as the national emergency nursing competency framework. As such, my professional duty will ensure the results of this study are made public, to create opportunities for critical evaluation, in order to appropriately influence strategic developments in emergency care with regards to young people who self-harm.

In addition to my professional role, as a mother to two school-aged girls, I have been mindful of the devastating effects that self-harm can have on families, and been conscious of the empathy that I have had with some mothers, resulting in an emotional investment to conduct this study with integrity.

Chapter Eight: Recommendations and Conclusion

8.1 Recommendations

The findings from this study (Chapter 6), and the subsequent discussion about their implications (Chapter 7), resulted in the production of the following recommendations. They are organised into those pertinent to policy, education, practice, and future research, with rationale for each.

8.1.1 Recommendations for Policy: Table 6.

Number	Recommendation
1	Future revisions of the Royal College of Emergency Medicine Curriculum for educational preparation of Advanced Clinical Practitioners should take account of the recommendations for training detailed in section 8.1.2
	Rationale
	<p>The Royal College of Emergency Medicine provides a detailed curriculum, with accreditation on successful completion, for health professionals wishing to train as ACPs to work in emergency departments (Royal College of Emergency Medicine 2015). This is endorsed by Health Education England. Whilst completion of this curriculum is not mandated by any regulatory body, it is the only route to providing assurance of the required specialty specific knowledge and skills for this role. As such, the contents are highly influential in establishing training content for ACPs.</p> <p>The current edition has limited content to inform the competences required for caring for children who have self-harmed. This study identifies specific knowledge and skill requirements, and subsequently makes recommendations for training (See Recommendation numbers 2,3,4, and 5) which should be considered for inclusion in future editions.</p>

8.1.2 Recommendations for Education

The existing literature on children who present to EDs with self-harm suggests that staff training is beneficial for enhancing staff attitudes towards these children, and also for improving staff confidence. The collective experiences of the clinicians in this study, coupled with the review of the literature, has informed the recommendations listed below.

Table 7. Recommendations for Education

Number	Recommendation
2	<p>Educational preparation of ED ACPs should ensure that they have the knowledge and skills to undertake a comprehensive risk assessment, and initiate appropriate treatment and interventions for children who self-harm. This should include:</p> <ul style="list-style-type: none"> • Gathering appropriate information prior to the consultation, either from clinical records or ambulance personnel. • Taking a history from the young person and their parent(s) or carer. (Also see recommendations 5 and 6). • Identification of any injuries or potential poisoning, and the provision of any necessary treatment, including wound assessment and management and/or clinical management of overdose. • Pursuing any safeguarding concerns. (Also see recommendation number 3) • Evaluating the emotional state of the young person, including mood assessment. • Establishing any suicidal intent or further self-harm intent. (Also see recommendation 9) • Formulating a risk assessment based on the information obtained in the consultation and due regard for the: <ul style="list-style-type: none"> - Detail of planning and extent to which the child made attempts to evade detection or summon help. - Lethality, or level of ferocity of the self-harm method. - Vulnerability of the young person to exploitation or abuse. - Quality of parental or carer support, and their relationship with the young person. (Also see recommendation 4) Level of engagement of the young person, and their willingness or ability to access and accept help. (Also see recommendation 10) • Implementing an appropriate plan of care based on the overall risk assessment, including referral to specialist mental health services.
	<p>Rationale</p> <p>Risk assessment of children who have self-harmed, as recommended by NICE (National Institute for Health and care Excellence 2005) and identified by the clinicians in this study, is an essential yet complex process. There are no validated 'tick-box' tools which accurately calculate this risk. Rather, it requires a clinician to take account of the exacerbating and</p>

	<p>mitigating factors which influence the risk. The clinicians in this study used their experience to evaluate the importance of various factors in risk assessment. Analysis of their collective experiences has enabled these risk factors to be categorised into those pertaining to physical needs, safeguarding and social concerns, the child's emotional state and suicidal intent.</p> <p>Elements of the previous history, planning and method of self-harm, and the level of engagement of the young person also influenced the level of risk for these clinicians.</p>
3	<p>Recommendation</p> <p>ACPs must have in-depth safeguarding training commensurate with the intercollegiate document (Royal College of Nursing, 2019). This must include identification of, and appropriate intervention for risk of:</p> <ul style="list-style-type: none"> • Sexual Abuse or Exploitation. • Alcohol and Substance Misuse. (Also see recommendation 8) • Bullying from various sources including social media. • Absence of parental or carer attachment. (Also see recommendation 4) • Being subject to local authority care (Looked-after child) • Criminal Exploitation <p>Rationale</p> <p>The link between safeguarding issues and self-harm has been demonstrated within the existing literature, and evidenced through the experience of the clinicians in this study. Therefore, the ability to identify, and make appropriate interventions for any safeguarding concerns is paramount in order to terminate ongoing abuse, or provide necessary psychological support for historical abuse.</p>
4	<p>Recommendation</p> <p>Educational preparation for ACPs should ensure an understanding of attachment theory (Bowlby & Holmes, 2005), and its application in assessing the parent/child relationship.</p> <p>Rationale</p> <p>Having a supportive and caring relationship with a parent was identified as one of the protective factors for children who self-harm. The only clinician aware of Bowlby's attachment theory relied on it heavily to assess the parent/child relationship, and inform the overall risk assessment. Therefore it is anticipated that other clinicians assessing young people who self-harm may benefit from understanding the same theory.</p>
5	<p>Recommendation</p> <p>ACPs must learn the knowledge and skills of both verbal and non-verbal adolescent communication strategies. These include the use of environmental selection, appropriate body language, and content and style of speech.</p> <p>Rationale</p> <p>In order to facilitate engagement of young people, ACPs must have the knowledge and skills to communicate with them in a way which encourages young people to willingly participate in the consultation process. Communicating in an appropriate way may contribute to young people feeling more respected and 'listened to' (Storey et al. 2005).</p>

8.1.3 Recommendations for Practice: Table 8.

Number	Recommendation
7	All children who present to EDs due to a self-harm episode should have a comprehensive risk assessment leading to the initiation of appropriate care. (See recommendation 2 for details of knowledge and skills required to undertake a risk assessment)
	Rationale
	As well as being a NICE recommendation (NICE 2004), both the ED and CAMHS clinicians in this study articulated the importance of a risk assessment for ensuring the safety of a child who has self-harmed. Appropriate care should correspond to the risk and may include hospital admission for a period of 'cooling-off', close observation to prevent further injury or poisoning or absconding, or discharge to the care of a supportive and responsible parent or carer with specialist mental health follow up as an out-patient.
8	A validated alcohol and substance misuse screening tool should be routinely used as part of the comprehensive clinical assessment of all children who have self-harmed, and used to inform the risk assessment.
	Rationale
	The use of alcohol and other illicit drugs has been closely linked to serious safeguarding concerns such as CSE and criminal exploitation, which in turn have been associated with self-harm in young people. In addition, children under the influence of alcohol are more likely to engage in impulsive and risky behaviour, which may result in serious self-harm or increase the risk of accidental death.
9	Recommendation
	The CYP-MH-SAT (Manning et al. 2018) should be considered for implementation, as part of the immediate risk assessment for suicide or future harm intent, for children who have self-harmed in emergency departments.
	Rationale
	This tool has been developed and validated to assess the immediate risk of self-harm or suicide to young people in UK paediatric emergency departments. Whilst it does not provide a comprehensive assessment of risk as outlined in recommendation 2, it does inform the specific element on suicide intent and thus, should form part of the overall risk assessment.
10	Recommendation
	Clinicians should make every attempt to secure engagement of a young person. When this is unsuccessful, delegation to another clinician with attributes (such as dress, gender or age) more suited to the child's preference should be considered. A willingness of the clinician to accept non-engagement as a child's prerogative is also required, and should be evaluated as part of the overall risk assessment.
	Rationale
	Children who are brought to emergency departments, possibly against their will, may not wish to engage in the clinical consultation. Using an authoritative approach may precipitate further withdrawal or further fuel their determination to resist engagement. Deferring to a clinician with different attributes may provide the young person with an opportunity to engage with someone they would prefer to connect with. In the event of a child being persistently unwilling, or unable to engage, the clinician should respect the situation, and take this into consideration as part of the overall risk assessment

	alongside any information gathered from alternative sources. Demonstrating frustration, or adopting authoritative approaches may reinforce to a child that they are not respected
11	Recommendation
	All clinicians who treat children who self-harm should be provided with opportunities for debrief and regular clinical supervision sessions.
	Rationale Assessing and treating young people who have self-harmed can be highly emotive, as articulated by the participants in this study. If clinicians are to engage properly in the consultation, and listen carefully to young people and their carers, they will inevitably be exposed to potentially harrowing stories and/or raw emotion, including anger, desperation and hopelessness. Alternatively, they may be faced with an unwillingness or inability of the child to engage or accept help. This may result in feelings of frustration or potential failure for the clinician. In order to facilitate exploration and understanding of these feelings, clinicians may benefit from timely structured debriefs or facilitation of reflection through clinical supervision.

8.1.3 Recommendations for Future Research: Table 9.

Number	Recommendation
11	The relationship between the concept of engagement and risk of future harm should be explored.
	Rationale
	The findings of this study identified a general belief by both ED and CAMHS clinicians that those children who appeared engaged during the consultation were at lower risk of immediate harm than those who were not. No evidence was found in the literature to substantiate this belief, and as such, this research should be conducted in order to inform risk assessment in practice.
12	Recommendation
	The potential benefits of digital technology in reducing risks for children who self-harm should be explored and evaluated alongside any harm attributed to its use.
	Rationale
	Participants of this study described their experience of social media as an adverse risk for children who self-harm, due to the opportunities it creates for bullying at all hours and its potential for use in exploitation. There is some evidence that social media, and other digital applications, may also offer support and information, as well as a means of communicating for help in times of crisis for a people whose childhoods have been heavily influenced by digital communication, and is a preferred method of communicating for some.
13	Recommendation
	The relationship between the maturity of a child and their risk of future harm should be explored.
	Rationale
	Several participants of this study perceived an increased maturity of a child to be associated with a lower risk for future self-harm. No evidence was found in the literature to substantiate this belief. Therefore further exploration is necessary to inform risk assessment practice.
14	Recommendation
	The consequences of implementing the training recommendations detailed in section 8.1.2 should be studied to establish any impact on the care, as experienced and perceived by children and young people who self-harm.
	Rationale
	The wealth of literature on children who self-harm (Chapter 2) suggests training for staff as a method of improving their attitudes and confidence. Yet, the content of such training is not specified for ED ACPs, nor has it been evaluated with this group of health professionals. This study led to the recommendations for ACP training (Table 7). Therefore, any impact on ACP attitudes and confidence towards this client group should be evaluated, once the training is completed.

8.2 Conclusion

This study has demonstrated that clinical consultations in the ED with children who self-harm are complex. The two integrated themes of 'Engagement' and 'Risk Assessment' were identified as being crucial to all aspects of the consultation, and as such the specific knowledge and skills associated with the application of these are paramount for any clinician undertaking this role.

Reassuringly, the majority of the practice the study participants collectively described could be supported by evidence. However, most knowledge and skills identified were not universally adopted. Review of the evidence revealed that national recommendations on alcohol and substance misuse were not adopted, and that some clinicians' interpretation of risk related to repeat presentations could be erroneous.

Therefore, specific training in the assessment and treatment of children who self-harm is recommended for all ED Clinicians, including ACPs. This should promote the acquisition of the knowledge and skills to facilitate engagement with a young person, conduct a robust risk assessment, and implement a risk management plan. The risk assessment should include consideration of:

- The child's physical needs, including wound management and overdose management
- Any safeguarding concerns, particularly bullying in any form, CSE or Sexual abuse, alcohol or substance misuse (using a validated tool), or being in local authority care (looked-after child).
- Parental and social support, with the application of 'attachment theory' knowledge.
- Emotional and psychological assessment, with consideration of normal child development, as well as of mental health disorders such as anxiety, depression or eating disorders.

- Suicide risk

A risk management plan should facilitate mitigation of any specific risks identified in the assessment. It should be implemented with due regard for dignity and respect of the young person.

Further research is required to evaluate the outcome of any training which incorporates these knowledge and skills recommendations.

This study highlighted the absence of evidence for a correlation between the level of engagement of a child at ED consultation, and subsequent risk of future self-harm or suicide. Therefore further research into this topic is also recommended. Finally, social media or other digital applications could offer possible benefits in self-harm risk management, and therefore should be explored further.

8.2.1 Final Reflections on the Study Process

I embarked on this professional doctorate programme believing that I simply needed to establish and evaluate a risk assessment tool for use with young people who self-harm, comparable to those we used with adults in emergency care settings. This research journey has enabled me to see how wrong I was. The complexity of caring for children and young people who self-harm is far greater than any simple tool can determine.

I moved from pursuing a quantitative study, with strong beliefs in the value of positivist research, to realising and appreciating the importance of qualitative methods. Being exposed to the rich experiences of others allowed me to be enlightened about aspects of caring for this hugely vulnerable group of patients that I had not previously considered. Consequently, I learned more about myself: my nursing values, beliefs, and behaviour, as well as the importance to me of my role as a wife and mother.

There were times when I felt that the ability to bring this study to its conclusion was beyond my capability. However, the young people and their families I had the privilege to meet, the participants who were eager to tell their stories, the colleagues I have networked with, and the support, advice and encouragement I have had from my supervisors, has resulted in the completion of this thesis.

I am as passionate at the end of this journey as I was at the start about ensuring children and young people receive the right care, especially those who are vulnerable to the abuse of others, and feel their only release is to harm themselves. I believe the work I have conducted, culminating in the results and recommendations of this study, will help to facilitate better emergency care for these children.

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Appendices

Appendix 1: Details of literature identified through search process

Number	Title	Methodology	Main Focus
1	Rayner G. Blackburn J. Edward K-L. Stephenson J. & Ousey K. (2019) Emergency department nurse's attitudes towards patients who self-harm: A meta-analysis. <i>Int. Journal of Mental Health Nursing</i> , 28, 40-53	Quantitative Systematic Review	Attitudes
2	Saunders, K., Hawton, K., Fortune, S., & Farrell, S. (2012). Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review. <i>Journal of Affective Disorders</i> , 139(3)	Systematic Review of both Quantitative and Qualitative Papers	Attitudes
3	Clarke, D., Usick, R., Sanderson, A., Giles-Smith, L., & Baker, J. (2014). Emergency department staff attitudes towards mental health consumers: A literature review and thematic content analysis. <i>International Journal of Mental Health Nursing</i> , 23(3), 273-284.	Systematic Review of both Quantitative and Qualitative Papers	Attitudes
4	McHale, J., & Felton, A. (2010). Self-harm: what's the problem? A literature review of the factors affecting attitudes towards self-harm. <i>Journal of Psychiatric and Mental Health Nursing</i> , 17(8), 732-740.	Qualitative Literature Review	Attitudes
5	Cleaver K., Meerabeau L. & Maras P. (2014). Attitudes towards young people who self-harm: Age, an influencing factor. <i>Journal of Advanced Nursing</i> , 70, 2884-2896	Mixed Methods	Attitudes
6	Anderson M. Standen P. & Noon J. (2003). Nurses' and doctors' perceptions of young people who engage in suicidal behaviour: a contemporary grounded theory analysis. <i>Int. Journal of Nursing Studies</i> , 40, 587-597	Qualitative	Attitudes
7	Anderson M. & Standen P. (2007). Attitudes towards suicide among nurses and doctors working with children and young people who self-harm. <i>Journal of Psychiatric and mental Health nursing</i> , 14. 470-477	Quantitative	Attitudes
8	McCarthy L. & Gijbels H. (2008). An examination of emergency department nurses' attitudes	Quantitative	Attitudes

	towards deliberate self-harm in an Irish teaching hospital. <i>Int. Emergency Nursing</i> , 18, 29-35		
9	Perboell P. Hammer N. Oestergaard B. & Konradson H. (2015), Danish emergency nurses' attitudes towards self-harm- a cross-sectional study. <i>Int. Emergency Nursing</i> , 23, 144-149	Quantitative	Attitudes
10	Koning K. McNaught A. & Tuffin K. (2017). Emergency department staff beliefs about self-harm: a Thematic Framework Analysis, <i>Community Mental Health Journal</i> , 54, 814-822	Qualitative	Attitudes
11	McCann T. Clark E. McConnachie S. & Harvey I. (2006), Accident and Emergency nurses' attitudes towards patients who self-harm. <i>Accident and Emergency Nursing</i> , 14, 4-10	Quantitative	Attitudes
12	Conlon M. & O'Tuathail C (2012), Measuring emergency department nurses' attitudes towards deliberate self-harm using the Self-Harm Antipathy Scale	Quantitative	Attitudes
13	Friedman T. Newton C. Coggan C & Hooley S. et al. (2006). Predictors of A&E staff attitudes to self-harm patients who use self-laceration: Influence of previous training and experience. <i>Journal of Psychosomatic Research</i> , 60, 273-277	Quantitative	Attitudes
14	Mackay N & Barrowclough C. (2005). Accident and emergency staff's perceptions of deliberate self-harm: Attributions, emotions and willingness to help. <i>British Journal of Clinical Psychology</i> , 44, 255-267	Quantitative	Attitudes
15	McAllister, M., Creedy, D., Moyle, W., & Farrugia, C. (2002). Nurses' attitudes towards clients who self-harm. <i>Journal of Advanced Nursing</i> , 40(5), 578-586.	Quantitative	Attitudes
16	Timson, D., Priest, H., & Clark-Carter, D. (2012). Adolescents who self-harm: Professional staff knowledge, attitudes and training needs. <i>Journal of Adolescence</i> , 35(5), 1307-1314.	Quantitative	Attitudes
17	Rees, N., Porter, A., Rapport, F., Hughes, S., & John, A. (2018). Paramedics' perceptions of the care they provide to people who self-harm: A qualitative study using evolved grounded theory methodology. <i>PLOS ONE</i> , 13(10), e0205813	Qualitative	Attitudes
18	Storey, P., Hurry, J., Jowitt, S., Owens, D., & House, A. (2005). Supporting young people who repeatedly self-harm. <i>Journal of the Royal Society for the Promotion of Health</i> , 125(2), 71-75	Qualitative	Patient Experience
19	Cloutier, P., Kennedy, A., Maysenhoelder, H., Glennie, E. J., Cappelli, M., & Gray, C. (2010). Pediatric mental health concerns in the	Quantitative	Patient Experience

	emergency department: caregiver and youth perceptions and expectations. <i>Pediatric Emergency Care</i> , 26(2)		
20	Cerel, J., Currier, G. W., & Conwell, Y. (2006). Consumer and Family Experiences in the Emergency Department Following a Suicide Attempt. <i>Journal of psychiatric practice</i> , 12(6), 341-347	Quantitative	Patient Experience
21	McAllister, M., Zimmer-Gembeck, M., Moyle, W., & Billett, S. (2008). Working effectively with clients who self-injure using a solution focused approach. <i>International Emergency Nursing</i> , 16(4), 272-279.	Quantitative	Education of staff
22	Egan, R., Sarma, K. M., & O'Neill, M. (2012). Factors Influencing Perceived Effectiveness in Dealing with Self-harming Patients in a Sample of Emergency Department Staff. <i>The Journal of Emergency Medicine</i> , 43	Quantitative	Education of staff
23	Holdsworth, N., Belshaw, D., & Murray, S. (2001). Developing A&E nursing responses to people who deliberately self-harm: the provision and evaluation of a series of reflective workshops. <i>Journal of Psychiatric and Mental Health Nursing</i> , 8(5), 449-458	Quantitative	Education of staff
24	Latif, A., Carter, T., Rychwalska-Brown, L., Wharrad, H., & Manning, J. (2017). Co-producing a digital educational programme for registered children's nurses to improve care of children and young people admitted with self-harm. <i>Journal of child health care</i> , 21(2), 191-200.	Mixed Methods	Education of staff
25	McAllister, M., Moyle, W., Billett, S., & Zimmer-Gembeck, M. (2009). 'I can actually talk to them now': qualitative results of an educational intervention for emergency nurses caring for clients who self-injure. <i>Journal of Clinical Nursing</i> , 18(20), 2838-2845.	Qualitative	Education of staff
26	Patterson, P., Whittington, R., & Bogg, J. (2007). Testing the effectiveness of an educational intervention aimed at changing attitudes to self-harm. <i>Journal of Psychiatric and Mental Health Nursing</i> , 14(1), 100-105	Quantitative	Education of staff
27	Giordano, R., & Stichler, J. F. (2009). Improving Suicide Risk Assessment in the Emergency Department. <i>Journal of Emergency Nursing</i> , 35(1), 22-26	Quantitative	Education of Staff
28	Hawton, K., Witt, K. G., Tatiana, L. T. S., Arensman, E., Gunnell, D., Townsend, van-Heering K, Hazell, P. (2015). Interventions for self-	Systematic Review	Clinical Management

	harm in children and adolescents. The Cochrane database of systematic reviews(12),		
29	Randall, J. R., Colman, I., & Rowe, B. H. (2011). A systematic review of psychometric assessment of self-harm risk in the emergency department. <i>Journal of Affective Disorders</i> , 134(1–3),	Systematic Review	Clinical Management
30	Dieppe, C., Stanhope, B., & Rakhra, K. (2009). Children who harm themselves: development of a paediatric emergency department triage tool. <i>Emergency Medicine Journal</i> , 26(6)	Development of clinical decision support tool	Clinical Management
31	Tishler, C. L., Reiss, N. S., & Rhodes, A. R. (2007). Suicidal Behavior in Children Younger than Twelve: A Diagnostic Challenge for Emergency Department Personnel. <i>Academic Emergency Medicine</i> , 14(9),	Literature Review	Clinical Management
32	Manning, J., Carter, T., Walker, G., Aubeeluck, A., Witchell, M., Armstrong, M., . . . Bean, D. (2018). Children and Young People-Mental Health Self-harm Assessment in Paediatric healthcare Environments (CYP-MH SAPhE): A tool development and evaluation study. Nottingham. Nottingham University Hospitals	Tool Development with Quantitative Validation	Clinical Management
33	Kennedy, S. P., Barraff, L. J., Suddath, R. L., & Asarnow, J. R. (2004). Emergency Department Management of Suicidal Adolescents. <i>Annals of Emergency Medicine</i> , 43(4), 452-460.	Expert Opinion	Clinical Management
34	National Institute for Health and Clinical Excellence. (2004). Self-harm. The short term physical and psychological management and secondary prevention of self-harm in primary and secondary care. London.	Evidence Review with recommendations for practice	Clinical Management

Appendix 2: Indicative Interview Guide and Questions

- Thank you for agreeing to participate.
- Reminder about use of audio recording equipment.
- Reminder about permission to stop at any time.
- Permission to make notes at the end of the interview to record anything not captured on audio.
- Reiterate my role as a researcher- “pretend I know nothing about emergency care of children”.

Please remember you need to keep information about patients and other staff members confidential. You can say “he” or “she” and describe the situation as long as they can’t be identified in any way.

Ice-breaker to establish rapport: How long have you worked as an ACP/PEM Consultant/CAMHS practitioner? Have you worked in any other areas whilst in this role?

- 1. Can you describe a time when you treated a child (under 18yrs) who had presented with self-harm?**
 - a. Prompts may include:
 - i. Can you describe the approach used to gather information in order to make your clinical decisions?
 - ii. Further prompts may include: History and patterns of self-harming behaviour?, family history?, physical and mental health?; support available from (extended) family, peers, teachers and professionals?; and the patient's beliefs about their self-harming behaviour/illness?.
- 2. What knowledge do you think was important for you to have during the episode?**
 - a. Did you use any specific theories?
 - i. Prompts may include child development?, Safeguarding?, Coping strategies of adolescents?, Parental interaction with adolescents? Suicide risk assessment?
 - b. How did you acquire this knowledge?
- 3. What skills did you use during the experience?**
 - a. How did you think you acquired these skills?
- 4. What were your feelings about the episode (before, during and after?)**
- 5. Can you identify any gaps in your knowledge and skills? Is there anything you know now that you had wished you knew then?**
- 6. Do you feel your training adequately prepared you for undertaking this role in relation to children who have self-harmed?- Can you expand on this?**
- 7. What were your reflections on the encounter?**

Additional questions for the CAMHS practitioner and PEM Consultant:

What is your experience of working with ACPs who initially assess and treat children who have self-harmed?

What is your view about the knowledge and skills of ACPs in this area?

What is your view about ACPs taking a lead role in this area?

What do you think should be the contribution of other professionals, eg, CAMHS specialists, Doctors/Consultants/ social workers?

Final question for everybody:

8. Is there anything else you want to tell me?

Appendix 3: Background Information Sheet

INFORMATION SHEET

You are being invited to take part in this study to investigate the knowledge and skills needed by advanced practitioners who treat people aged under 18 years who have self-harmed.

Before you decide to take part it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with me if you wish. Please do not hesitate to ask if there is anything that is not clear or if you would like more information.

What is the study about?

The aim of this study is to explore the knowledge and skills used by advanced clinical practitioners (ACPs) to treat people, aged less than 18 years, who have presented to emergency departments with self-harm.

The number of young people who use self-harm is on the increase in the United Kingdom. The first health professional encounter these young people have in relation to their self-harm is often in an emergency department. Traditionally they are seen by a member of the medical team (doctor). More recently there has been an increase in the number of Advanced Clinical Practitioners (ACPs) employed by emergency departments. These ACPs often take a lead in assessing and delivering first-line treatment to these young people.

As a Children's Nurse Consultant in Emergency Care I am interested in the experience of a variety of clinicians working with this client group in the emergency care setting. I believe that by exploring this experience in-depth, the specific knowledge and skills needed by ACPs to complete the care episode for these young people will be revealed. As such this study forms part of my professional doctorate programme.

It is anticipated the results of the study will inform future curriculum development for ACPs.

Why I have been approached?

You have been asked to participate because you work as a health professional in an emergency care setting, treating young people who have self-harmed.

Do I have to take part?

It is your decision whether or not you take part. If you decide to take part you will be asked to sign a consent form, and you will be free to withdraw any time before May 2017 then all data will have been anonymised.

What will I need to do?

If you agree to take part in the research, I will conduct a one to one interview with you, at a time mutually convenient. This will last approximately one hour and will be recorded. Only myself, and the transcriber will hear the recording. The transcriber will be employed by the University of Huddersfield and will be bound by rules of confidentiality and information governance.

Will my identity be disclosed?

All information disclosed within the interview will be anonymised, except where legal obligations would necessitate disclosure to appropriate personnel.

What will happen to the information?

All information collected from you during this research will be stored on an encrypted memory stick and secured on the University of Huddersfield computer server for a period of 5 years and then destroyed. Any identifying material, such as names will be removed in order to ensure anonymity. It is anticipated that the research will, at some point, be published in a journal or report and included in my final thesis which will be stored in the University repository. However, your anonymity will be ensured, although it may be necessary to use your words in the presentation of the findings and your permission for this is included in the consent form.

Who can I contact for further information?

If you require any further information about the research, please contact me on:

Name: Janet Youd

E-mail: Janet.youd@cht.nhs.uk

Should you wish to complain about any issue in relation to this research please contact:

Name: Dr Karen Ousey (Academic Supervisor of the Project)

Email: k.ousey@hud.ac.uk

Appendix 4: Consent Form

Exploring the knowledge and skills of Emergency Department Practitioners who assess and treat young people who have self-harmed:

It is important that you read, understand and sign the consent form. Your contribution to this research is entirely voluntary and you are not obliged in any way to participate, if you require any further details please contact your researcher.

I have been fully informed of the nature and aims of this research ☐

I consent to taking part in it and having the interview recorded ☐

I understand that I have the right to withdraw from the research up until 1 July 2017 ☐

I give permission for my words to be quoted (by use of pseudonym) ☐

I understand that the information collected will be kept in secure conditions for a period of five years at the University of Huddersfield and will then be destroyed. ☐

I understand that no person other than the researcher and supervisors will have access to the information provided. ☐

I understand that my identity will be protected by the use of pseudonym in the report and that no written information that could lead to my being identified will be included in any report. ☐

If you are satisfied that you understand the information and are happy to take part in this project please put a tick in the box aligned to each sentence and print and sign below.


Signature of Participant: _____ Print: _____ Date: _____	Signature of Researcher: _____ Print: _____ Date: _____
---	--

(one copy to be retained by Participant / one copy to be retained by Researcher)

Appendix 5: Health Research Authority Decision Document



Do I need NHS REC approval?

 To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

The Knowledge and Skills of ANPs who treat children who have self-harmed

IRAS Project ID (if available):

164560

Your answers to the following questions indicate that **you do not need NHS REC approval for sites in England.** However, **you may need other approvals.**

Appendix 6: Evidence of School Research Ethics Panel Approval

From: Kirsty Thomson

Sent: 02 July 2015 15:53

To: Janet Youd U1179047

Cc: Karen Ousey; Martin Manby; Dawn Leeming

Subject: Your SREP Application - Janet Youd (Prof Doc Student) - APPROVED* - Exploring the knowledge and skills of Emergency Department (ED) Advanced Clinical Practitioners (ACPs)..... (SREP/2015/67)

Dear Janet,

Dr Dawn Leeming, SREP Deputy Chair, has asked me to contact you with regard to your SREP application as detailed above.

*Your application has been approved with just a couple of essential but minor amendments that can be discussed with supervisors.

However, if you and your supervision team feel you can't make these amendments, you should let us know.

Essential amendments

- there may be issues related to professional scrutiny when you are interviewing staff of lower grade or less experience. This may have an impact on how open and honest they feel that they can be during an interview. Approval is given on the assumption that you will discuss with supervisors how this will be managed
- In the section '**Who can I contact for further information?**', please make it clear that Dr Ousey is your academic supervisor

Recommended amendments (left to your discretion for consideration - not required for ethical approval)

- 'time line' dates of June and January may need to be amended

Please also note, if in your R&D application you plan to name the University as sponsor for the research with either Rachel Armitage or Dawn Leeming (SREP Chair / Deputy Chair) as sponsor's representative, you should send your completed R&D approval form to SREP for approval before submitting the form to R&D.

With best wishes for the success of your research project.

Regards,

Kirsty

(on behalf of Dr Dawn Leeming, SREP Chair)

Kirsty Thomson

Research Administrator

School of Human and Health Sciences Research Office (HHRG/11)

University of Huddersfield | Queensgate | Huddersfield | HD1 3DH

Appendix 7. Evidence for Thematic Identification

Excerpts from the data of indicative quotes for each theme.

<u>Looking for Injuries or Potential Poisoning</u>
<i>"Is there something I need to treat first? Particularly from the overdose point of view, or the self-harm. And then think about the other side of things when they're fit and well." (PEM 1: 98-101)</i>
<i>"You deal with their medical issues first, and prioritise." (PEM 2: 58)</i>
<i>(The purpose of the consultation is) "...to assess, to treat the actual problem that they've presented with. So obviously if they need emergency treatment, if they've overdosed, or if they need any wound care or emergency treatment." (ACP 1: 103-105)</i>
<i>"As I say the first (priority) will be the medical." (PEM 1: 148)</i>
<i>"The primary role would be to identify if there are any acute life or limb-threatening issues to immediately get on with, and deal with those as they identify themselves." (PEM 2: 99-100)</i>
<i>"My primary role was first of all to make sure there's no kind of, acute injury." (Paed ACP: 42-43)</i>
<i>"As I say the first (priority) will be medical, so if it's something dangerous, have I got to get on and treat it? In that case I'm not going to take a really detailed history." (PEM 1: 126-127)</i>
<i>"Yeah, so I certainly think from the emergency department point of view it's assessment of immediate injury or illness as a result of their self-harm." (Paed ACP: 221-222) (Discussing purpose of the consultation)</i>

(The purpose of the ED Consultation is to) "...initially establish there is nothing life threatening going on, as in immediately." (ACP 3: 160)

Wound Management

"I might say, "Ok, we'll just give these a bit of a clean" but maybe they don't need closing, or some of them might need steri-strips." (ACP 3: 112-113)

"Is it something needs suturing?" (PEM 1: 100)

"Usually they don't need stitching... So, they might need glue or steri-strips, but sometimes they just need a bit of a clean and a dressing" (ACP 1: 112-114)

Overdose Management

"...she re-presented the next day having taken an overdose of paracetamol." (Pilot: 36)

"...she'd taken an overdose and told her friends more or less straight away." (Pilot: 39)

"...so if you have someone coming in, oh I don't know, who's taken six paracetamol and they've presented..." (ACP 2: 242-243)

"...make sure the liver's not tender from paracetamol overdose." (ACP 3: 118)

"If they've only taken two paracetamol, you're not really going to go into a huge thorough history compared to a mixed overdose of dangerous drugs." (PEM 1: 104-106)

"...you know, we are seeing more young people take overdoses. They're split between overdoses and, ...people who've done harm to themselves, probably used to be 50/50 split, but we're tending to see more people take overdoses than superficially self-harming by cutting." (CAMHS: 55-58)

Pursuing Safeguarding and Social Concerns

"...a lot of knowledge comes from a child protection background, as in seeing children that presented with signs and symptoms of abuse." (Pilot: 300)

Child Sexual Abuse and Exploitation

"... so whether they are with somebody who might be manipulating them or 'grooming' is one word you need to think about these days." (Pilot: 173-174) "Or whether they are with an appropriately aged person or whether they are with an older man or a woman." (Pilot: 174-176)

"I suppose it's two things really isn't it? It's looking at the triggers for the self-harm episode. So has something happened? Have they been adequately safeguarded against whatever trigger? So, is it sexual abuse? Is it assault? Is it, you know a child last week came in having taken an overdose because there was a boy at school who was repeatedly asking her for explicit pictures and was threatening to hurt her if she didn't send any." (Paed ACP: 254-258)

"...one of the big things in this area is CSE. You know, have they got new phones? ... who's accompanying them?" (ACP 2: 404-405)

"I would pick out bits from what they'd already told me, and then expand on those things. So if that (CSE) came up, then yes, 100% I would go down that route. If I felt that they were involved or had any indicators that they might be child exploitation, then yes I would ask about that, and I would try and get as much information as possible out of them in the emergency department because at that time, unless they come by ambulance or school have brought them in, then we might be the only chance to get as much information out of the child as possible." (ACP 3: 215-221)

(I would be suspicious about CSE) "... if they were involved with sexual behaviour, if they were out a lot at night time, I might think who are they hanging out with? If there was any mention of older people involved, if they mentioned anything about the fact that they were involved in something or any kind of grooming. If school had alerted any concerns, or the parents had alerted any concerns that this might be going on. People from abroad, so young girls especially, but boys as well, but young girls especially who've potentially come from abroad." (ACP 3: 232-237)

"More recently, as it has become more publicised, I focus on the issues around child sexual exploitation and sexual abuse and the questions that I now ask are more in depth in terms of use of social media, giving of gifts, access to websites, expectations around, you know, when you can go out, for example." (PEM 2: 126-130)

"...there's all the cyber stuff and all the CSE you know." (CAMHS: line 392)

Alcohol and Substance Misuse

"Is it recreational drugs that they've been using?" (PEM1: 130)

"You think about drugs and alcohol. Have they been abusing that for a while? So you have to think about that as a safeguarding issue as well." (PEM 1: 135)

"Are they eating? Do they smoke? Do they drink? If they drink, how much? If they are using other drugs?" (ACP 2: 158-159)

Bullying

"You're also looking at long term abuse, whether it's bullying or whatever." (CAMHS: 152-153)

"... I don't see the juniors (doctors) asking about text bullying. I don't see the juniors asking about Facebook bullying." (PEM2: 235-254)

Social Media

"...has anyone asked to take a picture of you with no clothes on?" for example." (PEM 2: 255)

"...part of my assessment is to ask, the old fashioned "are you bullied at school? Is that taken outside of school as well? Is it not just happening (in the) local community? Is it happening on Facebook, on Twitter, on any other kind of social media? It's all part of the assessment now. And it is, you know, we see a lot of young people who react to that, social media bullying." (CAMHS: 396-400)

"...we see a lot of those impulsive acts because of something what's happened on-line." (CAMHS: 404-405)

School

"...they might start off and say "Well, I'm having problems at school". (ACP 2: 360-361)

"Are they aware of problems at school? The child might tell you there are problems at school and the parents might be completely oblivious to that." (PEM 1: 117-118)

"...Just more about the self-harm, or whether there's something that's made them do it at home, so they are so unhappy at home or at school that they felt it necessary to self-harm." (PEM 1: 328-330)

"And who's been aware of this? Have the school nurses been aware? So we're probably talking to our safeguarding team to contact school nurses and for the school team to know that's been going on." (PEM 1: 330-332)

Support

(Our risk assessment tool (SADPERSONS) is good), "...because it talks about social isolation, have they got any support networks in place?" (ACP 2: 470)

(Try to identify) "...clues as to what has been happening in that child's social environment, their relationships, their schooling, the stability of their background." (to influence the risk assessment) (PEM 2: 83-85)

"How was her relationship with her parents? With her brothers?" (ACP 3: 272-273)

"Do you have any other outlets for your feelings?" "Do you talk to anybody at home or in school?" (Paed ACP: 153-154)

"You've got to look at the family. Ask questions around the family dynamics and relationships. Speak to mum and dad, if they are there, and how they are coping with the situation. And quite often they are not coping very well." (ACP 1: 206-208)

"What has their behaviour been like at home? Are they difficult to manage? Are the parents struggling to manage them or struggling to keep them safe, which is another risk." (PEM 1: 118-120)

"(If) things at home aren't great, and they would be at a greater risk if you were to discharge them. Maybe they wouldn't be observed. So can the parents keep them safe?" (PEM 1: 145-147)

"You're drawing on how you feel that young person's relating to the family, you know, how does that family come across?" (CAMHS: 107-109)

"I always try and see, whether the young person likes it or not, because I'm sending them home to that environment. What the parents or the carer or, sometimes partners who they are living with, on what I'm gauging there, I'm assessing them as well during that assessment about whether or not I feel they have got a real grasp on how serious this is." (CAMHS: 111-115)

"During that assessment you're actually wanting to assess the parent, the carer, that partner, whoever they are with as well." (CAMHS: 118-119)

(When you work with adult patients) *"You don't work with families. Families are just somebody who come along. You work with that individual 90% of the time, 99% of the time."* (The difference with working with children) *" is that having to realise that young people live within families so you're working with the whole system rather than that one individual."* (CAMHS: 348-352)

"Looking at the interaction between that young person and who they are with, I've picked up one thing that girl said was "My mum's not important". I said "I want to bring your mum in to speak to me". I thought that was such a funny thing for her to say... "She's not important" She was quite upset and she didn't want her mum to know, but I just picked up on that one phrase she said to kind of think "There's something else going on here." You know there's more of a kind of family system kind of relationship problem." (CAMHS: 505-510)

"And then it's also about how the family or the home environment is protected from increasing that risk of self-harm. So a child who's previously taken overdoses, are the parents doing everything they can to limit the risk? Are they locking up medication or is medication still around? Are they putting in place the plans that have been set out in the risk assessments that have gone on before?" (Paed ACP: 259-263)

Should Parents Stay or Should They Go?

"I asked her mum to leave the room." (Pilot: 50-51)

"I'd normally go in and ask if they wanted the mum and dad to stay in. Or do they want to talk to me on their own? Or do they want mum and dad to go out?" (ACP 1: 215-216)

"Normally they want them to stay in..." (ACP 1: 223)

"First of all I'd see if they've got someone with them. Then I'd ask them whether they'd want that person to stay. And whether they were happy to talk with someone else in the room. If not, then I'd ask the person to leave. If they were happy, to say no at any point and to get them to leave." (ACP 2: 78-81)

"You might find some people are totally different when their parents are there, or when they've come in with a friend. If you remove them from the situation, you may get a more realistic picture of what they are actually like, because they maybe are not going to put a front on if there is no one else in the room with you." (ACP 2: 548-551)

"Some patients might be like "No, I want my mum to stay in, she already knows everything that's been going on, I'm quite happy for her to stay here". So that's fine." (ACP 3: 88-89)

"...then other times I would ask them if the parents would mind leaving the room just so I could have a chat with them by themselves. And then have a chat with them by themselves, sometimes you won't get anything, or very much from them, but it's just trying to establish what you can." (ACP 3: 89-92)

"And then I asked her about what was going on at home? and I just asked her questions like that, and I think the fact that I asked them to leave the room, because she seemed to be less open when they (teachers) were in the room." (ACP 3: 330-332)

"So if they are alone, or if there is someone with them, whether they want that person in the room with them?" (PEM 1: 40-41)

"You might get more out of the consultation if they (the parents) are removed. But I also speak to the parents as well. So it's maybe that I have to do two histories, but in separate places." (PEM 1: 109-111)

"Normally I would go in and introduce myself and establish who is with the patient and their relationships with the patient, and then I would make a very quick judgement call depending on the level of anxiety of the other individuals." (PEM 2: 63-65)

"I like to take a history from the patient. That is the child, first. On their own. Followed by whoever the child is with, on their own. And then, together. But I would get consent from the patient first, and ask would they rather have their parent with them? Some families and patients want to be seen on their own and they will say they "I want to see you on my own." Some won't say anything at all and the parent will say "Well, they haven't said anything to me, and they won't talk to you." and some will say "Well I'd rather have my parent with me". So the order in which I approach that may alter, but I think, ideally I'd like to see the child on their own, followed by the parent on their own, followed by both together." (PEM 2: 66-74)

Looked-after Children

"Yeah, they are quite a high risk group (Looked-after children), because a lot of them are very socially isolated. Because they have been in the care system and suddenly they are in a bedsit on their own. Who's actually supporting them?" (ACP 2: 477-479)

"Then if the child's saying to me "I'm going to run away" which you get with some of the looked-after children in foster care. "I'm still going to run away". Then you've got the whole social side of things to sort." (PEM 1: 171-173)

"She was in a local authority care home , she'd absconded from the care home that morning and was known to have risk taking behaviour and had kind of, previously self-harmed." (Paed ACP: 34-36)

"She was in a care home where she didn't have any relationship with the carers. They were just carers. She had no parenting figures. She had been separated from her siblings. Part of the local authority care situation. She had two, a younger and an older sibling of which she got on really well with prior to leaving the kind of, home environment, and she had very little contact with them now. She had no contact with mum. And her father she'd not seen for pushing on for 10 years." (Paed ACP: 60-65)

Attachment Theory

"Definitely. Definitely attachment theory. Because I would say that most of those one-off impulsive acts come (about) because there is an issue between the person and the carer. And then, interestingly, when you start to think about that attachment, you can see it (the problem). Yes adults

and children fall out and they don't look at each other. But you get a sense that there's something just not right, and you're relying on that a lot, that attachment theory to make you inquisitive. And sometimes that does hone the way you do that assessment, because you're concentrating on their relationship. So yeah, you are assessing the risk and why they are there, but you're also assessing a little bit about the whole holistic bit as well. So I would definitely think about attachment theory, yeah." (CAMHS: 868-880)

"So I think attachment theory and early child development go hand in hand. You know we do get a lot of young people with Autism and ASD (Autism Spectrum Disorder) who come in with more emotional difficulties which cause them to react, and then do what they do, and come into A&E. The vast majority we get, you know, it is more about that early development, early child development and attachment theory go hand in hand for me." (CAMHS: 890-896)

Boyfriend/Girlfriend Issues

(They might say) *"...I've split up with my girlfriend or whatever."* (ACP 2: 361)

"Is it just a case of 'I split up with my boyfriend last night'?" (PEM 1: 96-97)

Interpreting Emotional State

Mood Assessment

"...child presented without any actual harm but had come in complaining of low self-worth, feeling depressed." (Pilot: 31-32)

"...feelings of low mood." (Pilot: 33)

"...just had feelings of low self-worth, low mood." (Pilot: 53)

(Mood assessment)... "it's if they're tearful, distressed, anxious." (Pilot: 70-71)

"...or "Actually I've been quite low for a long time..." that would concern me." (PEM 1: 97-98)

"What's their mood's been like?" (PEM 1: 116)

"...created a feeling of, lack of self-worth and that's what tended to push her into these self-harm or suicidal ideations." (Paed ACP: 52-53)

"Their general tone is an indicator, do they sound like they're depressed? And I don't know whether there's a real medical definition of what somebody sounds like when they're depressed. What's their outlook on life? I suppose if you've got someone who, they're a teenager who's looking forward to going to college and you know want to be a doctor or an engineer or whatever, and they are going to this university, then it gives you some indication that they have a life plan ahead of them or in place. Rather than a child who maybe says "No, I don't want to be here. I don't want to be here next week. I want to die", would indicate more of a risk. If they've got some kind of plan. So if these were

spontaneous episodes of self-harm then, I suppose that, kind of, I think technically lowers the risk... yeah I would imagine the children that I've seen that have had significant life threatening self-harm tend to have been ones that have acted quite spontaneously as well. So those are some of the things that you might look out for. But then it's also the things that they say, the repetition of "I don't want to be here", "Nobody cares about me" "I don't want to be here" would kind of concern me more rather than the kind of 1 or 2 mentions of it at the beginning of the assessment and then fully engaging afterwards and having the kind of life plan I suppose." (Paed ACP: 232-245)

"I suppose, with depression like illnesses as well. You kind of assess for their kind of mood and their appetite and stuff as well." (Paed ACP: 420-422)

Cooling-off Period

"...a bit risk averse sometimes with things like that. But I can actually understand in some instances it might be a good idea if they've had an argument at home or something's set it off, or something's fuelled it, and then everything's calmed down and they might be better. I can understand that a cool-off period in some situations would be a good idea." (ACP 1: 263-267)

"I'm probably a lot more cautious with children in admitting them for their cooling-off period than we are with adults. And I think people under value the cooling off period." (PEM 1: 231-233)

"So the children are usually admitted even if they have only taken an overdose a few hours before, just because it's felt that it may be just a reaction to home circumstances and if you can remove them from the home circumstances or school for a number of hours, they'll cool down and regret it. Whereas adults tend to work more under the influence of sort of, alcohol or drugs, but can be more serious about the overdose. It's not that they are not serious but a cooling off period means that the assessment can be done much more thoroughly, in a better way and in a controlled manner, once

they've got the anger and aggression and the upset out of their system. And I think, I probably didn't appreciate that when I started out and probably like many of my colleagues who poo-poo the cooling off period as just time-wasting, and taking up beds, actually it's a very important part of the mental health assessment." (PEM 1: 237-247)

"And the concept of a cooling off period is a very difficult one isn't it because, you know it's slightly opaque as to how long that needs to be." (PEM 2: 407-408)

"I have my reticence that it (cooling-off period) is required in everybody. I think that the adoption of it being needed for everybody made it easier for the secondary teams to make a decision as to what they would and wouldn't do. I can rough guess that probably only half need it, and the other half are engaging and you can get a story and they don't need a cooling off period, but again that's the psychological development of the child and their interaction." (PEM 2: 413-418)

"I guess we work on the fact that what we're relying on our colleagues in the emergency department to make a decision to say whether that person is still expressing thoughts of harming themselves because, it's not surprising actually, the amount of people who come in who have expressed suicidal ideation, when they've waited a couple of hours in A&E, how many people are NOT actively suicidal and wanting to go home. So you know, the mini crisis if you like, which could be triggered by anything in a young person's life, kind of does naturally drop off. " (CAMHS: 79-85)

"...there is that cooling off period, but there's also that thing about children supposedly don't control their emotions as well as adults do. ...so they do need a little bit of a cooling-off period and I guess they're not sat there reminiscing and ruminating about it, but there's sometimes, magically 8 hours later all those things they were saying have disappeared when we have to come back. So I think that

cooling-off period is essential. And I also think it is for parents as well, you know." (CAMHS: 681-686)

"I think it allows them a period of reflection and I think what you often find for a lot of these children who self-harm or self-poison, that a period of reflection can put everything more into context for them rather than that acute episode of whatever's driven them to take that overdose for example. And you often find that with the children that take the overdose and don't tell their parents until a few days down the line and they've sat there and they've thought about it and they've reflected and stuff, so I can see why it's there, and it probably is a useful tool in terms of mental health assessment to have that period of cooling off and reflection." (Paed ACP: 459-465)

Maturity Assessment

"I think an older child is probably easier because it's the same, I'd assume it's the same as you would for an adult... So I tend to see children fourteen or above, but it depends on when I see them if I think they are immature for their age." (Pilot: 70-74)

"...younger children, I feel less confident with, so tend to not see those." (Pilot: 228)

"Depending on the age of the child, you are going to ask them different questions." (Pilot: 153-154)

"For a younger child, I think that'd be more difficult." (risk assessment) (Pilot: 71)

"...she did seem like a very mature 16 year old." (ACP 1: 66)

"So I would probably adapt style depending on how mature they appeared, if it seemed like a very young 16 year old, because some 16year olds are like 12 year olds. They are very immature in their look and approach." (ACP 1: 70-72)... "

"But if they're communicating openly and appear to be quite mature in their approach, then I would approach them in a similar way as an adult." (ACP 1: 81-82)

'Cos some 16-18year olds are very mature and adult like, but then some others might only be more around 13/14 age group." (ACP 2: 531-532)

"... I suppose it's just the way they are with you isn't it? It's very difficult. I think to gauge whether someone... it's like if you put a row of 14-18 year olds just in a room, and you didn't know how old they were, and you were asked to go and age them, well it's, that language they use, what they look like... But then just because you've got a 16 year old girl fully made up, looking like she's going out to a night club, doesn't mean that she's actually mature? It doesn't. Because if you actually talk to her she may actually be... (quite immature)" (ACP 2: 538-543)

"It (risk assessment) depends on the age of the child as well." (PEM 1: 39)

(Elements which inform the risk assessment) "Age. First of all if they are very young, that would really concern me. So, I've seen a 6year old who tried to jump out of a moving car before, distraught. Which concerns (me)... huge alarm bells ringing." (PEM 1: 141-143)

"I think it's just handling different ages differently isn't it? That you've got to be aware that your 16/17 year olds can be very, very different in their maturity. So you've got some very young 16year olds, who are still at home with mum and dad and go to school. Compared to your 16year old that's living independently and maybe pregnant. And again you might just change the way you assess those differently." (PEM 1: 342-346)

"A mature 16year old's got more street cred. They're more savvy. In some ways you might be less concerned than someone who's quite immature for their age." (PEM 1: 351-352)

"I'd be more concerned at the ones who are quite young and immature but I think that's what you need to know that, yes you still need to be concerned about the 16year old that's pregnant, because they're very vulnerable out there. But probably the way you speak to them in your interview may be very different. You are not going to ask your 16yrold living at home with mum and dad about pregnancy, drugs, alcohol being a major issue in their life because they've probably never done any of that. Whereas you need to ascertain how often they are using drugs, who's influencing them? Where are they living? You know we see some 16yr olds who going from one house to another... Who's influencing them at home?" (PEM 1: 361-369)

"I think it (suicide risk assessment) is difficult as the young person or child gets younger." (PEM 2: 194-195).

"And you know, in the very young child, which for me is more difficult, probably the under 12s, it is much harder because they are so much more young, mentally. I feel that they are more, more of a challenge to converse with." (PEM 2: 201-204)

"It's the ones, young ones, who don't tell people, they're the ones who worry me the most." (CAMHS: 101)

Child Development Theory

"I think any training package needs to look at the psychological development of the child, and the influence of different stressors on this." (PEM 2: 249-251)

"So assessment of their developmental appropriateness is something that's definitely used. Yeah, absolutely." (Paed ACP: 279-280)

Physical Appearance

Body Language and Behaviour

"As I went to speak to her, sort of observed how her persona was, how she looked physically I suppose. So, she was well dressed and her hair was brushed, and she was sat with her mum and gave reasonable eye contact at that time." (Pilot: 47-49)

"...so I think more about physical things, physical interaction with you, and how they communicate and eye contact." (Pilot: 75-77)

"...general behaviour or, if they look withdrawn, or if they look pale and they look particularly withdrawn. If there's no eye contact." (ACP 1: 114-115)

"I think you read a lot more into the body language of your patients." (ACP 2: 100) "...there are certain things that I look out for that would cause me concern. Like if they are not making eye contact with you. If they are looking down. If they are talking monotone. If they look unkempt. You know, all of those kind of warning signs that you pick up. Not from what they're telling you, just from what you are observing with the person." (ACP 2: 102-105)

"And then, their actual behaviour in the cubicle at the time. Are they very withdrawn and very quiet? Or have you got the opposite, where they are running round the department and very disruptive, which would concern me as well." (PEM 1: 98-101)

"Appearance, general appearances as they come in. Are they smiling? Alert? Happy? Good interaction with parents? Or is this a quiet withdrawn person? Not interacting with parents? Which just makes me concerned." (PEM 1: 143-145)

"But it's also more than that. It's picking up on the none-verbal cues as well. So someone who's non-engaging, someone who's looking nervous, whereas you've got other children who might be kind of confident in their appearance, somebody who has just taken a one-off overdose after a row with their parents because they didn't get what wanted, who maybe sits there being confident. And er... kind of quite overt rather than someone who's quite within themselves." (Paed ACP: 292-296)

"I would be more concerned about the one who's more withdrawn." (Paed ACP: 303-304)

Assessment Environment

"...try to get an environment that's comfortable for both of you, so that all the things about environment. ...that the environment's relatively quiet." (Pilot: 86-87)

"Sometimes I think, it's difficult in A&E, as in you know it's a really busy environment and people walk in on conversations." (Pilot: 95-96)

"Offer them something, food, nourishment, that kind of thing." (PEM 2: 180-181)

Identifying Suicide Intent

"I did ask her directly towards the end of the discussion with her about if she was suicidal or not."

(Pilot: 59-60)

"I ask very openly, and I'm not afraid to say "Do you feel like you're going to kill yourself?" "Have you been thinking about killing yourself?" (ACP 1: 187-188)

"How did you feel? What was your intention at the time? Was it to end your life?" (ACP 3: 361)

"Asking them... "Is it just a cry for help? Or did you really intend to kill yourself?" So you're a lot more concerned if they said "Yes, I still want to kill myself."" (PEM 1: 149-150)

"It (Suicide risk assessment) should be part of the history taking for all self-harm." (PEM 2: 193)

"She wanted to die. That's what she said to me. She wanted to die. She didn't want to be here. She didn't feel like she had any benefit. Nobody would really value her being here." (Paed ACP: 57-60)

Repeat Attendance

"She openly discussed it and told me she'd done it loads of times before." (ACP 1: 63-64)

"...first presentation is very high risky behaviour, then that automatically sets alarm bells ringing." (ACP 2: 296)

"...but if they have got recurrent episodes and their behaviour hasn't escalated to more risky behaviour, you might not be as concerned if they did leave." (ACP 2: 212-213)

"...we all have our regular overdosers who will come in, and at some point they will take too much, and they will be dead, and I think it's to be aware of escalating behaviour and not just to assume because they are a regular attender that they are not going to do something else." (ACP 2: 522-525)

"...often these people are re-attenders, and then it kind of alters the way that you approach it." (PEM 1: 38-39)

"My risk assessment starts at the beginning. Looking at the computer to see if they have done it before. So I'm always a bit more wary on the ones that are new. New presentations, particularly if they are quite young as well. If they've never done it before." (PEM 1: 90-92)

"It's difficult because you might have someone who comes every week with the same thing and you get blasé. When actually this time there might be something different." (PEM 1: 222-223)

(Repeat attendance) "...should inform your assessment about patterns of behaviour, but not influence the actual attendance." (CAMHS: 415)

(Repeat attendance) "...shouldn't change the way you do the assessment. You shouldn't be doing a judgemental assessment. The day you take your eye off the ball on that, is the day that something bad happens. But knowing what triggers someone's self-harm, why they got to A&E, will inform your assessment." (CAMHS: 433-436)

(Looking at previous attendances) "...gives you a good indication of the risk." (Paed ACP: 127).

Planning, Method and Preparedness

"Yeah, or jump from a car, or a train. Something that takes method and planning rather than impulse." (ACP 2: 334-335) (Seen as higher risk behaviour)

"Notes (Suicide). Have they done it when they know nobody is going to be in the house? Or no-one's coming back?" (ACP 2: 340)

"Was this a planned thing? How long did you plan it for?" (ACP 3: 353)

"I'd want to know if it was a spontaneous thing. Had they just had a fight with their friend? Had it been something they'd planned for a long time so? If it's been planned for a few weeks and they decided that this Saturday night when their mum and dad were out that they were going to do this, then that's obviously a massive alarm bell over somebody who's (said) "Oh I had a fight with my boyfriend and we broke up and I took six paracetamol. "" (ACP 3: 355-359)

"Have you been thinking about it?" "Have you been planning it?" (PEM1: 69-70)

"If they've only taken two paracetamol you're not really going to go into a huge thorough history compared to a mixed overdose of dangerous drugs." (PEM 1: 82-84)

"What have they taken? Is it something that's quite dangerous? Where have they got it from? How have they gone about trying to get it? Where have they done it? Have they done it in a public place? Like in school in front of their friends? Or have they locked themselves away in their room?" (PEM 1: 93-96)

"The mechanisms which they might have thought about (self-harming), so hanging versus cutting, and violent mechanisms would make you concerned." (PEM 1: 151-153)

"How have you gone about getting the tablets? Where have they come from? Have you gone out and bought them? How many did you intend to take? I often ask how many it can take to do you harm with paracetamol, because there could be a lack of knowledge there. I say 'Where have you done it?' Is it a public place? Was it in front of their friends? Did they do it quietly at home? What did they think was going to happen when they took the paracetamol or the drugs? Did they intend to be found? Was someone coming back to the house? Or back to school to find them?" (PEM 1: 378-384)

"I always get worried about young people who don't tell people, who wait a long time until they tell somebody they've taken an overdose." (CAMHS: 94-95)

"She has certainly made some significant attempt to end her life." (Paed ACP: 73) (Describing how a 13yr old girl had tried to use a sock as a ligature in a cubicle in the department.)

"So I tend to do it (Risk Assessment) informally now. So looking at their methods of which they have harmed themselves. So, the extent of their lacerations to their arms, how frequently they do, and the reasons for why they do it. So I might think, you know, a child who has superficial self-harmed after argument. When I ask them, is it a stress release "Do you feel better afterwards?" rather than a child who's tried to hang themselves, or is found on the wrong side of a motorway bridge, kind of enhances that risk for me. So I have no formal scoring tool, it's all very, I suppose, subjective based on the questions and the answers they give really." (Paed ACP: 165-171)

"...the things like "Did you have a plan?", "Have you thought about this? Or is this something you've done spontaneously?" (Contribute to risk assessment) (Paed ACP: 321-322)

Help-Seeking Behaviour

"If you've had someone who's threatening, but not actually done anything, then that sort of, in some way, they've sought help before they've done something. So that's good, because that means they want to interact with you prior to having actually done something and they thought "I need to get treatment for that" so " that's why I'll go to the hospital" rather than "I'm going to the hospital because I want help because I could do something." (ACP 2: 125-129)

"Time of delay from presentation. Did they tell somebody what they'd done? Or was it found out by accident that they'd done something? If they hadn't told anybody and mum noticed self-harm marks, or discovered tablets were missing, that's high risky, that raises my level of concern." (ACP 2: 133-135)

"You know, someone who goes and takes themselves out into a wood with a bit of rope to try and hang themselves is more, in my mind, much more risky behaviour than someone who may have taken two paracetamol and told their mum two minutes later that's what they've done." (ACP 2: 136-139)

"I'd much rather you come and see us before you do something, because it makes life so much easier if you come and see us before you've taken an OD or cut yourself, or anything." (ACP 2: 259-260)

Deliberating Professional Practice Issues

Scope of Practice

Personal Scope of Practice

"(if) I'm not sure of the assessment then I'd obviously not continue to see that child." (Pilot: 74-75)

"...the younger children I feel less confident with, so tend not to see those within my scope of practice." (Pilot: 212-213)

"...but my scope of practice I tend to stick to the group I feel happy communicating with." (Pilot: 231-232)

(I wouldn't do anything) "...apart from doing anything immediate in A&E for their safety, and then talking to them and establishing what's happened, and why, and what the risks to them are now. Trying to get as much as I can, so they can tell me as well, so I wouldn't start any (mental health) treatment in A&E." (ACP 3: 386-389)

Role Specific Scope of Practice

"...you get more involved as an ACP than I did as a nurse." (ACP 3: 470)

"Well you are a lot more of a nurse as an ACP, than you are as a nurse. You get to spend loads more time with the patients. Which you do, so I think you get a lot more involved and you form a bigger bond and relationship with the patient than you did as a nurse." (ACP 3: 472-474)

"I don't know how they do their assessments, because it's completely alien to me is physical health." (CAMHS: 372-373)

"...not knowing about the mental illness side of things doesn't stop you doing a risk assessment. So I don't necessarily think you need to know that. Certainly the social workers in the team wouldn't."

(CAMHS 478-480)

Service Provision

"We're here to deal with the acute emergency issues." (PEM 2: 91)

"Some might argue that the secondary elements (mental health and social issues), other teams can manage, and there's a fine line between just dealing with the immediate stuff and leaving go and referring on, and trying to at least touch on the secondary elements, to try and holistically identify issues that may have not been identified in the past." (PEM 2: 103-105)

"But also to deal with the, I suppose, the acute risk of self-harm and do a brief kind of assessment of her needs before referring her on to the Child and Adolescent Mental Health Service." (Paed ACP: 43-45)

(When asked whether they thought the ED was concentrating on the physical needs rather than the holistic person) *"Yes. Without a shadow of a doubt, without a shadow of a doubt. It doesn't say "Accident and Emergency for physical conditions only" but that's impression we have."* (CAMHS: 251-254)

"...she'd been seeing the school counsellor. She's been seeing the school nurse. She'd been seeing her GP. No one has got the guts if you like, to sit down and go "Why are you so thin?" "Why aren't you eating?" "We've done some medical tests and you're not medically ill, why are you so thin?" Because people think this is a mental health problem. Actually when I asked her, she just told me straight away" (CAMHS: 513-518)

"...she hadn't been waiting for an RMN, or someone from CAMHS to turn up and ask her that question. So why didn't the other professionals ask her? The healthcare professionals? So, I wonder if some of it is "This is a mental health problem and I don't know how to deal with mental health problems." You know it's not a magic formula. You've got to sit down and ask questions to young people." (CAMHS: 523-527).

"It's becoming a little bit of an epidemic really about, if a doctor or a nurse is thinking "Why is this person in our hospital?" "Why are they in our A&E department because they are not medically unwell?" "Why have YOU admitted them onto our ward? Because they're not medically unwell?" I've seen it quite a few times and (what) gets fed back to me as well is that, the medical staff say things about that young person to us and to other doctors and to themselves in front of that young person." (CAMHS: 915-919)

"We've got a duty to safeguard them. Again, it goes back to that, they're not physically ill....but I can quite understand it... I can understand the frustrations. I just think sometimes, that child's wellbeing, overall wellbeing, because they're not deemed to be medically unwell, sometimes goes out of the window. And I think, certainly at times during the winter, that's more evident." (CAMHS: 972-976)

"And we've had feedback from young people who've said "I've heard them talking about me" "I've heard them shouting at you about me". So, you could be talking about somebody who has problems with their emotions, who has problems with their mood, has problems with their self-esteem and image. And this.., this doctor is, not saying, not particularly using their name or saying bad things about them, but in general is saying "I do not want them on this ward", so they're getting rejected

."Get them out of here". And that young person is in crisis and they are thinking "Where am I going to go?"" (CAMHS: 1007-1013)

(I don't know) "...if there are any differences in the way that CAMHS and the RAID team work and function. Because they will be very similar, but if there's any differences in their protocol and the way that they assess. I don't know what an in depth CAMHS mental health assessment would look like." (ACP 1: 274-277) RAID is the Rapid Access, Intervention and Delivery team who are commissioned to see adult patients who present to the ED in mental health crisis.

"I don't think there's any. Or very limited CAMHS service over the weekend." (ACP 2: 209)

"And who are we going to involve to get the best for them. And that is often the most difficult thing, is the other agencies. Who do you involve? When do you involve them?" (PEM 1: 295-296)

"Social Workers, Drug and Alcohol Services, CAMHS or adult services if it's RAID. I don't actually have much knowledge of the different systems that are out there once they leave here (ED). What CAMHS actually do with them, the counselling they get. Do they get CBT? I don't know these things." (PEM 2: 301-304)

"Very often these children will all need Child and Adolescent Mental Health Services. They'll need paediatrics. They'll need all these other services." (PEM 2: 318-319)

"In terms of the finer aspects of what's available, I think it's really difficult. There were so many different kind of groups, and I was finding some of them on the hoof really. I don't really understand what they did, and schools have access to different things as well, that I didn't have knowledge of." (PEM 2: 334-339)

"CAMHS situation is challenging isn't it? And I think incredibly challenged for emergency departments to get that kind of formal risk assessment. I say it's challenging here... I used to work in (another part of the UK) and you used to get these kids who you'd wait for 7 days for that initial CAMHS assessment, whereas at least we're lucky here in that you get the CAMHS assessment the same day as they come in in the day time. Potentially overnight depending on the severity of their presentation, if not the next morning." (Paed ACP: 428-433)

"But, you know, we think about litigation as well, everyone thinks about litigation in their practice don't they? If I'm not sure, or I'm not willing to take an educated, calculated risk, I have no option but to put somebody on the ward. You can dress that up as a cooling off period, but I am actually thinking about litigation as well. I don't want to go to court and defend "Why have you let that young person go from A&E and they've killed themselves?" So everybody thinks about that. So I can understand if A&E practitioners are thinking about that (when they refer everyone to CAMHS)." (CAMHS: 664-669)

Lack of Formal Training

"I think we all need better training in CAMHS." (PEM 1: 395)

"...in the past we have had teaching from psychiatry with regards to risk of self-harm, but not specifically for kids." (Pilot: 204-205)

"I think you do learn from experience in A&E... you've got to go and see the child and then identify things that you don't really know, and seek expert help for that." (Pilot: 250-252)

"...not that I'm child trained." (Pilot: 69),

"I'm not specifically trained in that arena." (Pilot: 208)

"I tend to focus on adults, so, for me, I don't always know...Like I say with the younger end, I don't know what I don't know." (Pilot: 248-249)

"Well I ... rightly or wrongly (I) treated her in a similar way to an adult presenting with a similar... (problem)." (ACP 1: 55-56)

"And whether I'm doing that correctly or I'm not... from a mental health point of view I'm not 100% sure whether I am or not." (ACP 1: 177-178)

"I think, first of all I'm not a practitioner in mental health, I don't have, I wouldn't know where to start (to treat someone with mental illness)." (ACP 3: 376-377)

"I wouldn't start treatment for mental health in A&E." (ACP 3: 381)

"I haven't had any formal training (in children's mental health) I don't think." (ACP 1: 146)

(Have you come across attachment theory?) *"No, not me. But I don't know if that's because I'm not paediatric trained."* (ACP 2: 485)

"I think a lot of it would be I've learned through experience." (ACP 3: 442)

"I don't even know whether I've had proper formal training." (PEM 1: 178)

"You don't get anything on adolescents and mental health at all (in the RCEM curriculum for doctors in specialist training)" (PEM 1: 186-187)

"I can't think of any training we've had in adolescent mental health." (PEM 1: 257)

"I've never been taught anything about paediatric (suicide) theories." (PEM 1: 389)

"I think, certainly from my perspective at a senior level there's been very little training in terms of how to engage with a young person. So, a lot of what I observe is by watching media resources. Not necessarily around talking to young people, because I don't know what exists." (PEM 2: 144-146)

"And certainly through my advanced practice course, the mental health assessment part of it was very adult focussed." (Paed ACP: 85-86)

"...in terms of training, initially there was nothing like that. I think it's quite a big educational need, and there's probably a general awareness that A&E departments, and even paediatric wards, are not that well prepared for children with such significant proper suicidal ideation as she had." (Paed ACP: 87-90)

"You don't get taught that at university, how to talk to young people." (CAMHS: 220)

"There is no children's training in mental health." (CAMHS: 284)

"...unfortunately you have to do so much on the job learning. Which is quite difficult when you are dealing with risk." (CAMHS: 364-365)

"The vast majority of our team don't know about mental illness disorders." (CAMHS: 469) (Some are from a social work background rather than health professionals)

Refection and Supervision

"If there's something you don't feel you've handled very well or dealt with, either talk about it first of all, and if it's something that I might not know much about, then I'll go and investigate it or research it more." (ACP 3: 496-498)

"Just like I say, seeing cases and then the more you see, the more you discuss (helps learning)"
(PEM 1: 179)

"I think I've learnt over the years to talk about these things to colleagues. But normally I'll only do so after a period of rumination and reflection and you know, to a certain extent, depending on what it is, it can almost be almost be like a mini post-traumatic stress event. And I recognise that because I've seen a number of cases in my time where you know one wakes up and thinks is there anything else one could have done?. Why didn't you do this? Why didn't you do that? So.. you know if it really is that bad then I guess I would discuss it with sort of named protection specialist, but it rarely comes to that because I think that normally just a discussion amongst colleagues is sufficient, but that's done on an ad-hoc basis, and very often we don't get time to debrief, but you know it's got to be particularly bad to debrief. And that doesn't happen." (PEM 2: 350-358)

"...often it's peer support. Just having that... having the discussion with the colleagues around you on the day about how it's made them feel, and how it's made you feel. So we do kind of try to have a little bit of an informal debrief afterward where people can discuss how it's been." (Paed ACP: 386-389).

Maturity of the Clinician

"You know, just by virtue of my age, my uniform representing some level of authority may have meant they didn't want to open up." (PEM 2: 163)

"If necessary, pick a younger member of staff to try and engage them." (PEM 2: 179)

"...so they come with a more mature psychological approach." (PEM 2, 304-30) (Discussing strengths of ACPs who often have years of nursing experience prior to undertaking the ACP role.)

"I think equally children or young people with self-harm may engage with a younger person with less knowledge as well, so I don't necessarily think one rule fits all." (PEM 2: 311-312)

Gender of the Clinician

"So, ok, I tend to try a bit of a relaxed approach. I'm also mindful that the vast majority of these, well a large proportion of these children are teenage girls. And I'm not sure how sometimes being a man, kind of, allows them to feel like they can open up. So I do think about whether, and I do ask them whether they'd rather speak to a female. Whether they can develop that relationship slightly more with them." (Paed ACP: 190-194)

"I've seen it work the other way as well. I've seen children who've come in regularly who won't engage with my female colleagues and I've managed to." (Paed ACP: 200-201)

Time Pressure

"Obviously if I can see the screen building up, you are aware of it, and you try and go as fast as you can." (ACP 1: 320-321)

"You have a very short period of time, and it's hard, you cannot form a relationship deeply with somebody within half an hour or an hour, or whatever you've got in A&E to do that." (ACP 3: 288-289)

"I think that (universal referral to CAMHS) is the right way (to ensure proper risk assessment) because these issues can't be drawn out in a 10 to 15 minute conversation on a tick box checklist in the ED." (PEM 2: 394-395)

"I think, when you are under a lot of stress and it's busy in the emergency department , sometimes it can just be 'Here's another overdose' and you go in there and you are a bit "Why have you done this?" "Don't you realise how dangerous it is to take Paracetamol? Now you've got to be admitted" and that's not the way you want to be, but you can be at the end of your tether, and that doesn't help them and it doesn't help you. You instantly lose that connection." (PEM 1: 208-213)

"...this is not a criticism, but the chaos you walk into quite a lot, when you go to A&E. It is so busy." (CAMHS: 719-720)

"I wouldn't want to work in A&E under that pressure myself." (CAMHS: 785)

"I suppose the emergency department is quite a difficult place to develop those relationships. It's a bit different when a child's been sat on the ward for 3 days and has been looked after by the same clinicians and nurses. You kind of see that little bit of a relationship starting to build, whereas in the emergency department if you're seeing them you've got to go and see them and decide what to do within 4 hours. Then you haven't really got much time to find out that much about them and develop that kind of patient relationship that might be more beneficial to them opening up." (Paed ACP: 207-213)

Identification of the Cause of Self-harm

"...seeing if anything had happened to make her feel like she needed to take an overdose." (Pilot: 33-134)

<i>"Just to try and find out what the cause of herself-harm was..." (Pilot: 134-135)</i>
<i>"...trying to get a whole picture and find if there is an underlying cause for the event..." (Pilot: 142-143)</i>
<i>"I like to think or suspect that there's an underlying cause for the self-harm." (Pilot: 146)</i>
<i>"It's not just about the event. It's about what's caused it and everything around that" (Pilot: 152)</i>
<i>"And so I asked her what triggered it (the self-harm) off." (ACP 1: 64)</i>
<i>"'Cos to them the big thing might not be what they've actually done to themselves, it's why they've done it." (ACP 2: 359-360)</i>
<i>"...to try and find out why, what had been triggered them to get to this point, or what had led to this point?" (ACP 3: 225-236)</i>
<i>"Trying to engage with her and trying to find out why she's said what she's done, and also if she had done it, why had she done it?" (ACP 3: 256-257)</i>
<i>"Was there anything particular today that made you do it?" (PEM 1: 69)</i>
<i>"The history can be quite lengthy because usually the precipitating event is not necessarily simple. So there can be one precipitator of why the child has self-harmed, but usually leading up to the precipitator there can be a catalogue of escalating events." (PEM 2: 81-83)</i>
<i>"You are looking at recent traumatic events, you are looking at triggers." (CAMHS: 142)</i>

"...the primary drivers for her self-harm were these flashbacks, but also the lack of contact with her siblings who she got on with very well with." (Paed ACP: 67-68)

"What are the trigger factors?" "What things do you kind of use to cope with stresses?" "Do you self-harm to deal with stress?" (Paed ACP: 152-153).

"It's looking at the triggers for the self-harm episode so is there something, has something happened? Have they been adequately safeguarded against whatever trigger?" (Paed ACP: 254-265)

Information Gathering

"Just general health history first. Asked her about her medical history and who she lived with, her support systems." (ACP 1: 60-91)

"So I try and get a bit of background to start with, just rather than going in, sometimes I go in with a fresh pair of eyes, but it's always... I like to know a bit of background. So if they come by ambulance I read the ambulance sheet." (ACP 3: 80-82)

"I often gather information before I go and see them, so... look at previous attendances, previous attendances with self-harm. It usually flags up if they are known to CAMHS, whether there is an alert on a looked-after child or a child protection register." (PEM 1: 32-34)

"The first thing that you would do as a clinician is to look at the information, either prior to the child arriving or the information on the A&E card. And that would give you information about time of presentation, it will give you a set of observations, it will give you a basic triage history of what the nurse who has assessed has been told. And one would also look at an ambulance record as well

because that would, if the child has come in by ambulance, because that may give a different light to the story.” (PEM 2: 26-31)

“If the child has had multiple attendances in the past, there is some merit in looking at at least one of the previous attendances to gather information on family background, social workers, whether the child is subject to a child protection plan, or previously known to social services, or previously known to mental health services beforehand. Partly because it's not always easy when a child comes in acutely, to gather all that information. A child may not be willing to give that information. They may not want to go through that story again. So I think it helps formulate a mental approach before going to see the child.” (PEM 2: 44-50)

“If the child not in a state where you have to urgently act, then I think there is some merit in actually looking through the IT system, the notes that are in front of you beforehand, and go in with some information and then that means that you can kind of... you know what state you are going to approach the child in, you've got an approach, you've formulated some kind of approach. Whether you stick to that is another thing, but, so that's how I would begin.” (PEM 2: 52-57)

(Risk assessment) “...is all about context. It's all about gathering information.” (CAMHS: 486)

“Making an assessment of risks including things like your family history of mental health problems and then any significant attempts of self-harm from family members as well, are usually carefully, what I tend to ask.” (Paed ACP: 156-158)

Risk Assessment

"I think risk assessment is key for me." (Pilot: 269)

*"Or to work out whether I think they are low risk or whether I'm really, really worried about them."
(ACP 2: 114-115)*

"We do the risk assessment, we do the Sainsbury's risk assessment.... It's part of the comprehensive assessment, but it's not particularly child friendly... " (CAMHS: 120- 126)

"They (CAMHS practitioners) really are there just to do the risk assessment. "Is this young person safe to go?" The rest of it we can pick up the day afterwards, if it's during the night. But really we are there to do that assessment." (CAMHS: 182-184)

Engagement

(I) *"Just act friendly and open and try to get them to like you a little bit. Ask about hobbies and what they like to do. What are they into and just try to build up a rapport. And if that doesn't work then I go through... it's just very difficult. I just try and... You might have to go through the parents if they are not engaging at all. But I do try and get them to."* (ACP 1: 95-99)

"But if somebody was very, very quiet and all the information was through the parents and I couldn't really get any further information out of them, then I'd be a bit more concerned." (ACP 1: 116-118)

"Are they willing to talk? Are they withdrawn?" (ACP 2: 157-158)

"...she was quite difficult to engage with to start off with. She (had) really poor eye contact, really reluctant to engage." (Paed ACP: 39-40)

"You find those ones who absolutely don't want to engage, who won't look at you, who will barely talk to you and you know, you get the children you go "I'm not talking to you", "I'm not talking to you, I don't want to talk to you". And then you get the other children, like her, where you can just encourage them by being a little bit friendly and just allowing them to open up." (Paed ACP: 142-146)

"...communication is massively the key and being able to, I suppose, develop that relationship is the key thing. You know, there's nothing probably more frustrating as a practitioner than sitting in a room with a patient where you can't... Our jobs are all about developing relationships aren't they? And caring. And there's nothing more frustrating or disappointing than sitting in a room with a teenager who doesn't want to be there. Doesn't want to tell you why they've done what they've done, or what's gone on before, or what's caused them to do it. And certainly doesn't want to open

up as to why they've harmed themselves. So that's the big communication challenge.” (Paed ACP: 285-292)

“...you've got to gain their trust, because that's going to make a big impact on how they are going to relate to psych services when they come. If you're judgemental with them, or you know, come across as having an attitude or, then they are less likely to engage with the next person who comes along.” (ACP 2: 255-258)

“...to try and establish a bit of trust with her, just so I could see where she was at.” (ACP 3: 272-273)

“I think the biggest thing is the interaction between you and the child... Because I think if you get that wrong from the start then things are going to be difficult” (ACP 3: 430 – 434)

“You literally have to find out so much and seem to help them, and make them feel that they are going to get help.” (ACP 3: 435)

“You always feel a personal responsibility and you form that relationship with them (the child), and they rely on you to try and help” (ACP 3: 478-479)

“I think ones I find the most difficult are the teenage girls that seem to clam up and don't really want to talk to you.” (ACP 3: 507-508)

“It depends on your first initial interaction, some children don't want to speak at all, and others are quite happy to tell you what they've done. So you have to take a hard line with the quieter ones that don't want to speak or tell you what they've done.” (PEM 1: 56-58)

“Sometimes one may be the only clinician that they can engage with that you might draw out that information, you might be the clinician where they don't wish to talk to you, and they may talk to

somebody else, but you don't know until you are in there whether you can have that level of engagement, whether they will open up." (PEM 2: 107-111)

"So sometimes you have families that say "You know, you've really taken the time to sit and listen, and understand, and address these issues, and we know that you can't really directly do anything but we thank you for actually taking the time to listen" and that in itself provides satisfaction." (PEM 2: 111-114)

"You can at least be somebody that they feel confident in opening up to, and, you know, that is part of the reward of trying to help the individuals that come to your service." (PEM 2: 115-117)

"I guess you are starting treatment aren't you? You are starting to engage with a mental health professional, so you're starting, if you want to call it a journey, you're starting on that journey. That journey is just starting with a risk assessment." (CAMHS: 843-845)

Methods to Facilitate Engagement

"I think it's being able to talk to someone on their own level, not using medical terms. Get down, and sit down next to them. You know, often assessments where you've taken them outside and they're having a fag whilst you are talking to them, because that builds the rapport with them." (ACP 2: 345-348)

"I find that sometimes it's awkward sitting opposite somebody and saying "So tell me what's happened..." and then they look down at the bed and they don't really want to talk to you. Or it's just stilted, and it's not a natural flowing thing. Whereas, if you've got distraction and you're feeling someone's abdo (abdomen) to make sure the liver's not tender from paracetamol overdose or something, then you might say "So, what made you take them today?" And they seem a lot better to respond, because what you're doing is examining the abdomen, you happen to have asked them

a flippant question, but it seems like... that seems to engage them a bit better because you're distracted. Or looking at their arms, making comments about "ok, we'll just give these a bit of a clean" but maybe they don't need closing or some of them might need steri-strips then you can.... It's almost like you've got a link in as soon as you start to pull away from something physical as opposed to something mental to pull on." (ACP 3: 115-125)

"So don't go in with a checklist in your head. Or in your head don't think "Right, this is the information I need to get." But try and get into the mind-set that this is somebody who needs help." (ACP 3: 286-287)

"I tried to just say "Look I'm not here to annoy you, or to hurt you, or make things difficult for you. Everybody is here to try and help you and people are just concerned for you." And that seemed to work for her." (ACP 3: 314-316)

"And, also found that trying to establish a relationship with them (the child), saying "Hello, I'm (name), I'm one of the advanced clinical practitioners" and asking them (the child) who they've brought with them as opposed to going in and speaking to the parents or the teachers, so you are going in and your relationship is with your patient." (ACP 3: 334-338)

"That I think helps as well, because your focus is on them. You're not treating them as a child if they are making these grown up decisions about harming themselves. And taking their own decisions into their lives and treating them like that as opposed to treating them as their parent's daughter or son. So treating them as an individual." (ACP 3:338-341)

"...it depends on the mood in there, so sometimes, you can bring in humour. You know, if you've got a good interaction with the young person. Try and talk to the young person in a way that they

understand... Ask about their life, what's going on? Hobbies that make them happy? Sometimes you don't get much of an interaction, so it might be just a case of just leaving long pauses and just trying to get them to speak." (PEM 1: 193-198).

"I try to adopt a much more relaxed questioning technique. Keeping the sentences short. Not necessarily wanting an answer, if they don't wanna give it. Giving them the options. Being very clear that I'm not necessarily wanting them to go in depth about their personal problems. I make that very clear, quite often from the start and making the statement such as "There's probably been a lot going on in the past for you. It may be very difficult for you to discuss that with someone like me who you've never met before, when you don't know and you may not have much trust, and you may indeed not want to speak to me so I'm just going to start off with the basics" and seeing how they engage with that." (PEM 2: 152-159)

"There are some occasions where I've blatantly failed to be able to get any answer out of the young person, and that may just be that any technique wouldn't have worked. Or it may have been that somebody else who wasn't dressed in a uniform, who was dressed relaxed, was perceived to have been much younger, could have engaged a lot better." (PEM 2: 160-163)

"I think, particularly if you have a young person that is under the influence of drugs and alcohol, then they are much more ready to vocalise if they wanna have a conversation with you, and I think you have to be really very careful how one manages those. So the first sentence needs to be a very non-judgemental, very calm. Probably not even asking any questions- a very simple "Hello, how are you doing?" And I think if that is met with aggression, then allow that young person to just be. And give them time. "Offer them something, food, nourishment, that kind of thing. There's no point allowing that situation to escalate so that they completely develop a barrier. And I think it's about

finding alternatives much quicker, rather than persisting with that group. For me anyway.” (PEM 2: 174-184)

(Other elements of essential training) “Would be different techniques of conversation to engage. The ultimate aim would be to ensure that the child does not abscond and disengages. So your worst case scenario is absconding or disengaging and needing to call the Police and creating this kind of, mountain where it didn't need to exist.” (PEM 2: 257-260)

“I think the rules (of engagement) are, you've gotta really have a good degree of situational awareness. And that situational awareness you can develop with maturity and having seen a lot of families and young people in the past. So looking at the position that the clinician, comes in at, and the distance that one stands away from the family is quite important. So, do you take the story standing? Do you take it sitting? And if you sit where do you sit and how far away do you sit? Do you sit next to them? Do you sit a metre away? Do you sit 2 metres away? Do you sit at the end of the room? As far away as possible? And that partly is something one gauges from just looking at the child. Now if the child is bashing its head against the wall, I'd probably stand 2 metres away and try and be as non-threatening, and as not in their immediate field as possible. If the child is extremely tearful, on their own I'd say "Do you want me to sit next to you?" "Do you need a hug?" because some children will quite happily have that, and I don't have a problem giving them a hug and, so it's really very variable. In terms of the pitch and the pace. High pitch and fast pace just doesn't work. I think that is something I've learnt from the past. I've begun to drop my voice. And eye contact..., mostly works depending on who you're giving it to and length of time. It's got to be short in general, but again I don't have any fixed knowledge about that. And open hand signals, if used at all. Sometimes I might not use any hand signals. Open gestures, open hand signals. Drink of water, food, quite often works. And allowing, I allow a lot of space for conversation. So, you know, I may not fire

out questions at all. You know, I can sit for 5, 10 minutes and allow people to speak without interrupting them because the first impression that you make is very important in the first 3 to 5 minutes. It just depends how much comes flooding out. Sometimes nothing, sometimes you'll get this whole raft of information and you just let them carry on and try and pick out bits that are relevant." (PEM 2: 271-293)

"I try and find something, particularly for the ones that are known, they might have something that they have been known previously just to start talking about and see if that's a starting point. You know even if it's completely unrelated to, you know,... interests, hobbies, that kind of thing can just trigger that little something that allows them to then open up and build that little bit of a relationship." (Paed ACP: 203-207)