THE EMERGENCY CARE OF

YOUNG PEOPLE WHO SELF-HARM

An exploration of attitudes towards young people who self-harm
and the care they receive from practitioners working in pre-
hospital and hospital based emergency services.

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A thesis submitted in partial fulfilment of the requirements of the

University of Greenwich for the Degree of Doctor of Philosophy

March 2012

ACKNOWLEDGEMENTS

ABSTRACT

Aim:

Using a mixed methods approach, this thesis seeks to explore the attitudes of emergency care staff towards young people (aged 12– 18 years) who self-harm and to gain an understanding of the basis of attitudes that exist.

Background:

This thesis has drawn on Strauss et al's (1964), concept of the hospital as a negotiated order, a perspective that has latterly been applied to the organisation of hospital A&E services (Sbaih1997a&b 1998a&b, 2001, 2002). As the fundamental premise of emergency care work is the rapid assessment of patients' needs, categorisation is an essential element of this work. This thesis therefore also draws on the sociological theories which have examined the categorisation of patients as 'good' or 'bad', as earlier sociological work has clearly demonstrated that practitioners working in emergency services judge patients based on their reasons for accessing the service (Roth 1972, Jeffery 1979, Dingwall & Murray 1983); patients who self-harm are amongst those adversely judged. However the extent to which these categorisations extend to young people was not wholly clear. Findings from earlier research that had considered this were inconclusive and inconsistent (Dingwall & Murray 1983, White 2002).

Methods:

A mixed methods approach, using a triangulation convergent design was employed. Staff employed in four emergency departments in South East London and five London Ambulance complexes that served these departments were surveyed; data from 143 questionnaires were analysed using SPSS. Qualitative data were obtained through semi-structured interviews with 12 practitioners, seven nurses and five paramedics, with thematic analysis undertaken. The two data sets were integrated and analysed to identify where the two data sets were consistent and whether/where discrepancies existed.

Results:

Findings from this study indicate that age, i.e. being a young person, does influence attitudes towards self-harm. Young people are less adversely judged as their self-harm is seen as symptom of distress, a coping mechanism or response to a stressor out with

a young person's control, thus as a consequence, attitudes towards young people who self-harm are benign. The findings lend support to previous research which has indicated that as an occupation, nurses have less positive attitudes than their peers working in emergency services. Although not statistically significant, the nurses surveyed in this study obtained lower scores on the scale used to measure attitudes than their medical and paramedical colleagues. The data from the interviews illustrated the difficulties and frustration the nurses faced in managing the care of young people who self-harm, which centred on the pressure to 'move young people on', pressures that were exacerbated by the need to do this within four hours. The paramedics interviewed did not face these challenges. Nurses faced considerable difficulty in securing admission to a children's ward; the accounts of the nurse interviewees suggested that their ward colleagues expected and anticipated that young people who had self-harmed would be challenging in terms of their behaviours, whereas no such expectation existed with other adolescent patients. To this end the diagnostic label of self-harm had negative connotations

Conclusions:

The findings from this study have extended existing knowledge in relation to practitioners' attitudes towards young people who self-harm, providing as they do an insight into how young peoples' immaturity and diminished agency, contribute to the framing of young people as vulnerable, thus their self-harming behaviour is less adversely judged. A negotiated order perspective remains a relevant lens through which to analyse and explore the organisation of hospital services and specifically the work of the A&E department; the findings of the research presented in this thesis have revealed how young people who self-harm, through both their actual and perceived behaviours, disrupt the organisation of children's accident and emergency care, thereby distorting its 'shape'. The ambiguity of adolescence as a life-stage is reflected in the attitudes and perceptions of the study participants and is also reflected in health policy and guidelines, which is particularly exemplified by inconsistency in how the emergency care needs of young people between the ages of 16– 18 years generally, and young people who self-harm specifically, are addressed. This inconsistency and ambiguity in turn serves to impede young people's progress through emergency services following an episode of self-harm.

ABBREVIATIONS COMMONLY USED IN THIS THESIS

A&E   Accident and Emergency

AYP   Attitudes towards Young People

AYPSH   Attitudes towards Young people who Self-harm

CAMHS   Child and Adolescent Mental Health Services

LAS   London Ambulance Service

NHS   National Health Service

NICE   National Institute for health & Clinical Effectiveness

SOQ   Suicide Opinion Questionnaire

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CHAPTER ONE

INTRODUCTION

1.0   Introduction

This thesis examines the attitudes of emergency care practitioners towards young people (aged 12 – 18 years) who self-harm. The findings of the study will have relevance to young people, practitioners and students alike, and will inform and contribute to ongoing policy development in relation to the location and delivery of integrated emergency care services (Fernandes 2011).

1.1   Background

My motivation and interest in this subject area arose from my background as a children's nurse who specialised in accident & emergency (A&E) care. This has remained my area of interest during my subsequent roles in Higher Education. I have successfully published in this field, and in so doing draw on my academic background as a nurse and a sociologist (Cleaver & Webb 2007a Cleaver & Webb 2007b, Cleaver 2007) - I completed an MSc in Sociology (Health & Illness) soon after joining Higher Education.

The impetus for this study arose from a realisation that students on our pre-registration children's nursing programmes were increasingly encountering young people who self-harmed during their A&E placements, encounters I had not personally experienced despite my long association with this speciality. The students' experiences were further illustrated when I invited a child psychiatrist to contribute to a module which included content on the mental health needs of children and young people. Given that the students' placements were largely in acute secondary services, including A&E and inpatient children's wards, my colleague opted to illustrate his teaching using a young person who had self-harmed as a case study. The student's responses to the case study and the discussion that ensued confirmed that the students had nursed numerous young people who had self-harmed. It was also evident that they themselves had found these young people difficult to care for, largely due to lack of knowledge on their part; it also became apparent that they had witnessed negative attitudes towards these young people.

The students' responses and recounted experiences left me questioning why nurses and other health care staff would respond to young people who self-harm in the way they described. I could recall through my own experiences of A&E nursing work, encountering adults who had taken overdoses, and the often-adverse comments made by nursing and medical staff about these patients, but not young people. When studying for my MSc I had come across papers that confirmed that A&E staff make pejorative judgements about patients (for example Roth 1972, Jeffery 1979) but that such judgements were not passed on to children (Dingwall & Murray 1983). Knowing this, led me to question whether indeed emergency care staff have negative attitudes towards young people who self-harm and if they do what are the basis of these attitudes; are these attitudes based on perceptions of young people as 'feral' and out of control, or conversely their vulnerability, or are they related to the viewpoint that self-harm is a 'failed suicide' attempt and 'not serious', i.e. were any negative attitudes embedded in and attitudes towards young people, self-harm, or both? These were questions I felt warranted exploration and hence this thesis was conceived.

1.2   A Summary of the Key Issues Leading to this Research

Around 3.5 million children and young people attend Emergency Departments in the UK annually, representing around 28% of the child population each year, accounting for between 1/4 and 1/3 of all attendances (Royal College of Paediatric & Child Health 2007), with 58% of all (paediatric) emergency admissions to hospital being initiated through hospital A&E departments (Department of Health 2008a). The report by the Department of Health (2008a) provides data on admissions by speciality but of note and relevance to this study, no admissions are recorded for child & adolescent psychiatry. This is perhaps surprising given that mental health problems in young people, which usually manifest between 12 – 15 years of age, account for a significant proportion of morbidity in young people globally (Patel et al 2007), and are increasingly prevalent in young people residing in the UK (Green et al 2005).

Fernandes (2011) reports that there has been an 11% increase in the numbers of patients attending A&E with a presentation of self-harm over the past three-years. Although Fernandes (2011) does not distinguish between adult and young people's attendances, prevalence studies of self-harm in young people confirm that it is a

global health concern; an increasing number of young people engage in self-harming behaviours (Madge et al 2008, Scoliers et al 2009, Moran et al 2011), with a correlation between self-harm and subsequent suicide evident (Hawton et al 2003a, 2003b, 2006, Hawton & James 2005).

Notwithstanding this, Hawton & Rodham's (2006) community study found that the proportion of young people who self-harm who present to emergency services represented the 'tip of the iceberg'. Indeed it is recognised that generally young people are less likely than adults to access formal health services as they have limited knowledge of services available, are concerned about levels of confidentiality and do not feel comfortable about disclosing health concerns (Booth et al 2004). This reluctance is possibly compounded in the presence of mental health problems as Rickwood et al (2007) found that that as well as lack of knowledge surrounding access to health care, young people were also fearful of being stigmatised and being labelled as "mad', and believed that they could manage their mental health problems themselves (Rickwood et al 2007).

Interest in attitudes of A & E staff towards self-harm has arisen as there is evidence that emergency care practitioners make moral evaluations about patients' 'worthiness' (Jeffery 1979, Hughes 1980, 1988, 1989, Dingwall & Murray 1983), patients being negatively evaluated if they breech social rules (Grief & Elliott 1994). Patients who take overdoses are frequently cited as being 'unpopular', an observation made in Jeffrey's (1979) study and further conceptualised in a recent review by Creswell & Karminova (2010), which draws attention to the discriminatory treatment of patients who self-harm in both in-patient psychiatric units and A&E departments. Concerns about the attitudes of emergency care staff toward people who self-harm were acknowledged by the National Institute for Health and Clinical Excellence to be problematic, with attitudes described as being 'often unacceptable' (National Collaborating Centre for Mental Health 2004). Studies which have ascertained (retrospectively) service users' perspectives of their care as adolescents reveal less satisfaction with care received in A & E departments than in other services (Harris 2000, Nada-Raja et al 2003), with a graphic account of the poor quality care as experienced by a young person in an A & E department evident in McDougall et al's book (2010:175).

The most wide-ranging study of young people's experiences of health care associated with self-harm is presented in an inquiry undertaken for the Mental Health Foundation (Brophy 2006). The report noted that in order to be treated in A & E departments young people often found themselves having to disclose their self-harm, some for the first time. This is of significance as the young people themselves identified that,

> *"the reaction a young person receives when they disclose their self-harm can have a critical influence on whether they go on to access supportive services"* (Brophy 2006:3).

Consequently, as attendance at an emergency department might provide the first opportunity for a young person to disclose their self-harming behaviours (whether through choice or not), it is imperative that practitioners respond appropriately. Indeed it is recognised that A&E departments and by implication the staff therein, are an essential element in the Government's strategy for suicide reduction (Department of Health 2002).

1.3   Research Aims and Questions

Using a mixed methods approach, this thesis seeks to explore the attitudes of emergency care staff towards young people (aged 12– 18 years) who self-harm and to gain an understanding of the basis of attitudes that exist. The questions this study aims to address are as follows:

i.   What are the attitudes of emergency care staff toward young people generally and young people who self-harm specifically?

ii.   Is there a relationship between emergency care staff attitudes towards young people generally and young people who self-harm specifically?

iii.   What are the attitudes of young people participating in this study in relation to deliberate self-harm?

iv.   What were the factors that led the young person to seek help from emergency services?

v.   From the perspective of the young people, how do they experience the care received from emergency care staff following an attendance with deliberate self-harm?

1.4   Theoretical Perspective Underpinning the Study

In undertaking this study I have drawn primarily on sociological perspectives of young people, and also of organisations, however given the extensive debates and theories that underpin both, neither is considered exhaustively, rather the key principles as applied to the debates in this study are drawn upon. Both perspectives are concerned with the maintenance of the social order, and to this end the study considers how young peoples' lives and behaviours have been (sociologically) theorised, and how through a process of continual negotiation the social order is maintained.

1.5   Structure of the Thesis

Following this introduction, Chapter Two examines how the organisation of emergency care work has been theorised, drawing on the perspective of a negotiated order, and the need to maintain 'shape' (Strauss et al 1964, Sbaih 2001, 2002). Accident and emergency care is predicated on the need to mobilise patients through its service in order to maintain this shape and thereby retain a negotiated order; this is formally managed through an objective approach to assessment, triage. However although triage employs a nationally standardised approach to determine clinical priority, A&E practitioners also make moral judgements about patients with conceptualisations of good and bad patients manifest, and evidence that negative moral evaluations can adversely influence the care patients receive. These 'moral evaluations' have added to the debates around 'popular' and 'unpopular' patients, although the extent to which they apply to young people is unclear and is thus explored.

Chapter Three reviews how proponents of the sociology of childhood (James & Prout, 1997; James et al, 1998) have advocated that childhood be seen as worthy of study in its own right, and that children rather than 'becoming adults', are active 'beings' in their own right, 'beings' who possess agency. However given the limitations in considering childhood as an all-encompassing term, perspectives on adolescence and adolescents are also considered; the basis of the term adolescence is reviewed and its usefulness in terms of explaining young people's behaviours is considered. The nature of young people's behaviour has also been theorised (sociologically) within a

deviance framework, and the resultant opposing discourses that have arisen are discussed.

Chapter Four examines self-harm in young people; the chapter begins with an outline of the debates around definitions and how self-harm is differentiated from suicide and the implications of this in light of aforementioned debates around moral judgements. There is a plethora of research that has examined motives and risk factors for young people's self-harming behaviours, which is reviewed. A critical appraisal of the research literature that has examined attitudes towards young people who self-harm is presented, forming as it does the basis for the research aims, questions and methodology.

Chapter Five details the methodology, mixed methods research, and the approaches to data collection and analysis. As the research aimed to survey and interview National Health Service (NHS) staff, National Research Ethics Service (NRES) approval was required to undertake the study. Moreover the intention of the study had also been to obtain young people's perspective of the care they received in a local emergency department. Consequently the methodology chapter provides details of the considerations made in relation to accessing young people for research. However despite gaining ethical approval it proved difficult to recruit young people, and despite changing my approach, ultimately, due to time and resource constraint, it has not been possible to gain the young person's perspective. As a consequence the study aims and research questions were amended to reflect this, and are re-framed within the methodology chapter.

Three chapters are concerned with the presentation of the findings from the study. Chapter Six presents the findings of preliminary data analysis which was undertaken to assess the consistency and reliability of the scales used in the survey instrument. Chapters Seven and Eight present the findings from the survey and interview data respectively. Chapter Nine provides a discussion of the findings. When writing up a mixed methods study an integrated or segregated approach can be adopted; the latter is more commonly observed (O'Cathain 2009), and is the approach adopted for this study. Given the centrality of research questions to a mixed methods study, the research questions form the focus for discussion, providing the structure to this

chapter. Chapter Ten draws the study to a conclusion and in so doing answers the mixed methods research question – To what extent are the findings from the qualitative data consistent with the findings from the quantitative data? This chapter also discusses the limitations of the study, makes recommendations for future research and identifies implications for emergency care policy and practice.

1.6   A Note on Terminology

In Chapter Four I provide the rationale for the (medically orientated) definition of self-harm used for this study. In so doing I outline the emergence of 'attempted suicide' as a distinct behaviour from 'suicide', subsequent attempts by psychiatry to medicalise self-harm, and the ensuing opposition to medicalisation from 'self-harm survivors' who have successfully raised awareness of self-harming behaviours as an emotional response and a coping strategy. An array of alternative (to self-harm) terms exist including self-injury, self-hurting, self-mutilation, self-poisoning, and non-fatal suicidal behaviour. My reason for adopting the term 'self-harm' as apposed to for example, self-injury, is that in the context of A&E work and the settings used for this study, self harm is the 'discharge diagnosis', and is thus used to formally report on attendances for both self-poisoning and self-injury. Moreover 'self-harm' is the term used in the NICE (2004) guidelines, guidelines that address the short-term physical and psychological management of self-harm in emergency departments (National Collaborating Centre for Mental Health 2004).

CHAPTER TWO

THE CONCEPTUALISATION OF EMERGENCY CARE WORK

2.0 Introduction

This chapter provides an overview of the key features of emergency care work and focuses specifically on the social processes that underpin this field of practice. In so doing it draws on Strauss's (1964) concept of the hospital as a negotiated order, a concept that has been widely used to illustrate, from an interactionist perspective, how hospitals function as organisations. Central to the success of the hospital as an organisation is the construct of 'shape', a construct that Sbaih (2001, 2002) applied to the production of routine order in A&E nursing work. This chapter therefore draws on this analysis to further examine emergency care work.

It is of note though that the literature that examines pre-hospital emergency care does so largely with a view to comparing and evaluating the competence (of paramedics) and effectiveness (of the staff and service), the comparisons normally with A&E physicians/doctors. Only one study of ambulance personnel that takes an interactionist approach was located (Hughes 1988). Consequently the focus of this chapter is largely on the hospital A&E department and therefore doctors and nurses, although given the central role of nurses in patient categorisation (Hughes 1988, Sbaih 1997a, 1997b, 1998a, 1998b), much of the literature and thus discussion in this chapter focuses on nurses' contribution to this process.

2.1 The Hospital as a Negotiated Order

Strauss et al (1964) were the first researchers/theorists to conceptualise the hospital organisation and the work therein as a negotiated order. They based their theory on observational work undertaken in psychiatric hospitals in North America where they observed that the work of health personnel, including psychiatrists, social workers, psychologists, nurses and nursing aides involved a complex set of interactions. These interactions served as a basis from which the various personnel worked towards a shared but unwritten goal, that being the discharge of patients. Nevertheless, while the staff were engaged in achieving a common goal, professional hierarchies both within and between occupational groups, distinct professional cultures and consequent

differing priorities gave rise to potential conflict in ways of working and addressing patients needs; in order to address these the staff actively embarked on a process of negotiation.

Central to the maintenance of the negotiated order is the construct of shape. Shape as defined by Strauss et al arises from *"the staff's efforts to keep relative order in the face of continual change, albeit order consonant with therapeutic conscience"* (Strauss et al (1964:298). The hospital's central administration influences shape by ascribing from an organisational perspective what each ward specialises in and who works, or in the case of psychiatrists, who has access on to the ward. Strauss et al (1964) note that a ward can though occasionally change to such an extent that the personnel working there can themselves alter their perception of what constitutes shape in their area, with staff also demonstrating an implicit but shared understanding of when the ward was out of shape, this occurring for example when they had more patients from a speciality that was out-with the designated speciality of the ward, i.e. females lodged on a male ward, or having more patients admitted with physical as opposed to mental health problems. Depending on the extent to which shape is distorted the staff reported that they felt 'useless' or even 'violated' and actively tried to redress the balance; examples of strategies used by staff (mainly nurses and aides as they had more day-to day contact with patients) were restricting patients privileges, sedation and ultimately patient transfer out or refusal to admit a patient in. Under these circumstances patients that might ordinarily have 'fitted' into the ward, temporarily did not 'fit', until such a time as the balance was redressed and shape regained (Strauss et al 1964).

Strauss et al (1964) observed that while nurses could affect changes to redress shape by controlling what patients were admitted to the ward (or not), the principal "danger" to the maintenance of a ward's shape was the "recalcitrant doctor". They note that while individual doctors might be open to negotiation, and subject to discipline and pressure, the nurses had no power – they had to work with the doctor and by definition his patients. Doctors, unlike nurses, saw shape in the context of patient therapy rather than organisation, and when disagreements occurred doctors drew on psychiatric vocabulary to accuse ward staff of being, "rigid", "over anxious", or "compulsive".

2.2 The A&E Department and the Negotiated Order

Accident and emergency services within the context of UK healthcare are unique in that patients can access health care directly without the normal recourse to a general practitioner or other medical referral source such as NHS Direct – a telephone advice service. This, combined with what might be deemed 'conventional' access to emergency care, either via a general practitioner (GP) referral or through contact with other emergency services such as ambulance and police, means that A&E departments see a range of patients, who hail from a variety of social and cultural backgrounds with diverse health care needs. This range and diversity while encapsulating what is for practitioners the key component of A&E work, presents both challenges and rewards, and influences how A&E practitioners organise and manage their work.

Sbaih (2001, 2002) drew on Strauss et al's (1964) work to contextualise the organisation of A&E care. She proposed that shape in the context of A&E work is contingent on nurses having an appreciation for the volume of patients and their reasons for attending, an understanding of their colleagues and their reasons for working in A&E, and an appreciation of the goal of A&E work – the need to move people on, and to this end, the nurses needed to be aware of the department's relationships with other wards and departments within the hospital. When good shape is maintained the department operates smoothly, whereas poor shape occurred when the work of the department becomes distorted and patients became 'stranded'. When this occurred nurses employed a number of tactics to re-dress the balance and restore shape, including liaison with the bed manager, finding doctors who would admit patients quickly, re-evaluating patient priorities, and re-allocating nurses to minor injury work in an attempt to move these patients on, thereby regaining some shape.

The placement of patients is of particular significance in A&E work, as failure to place patients will distort shape. Green & Armstrong (1993) explicitly drew on a 'negotiated order' perspective to examine how hospital staff manage acute emergency admissions, interviewing key hospital personnel responsible for the admission of patients. They draw attention to how historically hospital beds 'belonged' to a consultant, who controlled admission and discharge to these beds, this control being an inherent aspect of medical control based on consultants' claims to clinical freedom and autonomy, such control also being evident in Strauss et al's (1964) earlier work.

Contrary to the historical medical dominance, Green & Armstrong (1993) concluded that as a response to problems framed in terms of crisis and efficiency, the hospital as a unit of organisation has gained ascendancy (over the traditional medical dominance) and that '*acute emergency admissions illustrate an important way in which hospital organisation is achieved*' (Green & Armstrong 1993:338). The changes observed by Green & Armstrong (1993) reflected the increasing managerialism within the NHS which occurred during the late 1980's and which would have been implemented prior to Green & Armstrong's (1993) study. This is of note as arguably increased managerialism within the NHS has reduced medical (and nursing) power (Strong & Robinson 1990, Cox 1991). Notwithstanding this, Green & Armstrong (1993) note, *emergency admissions represent an area par excellence in which clinical autonomy has a major claim to operate solely in the interests of the patients, particularly in that the application of bureaucratic rules are (sic) less appropriate in a situation by definition characterised by unpredictability and crisis*' (Green & Armstrong 1993:338).

Green & Armstrong (1993) propose that hospital organisation was achieved largely through the system of bed management, a system that places emphasis on the hospital as a whole rather than the specialities therein, with the bed manager being the "honest broker" of beds. Parallels can be drawn with Strauss (1964) and Sbaih's (2001,2002) findings and shape, the shape in this context being the shape of the wider hospital organisation, which in itself will influence the shape of the A&E department, difficulty in admitting patients to hospital beds causing a back log of patients in A&E. Indeed the accounts of the participants in Green & Armstrong's (1993) study emphasise how there is a constant threat of crisis and potential for chaos if beds for emergency admissions are not available.

The potential for crisis identified in Green & Armstrong's (1993) study was though realised, as despite the 'ascendancy of the hospital as the main unit of organisation,' the 1990's saw media accounts of patients being left on trolleys overnight in A&E departments and waiting unacceptably long times to be seen and treated. As a consequence and in line with NHS reforms that aimed to put patient choice at the centre and make the NHS more accountable, the Government imposed a number of targets for the NHS (Department of Health 2000, 2001, 2003a) and more recently

introduced The Quality, Innovation, Productivity and Prevention (QIPP) programme, with the QIPP[1] urgent care work stream established in 2011 (Department of Health 2011). It has though been the imposition of targets that have generated much debate.

Targets that were specifically directed at A&E were the requirement that all patients have an initial assessment within 15 minutes of arrival in the department, and most controversially, the target that by 2005, 98% of patients attending should be seen, treated and discharged within 4 hours (Department of Health 2000, 2001, 2003a). The imposition of the '4-hour' target, which has been referred to as 'a re-engineering process' (Banarjee et al 2008, Weber et al 2011), has been particularly controversial and extensively debated and although it is widely acknowledged that it has improved waiting times, it has not been universally welcomed by those working in the field (Leaman 2003, Mortimer & Cooper 2007, Banarjee et al 2008, Royal College of Nursing 2008, College of Emergency Medicine 2010, Weber et al 2011). Much of the debate around the 4-hour target centred around the re-prioritisation of minor injuries with a 'see & treat' stream operationalised, which allows staff to see, treat and discharge patients with minor injuries as a priority, thereby reducing their waiting times, a strategy that Sbaih (2001,2002) had earlier made reference to as a tactic for managing poor shape. Critics of the policy point out that NHS managers, rather than divert resources to those who are not in need of admission but who, due to their volume, potentially increase the department's waiting times, should instead ask the question why long waits prevail, these critics pointing out the challenges A&E departments face in gaining admission due to 'bed blocking' (Castille & Cooke, 2003, Leaman 2003, Windle & Mackway-Jones 2003).

Weber et al (2011) undertook a qualitative study involving senior clinicians and leaders (both nurses and doctors) in nine Acute NHS Trusts. A purposive sample was used in order to select participants whose organisation reflected an equal spread of good, average and poor compliance with the 4-hour targets. A total of 29 interviews were conducted and subjected to content analysis with four themes emerging:

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[1] The Department of Health Defines The Quality, Innovation, Productivity and Prevention (QIPP) programme as follows:
QIPP is a "large scale transformational programme for the NHS, involving all NHS staff, clinicians, patients and the voluntary sector and will improve the quality of care the NHS delivers whilst making up to £20billion of efficiency savings by 2014-15, which will be reinvested in frontline care" (DH 2011).

'Interdependency' (the need for Trust-wide ownership of the target), contrasting change management strategies in the emergency department versus the rest of the organisation, burden and benefits for staff and costs and risks of sustainability.

A striking feature of Weber et al's (2011) study is that although not contextualised within the construct of a 'negotiated order perspective', the need for a negotiated order is apparent throughout the findings. They identified that the personnel across the NHS Trusts contacted had a common belief and thus goal, namely that the target offered an opportunity to improve care and to that end it should be implemented. However they also identified that the 'most salient theme of the study' was the need for Trust wide engagement, without which this goal was unachievable, and in particular while emergency departments might have signed up to the target (largely due to lack of choice) unless the rest of the hospital was also signed up to it and saw it relevant to their areas of practice, progress was slow, and to that end they propose that '*the 4-hour target relies on, and influences, multiple parts of a health care organisation'*. The accounts of the participants in Weber et al's (2011) study evidence the strategies they have employed in order to raise the profile of the target across their respective organisations, which include negotiation, collaboration and some coercion, all strategies previously identified by Strauss et al (1964) as necessary to ensure the effective coordination of work and maintenance of the negotiated order.

2.3   The Ideological Basis of Nursing and Medical Work in the A&E Department: Its contribution to the Maintenance of the Negotiated Order

Strauss (1964:351) proposes that the hospital's 'social structure' is principally derived from three sources, the number and kinds of professionals who work there, their treatment ideologies and related professional identities and the relationships of the institution and its professionals to the community (both professional and lay) – all of these sources being interrelated. In the context of A&E, the range of patients attending means that practitioners working in this field, regardless of professional background, need to be able to call on a wide repertoire of knowledge and have an extensive skill base, and are therefore able to distinguish and recognise symptoms of concern and then act upon them (Sbaih 1998a & b).

In relation to nursing, Sbaih (1997 a & b) observed that there exist everyday taken for granted rules, which she termed 'maxims' which underpin nurses' A&E work, and while they are not formally recognised by A&E nurses, they constitute the everyday taken for granted actions or the 'rules' within which the nurses work. The maxims identified in Sbaih's study and concurred with by the nurses participating were as follows:

- Act upon impressions gained
- Work out the work for yourself
- Recognise the deserving patients
- Take risks when you have to
- Challenge doctors decisions
- Enjoy doing more than one job at any one time
- Be seen

(Sbaih 1997a:29).

Maxims direct, instruct, and make nurses accountable for the way in which the work gets done and the way the work is seen, heard and talked about, thereby directing the organisation of (A&E) work and its development within the setting (Sbaih 1997b). It is this combination of knowing the 'normal' based on the 'mental library of cases' and having insight into and understanding of the 'maxims' of A&E work that promotes the negotiated order within A&E departments (Sbaih 2002).

Similarly Allen (2004, 2007) drawing on field and observational studies identified eight 'bundles of activity' that she proposes epitomises nursing work. As would be expected therefore these activities are evident in A&E nurses' work and involve the management of multiple agendas, circulating patients, bringing the individual into the organisation, managing the work of others, mediating occupational boundaries, prioritising services, obtaining, generating, interpreting and communicating information and maintaining records. However, as Allen (2004, 2007) highlights, while nurses might espouse individualised patient centred care, in reality they manage patient populations rather than individual needs, with patients and nurses being bound by organisational routines and operating practices. Indeed Allen (2004) concluded that:

"The overarching picture of nursing work to emerge from the bundles of activity described herein is that of the intermediary. Field studies indicate that in modern healthcare systems the core nursing function is to mediate different agenda, articulate the work of different care providers around individual patients and fabricate patient identities. It is nurses who reconcile the requirements of healthcare organisations with those of patients, and constitute and prioritise needs in response to available resources. It is nurses who broker, interpret, translate and communicate clinical, social and organisational information in ways that are consequential for patient diagnoses and outcomes. It is nurses who work flexibly to blur their jurisdictional boundaries with those of others in order to ensure continuity of care. In fulfilling these roles, it is nurses who weave together the many facets of the service and create order in a fast flowing and turbulent work environment" (Allen 2004:278-279*).

Although not explicitly stated, this conclusion from Allen (2004) illustrates the centrality of the nurse's role in maintaining the negotiated order. However as noted above, differing professional ideologies can result in tensions whereby nurses and doctors have differing priorities in patient management. These tensions can lead to a distortion of shape, as illustrated by the tensions between the psychiatrists in Strauss et al's (1964) study, who when compared with the nurses, prioritised single rather than groups of patients and focused on therapeutic interventions rather than patients' daily behaviours, behaviours that the psychiatrists were rarely exposed to and consequently interpreted differently from the nurses.

These ideological tensions have also been found to exist in studies based in acute hospital settings. For example, hospital doctors working in acute hospital care have been found to prioritise curative functions in order to 'fix' the patient. This was noted by Jeffrey (1979) in his ethnographic study of A&E work and observed by Cassell (1994) in her ethnographic study of an intensive care unit. Indeed Cassell (1994) noted that, whereas nurses were interested in the patient's stories, *'doctors perform a culturally identified masculine instrumental role, concerned with curing patients' bodies.... they focus on disease, dysfunction and cure... the doctors focus on the disordered body'* (Cassell 2004:667). Similar conclusions have since been drawn by

Hadfield et al (2009), who found that A&E doctors prioritised the treatment of the physiological (body) over the psychological (mind) needs of patients who attended A&E following self-harm. Conversely nursing has always made claims to consider the patient from a holistic stance (Allen 2004, 2007) although it is noteworthy that when under pressure due to lack of resources, priorities are re-evaluated and under such circumstances nurses downgrade the psychological dimensions of care, prioritising instead physical care as this is less time consuming and thus resource intensive (Allen 2004, 2007). This is particularly observable in A&E work.

Such ideological differences are in part driven by the differing histories and cultures of the health care professions resulting in professional demarcations with each group claiming an exclusive right to perform its professional function, with sapiential knowledge and consequent authority amongst high status groups frequently deferred to (Boreham et al 2000). However, contrary to the findings of Strauss et al (1964), the relationship between doctors and nurses is more complex than their analysis would suggest, particularly when applied to the context of hospital accident & emergency departments. Paradoxes have been noted in relation to the skills of staff working in A&E (Jeffery 1979, Dingwall & Murray 1983, Hughes 1988, Sbaih 1997a &b) as many nurses working in A&E departments are very experienced and are therefore able to draw on a wide repertoire of skills and knowledge whereas many doctors, notably junior doctors, are often transitory, from overseas, have no previous experience of A&E work, and have no intention of remaining in this field of practice (Jeffery 1979, Dingwall & Murray 1983, Hughes 1988, Sbaih 1997a &b); this paradoxical situation arguably influences interactions between doctors and nurses in the A&E setting.

The doctor nurse relationship has been described as a 'game' (Stein 1967, 1990), contextualised within the framework of medical dominance whereby nurses, who cannot be seen to challenge the authority of the doctor, overcome this by employing subtle methods in order to exert influence over doctors in their decision-making. More recently the relationship has been conceptualised within the context of a negotiated order (Hughes 1988, Svensson 1996, Allen 1997), resulting in a less deterministic approach (Svensson 1996).

Allen (1997) proposes that the division of labour between nurses and doctors has had to change to accommodate changes in working practices brought about by reductions in junior doctors' working hours and more latterly EU working time directives. The findings from her observational study revealed that, while a hierarchical relationship remained (doctors believed that nurses needed to work within clearly defined protocols), the nurses themselves would only do what were considered 'extended roles' if they had time, and were conscious of being 'dumped on' by their medical colleagues. Tensions would arise in the working relationship in relation to spatial and geographical boundaries, and specifically having to bleep a doctor to attend the ward. In order to overcome these difficulties the nurses in Allen's study would undertake the 'medical work' in the doctor's absence, but if doctors were present the nurses were less likely to undertake what Allen (1997) termed 'boundary blurring work', which largely involved diagnostic decision making, unless they considered it in the patient's best interests.

Arguably, within the context of A&E work, the geographical and spatial boundaries do not apply, as doctors are a constant presence in the department, while diagnostic decision-making, initially through triage, is recognised as a fundamental aspect of A&E nurse's work. Moreover, hierarchical and professional divisions in A & E have been found to adversely affect patient care in this setting (Boreham et al 2000), thus increasingly within critical care environment such as ITU and A&E interprofessionalism and an appreciation of the role and contribution that each member of the team plays, has become the norm (Boreham 2007) in recognition that rigid and hierarchical approaches to critical care work is inappropriate as such an approach increases risk to patients due to increased risk of error (Boreham et al 2000).

2.4   The Role of Categorisation in the Maintenance of the Negotiated Order

Strauss et al (1964:355) propose that classifying patients is an inherent requirement of doctors' and nurses' work in the maintenance of the negotiated order, as by making distinctions about patients, the institution's 'map' can then be applied, i.e. the most suitable location/destination for individual patients can be determined, allocation involving 'delicate negotiation and careful relationships between the "allocators" [those admitting patients] and ward staff'.

Hughes's (1980, 1988, 1989) ethnographic study of a hospital emergency department examined the contribution of ambulance personnel, nurses and receptionists (respectively) in categorising patients attending A&E. With regards to nurses, Hughes (1988) identified that they were central to this process; consequently nurses were noted to be highly influential in determining the pace and organisation of the department's work, the movement of patients, and the allocation of patients to doctors. In so doing nurses provided doctors with both implicit and explicit cues in terms of their impression of patients presenting problems, as well as potential actions that need to be taken.

Within the same study Hughes (1980) also spent a month at the city ambulance station. He noted that in their interaction with A&E staff, the ambulance men would give cues, which would be picked up on by A&E staff. For example, Hughes observed how, contrary to policy, if a patient was critically ill and in need of urgent resuscitation, the crew would keep their siren going as the ambulance journeyed through the hospital grounds. This indicated to the hospital staff the extreme urgency of the situation. Similarly, if a patient was in the view of the ambulance man dead with no possible chance of being resuscitated, the crew would park the vehicle away from the emergency room entrance, the doctor would then assess the patient on the vehicle so that the patient could, if pronounced dead, be delivered straight to the mortuary rather than admitted to the department. Such practice had previously been witnessed and confirmed by Sudnow (1970) in a US based study. Similarly, as is (in my experience) the case today, when an ambulance crew delivered a patient to the department they would either bring the patient straight to the treatment area, or deliver them to the reception area. By doing so the ambulance crew were indicating that the patient was urgent or non-urgent respectively, decisions that the A&E staff never questioned. Hughes (1980:130) concludes that, having built a picture of the patient when collecting them from a given destination that *ambulance men's descriptions of patients have a clear influence on an intermediate outcome – the patient's initial handling in the casualty department*.

Hughes's later paper (1989) arising from the same study, but focusing this time on the work of casualty receptionists, similarly identifies how the reception staff make judgements about patients, this time in terms of their eligibility for A&E care. Thus

for example the reception staff, while fulfilling a bureaucratic function, also screened out patients attending with old injuries, who were advised to see their GP instead. Moreover, despite having no physical contact with patients, reception staff could at times 'tell at a glance' if the patient was a priority, such examples being, head injuries, bleeding or burns. Hughes (1989) observed that reception staff were not always consistent in their decision-making, but notes that they made their decision with certainty and were rarely challenged by the patients, or indeed the nursing and medical staff.

A key aspect of the receptionist's role noted by Hughes was in keeping order in the queue, and thereby arguably assisting in the maintenance of shape within the department. If patients had visible and distressing symptoms, such as wounds or blood stains, or their behaviour was deemed inappropriate (examples given were patients moaning or patients who were drunk), then the reception staff would be keen to move them on, as they felt this was off-putting to other patients waiting. They also wanted to protect children from these sights and sounds and would wherever possible move children on from the waiting area. Hughes concludes that:

> *"Generally, the conceptions of clientele that reception staff hold, the behaviours they disvalue and the control strategies they adopt are elements of a 'casualty culture' into which clerks must be socialised if they are to become accepted members of the casualty staff"* (Hughes 1989:403).

2.5   Triage – A Clinically Objective Approach to Patient Categorisation?

As outlined above, A&E departments play a key role in determining the 'order' of the hospital organisation, as they are required to manage and place a high volume of patients. The volume of patients attending A&E departments is dependent on a number of factors, including local access to primary care, and the level of deprivation in a given area. Regardless of how many patients attend, the fundamental premise of A&E work is to ensure that patients attending are moved through the department, and as appropriate to individual need, are either discharged or admitted, thereby maintaining the shape of the department. The fundamental premise of hospital emergency work is therefore the classification of patients and their needs. This classification occurs as soon as the patient enters the A&E department, and as mentioned earlier, needs to occur within 15-minutes of the patient's arrival. This

initial assessment is normally undertaken by nurses and is based on the concept of triage.

Triage originated from the battlefield, whereby medical practitioners working in the 'theatre of war' would assess the likelihood of a soldier surviving his injuries and indicate their decision by placing a colour coded card on the wounded soldier's chest. This coding would indicate to stretcher bearers whether the soldier should be left to die, removed for urgent treatment, or could be left, as his injuries were not immediately life threatening or urgent.

Within the context of contemporary emergency care triage is defined as a process of *'determining clinical need as a method of managing clinical risk'* (Mackway-Jones 2007:4). In the UK this is based on the Manchester Triage system developed by a range of experts in emergency care. In making decisions about clinical priorities using this system, the nurse is required to determine 'discriminators' which can be general or specific, which then enables the nurse to identify which of the 5 designated categories the patients will be ascribed to (see Table 2.1). Thus for example pain is viewed as a general discriminator, whereas cardiac or pleuritic pains are specific discriminators and will therefore influence to a greater extent patient priority.

TABLE 2.1

Allocation of Clinical Priorities using the Manchester Triage System

Number	Name	Colour
1	Immediate	Red
2	Very Urgent	Orange
3	Urgent	Yellow
4	Standard	Green
5	Non-urgent	Blue

(Mackway-Jones 2007:18)

In developing the Manchester Triage System the collective experts have devised numerous flowcharts and decision-making trees to assist the nurse in their decision making process, thus suggesting that the process is entirely objective; indeed as Edwards and Sines (2007) point out, triage is based primarily on an assessment of threat to physiological function. Objectivity is important given that it is well documented that nurses and doctors have views about what constitutes appropriate attendance at A&E departments and arguably such views may influence their objectivity when determining a clinical priority. Indeed, Mackway-Jones noted that the Manchester Triage System *"is not designed to judge whether patients are appropriately in the emergency care setting, but to ensure that those who need care receive it appropriately quickly"* (Mackway-Jones 2007:4).

2.6   Accessing A&E Care

The above statement reflects what is seen as a fundamental contradiction of emergency care work (Dodier & Camus 1998, Boreham et al 2000) unrestricted access, resulting a in a large number of attendees, including many who are not ill, or could be more appropriately treated in other parts of the health service. As a consequence of this contradiction, much has been written about what has been termed in-appropriate attendance in A&E departments (Murphy 1998a, MacFaul et al 1998, Sanders 2000). Increasingly though, it is recognised that reasons for inappropriate attendance are complex, and as Byrne et al (2003) et al found, frequent attendees are a psychosocially vulnerable group, reporting poorer mental health, and low levels of social support. It is now increasingly recognised that the label inappropriate belongs to the service rather than the patient (Steel 1995, Walsh 1995, Murphy 1998b, Sanders 2000, Byrne et al 2003). Notwithstanding this, some patients find it easier to access health services than others.

In an extensive review of how vulnerable patients access health services, Dixon-Woods et al (2005) report on a critical interpretive review of the evidence surrounding patient access to health care. As a result of the review they theorise that in order to gain access individuals have to gain 'candidacy'. They propose that, '*Candidacy describes the ways in which people's eligibility for medical attention and interventions is jointly negotiated between individuals and health services*'. (Dixon-Woods et al 2005:6). Candidacy is seen as a dynamic process that is constantly being

defined and re-defined through interactions between individuals and professionals, with a number of factors affecting an individual's (or group's) candidacy. In order for candidacy to be implemented individuals need to be able to identify and evaluate their symptoms, and as a result identify and negotiate appropriate routes to health care. Health care services are conceptualised as being "porous" or 'permeable'. Emergency and out of hours services are classified as 'porous', or more easily permeable, as they do not require appointments, literacy, knowledge or social skills, and are therefore more easily negotiable (Dixon-Woods et al 2005). This, the authors propose, accounts for why people who are deprived and more vulnerable are more likely to access these services, as they do not impose such strict conditions of candidacy, and do not rely on judgements by clinicians about candidacy at an individual level.

Arguably therefore it is the 'porous' nature of A&E services that result in increasingly high level of attendees (Department of Health 2008a, Hospital Episode Statistics 2010, Lothian et al 2010) and which therefore places increasing demands on the service, which then has an impact on how patient throughput is managed. Dodier & Camus (1998) undertook an ethnographic study that examined the patient journey through a French emergency department. They concluded that, *'work in the emergency service can be seen as the task of controlling a variable flow of patients, each of which has a different mobilising worth'* (Dodier & Camus 1998:438). 'Mobilising worth' involved first and foremost getting the attention of the doctors. A number of strategies were employed and were mostly initiated by nursing staff, as attempts by patients themselves to get noticed were found by the researchers to have a high failure rate. The more "appropriate" the attendance was deemed the sooner the mobilisation of resources was seen. The intellectual interest of a case – the extent, to which a case presents a challenge in terms of diagnosis, also influenced mobilisation, a clear correlation between high level of interest and more rapid mobilisation. Consequently, patients who are not necessarily an emergency but who are clinically interesting can have high mobilising worth. Social demands also influenced mobilisation, although this tended to vary according to the attitudes of individual personnel. Nurses and non-specialist medical personnel were more likely to see social demands as worthy of mobilisation (Dodier & Camus 1998).

As noted above, Strauss et al (1964) observed that when a ward became out of shape, some patients who might previously have been seen to 'fit' no longer did, until shape was restored. This finding was later supported by Sbaih (2002) who found that when shape in the A&E department becomes distorted, nurses become more sensitive to the requirements for patients to 'fit'. Consequently some categories of patients, namely those with psychiatric conditions, chronic medical problems, patients who are aggressive, drunk, taking illegal drugs, and those who could have gone to their GP, become more 'undeserving'. In order to get the department back into shape, these patients' needs are re-categorised, and the only group of patients likely to 'fit' are those who are categorised as seriously ill. Sbaih (2002) observed that,

> "a*ll others, particularly those who require supervision for psychological problems, challenge the nurse's ability to manage tensions and troubles caused by balancing the expectation that patients can safely wait against the need to ensure patients receive monitoring and treatment*" (Sbaih 2002:1348).

On this basis Sbaih proposes that categorisation is part of the normal irritation of A&E work and at times an illustration not of moral evaluation, but nurses sensitivity to changes in shape and order. When the department is in good shape, all patients irrespective of reason for attendance receive care with minimal comment.

2.7   Moral Judgements of Patients

Hill (2010) acknowledges that moral judgements are an inherent feature of how we distinguish in our lives between morally good and morally bad, and suggests that just because an individual becomes a patient they are not exempt from these moral judgements, proposing that, '*barring incapacity, patients remain moral agents and retain accountability'; consequently, their behaviour is subject to legitimate moral judgements*' Hill (2010:10). However once an individual becomes a patient, moral judgements are framed around conceptualisations of 'good' and 'bad' patients.

Dixon-Woods et al (2005:6) propose that 'health care organisations often rely implicitly on an 'ideal user', who is *able to match the precise set of competencies and resources to the way in which the service is intended to be used by providers, and whose preferences are in line with the way the service is organised and delivered*', thereby suggesting, as is evident in other literature, that there is a 'model' of an ideal

patient, and by definition the not so ideal, or unpopular patient. Literature that has addressed the labelling of patients as 'good' or 'bad' has focussed on patients' traits/characteristics, clinicians' characteristics, and task and organisational factors (Strauss et al 1964, Kelly & May 1982, Johnson & Webb 1995, Hill 2010).

An illustrative description of what constitutes a good patient, and thus by implication what makes a bad patient, was provided by a participant in a study undertaken by Rosenthal et al (1980:27) (cited by May & Kelly 1982), who described the ideal patient as follows:

> *"Ideally from the nurse's perspective, all patients should be sick when they enter hospital, should follow eagerly and exactly the therapeutic programme set out by the staff, should be pleasant, uncomplaining, fit into the hospital routine and should leave the hospital cured. Good patients handle their illness well, are cooperative, as cheerful as possible, comply with treatment, provide the staff with all relevant information, follow the rules and do not disrupt the ward or demand special privileges and excessive attention"* (May & Kelly 1982:281).

This account makes a number of assumptions about patients, which mirror the assumptions made by Parsons (1951) when defining the sick role, notably that patients can be cured, and know when and how to access care and treatment. It is also apparent from this statement and the wider literature (Hill 2010) that control is an important factor when considering what constitutes a 'good' or 'bad' patient. As the account above illustrates, compliance by the patient is an important element of the good patient's characteristics, and arguably compliance indicates acknowledgement, by the patient, of the doctor's and or nurse's therapeutic skill. Indeed May & Kelly (1982) note from their case study that problem patients are those who deny practitioners' claims to therapeutic competence.

Kelly & May's (1982) review identified that certain illnesses, diseases and symptoms invoked judgements, with self-mutilation, incontinence, long term or serious illnesses, confusion and incapacity and mental disturbance all invoking negative judgements. Hill (2010) refers to this as the 'dirty work literature' so called, as the work *is inherently onerous and often ineffective* (Hill 2010:8). Similarly patients' behaviour

was also found to attract negative evaluations; patients who fail to conform, or who are stubborn, unpleasant, angry, aggressive, drunk or alcoholic have all been found in Kelly & May's (1982) review to attract disapprobation. The patients' social status has also been found to be a factor in determining the extent to which moral evaluations are extended (Hill 2010); drawing on Glaser & Strauss's (1964) work Hill (2010) draws attention to how judgements about terminally ill and dying patients are made, with perceived social loss influencing how patients were viewed. Notwithstanding this, Johnson & Webb (1995) found that patients normally judged negatively could be found to be likeable even where normally ascribed negative labels existed, and that nurses varied in their responses to patients, with individual nurses changing their views of individual patients depending on circumstances.

Kelly & May's (1982) review of the literature identified limitations in previous methodological approaches to determining what constitutes a good or bad patient, and adopted an interactionist perspective to review the nursing role. They concluded that *'patients come to be defined as good or bad not because of anything inherent in them or in their behaviour, but as a consequence of the interaction between staff and patients'*. This social constructionist perspective of interaction between nurses and patients has been endorsed by subsequent research in relation to the nurse/patient relationship (Johnson & Webb 1995, Breeze & Repper 1998, Shattell 2004), with Johnson & Webb (1995) proposing that as distinct from a moral judgement, social judgements are made, a social judgement being '*the judgement of the social worth of persons by others'* (Johnson & Webb 1995:471), this approach focussing on the process by which patients come to be positively or negatively evaluated and how judgements of patients are made when balancing the competing claims on (nurses') time and other resources. Johnson & Webb (1995) and latterly Shattell (2004) drew on Goffman's (1959) theory of 'face work' to conceptualise, in both cases, nurse-patient interactions. This perspective is therefore concerned with how an individual presents them self to another, and in so doing, acknowledges both how the individual wishes to be presented, while accepting that the other has an expectation of how that (same) individual should present, with issues of power fundamental to this interaction.

Much of the literature that looks at interactions and relationships between clinicians and patients does not consider the perspectives of the patient. An exception is the

study by Breeze & Repper (1998) who used an ethnographic approach to identify the patients which mental health nurses defined as difficult; from these descriptions mental health service users were identified and interviewed. Congruent with previous studies, patients who were aggressive, violent and who threatened staff, were deemed and labelled difficult, as were patients with self-harming and destructive behaviours. As noted above, threats to nurses' competence and control were also important characteristics when determining the difficult patient. On the basis of the nurses' responses patients were included in the study if they met the characteristics identified by the nurses as representing difficult patients, which were as follows:

- Does not respond to intervention

- Does not conform (e.g. ignores boundaries or ground rules)

- Primary or secondary diagnosis of personality disorder

- Long-term mental health problem

- Detained under 1983 Mental Health Act

- Multiple and complex needs

- Demanding (of staff, time or resources)

- Disruptive

- Aggressive or violent (to self or others)

- 'Misplaced' on an acute ward.

(Breeze & Repper 1998:1303)

Initially 17 patients met the inclusion criteria for being difficult, however only six were ultimately interviewed, as the remainder were unable to participate for a variety of reasons. What is evident from the patients' accounts is that they often feel powerless; decisions were made in relation to their care and treatment without consultation or discussion, and often they felt coerced into agreeing or accepting admission and treatment. As a consequence of this lack of collaboration and partnership, and their relative powerlessness, the patients respond accordingly. Where the nurses were perceived to demonstrate respect, displayed empathy, held meaningful conversation, and allowed patients to have some meaningful control, these were viewed by the patients as being good nurses, with positive responses in patients' behaviour reported, patients being less likely to respond aggressively. This study therefore re-iterates that the behaviour of patients is influenced by the behaviour of

nurses and, no doubt, other practitioners, and to that end clinicians themselves sometimes create what constitutes a difficult patient.

2.8 Moral Judgements of Patients in A&E

Strauss and his colleagues found that,

> *"to some extent definitions of deviance within the hospital reflect the transfer of moral standards from the outside world, but for the most part, patients' deviance appears to be a function of distributive processes within the hospital"* (Strauss et al 1964:367).

The distributive function of A&E departments has been highlighted above and the requisite need for staff to categorise patients is an inherent part of clinical decision making in order to fulfil this distributive function. However, it is evident that clinicians working in A&E make moral judgements about patients (Roth 1972, Jeffery 1979, Dingwall & Murray 1983, Hughes 1980, 1988, 1989), and arguably the categorisation of patients in A & E forms the basis for moral judgements of patients in this setting.

Accident and emergency work is seen by practitioners as a fundamental experience for the development of expert knowledge and skills, while allowing opportunity to exercise and practice certain technical and practical skills, thereby making these practitioners feel technically expert, with job satisfaction deriving from the use of specialist skills on trauma patients and those who are critically unwell. The unpredictable nature and variety of accident and emergency work, the challenge of managing and responding well in an emergency situation and the feeling of working closely as a member of a team, are all seen as benefits of working in this field of practice (Jeffery 1979, Lewis & Bradbury 1982, Byrne & Heyman 1997, Cronin & Cronin 2006). Consequently patients who do not live up to these expectations are more likely to be adversely judged. This is reflected in the literature surrounding inappropriate attendances whereby patients who are neither an accident nor an emergency are seen by staff as time consuming, unrewarding and irritating with staff less inclined and motivated to help these patients (Dodier & Camus 1998, Murphy 1998 a & b, Sanders 2000, Olsson & Hansagi 2001).

Jeffery (1979) undertook a participant–observation study of three A&E departments in order to examine how staff categorised patients. He identified that doctors distinguished between 'good' (or 'interesting') and 'bad' (or 'rubbish') patients. The former allowed doctors to develop and practice the skills required to enable them to pass professional examinations; the latter were mostly 'trivia' (minor ailments or injuries not needing attention), overdoses and tramps. He proposed that 'bad' patients broke one or more of four rules; they must not be responsible for their illness; patients should be restricted in their reasonable activities by the illnesses they report with; they should see illness as being undesirable; and should cooperate with agencies in trying to get well, this being analogous with Parsons' (1951) definition of the 'sick role'.

In addition to the debates around appropriate attendances, other factors surrounding patients attending A&E also influence how they are perceived. Roth (1972) was one of the first to observe that emergency care staff had negative attitudes to what they (the staff) termed 'deviant patients', these moral evaluations being based on negative social stereotypes. Thirty-five years later, with triage firmly established as an objective approach to the systematic assessment of patients, Edwards & Sines (2007) found that nurses start the process (of triage) without actually talking to patients, using visual cues in the first instance, around for example how patients and their families are dressed, how they are behaving and whether or not the behaviour accords with the story of the illness or injury, the patient being an active agent in presenting and constructing their problems and reasons for attendance. They conclude that,

> *"triage can, alternatively, be regarded as a performance whereby triage nurses act as an adjudicating panel judging the clinical data before them through the appraisal of the way patients act out their problems and narrate their stories"* (Edwards & Sines 2007:2).

Of particular note and relevance to this study, is how patients who are drunk, who take overdoses and who are abusive are widely seen as being unpopular by A&E staff, with psychiatric patients being synonymous with problem patients (Jeffery 1979). Moreover, while patients who intend to commit suicide are seen as legitimate users of emergency services, those who self-harm or attempt suicide have always been more negatively evaluated, their actions (and omissions) being compared unfavourably with patients who do complete or displayed serious intention to complete suicide

(Cresswell & Karimova 2010), a theme that is returned to in the next chapter when discussing self-harm.

2.9   Do Judgements Extend to Children and Young People Who Attend A&E?

Dixon-Woods et al (2005) found that there is a very high use of emergency services among children. However, while the literature is replete with debates around inappropriate attendance in A & E, only one paper, (Prince & Worth 1992), has been located which specifically examines inappropriate attendance of children. Dixon-Woods et al (2005) propose that unlike adults, the nature of children's candidacy is often contested at different levels. On the one hand, children's attendance is "*indulged... because of the claim to candidacy implicit in children's vulnerability*" (Dixon-Woods et al 2005:204). Arguably therefore children and young people are viewed differently to adults and thus labels such as 'inappropriate', 'deviant', 'trivia' or 'rubbish' are not applied. For instance, in Hughes's (1980) observations of the ambulance service he noted that ambulance crews would drive faster when knowingly attending to babies or children. Likewise in Sudnow's (1970) study he observed that ambulance crews who were transporting a child or young person who although likely to be 'dead on arrival' would turn their sirens up loud and keep them going even when the vehicle had stopped; the crews' demeanour would be more frantic and their speech was more 'excitable', practices not observed when transporting adults who similarly were likely to be assessed as deceased.

Dixon-Woods et al (2005) found that young people (as distinct from children) represented a neglected group in terms of being the subjects of research, or focus in relation to the literature on accessing healthcare. As they note, young people are particularly vulnerable both as a result of an increased propensity to participate in risk taking behaviours, and at the same time they lose their health advocates by rejecting their parent's involvement in matters relating to their health. As a consequence of this, young people are left to navigate and negotiate their own way into our health care systems, and have been found to have low use of permeable services such as the GP, possibly, they postulate, because of the barriers young people may face when trying to access health care without their parent's presence.

There is also evidence that young people are not always perceived in the same way as children, and are therefore judged and treated differently. Hughes (1980) found that, regardless of the age of the patient, the ambulance crew would commonly elicit information from either the patient or other relatives/witnesses at the scene of an accident, or location to which they had been called, from which they would begin to 'build a picture' of the patient. However, when a crew had a negative attitude, they asked fewer questions, basing the picture on potential social stereotypes. One example Hughes uses to illustrate this is a call to a 'youth' who had hurt his back outside a pub. The crew assumed that the youth had been involved in a fight and circled the area until the police arrived, thus in this case speed was not of the essence. Moreover, despite being given accounts by the young man's friends of how the injury occurred, the crew did not examine the young male (who was later found to have fractured his femur), the crew member advising Hughes that there was no obvious injury.

The invisibility of children in research that has examined categorisation in A& E departments is noted by Dingwall & Murray (1983) who therefore set out to 'take children seriously', by reviewing previous analyses of patient classification to determine whether such labels applied to children. Their work is based on a critique of Jeffery's (1979) work, which they propose is based on an inconsistent and flawed approach to assigning the labels 'good' or 'bad', on the basis that merely complying with the rules broken by 'bad' patients, does not necessarily make a 'good patient'. They also argue that Jeffery's reliance on commonsense conceptions of deviance as developed by McHugh (1970), is limited. Dingwall & Murray's (1983) ethnographic study was located across four emergency departments in three English local authority areas. Data collection involved a period of observations followed by interviews, although the observation period was relatively short having been terminated early, for reasons not given by the authors.

On the basis of their analyses from their fieldwork Dingwall & Murray (1983) propose that if employing Jeffery's approach, children would seem to consistently break the rules, and should therefore be deemed as 'bad' patients. They break the rules because in many instances children are responsible for their own injuries, as they are caused by an act of omission or commission. Many of the injuries do not restrict the child's normal activities, and while children do attend with serious injuries, the

minor nature of the majority of injuries, i.e. the 'trivia,' is not commented on when displayed by children. Children are not consistent in their response to injury, some were observed to make a disproportionate 'fuss' to an injury while others observed with more serious injuries, were noted to be not unduly concerned. Finally children are often, notoriously uncooperative. On this basis Dingwall & Murray (1983:134) argue that, *"children fit the commonsense criteria of bad patients at least as well as drunks, overdoses, tramps or trivia",* and propose that although children break the rules, they are not held responsible. Staff were also observed to ameliorate the effects of 'rule breaking' by, for example, containing the children, keeping them happy and processing them through the department more speedily; thus rather than being 'punished' the children's treatment corresponded with McHugh's (1970) notion of rehabilitation.

While Dingwall & Murray (1983) provide an explanatory framework for the process of categorisation, which builds on that of Jeffery (1979) and explores the underlying social processes that lead to such categorisations, what they fail to fully address is why the staff responded differently to children. They allude to the fact that children have 'mandatory preciousness', but this is not explicitly explored with participants. Dingwall & Murray (1983) highlight that while it might be supposed that judgements made by staff in relation to 'good' or 'bad' might pass to parents, they generally found this not to be the case, as it was accepted by staff that parents would (or indeed should) be concerned about their children, as "adults are required to treat children as especially precious" (Dingwall & Murray 1983:137).

Dingwall & Murray (1983:143) suggest that 'mandatory preciousness' is associated with 'reverse social loss calculus'. Glaser & Strauss used the term 'social loss calculus' to illustrate how nurses and doctors made different judgements about (dying) patients, based on their perceived value to society, with certain traits and characteristics attracting perceived high social loss. Indeed Glaser & Strauss (1964:119) propose that age is the single most important factor in determining the level of social loss, thus children are considered to have a high social loss. Nevertheless, other factors and traits also come into play, thus for example while young people have high social loss as they still have a life to fulfil, an adolescent on the verge of death having killed others in a car crash, and who is considered

blameworthy, will be seen and treated differently to, for example, the victim or a young person dying of cancer (Glaser & Strauss 1964). Low social loss was found to result in these patients receiving less than routine care, due to an "it's their own fault" rationale (Hill 2010).

As age is a significant factor in the social loss calculus, Dingwall & Murray (1983) suggest that even in those children where, if they had been adults, they would have attracted low social loss, this is not applied to children, in part because their parents 'could make trouble', and also because as 'pre-theoretic actors' they could not be appealed to. However, this was not applied to young people, as illustrated in the case of a teenage boy who Dingwall & Murray (19833:138 called 'the young pretender'. This young boy was a repeat attendee and was described as having a 'thick brown file' rather than a 'sheet of paper'. The medical staff did not treat the young boy as a priority, and dissuaded a junior nurse from responding sympathetically towards him when she offered the young boy a pillow to rest his injured ankle on. In this instance the young boy was judged on the basis that at his age he should have known better i.e. able to determine when an injury or ailment needs medical attention; similarly the mother was adversely judged because she both allowed him to injure himself, and then brought him to the A&E department despite having been previously advised not to unless a serious injury had occurred. He was not therefore ascribed as having the innate preciousness attributed to children, and while Dingwall & Murray (1993) note that the young boy was an exception, it would appear he did not have a high social loss calculus.

White's (2002) subsequent ethnographic study examined social relations and case formulation in an integrated child health service, the service comprising acute paediatrics, community child health and child & adolescent mental health services. Her study illustrates the complex sets of interactions that contribute to mutual understanding and agreement of the nature of 'the (paediatric) case'. In formulating the case White (2002) observed that, necessarily, patients were categorised, but in line with the findings of Dingwall & Murray (1983), she observed that children are exempt from classification as 'bad patients'. Any negative traits being ascribed to their underlying medical condition, their parents, or some other relevant aspect of their past lives. Moreover White (2002) also found that exemption from categorisation

as 'bad patients' extended to and included young people, including those whose behaviour breached moral codes, citing as an example young people who had self-harmed or whose behaviour potentially harmed others (White 2002).

2.10   Summary

This chapter has examined the conceptualisation of A&E work as an influential component in the maintenance of the (hospital as a) negotiated order (Strauss 1964). Central to the preservation of a negotiated order is the maintenance of shape, which in the context of emergency care work is ensuring that the distributive function of the A&E department is performed. In distributing patients, practitioners necessarily categorise patients in terms of clinical priority, however priorities change in order to maintain shape and are also influenced by variations in professional ideologies and concomitant variations in approaches to patient care across professional groups.

While patient categorisation might be an inherent part of determining the distribution of patients, it is not wholly objective, with conceptions of ideal service-users influencing how patients are prioritised, with moral judgements of patients evidently made. This has been conceptualised with reference to the debates around the 'good' and bad' patient and in so doing has drawn on seminal research that has provided insight into the social processes that underlie this categorisation in A&E. The extent to which categorisations extend to children and young people has been considered, with evidence that there are contradictory perspectives on whether young people as a distinct category are perceived and thus judged in the same way as children.

CHAPTER THREE

CONCEPTUALISING CHILDHOOD/ADOLESCENCE

3.0   Introduction

The previous chapter drew attention to the fact that, within the context of emergency care, children and young people can be perceived and thus treated differently from adults, and are seemingly less adversely judged when presenting with problems that in adults would otherwise be viewed as 'minor', 'trivia' or 'rubbish' (Dingwall & Murray 1983). Dingwall & Murray (1983:144) made reference to children having 'mandatory preciousness', this preciousness meaning that the 'social loss calculus' (Glaser & Strauss 1964) is reversed as children are necessarily seen to be valued as patients; moreover the tactics used in managing the care for those with low social loss calculus would be inappropriately employed in the care of children. Dingwall & Murray (1983) proposed that children's status as patients was at the level of 'pre-theoretic actors'; this status was associated with lack of agency and thereby afforded children, and (to a lesser extent) young people exemption from the same degree of adverse moral evaluation that adult patients attracted.

This chapter considers how children and childhood and young people/ adolescence is conceptualised. As noted in the introductory chapter, this will largely draw on a sociological perspective, and in so doing considers the relationship between agency and children as 'beings' (rather than 'becoming's'). The chapter does not consider the position of childhood from a psychological/developmental perspective, other than to consider historically how the emergence of adolescence as a biological and developmental phase of life has resulted in stereotypes and arguably, myths, surrounding young people and their behaviours. The resultant opposing framing of young people as 'deviant' and the more recent framing of young people as vulnerable, will be outlined, and their basis explored.

3.1   Conceptualising Childhood – A Sociological Perspective

Over the past two decades there has been increasing interest in locating the study of childhood as a distinct and separate phase of life, with proponents of the sub-discipline of the sociology of childhood advocating that children and childhood be

studied sociologically in their own right (James & Prout 1990, 1997, James et al 1998). Theorising of children and childhood by these proponents is based on a critique of socialisation theory (James et al 1998), as epitomised in the work of Parsons (1951) who created a universal picture of childhood, which was seen as a time for assimilating the norms and values of society in preparation for a meaningful [adult] role within society (Lee 1998, 1999). Proponents of the 'sociology of childhood' have countered this universalistic viewpoint of childhood and as a consequence, although the paradigm that emerged has a number of key features, its centrality lies in the fact that childhood is understood as a social construction, and draws on the twin dimension of *'childhood as a structural feature of societies and as a context of children's everyday lives'* (James et al, 1998:201).

The reference to childhood as a structural feature of society in the context of children's everyday lives reflects the central debates within sociology of structure versus agency. James et al (1998) note that structure within a sociological context has become incontestable, a factor similarly noted by Sewell (1992). Sewell (1992), drawing on Giddens' (1984) earlier work, proposed an alternative theory of structure which gave more credence to the notion that human agency can both be empowered by and thereby transform structure(s). Sewell sees agency as being a constituent of structure and proposes that,

> *"agency arises from the actor's control of resources, which means the capacity to reinterpret or mobilise an array of resources in terms of schemas other than those that constitutes the array. Agency is implied by the existence of structures'* (Sewell 1992:20).

Sewell acknowledges that while all humans exercise some agency, this might not be uniform and will, from a cross cultural perspective vary across societies, according to for example gender, wealth, social class and other categories. However age, as a social category, is not explicitly made reference to.

James et al (1998:201-202) note similar tensions within the debates between structure and agency; within the context of childhood they propose that (historically) it is adult society that constitutes the structure, and the child the agent, with the former socialising the latter. The rejection of the notion of the child being a passive recipient

of socialisation into the adult world sits at the basis of James et al's (1998) re-evaluation of the location of childhood, and development of the sociological conception of the child, a movement from the 'becoming' (adult) to the 'being' (here and now) child. Lee (1998:469) observes that, "*to decide that children are 'beings' is to return agency to children as their rightful possession";* by possessing agency children are able to both shape and be shaped by, social structures (James et al, 1998). Thus within this paradigm, children are no longer considered to be passive recipients of adult socialisation processes, but are instead active agents in shaping their own childhoods.

James et al (1998) outline the four sociological approaches to the study of childhood that have emerged as a consequence of these critiques. Firstly as noted above, childhood is conceptualised as a social construction. This perspective arises largely from the work of Aries (1962), which, although criticised by Hendrick (1997) and others for lacking academic rigour, is widely cited; its central theses is that in medieval times childhood did not exist, children were an extension of their parents/family, seen as miniature adults, with childhood as a concept only emerging around the 17th century. Latterly Qvortrup (2005) has drawn on Aries' (1962) analysis to illustrate the paradoxical situation whereby, when childhood did not exist children were more visible, their visibility more apparent because they inhabited their parents (adult) world. Now that childhood, as a time related period, is increasingly recognised, so does children's invisibility increase, their invisibility from the adult world being due to their segregation into their children's worlds, whether through nurseries, playgroups or schools.

Secondly, children have been conceptualised as 'tribal', where "*children's difference is honoured and their relative autonomy celebrated"* (James et al 1998:29) and in so doing the relationship between adults and children is re-appraised, with a view to "taking children seriously", as was Dingwall & Murray's (1983) intention when embarking on their study of how children were categorised in A&E departments. Children are seen as a social group worthy of study in their own right, studies being based on children's ontological viewpoint. Children are also conceptualised as a 'minority group' (James et al 1998), which drawing on earlier feminist

analyses/approaches, challenges power relations between adults and children and draws attention to other areas of discrimination, politicising the study of childhood.

The final perspective on the study of childhood is what James et al (1998) term the 'social structural child'. This perspective adopts the stance that children are a universal category (whereas childhood is not a universal experience) with a number of characteristics in common, characteristics that can and should be accounted for in empirical population based studies.

By and large, drawing as it does on its roots in social anthropology and sociology, the proponents of the sociology of childhood employ ethnography as the methodology used to study childhood, as exemplified in the work of Mayall (2001, 2002) and Christenssen (2004), both of whom have applied their work to aspects of children's health (Mayall 1998, Christensen 1998). Much of the research undertaken by proponents for a sociology of childhood focuses on primary school age children (for example Prout 1986, Mauthener 1997, Mayall 1998, Christensen 1998, Prout et al 1999) which potentially ignores the complexities associated with adolescence as a transitional phase of young people's lives, and how they therefore construct their reality. James et al (1998) in their theorising on childhood do not specify what they define as childhood from a chronological (i.e. age) perspective. Indeed they see age as 'time passing' rather than a categorical unit, age is relational and generational and they are therefore critical of age as a (hierarchical) category (Lee 1998).

Clearly though there are developmental differences between children and adolescents, which are, biological, social and emotional, differences which influence how children and young people behave and, possibly, are perceived, which due to the socially constructed nature of both childhood and adolescence can change over time. This is evident in the 'demonisation' of adolescents, with more general 'concerns' about childhood, (both of which are explored further in 3.3 and 3.4 respectively). This has a concomitant effect on the structures within society that govern how children's lives are structured and managed (Moran-Ellis 2010).

3.2   Perspectives on Adolescence

Heath (1997) encapsulates the difficulties associated with defining and locating adolescence. He comments that,

"adolescence... if it coincides with puberty, it seems, unlike puberty, to have no obvious beginning or end, running back into childhood and forward into adulthood with no clear start or finish and, concomitantly no particular existence" (Heath 1997:22)

While childhood is increasingly recognised as a social construction, the term adolescence has until more recently remained largely associated with biological and psychological developmental perspectives, with adolescence defined in relation and opposition to, adulthood (Lesko 2001).

The perspective of adolescence as biologically and psychologically determined arises from the early seminal work of Hall (1904) who arguably, normalised this period of the lifespan. Hall (1904) coined the phrase "storm and stress' when describing the period defined as adolescence, citing the onset of conflict with parents, mood changes and fluctuations and risk taking behaviours as being illustrative of this period. Hall's basis for his theory was that adolescence (and resultant behaviour of adolescents) arose out of evolutionary processes, a perspective that was subsequently supported and endorsed by Anna Freud (Freud 1946, 1969). This and Hall's views on sexual development and in particular masturbation have since been wholly dismissed, as has his emphasis on religious conversion (Saltman 2005, Arnett 2006). Notwithstanding this, Hall's observations about adolescent behaviour in particular have some resonance with contemporary beliefs about adolescence and as Baizerman (1999) notes, the terms adolescence and adolescent are part of our 'natural language', and have come to be used as a metaphor for what we expect and how we have come to view young people, with adolescent characteristics imbued with inherent meanings (Saltman 2005).

As Kehily (2007) notes, other eminent theorists, including developmental psychologists such as Winnicott and Erickson, have added to the body of knowledge of adolescence as a stage of development. Increasingly though, adolescence is also conceptualised as a social construction. In a similar vein to proponents of a sociology of childhood, those who identify with adolescence as a social construction (Lesko 1996, 2001, Saltman 2005, Montgomery 2007) cite anthropological/ ethnographic studies, and employ the terms 'youth' or 'young people' to denote the interest in the

'social' context of young people's lives, an approach that has been particularly relevant in studying youth sub-cultures (Kehily 2007).

Lesko (1996, 2001) proposes that historically there have been four 'professionalized' definitions of adolescence/youth apparent, each based on the perspective of the individuals or groups defining and discussing adolescence. Thus from a medical and social science perspective youth or adolescence is seen as a universal concept analogous to that of Hall's description, with biological (hormonal) and behavioural (psychological) elements of youth at the forefront of such conceptions. A second category identified by Lesko (1996) is that of youth as a social problem, which cites adolescence as a period when young people have a propensity towards violence, pregnancy and motherhood, school drop-out and 'other deviances'; therapeutic perspectives see youth as victims and (mental health) patients and the final 'rights' based perspective opposes the notion of the 'child as property of the parents'. Through her historical and literary analysis she highlights how the 'modern story' of adolescent development has resulted in a trivialisation of adolescence and the emergence of stereotypes (Lesko 2001).

3.3   Young People as Deviant

As Clinard & Meier (2007) note, a plethora of behaviours have been cited and studied on the basis that they have at one stage or another been identified as being deviant with no consensus evident in what constitutes 'normal' or 'deviant' behaviour. Consequently sociologists have been concerned with determining how behaviours come to be labelled as deviant and the implications of this for the individuals or groups so labelled (Becker 1963, 1974, Cohen 1972).

Becker's (1963) seminal work on deviance coined the term 'outsiders', 'outsiders' being external to 'insiders' or core members of a social group. Becker (1963) proposes that 'insiders' decide what constitutes the rules of the group; those who break the rules do not have, or lose, membership of the (dominant) group, thereby becoming 'outsiders'. He acknowledges that those considered 'outsiders' might not themselves see their own behaviour as being deviant, and as a consequence they might counter the dominant perspectives of the group(s) that created the 'rules'. Becker (1963) illustrates this by citing as an example how young people have rules

about, for example behaviour, decided for them by adults, which in itself creates potential for tension between adults and young people, as young people might not agree with adults about what constitutes good or appropriate behaviour. The decision as to how young people should behave is imposed upon them, as *'youngsters are considered neither wise enough nor responsible enough to make proper rules for themselves'* (Becker 1963:17).

Given the increasing focus on young people's agency (James et al 1998) and the more recent perspective of young people's rights (Lee 2001), Becker's stance would increasingly be contested, although arguably young people remain relatively powerless as they are not a group who are empowered to make the rules unless adults so choose, thus their behaviour is still judged with reference to what adults consider and define as normal and acceptable for young people (Lee 2001).

Having prescribed behaviour codes imposed upon young people can inevitably lead to disagreement between adults and young people, particularly given young people's (developmental) needs to form a separate identity from adults (Brewer & Hewstone 2004), thus young people's failure to conform to adult's prescribed notions of good behaviour can result in some of their behaviours being labelled as 'deviant'. Indeed, Greig et al (2007) observe that young people have historically been viewed as problematic as,

> *'the morals, values and standards of adolescents has (sic) long been a subject which has fascinated researchers'* (Greig et al 2007:12).

Similarly as Reicher & Emler (1995:15) observe, each generation (of adults) holds a nostalgic view of previous generations of young people, but as they note, if today's generation were to examine the previous generation they would find that the same fears and nostalgia existed as we find today.

As noted above, the term adolescent has become enshrined within our language and culture, and is still associated with the initial 'storm and stress' model as depicted by Hall (1904). As a consequence, stereotypes of young people's behaviour result, which in turn affect perceptions of young people and their behaviour and through negative reinforcement young people may respond by demonstrating behaviours as anticipated

by adults. This is reflected in research undertaken by Snyder et al (1977) who acknowledge that social stereotypes are inaccurate, being based on simple over-generalisations, but nonetheless arising as they do from visible and distinctive traits they serve to bolster and reinforce the social stereotype. They undertook research which demonstrated that by reinforcing the stereotype of physical attractiveness the stereotyped individual would come to see themselves as stereotyped, i.e. physically attractive. They concluded that,

> *'our research suggests that stereotypes can and do channel dyadic interaction so as to create their own social reality'* (Snyder et al 1977:663).

This perspective is similar to the sociological analysis of labelling theory whereby those who are labelled as deviant, are more likely to respond and behave in a way that conforms to the label (or stereotype) reinforcing the 'labellers' perception that that person or group is in fact deviant.

Social psychology theorists, in a similar vein to Becker (1963), make reference to 'in-groups' and 'out-groups' when discussing social categorisation. Brewer & Hewstone (2005) propose that through stereotyping, individuals are making sense of inter-group comparisons, thus stereotyping can be seen as functional. Reicher and Emler (1995) studied delinquency as a form of deviance in adolescents and found that delinquency could not be ascribed to young people on the basis of sociological or demographic factors such as class or ethnicity. Their research found that contrary to expectations delinquent white working class males were no different to their non-delinquent peers in respect of IQ, personality traits such as neuroticism and extroversion, moral insight or social skills, however young people themselves when presented with admissions and denials of delinquent acts, purported to have been carried out by young people (aged 12 – 16 years of age), subscribed to stereotypical notions of delinquency. For example, the young people participating in the research perceived that young delinquent males were more likely to be dishonest, unreliable, irresponsible and selfish, lazy, unintelligent, strong, tough unemotional and cruel (Reicher & Emler 1995:25). Reicher & Emler (1995) propose that delinquency can become the 'norm' for a young person's peer group, this being interrelated with representation of (group) self, with certain advantages being perceived by the group presenting themselves in a deviant mode, as well as enabling the establishment of a group identity.

The media often promote stereotypes of youth in the way in which they report and give coverage to young people (Porteous & Colston 1980, Falchikov 1986), with anti-social behaviour over emphasised and sporting achievements and issues related to the consequences of unemployment under represented (Falchikov1986), resulting in intermittent 'moral panics' (Cohen 1972). The current moral panic about young people's behaviour is reflected in media accounts of young people as being criminally inclined as evidenced in recent research which found that 4,374 out of 8,629 stories about teenage boys covered in the UK press focussed on crime, with the most commonly used term to describe boys being "yobs" (Bawdon 2009). Similarly a study undertaken by the National Children's Bureau and National Youth Agency (Clark et al 2007) found that young people were resentful of the way in which the media portrayed them, and in particular the way that young people from ethnic minorities were represented. Young people themselves were not given an opportunity to present their perspective, an observation previously made by Giroux (1996) who highlighted how all forms of media (not just news) represent young people as violent, Giroux's (1996) work adding a racial dimension to the analysis.

Clark et al's (2007) study, which drew on the perspectives of young people through consultation events, an on-line survey and focus groups, as well as reviewing news stories over a two-week period, found that the most common stories associated with young people were around knife crime, followed by gun crime and violent crime. Stories about teenage pregnancy, school and education and drugs were also commonly reported. As a consequence of the media representation of young people as deviant, the young people themselves reported that they were wary of other teenagers, such reporting having altered their own perceptions of self. Of particular note was how the media generated (negative) stereotypes of young people cause young people themselves to believe that no matter how they behave or present as individuals, adults would judge them adversely. This is particularly relevant to this study as young people in general, and specifically young people who self-harm, are reluctant users of health care, particularly mental health services, due to fear of stigmatisation (Biddle et al 2007, Rickwood et al 2007), and while such fears might be misplaced a study undertaken by Offer & Howard (1981) involving 62 mental health professionals

found that the health professionals viewed the 'normal' adolescent as significantly more disturbed than the young person viewed themselves.

Wright & Taylor (2007) note that much of the social psychology work examining stereotyping and prejudice has focussed on members of the dominant group without due consideration to how the dominant group interacts with the disadvantaged (or out) group. How the dominant group (health care professional/adults) interacts with the disadvantaged or 'out' group (young people who self-harm) is particularly relevant to this study, given that self-harm and suicidal behaviours are themselves considered deviant behaviours, which as discussed further in chapter four, meet with disapproval from health care professionals eliciting negative sanctions (Clinard & Meier 2007:27).

3.4   The Death of Childhood

A number of theorists and commentators have both lamented and debated the 'death of childhood' (for example, Postman 1982, Winn 1984, Heath 1997, Buckingham 2000, Elkind 2001, Aitken 2001, Abbs et al 2006, Darbyshire 2007). Much of the blame for this demise is laid at the door of the media, including television (Postman 1982, Winn 1984), books (Winn 1984, Elkind 2001) and more recently computers (Buckingham 2000). As Darbyshire (2007) observes much of the rhetoric about the death of childhood is viewed through a nostalgic lens, its proponents assuming that childhood is a universal experience, whereas for many children in the world childhood has never existed, with many children experiencing homelessness, brutality, conflict and exploitation (Darbyshire 2007:86).

The bases for these debates do though centre round children and young people's behaviours, particularly 'un-childlike' and violent behaviours" (Aitken 2001, Darbyshire 2007). With regards to the latter, Heath (1997) proposes that in a UK context, childhood died at 3.42 on the 12th February 1993 in Bootle when two ten-year old boys took Jamie Bulger from a shopping centre to his death at a nearby railway embankment (Heath 1997:25), an event that was captured on CCTV and generated worldwide media interest, condemnation and disapprobation. While this is an extreme example of the 'violent child', as noted above there has been a propensity for media coverage to focus on the violent crimes perpetrated by young people, but commentators (for example Postman 1982, Giroux 1998, Abbs et al 2006) have also

cited the increasing sexualisation of childhood as a further example of how children and young people are growing up too fast and in essence missing out on childhood. The sexualisation of childhood arises partly a result of children and young people's increased capacity as consumers because of the internet, and partly due to a cultural shift brought about by changing parenting practices, as parents increasingly have reduced amount of time to spend with their children and therefore mitigate this by spending money on them (Buckingham 2000, Aitken 2001, Darbyshire 2007) .

The demise of childhood has also located children and young people as victims; a letter to the Daily Telegraph (Abbs et al 2006), signed by 110 academics, writers and 'medical experts' proposes that 'modern life leads to more depression among children'. The collective experts suggest that technological and cultural changes as well as poor diet, lack of exercise, pressures of school and schoolwork, as well as the aforementioned sexualisation of childhood have all contributed to this increase in depression. Darbyshire (2007) also draws attention to how children are now limited in their freedom to play outdoors, or walk to school due to the perceived threat of 'stranger danger', and parental pressure to 'perform' well academically. The current epidemic of childhood obesity is also cited as a symptom of children's lack of freedom and childhood's demise (Darbyshire 2007). Thus while young people's anti-social behaviour might dominate debates around youth, a more recent conception of young people as vulnerable has emerged.

3.5   Young People as Vulnerable

Age, both in terms of old and young, is frequently associated with vulnerability, the old and young in society being viewed as in need of protection as both generations might lack capacity to make decisions, and both elderly adults and children require safeguarding to protect their interests (Hurst 2008). However, it might be argued that children are more highly valued than older people, as discrimination against older people on the basis of ageist attitudes is widely acknowledged to occur. A plethora of literature exists which has examined attitudes towards older patients, culminating in a meta-analysis (Kite et al 2005), with a replicating study undertaken by Tornstam (2007) revealing that negative stereotypes and misconceptions have improved minimally over a 23 year period. This body of literature has sought to determine whether ageist attitudes exist, ageist in the sense that the older person is discriminated

against on the basis of negative stereotypes as well as societal values which promotes youth i.e. being young is seen as being more desirable than old age (Kite et al 2005, Hagestad & Uhlenberg 2005). No such equivalent body of literature exists in relation to young people.

The shift towards young people as victims and therefore inherently vulnerable is, as with the antithetical discourse of young people as deviant, reflected in media headlines which as noted above, have highlighted the stress associated with exam pressures, concerns around the impact of early sexualisation and sexual behaviour in young people (Abbs et al 2006, Coy 2009, Papadopoulos 2010) and the increasing prevalence of mental distress in young people (Green et al 2005).

Indeed in relation to young people's mental health, evidence has revealed that 10% of young people residing in the United Kingdom (UK) suffer from a diagnosable mental illness (Green et al 2005), with 80,000 young people in the UK suffering severe depression and 8,000 children under the age of ten also suffering severe depression (Office for National Statistics 2004). Moreover as is discussed further in Chapter 3 the prevalence of self-harm in young people continues to rise (Fox & Hawton 2004, Brophy 2006).

Concerns about the health and wellbeing of young people in the UK are evident. A recent report from United Nations Children's Fund (UNICEF (2011) calls for more investment into adolescent health to address the cycle of deprivation and poverty and inequality, while an earlier report (UNICEF 2007) identified that the United Kingdom was in the bottom third of the rankings for five out of six of the dimensions of [young people's] health and well-being measured; indeed the UK had the lowest overall ranking of the 21 'rich' countries assessed, and in two of the six dimensions, family and peer relationships and behaviours and risks, the UK recorded the lowest ranking scores (UNICEF 2007:2).

Similarly, the Institute for Public Policy Research acknowledges UK society's concern with the state of the nation's 'youth' (as reflected in the media, academic and policy circles) they note that:

'commentators fear that British youth are on the verge of mental breakdown, at risk from antisocial behaviour, self-harm, drug and alcohol abuse. These concerns are, to an extent borne out in IPPR's findings and other research' (Margo & Dixon 2006:vii).

3.6   Locating Adolescence/Adolescents in UK Health Services

The perceived vulnerability of young people is evident in UK health care, research, policy and practice and is largely associated with children/childhood as an age category, one that is generally guided by the UN Convention on the Rights of the Child which defines a child as *"a human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier' (UNICEF 1989).* The National Service Framework (NSF) for children, young people and maternity services (DH 2004a), therefore defines children and young people as follows:

> *'the term child is used ...to include babies and children, and 'young person' to cover older children and young adults. However, 'child'/'children' is frequently used as shorthand to cover all under 19s* (Department of Health 2004a: 18).

Contradiction and ambiguity around children and young people's health care are though evident, with inconsistency as to when paediatric services end apparent, which is particularly exemplified in paediatric urgent and emergency care. Of note and particular relevance to this study is the most recently published report by The Royal College of Paediatrics & Child Health (2011), which explicitly states that the purpose of the report is, *'to set clear standards and guidance for service planning and commissioning of urgent and emergency care services to patients 0-16 years'* (Royal College of Paediatrics & Child Health 2011:1). However, it draws on what is colloquially known as the 'red book' (Royal College of Paediatrics & Child Health 2007), a key publication which provides the benchmark for standards in relation to urgent and emergency care for children and young people, children and young people in this guidance being considered up to the age of 18 (Royal College of Paediatrics & Child Health 2007).

Similarly, best practice guidance for urgent and emergency care pathways in children and young people published by The National Health Service Institute for Innovation and Improvement (2008) does not stipulate the age of the 'young person,' although much the data it draws on is pertinent only to children and young people up to the age of 16. This ambiguity is further evident in data that looks at paediatric admissions through emergency departments. Statistics collated by the Department of Health (2008a) reviews emergency admissions of children and young people up to the age of 19, whereas research studies which have examined trends in paediatric emergency attendances consider children up until the age of 15 (Armon et al 2000, Downing & Rudge 2003, Kyle et al 2011).

This contradiction as to when childhood/adolescence ends is particularly relevant to this study as a further set of guidelines also evidence inconsistency. The National Institute for Health and Clinical Effectiveness guidelines (NICE 2004) on short-term management of self-harm distinguish between adults and children, recommending that a young person under the age of 16 be admitted to a paediatric ward following an attendance at an A&E department; no such recommendation exists for adults. Requirements for those aged 16 – 18 years of age are not explicitly addressed in the guidelines, thus it could be assumed that in this context a young person aged over 16 years of age be considered and managed as an adult. Nevertheless, the NSF standard nine (Department of Health 2004b) which addresses child and adolescent mental health makes it clear that, *'child and adolescent mental health services are able to meet the needs of all young people including those aged sixteen and seventeen* (Department of Health 2004b: 5)

Historically hospitalised children were viewed as miniature adults, children admitted to hospital wards alongside adults, thus it has been the need to identify and distinguish children and young peoples' specific needs as distinct from adults that has exercised researchers, practitioners and policy makers within paediatrics and child health. The 'Platt Report' (Ministry of Health 1959) was the first report to make recommendations concerning the provision of separate inpatients facilities for children including dedicated children's wards, appropriately qualified staff, play facilities and education for the hospitalised child. Progress in achieving these recommendations was slow, as reflected by the need to restate them in the NSF

(Department of Health 2003b), although the value placed on children and young people is now implicit within health policy (Department of Health 2003b, 2004a) and explicitly stated by Professor Al Aynsley-Green:

> *Children and young people are important. They are the living message we send to a time we will not see[2]; nothing matters more to families than the health, welfare and future success of their children. They deserve the best care because they are the life-blood of the nation and are vital for our future economic survival and prosperity* (Department of Health 2004a: 4).

Previously, within the context of paediatrics, no distinction was made between children and young people (Dodds 2010). More recently it has been recognised that hospitalised young people have distinct needs that are different to children's, including the need for privacy, independence and psychosocial support, these distinct needs having increasingly been highlighted in policy documents, reports and guidance (Royal College of Paediatrics & Child Health 2003, Royal College of Nursing 2003) with the NSF including standards specific to the requirements of young people (Department of Health 2004b).

The vulnerability of children and young people is arguably associated with young people's (perceived) lack of agency. In the context of adolescent health, this is illustrated in an ethnographic study by Hutton (2007), which was undertaken in an Australian inpatient adolescent unit. Hutton found that whilst the unit was considered innovative in terms of its design and facilities, design and facilities that had been shaped by young people's input into the planning, their voice as young people vanished, as they became patients. Once young people took on the role of patients they were expected to conform to the rules of patient per se, and as such they lost their identity of being a young person. She observed that,

> *'when patients enter the ward space, they enter a setting that is set up for nursing and medical observation. This [bed] space takes precedence over other spaces and is the very reason patients are admitted to the ward... the nurse as a worker is active and vertical, whereas the patient is passive and encouraged to occupy the horizontal plane... the attire of patient is placed*

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[2] This phrase was used by Postman (1982) in his aforementioned discussion on the 'death of childhood.

over the adolescent and overrides whatever being an adolescent is' (Hutton 2007:3147-3148).

The same would though probably apply to adult patients, thus it is not wholly by virtue of their age that that these adolescent patients became passive and horizontal.

3.7   Public Attitudes towards Young People.

Qvortrup (2005) observes that in both North America and Europe a trend has emerged whereby adults are increasingly campaigning for 'child-free' zones, restaurants and holidays, a stance which he notes has coincided with decreasing fertility rates, and an increasing number of women choosing to remain childless (he cites as an example female academics in Germany, 40% of which are expected to remain childless). The basis of this stance is, he proposes, that [these] adults perceive children as a "private good", children's "intrusion" into the public arena being thought of as a "status offence" (Qvortrup 2005:1), as to these adults their choice is to be child free, thus children's intrusion is unwarranted. Indeed Qvortrup's (2005) proposes that due to social and economic changes associated with modernity, childbearing and rearing has changed from a public to private responsibility, with reproduction and production (of workforce/society member) now completely separate functions. Qvortrup (2005) argues that the 'privatising' of children coincides with a more caring attitude, which has rendered children more dependent, and depicted as vulnerable and in need of protection" (Qvortrup 2005:9). This privatisation does though render children more invisible, depriving them of their right to 'conceptual autonomy' – the right to be heard and seen in their own right (Qvortrup 2005:10).

However the extent to which this analysis would be borne out thorough empirical research is largely unknown. As noted above, there is a wealth of studies that have examined altitudes towards older people, such studies arising out of concerns about ageist attitudes towards older people, but arguably societal norms and values are such that, in the case of younger children, negative attitudes if expressed would not be sanctioned.

An example of empirical work on public attitudes towards young people[3] was commissioned by the Scottish Executive Education Department (Anderson et al 2005). The study is grounded in the discourse of young people as deviant, the basis of the study being that:

> *"despite longstanding political and media debate around issues related to young people and youth crime, little systematic information is available on public attitudes in this area"* (Anderson et al 2005:1).

ScotCen conducted the study across Scotland as part of a series of work following Scottish devolution. It involved face-to face interviews and a self-completion questionnaire with a random sample of 1,600 people, achieving a response rate of 93%. Young people were themselves part of the study population. Participants were asked to identify the three main problems in their local areas based on a list provided by the research team. Overall irrespective of age group, lack of opportunities for young people, young people hanging about on the streets, alcohol and drugs and crime and vandalism were the areas perceived as the most problematic, with more than a third of respondents identifying each of these four areas. The researchers concluded that the issues raised by and which pre-occupy the media and political agendas, are reflected to large extent in adults own 'talk' about the problems facing their communities.

Nevertheless, participants also framed 'hanging about on the streets' as a concern *for* young people (my emphasis added) and overall respondents who had more contact and interactions with young people were more likely to frame problem in terms of lack of opportunities for young people (Anderson et al 2005:2). There was also some ambivalence noted in the findings, particularly in the section of the questionnaire that specifically addressed attitudes towards young people (this aspect of the survey is discussed in more detail in Chapter 5 as it provided the basis for a component of the

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[3] The study's definition of young people was individuals aged 11 – 24. The authors note that: '*we chose to focus on those between the ages of 11 and 24, which early piloting work suggested was consistent with most public understandings of the term. For some of the questions, though, we addressed 11 to 15 year-olds and 16-24 year-olds separately. The reason for this distinction is that the issues relating to 11 to 15 year-olds (hanging around the streets, truancy, vandalism, etc.) are very different from those affecting the older age group (more serious drug and alcohol use, late- night disorder and violence, more serious offending).* Anderson et al (2044:6)

survey tool used in this study). Anderson et al (2005) provide a number of possible explanations for this ambivalence, and propose that the tensions and contradictions mirror the historical debates that depict young people as either 'angels' or 'devils' (Valentine 1996, cited in Anderson et al 2005) as young people pose both a threat to the social order as well as hope in the shape of the possibilities of new beginnings (Anderson et al 2005:35).

3.8   Summary

From a sociological perspective, childhood, as a period of time passing (James et al 1998), has been re-conceptualised and is now seen to represent a distinct but not universally experienced social category. Childhood cannot be seen in isolation from other variables such as gender, class and ethnicity, in acknowledgement that a variety of childhoods exist. Proponents of the sociology of childhood see that children's relationships and cultures are worthy of study in their own right, thereby moving away from previous approaches that either ignored childhood as a distinct social category, or located it within the study of the family and or socialisation. In studying childhood, children, by virtue of possessing agency, are active in the construction and determination of their own social lives and those around them (James et al 1998).

Proponents of the sociology of childhood have re-conceptualised childhood, successfully arguing that children and are active 'beings' who possess agency. Nevertheless, children and young people are themselves framed through a lens that sees them as either inherently vulnerable or deviant and thus in need of protection or control respectively. As discussed in this chapter, negative stereotypes of young people prevail, stereotypes that tend to be based on perceptions of young people's behaviour as (increasingly) deviant. This was evident in a research study undertaken by Anderson et al (2005), which measured attitudes towards young people but did so in the context of young people and crime, in acknowledgement that while there has been much preoccupation with young people and their behaviours, little systematic information is available (Anderson et al 2005). The findings of Anderson et al (2005) provided insight into factors that concerned communities in respect of young people and their behaviours/criminality, but also identified ambivalence in the participants' responses, ambivalence that (in part) reflected the perceived threat of young people

(to the social order) and their intrinsic value on the basis of their contribution to the future.

Within the context of health care it has largely been the vulnerable 'discourse' that prevails, although it is only more recently that attention has been drawn to the specific (health care) needs of young people which are different to those of younger children. There remains though ambiguity and contradiction within health care as to where young people are situated, both geographically and within (UK) health care policy.

CHAPTER FOUR

PERSPECTIVES ON, AND ATTITUDES TOWARDS, SELF-HARM

4.0   Introduction

Chapter two contextualised hospital A&E care as an essential element of the (wider hospital's) negotiated order, as well as representing how A&E work itself is organised, and the roles of staff therein. As noted, in order to maintain the negotiated order a ward, or in this context the A&E department, requires the maintenance of 'shape', good shape resulting form the steady flow of patients into and out of the department. Consequently A&E staff are necessarily involved in constant decision making to determine clinical priorities, resulting in the categorisation of patients. However it is evident that patient categorisation is not a wholly objective process, with a number of factors influencing how staff make 'clinical' judgements, with some patients adversely judged resulting in assignment of labels as 'good' or 'bad' patients. Dingwall & Murray (1983) found that such labels were not though applied to children, as children had 'pre-theoretic status,' a status that was associated with lack of agency; on this basis they were not adversely judged for attendance at A&E for problems that in adults, would have been deemed trivia. However, the detailed case of a young person Dingwall & Murray (1983) called 'the young pretender', indicated that a young person was ascribed the same theoretic status as an adult, thereby possessing agency, and was therefore similarly adversely judged, his attendance being deemed inappropriate (Dingwall & Murray 1983).

One group of patients who have historically attracted negative evaluations are individuals who attempt suicide, as attempted suicide is viewed as a non-serious or failed suicide attempt (Stengel 1952, 1956, Stengel & Cook 1958). This chapter therefore commences with an analysis of how suicidal behaviours are conceptualised and constructed. The medicalisation and de-medicalisation of suicidal behaviours is considered and the emergence of self-harm as a term used to describe patients who 'attempt suicide' is reviewed. The chapter then explores the features of adolescent self-harm, providing an overview of prevalence, motives and risk factors.

In light of the stigma attached to labels associated with self-harm and suicide, and the moral evaluations made by practitioners, this chapter then goes on to examine the specific research literature which has examined emergency care practitioners' attitudes towards young people who self-harm. However due to the dearth of research which has specifically examined attitudes towards young people, the review also includes research that has examined attitudes towards all patients who attend emergency services following an episode of self-harm; research that has examined attitudes towards young people who self-harm by practitioners working in other services is also reviewed.

4.1   Suicide and Suicidal Behaviours – The Medicalisation of Self-Harm

The term suicide has highly emotive connotations, as the taking of one's own life is contrary to social and cultural norms and values. Historically, behaviours not resulting in the death of the individual have been referred to as attempted suicide, a term which came to prominence following the seminal work of Stengel (1952, 1956, Stengel & Cook 1958).

Stengel noted that there was a dearth of scholarly work (both within psychiatry but also sociology and anthropology), which had examined attempted suicide as distinct from suicide. He set out to address this and interviewed individuals admitted to hospital who had attempted suicide but who survived (Stengel 1952, 1956, Stengel & Cook 1958). Drawing on the data from the interviews Stengel and his colleagues drew a categorical distinction between those who completed suicide and those who attempted suicide. The latter were different in that not only had they not intended to kill themselves, they were more likely to be women, more likely to be younger, and unlike completed suicide which was over-represented by higher socio-economic groups, those who attempted suicide were more likely to hail from lower socio-economic groups (Stengel 1952, 1956, Stengel & Cook 1958). The main distinction that Stengel drew was that those attempting suicide were making an appeal to other human beings, and as such those who attempted suicide were making a cry for help, their suicide attempt paradoxically being the individual's attempt at survival in what were frequently adverse circumstances or exceptional life events (Stengel 1952, 1956).

However the term 'attempted suicide' was subsequently deemed inappropriate because as was evident in Stengel's own work, those who do not complete suicide did not normally intend to take their own lives. Thus alternative terms were proposed. The term 'para-suicide' was coined by Kreitman, which was defined as: *"a nonfatal act in which an individual deliberately causes self-injury or ingests a substance in excess of any prescribed or generally therapeutic dosage"* (Kreitman 1977:3). This initially became the accepted terminology and was adopted by the World Health Organisation (WHO) in its European Study on 'para-suicide' (Schmidtke et al 1996), the definition being useful for research purposes as it was "specific, concrete, observable and reliably measurable" (Linehan et al 2006). However the definition did not gain widespread popularity because as with attempted suicide, it failed to address whether the individual had suicidal intention, and as a term it is not easily translatable into other languages. Consequently, the WHO replaced the term 'para-suicide' with "fatal or nonfatal suicidal behaviour with or without injuries," such behaviour being non-habitual (Linehan et al 2006: 303-304).

As Skegg (2005) highlights, scholars working in the field of suicide have for over fifty years been trying to gain consensus on satisfactory terminology to describe various suicidal behaviours. McAllister (2003) provides an overview of the multiple meanings of self-harm and similarly notes that debates about its meanings have been apparent in the literature for over 60 years, leading Burrow (1992) to liken it to 'semantic paella'. Chandler (2011, 2012) draws attention to the variations in terminology as well as the tendency to focus research on specific groups, notably women, young people and clinical populations, proposing that the lack of consensus on definition, together with the inaccurate portrayal of the ''typical self-injurer'' has hampered the development of a sound understanding of self-injury (Chandler 2011)

The debates about terminology are relevant as the terminology used indicates the ideology of individuals or groups who are assigning labels, with many definitions historically adopting a bio-medical/psychiatric perspective, as self-harm was medicalised. This is exemplified by Pattison and Kahan (1983) who sought to identify through case analysis what behaviours constituted self-harm, and how these behaviours were distinct from suicidal behaviours, as their paper is proposing an argument for self-harm as a distinct category within the 'Diagnostic and Statistical

Manual of Mental Disorders (DSM). The DSM is the system used by American psychiatrists to classify symptoms of psychiatric disorders; Pattison & Kahan (1983) were therefore clearly articulating the perspective that self-harm was a psychiatric illness, one that was a 'clinically distinct behavioural syndrome' (Pattison & Kahan 1983). In so doing they compare the lethality of indirectly and directly destructive behaviours. Suicidal behaviours were classified as directly destructive, while what might be considered either human choices or foibles are indirectly destructive behaviours. Thus a single attempt at suicide was construed as being highly lethal, as were indirectly destructive behaviours such as patient choice to terminate vital treatment, the example given being dialysis. Directly destructive behaviours of medium lethality involved multiple episodes of suicide attempts compared with indirectly destructive behaviours such as high risk physical activities, including multiple performances of 'stunts'. Finally, low lethality was construed as being multiple episodes of self-harm (directly destructive) compared with chronic alcoholism, obesity and cigarette smoking (indirectly destructive) (Pattison & Kahan 1983).

In arguing their case for a distinctive diagnostic category, Pattison & Kahan (1983) draw attention to what they considered to be the distinctive features of self-harm when compared to suicide, based on case samples from the literature. They summarised their findings as replicated in Table 4.1 below.

TABLE 4.1.

Comparison of Self-Harm and Suicidal Behaviour in a Sample of Patients from the Literature (Pattison & Kahan 1983).

Self-harm Behaviour	Suicidal Behaviour
More frequent among young people	More frequent after age 45
Equally frequent in both sexes	Completed suicide more frequent amongst males
Increase in incidence during the past 20 years	Rates the same or decreased during the past 20 years
Low lethality	High lethality
400 – 600 incidents per 100,000 population per year	10 deaths per 100,00 population and 100 attempts per 100,000 population
Sense of relief experienced after the incident in most cases	No relief reported after the incident
Chronic repetitious pattern	Usually one or two episodes
Moderate incidence of alcohol and or drug abuse	High rate of alcohol and or drug abuse
Low-lethal methods	Highly lethal methods
Different methods used by the same individual	Only one method characteristically used
Seen by others as "manipulative" or "attention seeking"	Seen by others as "serious" or "cry for help"
Infrequent death orientated thoughts	Frequent death orientated thoughts

While Pattison & Kahan (1983) have distinguished self-harm from suicide, the division is somewhat artificial. The link between self-harm behaviour and suicide has been widely reported, with an association between self-harm and subsequent suicide attempts (Ferguson et al 2005) and completed suicide apparent (Hawton & Fagg 1998, Reith et al 2003, Hawton et al 2003a, Suominen et al 2004, Hawton et al 2006).

Moreover as Skegg (2005) highlights, individuals who self-harm are more likely to suffer a premature death, and while suicide is the most likely reason for this death, other physiological and psychiatric co-morbidities, notably from drug and alcohol misuse, are more prevalent in individuals who have a history of self-harm.

Hawton & James (2005) provide an overview of the key differences and similarities between suicide and self-harm in young people. Of significance is the fact that in young people, suicide in those aged less than 15 years of age is rare (although possibly underreported due to the assignment of an "open verdict"), whereas self-harm is not uncommon. Contrary to Pattison & Kahan's (1983) analysis, suicide rates in adolescent are increasing, but likewise, males are more likely to complete suicide than females, and similarly drug and alcohol use is an associated factor. Adolescents who complete suicide are more likely to have a psychiatric disorder, a history of behavioural disturbance, substance misuse, and difficulties in their relationships with their parents and family, as well as social and psychological problems. While the risk factors for self-harm in adolescents are similar to risk factors for suicide, Hawton & James (2005:891) highlight that *"although adolescents who self-harm may claim they want to die, the motivation in many is more to do with an expression of distress and desire for escape from troubling situations. Even when death is the outcome of self-harming behaviour, this may not have been intended."* As such the motive for young people's self-harm is the key difference (when compared with suicide), self-harm providing an opportunity to express distress and relieve tension (Hawton & James 2005).

4.2   The De-medicalisation of Self-Harm

Hawton & James's (2005) acknowledgement that self-harm can be an expression of distress and a method of releasing tensions is a reflection of how self-harm has been re-conceptualised, this re-conceptualisation being largely attributable to self-harm 'activists' and sociological analyses of the medicalisation of self-harm.

Medicalisation is '*a process by which non-medical problems become defined and treated as medical problems, usually in terms of illnesses or disorders*' (Conrad 1992:209). As a critique of medicine it initially emerged through the work of Szasz (1963), Illich (1975) and Zola (1972) all of whom were critical of the expanding

realm of medicine. Later debates around medicalisation came to represent sociologists' concerns with increasing expansion over other aspects of 'normal life' such as fertility and reproduction, or behaviours such as hyperactivity in children, and as such medicalisation was *not always the product of medical imperialism but of more complex social forces* (Conrad 2005:3). Conrad (2005) proposes that the three key social factors which influenced these debates were the power and authority of the medical profession, the influence of social groups or movements who actively sought medicalisation, and intra professional activities as demonstrated by both obstetricians and paediatricians in order to corner or redefine their respective areas of practice.

Arguably self-harm, when associated with the term 'attempted suicide', was initially medicalised with the introduction of the 1961 Suicide Act. As Cresswell & Karimova (2010) observe, the Suicide Act of 1961 decriminalised suicide and by association attempted suicide. As a consequence those surviving a suicide attempt could no longer be punished through the criminal justice system, instead they were diagnosed as mentally ill and were therefore detained under mental health legislation. So while still in effect 'imprisoned', their care became the jurisdiction of psychiatry rather than the criminal justice system, with A&E nurses and psychiatrists 'left to "police' the (moral) code' (Cresswell & Karimova 2010:164).

As well as the terminology, the medicalisation of self-harm is evident in the plethora of literature that reports on research that has (usually) explored from a positivist perspective suicidal behaviours. This research has employed a variety of methods including psychological autopsy, retrospective case studies/analyses, and large scale surveys, which have described suicidal acts, identified motives and risk factors (causal antecedents) as well as evaluated interventions and therapies. However the fact that there is no consensus on the definition and meaning of self-harm has led to claims that it is indeed a socially constructed phenomenon (McAllister 2003, Allen 2007). Such claims are based on the fact that definitions of self-harm vary in terms of whether they include alcohol and drug misuse, while other behaviours such as tattooing and body piercing, increasingly prevalent amongst young people, and which were once frowned upon, are increasingly seen as acceptable.

Redley (2003) in acknowledging the limitations of positivist approaches to gain an understanding of the social meaning of self-harm proposes a 'new' perspective, one that places agency rather than structure at the centre of the analysis. He conducted interviews with 50 people who had repeatedly taken overdoses, taking what he terms a 'twin track approach' by firstly analysing how the respondents described their lives, and then addressing and analysing what they described. The participants were either interviewed on the hospital ward or at home subsequent to their discharge. The data revealed the difficulties that the individuals faced, difficulties that encompassed a range of problems, including abuse, drug and alcohol addiction, poverty and social exclusion, and family breakdown. The challenges that the individuals faced led those who were providing health services for them to acknowledge the 'environmental determinism' underlying their repeated self-harm, with some patients' circumstances meaning that, in view of these practitioners, self-harm was an inevitable outcome. Redley (2003) suggests that the study participants (who resided in an area of multiple deprivation in Scotland) lacked agency, and as a consequence, they came to resemble the cases reported in the scientific literature. He proposes that taking the 'twin track approach', identified a need for a paradigm shift, one which moves from understanding self-harm as a collection of causal antecedents, to an 'understanding based on meanings and motives that are socially produced and sustained' (Redley (2003:370).

Adler & Adler's (2007) ethnographic study, which focussed on self-injury, draws attention to how this phenomenon has become de-medicalised. As they note sociological explanations for self-injury began to emerge over the past decade, which contrary to the psychomedical literature, draw attention to the diverse range of individuals who self-injure and how self-injury as a social learning process is transmitted through, amongst other forums, the media and peer groups. They also note that self-injury is not merely pathologically impulse driven, but intentional, 'guided by the social meaning they attach to the behaviour' (Adler & Adler 2007:560) giving rise to a sub-culture of individuals who see self-injury as a voluntary choice and lifestyle. Favazza (1996) has also drawn attention to the cultural associations with self-mutilation behaviours which are particularly prevalent amongst adolescents and reflected in various initiation ceremonies, while also drawing attention to a more

abstract perspective on self-harm including eating disorders, excessive drinking, smoking and unprotected sex (McAllister 2003).

Self-harm activists have been highly critical of attempts by psychiatrists and others to define self-harm by adopting a physiological behaviourist approach. Pembroke (1994) highlights this by comparing a definition of self-harm given by a psychiatrist and one by a female self-harmer. The former defines self-harm in line with that found in scientific literature, *'a deliberate non-fatal act, whether physical, drug overdosage or poisoning, done in the knowledge that it was potentially harmful, and in the case of drug overdosage, that the amount taken was excessive''*. Conversely the female self-harm 'survivor' defined it as follows: *'I'll tell you what self-injury isn't – and professionals take note...It's rarely a symptom of so-called psychiatric illness. It's not a suicide attempt...So what is it? It's a silent scream...It's a visual manifestation of extreme distress. Those of us who self-injure carry our emotional scars on our bodies'* (Pembroke 1994:2)*.*

Similarly Young Minds, a voluntary organisation for young people with mental health problems, describes self-harm as a variety of means by which young people deal with very difficult feelings that build up inside (Young Minds 2011). Moreover despite the widespread use of the term 'deliberate self harm' as illustrated in the work of the Centre for Suicide Research, (for example Fox & Hawton 2006) the term 'deliberate' as a prefix to self-harm has been dropped (Skegg 2005) largely due to critiques from service users who have clearly articulated that their harm is not deliberate.

Self-harm activists/feminists have drawn attention to self-injury as a coping mechanism that arises within a social context and emphasise a harm-reduction approach rather than a medically orientated harm prevention strategy (for example Harris 2000, Inckle 2011). Barton-Breck & Heyman's (2012) study confirms that individuals who self-injure and who remain invisible to health services (through choice) do so because they do not problematise their self-injury. However although their work challenges the pathologisation of self-injury, they also draw attention to the fact that the participants in their study expressed a range of positions from normalisation through to feeling overwhelmed and note that although the participants in their study *'were able to manage their self-hurting without causing medical*

problems [this] does not indicate reduced levels of anguish' (Barton-Breck & Heyman's 2012:17).Creswell & Karimova (2010) observe that self-harm activists have been criticised for celebrating their self-harm, a viewpoint they contest on the basis that (mostly female/feminist) survivors have drawn attention to the discriminatory attitudes experienced by individuals who self-harm, and thus their activism has been necessary in order to draw this to service providers' and policy makers' attention.

4.3　　Definition of Self-Harm Employed in this Study

Having reviewed the literature it is evident that the term 'self-harm' is, within the UK, the term now most widely adopted to explain behaviour whereby individuals purposefully harm themselves, but not necessarily with the intent of completing suicide, and is therefore preferable to the terms 'attempted suicide' and para-suicide'. It is also favoured over the term self-injurious behaviour as not all acts of self-harm involve injury, and while there is some debate as to whether there should be a distinction between self-injurious and self-poisoning in disease classification (Fagin 2006) there is as noted above, evidence that the two categories are not mutually exclusive. The term self-harm is also preferred to the previously adopted term, 'deliberate self-harm' following critiques provided by 'self-harm survivors/activists' (Creswell 2005) notably Pembroke (1994), who posit that self-harm does not conform to the illness labels applied by doctors, and has argued that it is in fact a 'sane response when people are gagged to maintain the social order'. She proposes that:

> *There are two distinct types of self-harm. Firstly, self- harm with suicidal intent (or attempted suicide). Secondly, self-harm without suicidal intent. The second category may lead to a suicide attempt but, in itself, is usually quite the opposite, it is an attempt at self-preservation* (Pembroke 1994:2).

On the basis of such critiques, the term self-harm is used throughout this study.

Notwithstanding this, although the term self-harm is widely used, the definition adopted in much research remains largely based on the World Health Organisation's [WHO] multi-centre study (Schmidtke et al 1996), which now uses the term 'suicide attempters'. The Centre for Suicide Research at Oxford University headed by Professor Keith Hawton, is one of the centres involved in this international study, and

is a source for many publications in this field. The centre adopts a definition of self-harm based on the WHO multi-centre study as follows:

> "An act with non-fatal outcome in which an individual deliberately did one or more of the following:
>
> - Initiated behaviour (e.g. self-cutting, jumping from height), which they intend to cause self-harm
> - Ingested a substance in excess of the prescribed or generally recognised therapeutic dose
> - Ingested a recreational or illicit drug that was an act the person regarded as self- harm
> - Ingested a non-ingestible substance

(Hawton & Rodham 2006:29)

This is the definition adopted for this study. It is acknowledged that this definition reflects a medical perspective; however as the participants in this study were largely nurses, doctors and paramedics, this definition is presented in language that has resonance with their respective professional cultures and ideologies[4]. It is though acknowledged that self-harm can be viewed as occurring within a continuum of suicidal behaviours, and that definitions of self-harm vary largely according to whether the individual defining self-harm behaviours comes from a psycho/medical, sociological or activist perspective.

4.4   A Note on Young People and Alcohol

As briefly discussed above, debates exist as to how self-harm is defined, with an array of behaviours constituting self-harm, distinctions evident between self-poisoning and 'working directly on the body' (Barton-Breck & Heyman, 2012, Chandler 2012). In respect of alcohol, although a respondent in Adler & Adler's (2007) study makes reference to using alcohol and self-injury to distract himself from his problems, misuse of alcohol tends to be associated with self-harm (National Collaborating

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[4] The initial intention when planning this study was to also include the perspective of young people, however this proved not to be feasible. Had this occurred then young people's perspective on how they saw self-harm would have been ascertained. Through data collection it was also apparent that the definition identified on this page was not wholly congruent with how the interview participants viewed self-harm, which is discussed further in the findings.

Centre for Mental Health 2004), rather than defined as a self-harming behaviour, leading to inconsistencies. For example, Hawton et al in their longitudinal study state that poisoning *"by non-ingestible substances, gas and alcohol alone are included if the hospital clinicians consider that these are causes of self-harm"* (Hawton et al 2003b: 1191), whereas other studies (Horrocks 2003, Nadkarni et al 2005) excluded alcohol or drug misuse from their definitions of (adolescent) self-harm.

Such inconsistencies have consequences for research that has examined prevalence as for these studies to have meaning and to enable comparisons to be drawn they need to be measuring the same phenomenon. Moreover, it is of note that definitions of self-harm are inconsistent in terms of the inclusion of alcohol, as alcohol has been identified as a risk factor for self-harm. A systematic review that investigated 25 studies where alcohol use had been studied, found an association between alcohol use and suicide attempts and suicide ideation in adolescents (Evans et al 2004), although compared with adult self-harm, young people are less likely to misuse alcohol (Haw et al 2005).

Young people in the UK are perceived as heavy drinkers, with the term 'binge drinking' coined to describe drinking to excess, and typically defined as drinking more than twice the recommended daily limit on any one day (Smith & Foxcroft 2009). The perception of young people as heavy drinkers is borne out in statistics. Harrington (2000), drawing on data from the 1998-1999 'Youth Lifestyles Survey,' identified that 84% of 12-17 year olds have drunk at some point in their lives, with 10% of 12 -1 5 year olds reporting they drank at least once a week rising to 50% amongst 16-17 year olds. Although this data does not specify overall how much the young people drank, nor how much they drink on a sessional basis (Measham 2008), 22% of those aged 12 -15 and 63% of those aged 16-17 had felt very drunk in the previous year, with 60% of those aged 12-15 drinking at home, alcohol mostly being provided by parents (Harrington 2000).

Overall research indicates that although teenagers drink in a variety of locations, most drink in their own homes (Newburn & Shiner 2001). The fact that young people largely drink at home reflects recent changes in UK policy and legislation, which makes it harder for young people to drink in pubs and clubs or on the streets.

Moreover, the fact that adults within society have an expectation that young people will drink is evident in a number of research studies. Ostergaard's (2009) mixed methods study revealed that both teenagers and their parents shared some perceptions of alcohol use; in particular they shared the view that it was not desirable or appropriate to get drunk, and that it was inappropriate to drink mid-week. The parents (unlike their teenage children) did not approve of their children drinking on two consecutive nights and if they did, they had to prove that they could still function the following day, i.e. get up, work, study as normal.

Measham (2008:212) notes that in comparison with other European countries, 'attitudes towards intoxication are distinctly favourable amongst British youth' which is also evident although not explicitly stated in Ostergaard's (2009) study, as the parents (and adolescents) actively developed strategies to minimise risk, these strategies being labelled 'controlled loss of control', parents playing a role in teaching their teenagers strategies associated with 'safe drinking'. The fact that drinking alcohol is not always seen as deviant is observed in a review for the Joseph Rowntree Foundation by Newburn & Shiner (2001), who note that *'although traces of the drinking as deviance equation are evident in the UK, such approaches have largely been rejected'* and that indeed for the majority of young people alcohol use is 'functional and purposeful' (Newburn & Shiner 2001:41-42). They conclude that for most teenagers contact with alcohol commences as a 'normal' part of family life and remains unproblematic. Moreover, they point out that where problems with alcohol have been ascertained, it is difficult to separate out the risks of alcohol from the other associated risks.

4.5   Incidence & Prevalence of Self-Harm in Young People

The incidence and prevalence of self-harm is difficult to determine accurately. Aside from the debates about what constitutes self-harm and thus variability in measurement, data about incidence and prevalence are largely accumulated through records of attendance at hospital emergency departments. Data drawn from these sources only account for those people who either choose to attend or who are transported to an emergency department because a family member, friend or member of the public has called an ambulance. Research studies that report on hospital attendances for self-harm often do not distinguish patients by age group, or do not

include data collected on young people. As this study is concerned with self-harm in young people, data examined in respect of incidence and prevalence is, unless otherwise stated, related only to young people.

Overall the literature suggests that there is an upward trend in the prevalence of self-harm, with UK teenagers having the highest rates in Europe (Schmidtke et al 1996). Brophy (2006) identified that between 1 in 12 and 1 in 15 young people self-harm in the UK, while hospital records show that some 142,000 young people present at accident and emergency departments each year as a result of their self-harm (Brophy 2006). The Mental Health Foundation undertook an inquiry into self-harm in young people and note that while there is limited research that specifically looks at incidence and prevalence amongst young people, the research that does exist suggests that rates amongst young people are higher than in older age groups, with self-harming behaviours becoming manifest on average around the age of 12 years. They cite previous studies undertaken, which estimate incidence of self-harm, based on emergency department attendances, as 25,000 admissions annually in the UK (Brophy 2006). Similar problems exist in the US, where although there is widespread concern about prevalence of self-harm, the reliability of data available is questionable, with estimates of prevalence ranging from 12- 38%, compared with 5 – 13% in the UK and Australia (Whitlock et al 2006).

The most often cited data that illustrates trends in self-harm in young people in the UK is the longitudinal study undertaken at the Centre for Suicide Research in Oxford (Hawton et al 2003b). Data on all adolescents aged 12 – 18 years who presented to a district general hospital following self-harm over an eleven-year period was collected. The definition of self-harm used is (as outlined above), based on the WHO Multicentre study. During the study period a total of 1583 adolescents attended the hospital with a total of 2120 episodes of self-harm. What is not clear from this data is what proportion of all attendances self-harm represents, thus the scale of the 'problem' (or not) is not immediately apparent. Nadkarni et al (2005) undertook a smaller scale study that retrospectively examined attendances at one emergency department, in this case in adolescents up to the age of 16 years, over a one-year period. Nadkarni et al (2005) report that during that period there were a total of 105,738 attendances of which 484 had been discharged home with a diagnosis of self-

harm, although ultimately only 117 met inclusion criteria and were included in the study thus representing 0.1% of all attendances; notwithstanding this, there is variations in recording attendances and many young people who attend with self-injury will be recorded by injury rather than as self-harm.

Hawton et al's study (2003b) provides evidence of recent trends. It is apparent that during the decade covered by the study (the 1990's) females were more likely to harm themselves, with a rise in incidence between 1991 and 1997. The gender bias was more apparent amongst the younger adolescents, but decreased with age; by 18-years of age the ratio of female to male self-harmers had dropped from eight to one to two to one. A feature of self-harm is repetition, with previous history of self-harm being a predictor for future occurrences of self-harm (Rodham & Hawton 2006). In their longitudinal study Hawton et al (2003b) found the mean repetition rate to be 14.6%, with a marked increase in repetition rate emerging during the study. The study also noted seasonal variations and found a decrease in numbers between July to September, Mondays being the day where most episodes occurred, and Saturdays being the least frequent. Hawton et al (2003b) note that this seasonal trend does not conform to seasonal trends associated with adult suicidal behaviour and postulate that both the days of week and months of year suggest school related stress is a factor for these young people.

In Hawton et al's (2003b) study, poisoning was the sole method of self-harming behaviour in 86% of the episodes, with paracetamol the most commonly used drug. Self-injury alone accounted for only 8.9% of all episodes, and self-poisoning and self-injury accounted for 5.1% of all episodes. A gender bias was evident with males more likely to employ self-injurious methods alone; the most common method of self-injury was self-cutting. The data also showed that over a fifth of the sample had received previous psychiatric treatment, with substance misuse identified in 13.6% of the assessed individuals; again a gender bias was evident with males more likely to have associated alcohol and drug misuse problems, as well as reporting being a victim of violence. The adolescents in the study reported a number of different problems; most frequently cited were difficulties in their relationships with their family, work/study, difficulties with friends and problems with partners (Hawton et al 2003b).

While this study provides an insight into the incidence, prevalence and factors associated with self-harm, this does not fully reflect the scope of the 'problem', as it is recognised that such data reflects "the tip of the iceberg" (Hawton & Rodham 2006).

It is widely acknowledged that in order to gain a more accurate picture of prevalence, community based studies are required, but as Hawton & Rodham (2006) note, with one exception, there is little research that takes a community approach, and those that have, have had small samples making results difficult to generalise. On this basis, using a survey approach, they undertook a community-based study involving 6020 Year 11 pupils (aged between 15 and 16 years) from 41 schools during 2000 and 2001. A total of 5293 adolescents completed all the questions on self-harm. The study revealed that 784 (13.2%) of the adolescents self-reported self-harming behaviour, although when study criteria for self harm were applied this dropped to 398 (6.6%).

The study was part of the wider collaborative study across Europe and Australia, where measures for assessing prevalence are the same across all study centres. Rodham & Hawton (2006:45) provide the comparative data, which demonstrates consistency across five of the countries (England, Ireland, Belgium, Norway and Australia), particularly for the percentages of girls engaging in self-harming behaviours.

What is of particular note in terms of this UK based study is that of those adolescents who had (according to the study criteria), engaged in self-harm in the previous year (n=398), only 50 (12.6%) had presented to a general hospital, thereby illustrating the limitation of data collected using hospital records. What also emerged from this study is that hospital presentation was related to the method of self-harm, and was significantly more common in those who took overdoses, whereas overall, self-injury was by far the most common method of self-harm. Overdosing using paracetamol was the most commonly used drug for self-poisoning (56.6% of all self-poisoning) and reflected figures found in hospital-based studies (Hawton & Rodham 2006).

4.6 Risk and Precipitating Factors Leading to Self-Harm in Young People

A range of factors have been identified through research and widely publicised as either precipitating an episode of self-harm, or making the young person more vulnerable and at risk of engaging in harming behaviours. As noted above a key factor

in determining whether a young person is at risk of self-harm is a previous history of having engaged in self-harming behaviours. As Webb (2002) notes, an understanding of the background to self-harm is necessary to appreciate the kinds of pressures being faced by young people, in order to determine what will best assist them in coping with these pressures, hence an overview of factors is provided below.

Evans et al (2004) published a systematic review which examined factors associated with suicidal phenomena in adolescents, based on population based studies. The authors identify their data sources, search terms and inclusion criteria from which a vast amount of literature was reviewed and analysed. The authors do not identify how many studies were actually included in the review, instead they organised their results and review into four sections based on correlations between suicidal phenomena and the observed/measured phenomena, these being, mental and physical health and well-being, other personal characteristics and experiences, family characteristics and social factors. They report that studies were grouped according to the types of suicidal phenomena investigated, the timeframe covered and survey methods employed. They categorised the behaviours into two groups, attempted suicide where death was the intended outcome for the behaviour and self-harm where death was not necessarily the intended outcome; how intentionality within the research studies is identified is not clear, and overall the review does not distinguish as to whether the observed phenomena were more or less significant in terms of attempted suicide or self-harm, reporting instead in general terms of suicidal phenomena.

The studies reviewed examined the correlation between suicidal behaviour and a wide range of factors, from depressive disorders to leisure activities. They found that many of the associations are in line with findings from studies of adults and hospital –based studies of adolescents (Evans et al 2004), including the aforementioned gender bias, as well as relationship with alcohol and substance misuse. A meta-analysis was not undertaken, but the authors found *a strong and direct relationship between depression and suicidal phenomena"*, as well as a relationship with other mental health disorders and suicide phenomena, although it was acknowledged that these (i.e. anxiety, low self-esteem, eating disorders, sleep problems, tiredness) might reflect their co-occurrence and co-morbidity with depression. There was also a strong and direct link between physical and sexual abuse, the authors noting that while much of

the literature had focussed on females' experiences, the effect of sexual abuse on males might be more profound, with more male rape victims attempting suicide than female, although in a later published review examining specifically the relationship between abuse and suicidal phenomena, Evans et al (2005) propose that culture and ethnicity may be important factors in relation to gender associations and abuse.

Evans et al (2004) also found that there was a significant association between suicidal phenomena and a family history of suicide attempts, as well as suicidal acts by friends suggesting a strong modelling influence on adolescents, and while their review only located one study which looked at the influence of the media on adolescents, Fox & Hawton (2004) note that research has found that suicidal behaviour can be learnt through imitation, giving examples of how mass media has contributed to upward trends in suicide attempts. More recently a spate of suicides by young people in the Welsh town of Bridgend has occurred with media speculation that on-line social networking sites may be responsible, although there is currently no research evidence to support or refute this (Boyce 2011).

Contrary to the literature on inequalities in health, the review by Evans et al (2004) found little evidence of an association between socio-economic status and suicidal thoughts and behaviours, but identified two potential characteristics that were seen as relevant, these being the father's level of education and stress or worry about the family's economic situation. Similarly, despite the "moral panic" about the state of family life in the UK today, associations between parent's cohabitation status and suicidal phenomena were inconclusive. Living apart from both parents did appear to increase risk, although there did not seem to be an association between suicidal phenomena and losing one or both parents due to death. The study also reviewed education and social factors and found a significant but indirect association between poor academic achievement and suicide attempts, while poor school attendance was positively associated with both suicide attempts and suicidal ideation.

At the commencement of the review Evans et al (2004) hypothesise, based on the stress-diathesis model, that there are factors which clearly contribute to vulnerability (diathesis) to suicidal phenomena; they conclude that indeed this is the case, and that other factors act as stressors, while some factors may act in either way, depending on

their temporal association with suicidal phenomena. This relationship is demonstrated in Table 4.2 below.

TABLE 4.2: Factors and Stressors Associated with Adolescent Self-harm (Evans et al 2004:972).

Vulnerability Factors	Stress Factors	Vulnerability/Stress Factors
Strong evidence for an association Family suicidal behaviour	Depression Alcohol use Use of hard drugs Mental health problems Suicidal behaviour by friends Family discord (especially for females) Poor peer relationships	Living apart from parents Antisocial behaviour (especially in females) Sexual abuse Physical abuse Unsupportive parents
Suggestive evidence for an association Poor communication with family	Hopelessness Eating disorders Smoking Drug use Sleep difficulties Media exposure to suicide	Low self-esteem Poor physical health Physical disability Sexual activity

Hawton & James (2005) report that young people with high suicidal intent are more likely to plan their suicide attempt, whereas a feature of self-harm is that it is frequently a highly impulsive act, which was also found to be the case in Hawton & Rodham's (2006) community based study, in which 43.2% of the sample had thought about it for less than an hour. Furthermore, as well as risk factors, Hawton & Rodham (2006) observe that it is important to understand young people's motives. Over the years a list of motives or intentions has been compiled, based on findings from previous research studies, and applied to studies of young people who self-harm who attend a general hospital; Hawton & Rodham applied the same approach in their community study. The proportion of adolescents in their study, who positively

endorsed the motives/intentions provided, is listed in table 4.3 below (the respondents could endorse more than one reason).

TABLE 4.3

Proportion of Adolescents who Endorsed the Intentions/Motives Provided in Hawton & Rodham's (2006) community study

Motive/Intention	Proportion of Adolescents endorsing this
I wanted to get relief from a terrible state of mind	72.8%
I wanted to die	52.8%
I wanted to punish myself	46.3%
I wanted to show how desperate I was feeling	40.7%
I wanted to find out whether someone really loved me	31.3%
I wanted to get some attention	24%
I wanted to frighten someone	21.1%
I wanted to get my own back on someone	14.3%

Overall the motivation for self-harming behaviour in this group of adolescents centred on coping with distress, as is evident in their wish to get relief from a terrible state of mind. With the exception of the last two motives, females endorsed each category more than males. Wanting to die was more likely to be expressed both spontaneously and endorsed by an adolescent who had self-poisoned; an association between the motive, 'finding out if someone really loved me' was also more likely to be expressed by adolescents who self-poisoned (Hawton & Rodham 2006). However, as noted above, a key finding of this study was the low number of young people reporting and engaging in self-harm who subsequently presented themselves to a hospital; those that did were more likely to have self-poisoned, many (more than three quarters) with potentially dangerous substances, did not attend. Hawton & Rodham (2006) found that these were the adolescents who were more likely to report wanting to die as a

motive/intention; moreover a quarter of these young people did not consider that they had a serious problem. Failure to seek help from hospital services means that the adolescent is less likely to receive a formal assessment, and is therefore unlikely to engage in services that enable them to manage and explain their self-harming behaviours.

4.7   Self-Harm and Moral Evaluations – The Basis of Attitudes.

As noted above, Stengel (1952, 1956) initially drew attention to the distinction between those who completed suicide and those who did not, noting that *'the survivor of a suicidal attempt is regarded by the public as having either bungled his suicide or not being sincere in his suicidal intention'* (Stengel & Cook 1958:19), and in doing so they propose that those who attempted suicide were (morally) judged in a different way to those who had completed suicide. Moreover as Pattison & Kahan (1983:867) observe, there exists a *"clinical paradox"* whereby an individual *"with apparent consciousness and wilful intent, performs painful, destructive and injurious acts upon themselves without the apparent intent to kill themselves"*. Such observations form the basis of what Jeffery (1979) observed in his ethnographic study of A&E departments, namely that staff made moral judgements about patients; patients who overdosed were particularly singled out, being adversely judged as they were viewed as being not serious in their attempt at suicide.

How behaviour is seen and the extent to which it is condoned or not is shaped by our attitudes towards given behaviours, as well as, in some instances, attitudes towards the group or individual exhibiting a given behaviour, with some individuals or groups likely to be viewed more prejudicially than others. As Oppenheim (1992) notes, social psychologists have a long and established history in theorising on the basis of attitudes, based on an assumption that attitudes can predict and explain social behaviours (Azjen & Fishbein 2005). Numerous definitions of attitudes abound, and although consensus is not evident it is generally accepted that an attitude is *'a state of readiness, a tendency to respond in a certain manner when confronted with certain stimuli'* (Oppenheim 1992:174). Ajzen (1988:4) proposes that an attitude is a disposition to respond favourably or unfavourably to an object, person, institution or event, the key characteristic attribute of an attitude being its evaluative nature, i.e. that

the person or event etc is good, or bad, acceptable/unacceptable, but as is widely agreed, attitudes do not predict behaviour (Ajzen & Fishbein 2005).

That attitudes do not always or accurately predict behaviours has been attributed to methods used for determining attitudes, which fail to address their multi-dimensional nature and the unpredictability of human responses. In response to some of these critiques, a theoretical framework, the theory of planned behaviour[5] (Fishbein & Azjen 1975, Ajzen & Fishbein 1980), was developed, the theoretical premise of which is that an individual's behavioural intentions will be based on their beliefs and subjective norms (beliefs that might not be accurate, unbiased or rational), and more latterly perceived behavioural control (Azjen & Fishbein 2005), these concepts combined enabling predictions of an individuals' intentions and behaviours.

McKinlay et al (2001) used the theory of reasoned action to predict the behavioural intentions of nurses working in acute medical and admissions units towards patients who self-poison. The purpose of the study was to determine how the distinctive roles played by nurses' own attitudes interacted with the social pressures represented by other peoples' attitudes in determining the types of caring behaviours the nurses would engage in. The researchers found that the nurses' own attitudes and what they believed about the attitudes of others predicted their behavioural intentions towards self-poisoning patients. Differences in normative and behavioural beliefs about self-poisoning patients were evident, which influenced the nurses' orientation towards the patients, although what these differences are or the beliefs associated with them are not fully explored.

McKinlay et al's (2001) study failed to address the extent to which the nurses in their study might discriminate against self-poisoning patients, based on prejudicial views they might hold. Critiques of the theory of planned action approach have highlighted that attitudinal research indicates that while prejudicial attitudes to, for example ethnic minorities, have seemingly diminished, discrimination has not. Ajzen & Fishbein (2005) propose that this might be accounted for in that individuals are less likely to be overtly prejudiced as it is now less socially acceptable while discrimination while also

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[5] Also referred to as Theory of Reasoned Action

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unacceptable and illegal, can be subtler, factors that arguably apply when interacting with patients who come from a minority background and or have stigmatising illnesses or behaviours, such as self-harm.

Oppenheim (1992) notes that attitudes have many attributes including intensity. Some are more enduring, some are deeply held either personally (opinion) or philosophically, or as Azjen & Fishbein (2005) acknowledge, are linked to societal norms and values. Much of the research that has been undertaken in relation to attitudes focuses on for example, attitudes towards minority groups, or attitudes towards stigmatising illnesses such as mental illness or HIV/AIDS. As such the focus is on how an individual responds or behaves towards a member of a minority group or a person with a stigmatising illness. However more recently focus has shifted towards looking at attributes that the person who is stigmatised or discriminated against might possess in order to obtain a better understanding of the basis of attitudes. Of particular relevance to this study is Corrigan's (2000) attribution model of public discrimination, a model that Corrigan et al (2003) have specifically applied to mental illness.

Corrigan's model is based on Weiner's (1980, 1985) attribution model of helping behaviour. Weiner's model is based on the premise that an individual's likelihood of engaging in helping behaviours is related to the extent to which they perceive that the cause of a person's distress, or requirements for help, are down to controllable or uncontrollable causes. Thus for example Weiner's (1980, 1985) early work involved research with undergraduate students who were given two different scenarios. One a man who had collapsed on the subway system and one a student who had enrolled on the same course as the students who were participating in the study, this student having asked if he could borrow notes. In both scenarios the cause of the events (i.e. subway collapse and student notes) were manipulated, with some students being told that the cause of the collapse was due to drunkenness (controllable cause) or illness (uncontrollable cause), and with the student the need to borrow notes was due to skipping class (controllable cause) or due to difficulties with his eyes (uncontrollable cause). Weiner found that students were more likely to offer help to the individual whose circumstances appeared to be out of their control, i.e. the collapse due to illness or incomplete coursework due to eye problems, and postulates that willingness to help

is not only based on the controllability of the person's need but is also mediated by the affective responses of sympathy and anger, with those problems perceived as being uncontrollable evoking more sympathy and less anger.

Corrigan (2000) and his colleagues (Corrigan et al 2003, 2005) have determined that there are variations in attributions between physiological and psychological illnesses, with physical illnesses such as cancer or heart disease perceived as having low controllability, whereas mental illness (despite evidence to the contrary) is seen as having causes which are controllable; thus individuals with mental illness are more adversely judged that those with physical illness. However, Corrigan (2000) notes that while controllability and stability attributions might indicate how individuals may respond to mental illness they do not explain attitudes. The attribution model does though provide some explanations as to how and why people with a mental illness are stigmatised, and goes some way to explain the basis of stereotypes that are associated with mental illness and behaviours such as alcohol abuse (Corrigan et al 2005), stereotypes which include dangerousness that lead to fear and lack of trust. The model has also been used to explore the extent to which familiarity with mental illness ameliorates these feelings, with familiarity found to be inversely associated with prejudicial attitudes (Corrigan et al 2001).

Mackay & Barrowclough (2005) and Law et al (2008) both used Weiner's and Corrigan's model to determine their respective participants' willingness to help individuals who self-harm, both studies being based on vignettes of hypothetical self-harm patients, scenarios that were manipulated to provide different motives for the subject's self-harming behaviours. Both studies confirmed the predictive nature of the model in that those individuals who were perceived to have more control over the cause of their self-harming behaviours were less likely to demonstrate willingness to help, thereby having the potential to adversely affect the care these patients receive.

4.8   Attitudes towards Self-harm – A Review of the Literature.

Having reviewed the contextual background for self-harm and self-harming behaviours, and the basis for moral evaluations and associated attitudes, a systematic search of the literature was undertaken in order to locate specific studies which had investigated attitudes of emergency care staff towards self-harm.

4.8.1 Accessing the Literature

A search of the literature was conducted by searching databases accessed via the University of Greenwich on-line databases, initially using Swetswise and then EBSCO Host, Health Sciences Research Databases. This allowed access to the following databases that were searched: British Nursing Index, CINAHL, Medline, Psychology and Behavioural Science Collection, and PsychINFO. Google Scholar was also used to follow up on specific papers using the facility of 'cited by' and 'related articles' to locate further papers. A search of the RCN Steinberg collection was also undertaken to determine if any unpublished PhD dissertations were available/relevant (none were located that were directly relevant to this study).

Given the variations in terminology associated with self-harm and young people, a range of search terms were used were used in various combinations (see Table 4.4.)

TABLE 4.4   Search Terms Used

Attitudes	Self-harm	Adolescents	Nurses
Perceptions	Attempted suicide	Adolescence	Doctors
Behaviours	Deliberate self-harm	Teenagers	Paramedics
	Self-injury	Young people	Accident & Emergency
	Self-laceration	Youth	Emergency Services
	Self-poisoning		Casualty

The search was limited to English language publications but no limits were placed on country of publication. In order to capture a range of research papers, papers were included that had been published over a ten-year period (2000 – 2010), however two often-cited studies published prior to this date (McLaughlin 1994, Anderson 1997a) were included as they were widely cited and reported in subsequent papers.   A further publication dating back to 1978 was also included as this was the only study located that had involved paramedics (Ghodse 1978). The initial search was conducted in

2005/06 prior to undertaking the study; the review was then updated (2010/2011) with literature subsequently published now included.

An initial search revealed that research examining attitudes towards self-harm amongst health care practitioners is relatively extensive, examining attitudes of staff working in an array of services including inpatient and community mental health, forensic mental health, learning disability services, probation and prison services. Consequently for the purpose of the literature review research papers were selected on the basis that they either examined attitudes of practitioners working in accident and emergency services towards self-harm and or specifically examined attitudes towards young people who self-harm, irrespective of service – with three papers in this latter category located (Anderson et al 2000, Dickinson et al 2009, Law et al 2009).

4.8.2   Overview of Findings from the Literature Search

A total of 20 papers were identified (Ghodse 1978, Mc Laughlin 1994, Anderson 1997a, Anderson et al 2000, 2003, Anderson & Standen 2007, McKinley et al 2001, McAllister et al 2002a, Crawford et al 2003, Mackay & Barrowclough 2005, Friedman et al 2006, McCann et al 2006, 2007, Sun et al 2007, Suokas et al 2008, Hadfield et al 2009, Dickinson et al 2009, Law et al 2009, McCarthy & Gijbels 2010, Conlon & O'Tuathail 2012). The majority of the research was conducted within the UK; one study was conducted in Taiwan (Sun et al 2007); one in Finland (Suokas et al 2008); three in Australia (McAllister et al 2002a, McCann et al 2006, 2007) and two in Ireland (McCarthy & Gijbels 2010, Conlon & O'Tuathail 2012). McAllister (2002 a & b) McCann et al (2006, 2007) and Anderson (Anderson et al 2003, Anderson & Standon 2007) published papers arising from the same data sets but with different emphasis. This is particularly relevant in respect of the papers by Anderson as of the 20 papers retrieved only six were specific to young people, of which two were the aforementioned studies headed by Anderson; thus in effect only five research studies have been conducted which specifically examine attitudes towards young people, only two of which are specific to A&E (Crawford et al 2003, Anderson et al 2003/Anderson & Standon 2007,) one in the context of secure units (Dickinson et al 2009) and one ascertaining undergraduates' attitudes (Law et al 2009).

With the exception of three papers (Anderson et al 2003, Dickinson et al 2009,

Hadfield et al 2009,) all the research was conducted using quantitative methods, employing survey approaches. The 'Suicide Opinion Questionnaire' (SOQ) originally devised by Domino in the 1980's (Domino 2005) was the most commonly used instrument, initially adapted by McLaughlin (1994) and similarly used by McCann et al (2006, 2007), Sun et al (2007), or employed in its full form (Anderson 1997a, Anderson & Standen 2007) and subsequently modified (Anderson et al 2000, 2003). McAllister et al (2002a& b) developed the 'Attitudes Towards Deliberate Self-Harm" questionnaire, which was subsequently adopted by McCarthy & Gijbels (2010). Similarly Crawford et al (2003) and Friedman et al (2003) developed tools specific to their studies, while the 'Self-harm Antipathy Scale' was used by Dickinson et al (2009) and Conlon & O Tuathall (2012), Weiner's 'Attributional Model' by Mackay & Barrowclough (2005), 'Reasoned Action Theory' by McKinley et al (2001), and the 'Understanding Suicidal Patients' instrument by Suokas et al (2008).

As Suokas et al (2008) note, a limitation of adopting survey methods and associated measurement tools to measure attitudes towards self-harm is that the results 'merely reflect the conscious feelings of the respondent'. Indeed a feature of many of these studies is a degree of speculation as to why their respective participants displayed the attitudes as measured; for example Ghodse (1978) speculates that it might be down to different work environment that result in ambulance personnel holding less positive attitudes towards patients who overdose accidentally through drug addiction than their nursing and medical colleagues. It is also particularly evident in relation to the studies that have found that age and length of experience influence attitudes (for example McLaughlin 1994, Anderson 1997a, Law et al 2009), findings that are discussed further below.

The studies that employed qualitative methods used grounded theory (Anderson et al 2003), interpretive phenomenology (Hadfield et al 2009) and a mixed methods study (Dickinson et al 2009), although it is of note that this latter study focuses on the quantitative element of the mixed methods data, with limited information given or emphasis placed on how their eight themes emerged from the qualitative data. Notwithstanding this, the qualitative studies inevitably provide greater insight into how the respective participants experience the frustration, lack of time and resources and unhelpful barriers that are apparent for health care professionals providing care

(Anderson et al 2003), as well as the influence of occupational roles and expectations on relationships with patients who self-harm (Hadfield et al 2009). A summary of the studies reviewed is included as appendix one.

4.9   What Do the Studies Tell us About Attitudes?

Irrespective of methods, the studies selected provide insight into how patients who self-harm are perceived by emergency care practitioners. Despite the oft-reported view that A&E staff have negative attitudes towards patients who self-harm, the research studies reviewed seem to contradict this, as overall positive attitudes are reported (McLaughlin 1994, Anderson 1997a, Crawford et al 2003, Sun et al 2007 Suokas et al 2008, McCarthy & Gibjels 2010, Conlon & O' Tuathail 2012). This suggests that attitudes expressed by emergency care staff towards individuals who have self-harmed have or are, changing, as most of these research studies do themselves refer to earlier studies where negative attitudes have been noted (for example Ramon et al 1975, Patel 1975, Suokas & Lonnqvist 1989, Alston & Robinson 1992, Sidley & Renton 1996, Hemmings 1999). However the studies that focussed specifically on self-injury (McAllister et al 2002a[6] Law et al 2009), or self-laceration (Friedman et al 2006) revealed less positive attitudes[7].

As noted above the majority of the quantitative studies used the Suicide Opinion Questionnaire (SOQ) or a modified version of this tool. As a consequence recurring themes arising in the papers are the extent to which self-harm is regarded as a mental illness, whether it represents a 'cry for help' or is attention seeking behaviour and aspects related to the normality/acceptability of self-harm. Where the SOQ is not the measurement tool some or all of these issues are also reflected in other studies that employ alternative tools.

4.9.1   Normality/Acceptability of Self-Harm.

The extent to which self-harm is viewed as normal or acceptable does, as might be expected, depend on circumstances. Anderson (1997a) investigated nurses' attitudes towards suicidal behaviour drawing on a sample of 33 A&E nurses and 33 community

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[6] The concurrent publication (McAllister et al 2002b) makes no reference to the data collection tool focussing specifically on self-injury

[7] Many studies did not specify what they defined as constituting self-harming behaviours

mental health nurses, using the SOQ. He found that nurses would view suicidal behaviour as being acceptable in the presence of an incurable illness. This finding was confirmed in Anderson et al's (2000) subsequent study, which also involved a survey using the SOQ as well as semi-structured interviews using the clinical categories from the SOQ as topic headings. Data were collected from nurses and doctors working in a medical inpatient unit, psychiatric unit and a nursing division associated with both units, within one hospital. However, although the study focuses on young people, it would appear that none of the respondents worked with children and young people, as it would seem that no staff from paediatric/children's services were recruited to the study.

Data from the quantitative component of Anderson et al's (2000) study identified that more experienced nurses were less likely to agree that suicidal behaviour is normal. Anderson's (1997) earlier finding that suicidal behaviour was acceptable when suffering a terminal illness was confirmed in the interview component of the study, although the extent to which this explicitly applied to young people is not evident, as terminal illness in young people is relatively unusual (when compared with adults) and not a known risk factor. However the participants did share the view that young people who are physically fit would be persuaded that life would be worth living. Self-harm in young people was associated with impulsivity and under such circumstances this was seen as less acceptable.

Subsequently Anderson & Standen (2007) surveyed a larger sample of practitioners (n=179), involving nurses from paediatrics, A&E and mental health (n=134) and doctors from the same disciplines (n=45). The SOQ was similarly used to assess and measure attitudes. They identified that the participants would regard suicide as a normal behaviour and that they do not see it as a puzzling phenomenon in young people. Moreover, both nurses and doctors expressed disagreement with the argument that suicide may be more acceptable in older people; it is of note though that this research uses the term suicide rather than self-harm throughout the paper, but draws on research and other related work which refers to self-harm, thus a lack of clarity is evident.

Conlon & O'Tuathail (2012) measured attitudes of 87 A&E nurses drawn from four

hospitals in Ireland using the Self-Harm Antipathy Scale (SHAS) first devised by Patterson et al (2007). While the tool does not share the same sub-scales as the SOQ there are related statements, for example, 'an individual has the right to self-harm', and 'a rational person can self-harm'. There was a strong level of disagreement with these statements suggesting that participants did not view self-harm as an acceptable or normal behaviour, although this is not explicitly discussed within the published paper as the emphasis of the discussion (as is the case with numerous other papers) is on the relationship between attitudes and independent variables in respect of gender age, profession and length of experience.

4.9.2 Understanding of the Relationship between Self-Harm, Suicide and Mental Illness.

As noted in chapter 2 there is a relationship between self-harm and suicide; mental illness is a risk factor for both suicide and self-harm, and although self-harm is not classified as a mental illness the three things are in many ways inextricably linked.

The extent to which self-harm is seen as a mental illness and the link between self-harm and suicide feature on the SOQ and other instruments used to measure attitudes towards self-harm, with variations evident as to whether practitioners correctly assert the presence of a link between suicide and self-harm and identify that self-harm is not seen as a mental illness. For example, participants in Anderson's (1997a) study did not view those who attempted suicide as being mentally ill, whereas in their later study Anderson et al (2000) found that both groups of nurses and doctors felt that the relationship between self-harm and mental illness was dependent on the individual's diagnosis and symptoms, and that ultimately as outlined above, mental illness may be related to suicide, but suicidal behaviour did not necessarily indicate mental illness.

Crawford et al (2003) examined knowledge and attitudes of staff towards adolescent self-harm using a survey approach. The study involved 68 nurses (n=48 non-mental health and n=20 mental health trained nurses) and 39 doctors (n=20 working in psychiatry, n=19 non-psychiatric) in three teaching hospitals in South London. The staff worked in CAMHS and Paediatric A&E. The data collection tool was specifically developed for the study and included 11 factual statements relating to

self-harm in young people; seven of the statements were false including the following: *Young people who self-harm are usually mentally ill.* Eighty three percent of respondents correctly identified this statement to be false (100% of psychiatrists), although 36% of non-psychiatric nurses thought this to be a true statement. Similarly for the following true statement, '*people who self-harm have an increased likelihood of committing suicide in the future*', 66% of the respondents answered this correctly, with 100% of psychiatrists correctly responding compared with 54% of non-psychiatric nurses – the differences across both groups across both scores was statistically significant.

Friedman et al (2006) surveyed 63 staff working in one A&E department in Leicester to determine the influence of previous training and experience on staff attitudes. The respondents were mainly nurses (84%) who had a mean of 4.6 years experience, with only 11% (n=7) having had specific training relating to mental health post qualification. A notable finding of the study was the extent to which the staff over - estimated the number of patients they saw with self-harm; staff estimated an average of 117/month when in-fact the department concerned saw only an average of 22/month. Staff in this study lacked awareness that individuals who self-harm are not mentally ill, with 69% of respondents wrongly asserting this relationship, while only 50% of staff recognised the increased risk of suicide.

4.9.3   Attention Seeking/ 'Cry for Help'

The term attention seeking has long been associated with negative attitudes towards self-harm, but as Fox & Hawton (2004) point out, many people who self-harm try to hide their self-harm (particularly self-laceration) and harm themselves in private so as not to draw attention to themselves. Attention seeking and the phrase 'cry for help' are both included within attitudinal statements on the SOQ and are also reflected on other instruments (i.e. Patterson et al's (2007) Self-harm Antipathy Scale), which might also partly explain why these terms are frequently associated with research and self-harm, and suicide.

The interview participants in Anderson et al's (2000) study agreed that the term attention seeking was derogatory, but thought that attention seeking behaviour only exists in a minority of young people; participants distinguished between attention

seeking and gaining attention, the former being a form of communication.

The link between attention seeking and self-harm is still reported in the most recently published study (Conlon & O'Tuathail 2012). As with the respondents in other studies (McAllister et al 2002a, Friedman et al 2006), nurses in this study were more likely to see those who repeatedly attend A&E following self-harm as attention seeking, and in this context self-harm patients evoked feelings of helplessness and frustration amongst the nursing staff. The nurses perceived that they could not help self-harm patients as they lack necessary skills, Conlon & O'Tuathail (2012) proposing that this skills deficit may cause the nurses to distance themselves from these patients, as they viewed them as either attention seeking, manipulative or beyond help.

4.10 Comparison of Attitudes within and between occupational groups and influence of education

The studies mostly measured attitudes in nurses and doctors working in either emergency care or psychiatry. An exception to this was the study by Ghodse (1978) who compared attitudes of casualty staff and ambulance personnel towards patients who overdose. The study, a survey, involved all staff working across the 62 of the (then) 66 'casualty' and associated ambulance departments across London. A total of 1350 questionnaires were distributed, 1248 were returned (92% response rate) and involved 669 nurses, 212 ambulance personnel, 189 medical staff and 153 'other' casualty staff (what constituted 'other' was not stated, but it is implied as receptionists). The questionnaire gave details of three different overdose patients, one who had overdosed accidentally, one who had overdosed accidentally through drug addiction and one who had overdosed as a suicide attempt. The patients who had overdosed accidentally were viewed most favourably, those who overdosed accidentally through drug addiction least favourably, the differences in scores being statistically significant. Scores between occupational groups were compared, with nurses displaying the most sympathetic attitudes overall. There was no statistically significant difference between senior and junior nurses other than for patients who took an overdose deliberately as a suicide gesture; junior nurses had more positive attitudes towards these patients, whereas senior and junior doctors had no such difference. The study also found that ambulance personnel had the most polarised views, with particularly negative attitudes towards patients who overdosed

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accidentally through drug addiction observed.

However more recent studies have not identified such contrasts. Anderson et al (2000) in a small survey of 33 medical and nursing staff (the sample included 10 doctors, one health care assistant and nurses working in both mental health n=10 and general nursing n=7) found no difference between occupational groups in terms of attitudes, as measured on the SOQ; however nurses were more likely to see self-harming behaviour as attention seeking and a cry for help. In his earlier study specific to nurses but different fields of nursing, a difference was noted between older community mental health nurses and A&E nurses, the former having less positive attitudes, (Anderson 1997a), but overall this study did not reveal any significant differences according to the nurse's speciality.

In their later study Anderson & Standen (2007) found that both nurses and doctors obtained high mean scores (thereby indicating positive attitudes) with agreement on the mental illness, cry for help, right to die, impulsivity, normality and aggression scales within the SOQ. The nurses and doctors also agreed that people have a right to take their own lives but such behaviours were often viewed as being impulsive. A two-way analysis of variance (ANOVA) was conducted which revealed that only the scores for mental illness were statistically different between groups, with doctors being more likely than nurses to (wrongly) view self-harm as a mental illness.

Suokas et al (2008) compared the attitudes of emergency personnel (n=66), in a general hospital with those working in a psychiatric hospital. The study employed the 'Understanding Suicidal Patients (USP) Questionnaire' and the 12-item version of 'General Health Questionnaire', which was given to all staff in the emergency rooms of a general hospital and a psychiatric hospital. Fifty nurses (n=27 working in the general hospital and n=23 working in psychiatry) and sixteen doctors (n=6 working in general hospital and n=10 in psychiatry) responded. Overall the staff were found to view patients who attempted suicide positively; however, there were clear differences in staff attitudes between the two hospitals. Those working in the general hospital expressed more negative attitudes than those in the psychiatric hospital. As the authors note the response rate from medical staff was low which could have introduced a bias to the results, although numbers of personnel in the two settings

were reasonably equal (n=32 in psychiatric hospital, n=34 in the general hospital); notwithstanding this the differences between occupational groups were not statistically significant.

Crawford et al's study (2003) demonstrated that overall the staff had low levels of negativity towards young people who self-harm, although no differences between occupational groups are identified or discussed. However although levels of knowledge were reasonable, variations were noted. There was no (statistically) significant difference between the knowledge of both groups of doctors, but psychiatric doctors had higher levels of knowledge than both groups of nurses and non-psychiatric doctors had greater knowledge than non-psychiatric nurses, findings that were statistically significant. The mental health trained nurses were more likely to see themselves as personally effective than non-psychiatric doctors and the psychiatrists worried more than other occupational groups about young people who self harm. Knowledge was not though related to effectiveness or negativity; a trend for higher levels of knowledge to be associated with increased worry was not statistically significant.

It is perhaps unsurprising that psychiatrists would be found to have more knowledge than nurses whose background is primarily working with children in an A&E context, although it might be expected that nurses working in CAMH services might have more knowledge than doctors whose role is primarily paediatrics. Crawford et al's (2003) study does not provide any information about prior access to study days and training undertaken by the participants in relation to self-harm (although it does make recommendation in respect of future education and training). However, Mackay & Barrowclough's (2005) study of 89 staff (30 doctors and 59 nurses) working across four A&E departments identified more negative attitudes amongst male staff and medical staff, the latter being of the view that their initial training had adequately prepared them for caring for patients who self-harmed and being less likely to see the need for further education and training than their nursing colleagues.

Friedman et al (2006) found that only 9% (n=6) of the staff had had previous training. The authors make constant references to 'the staff' but do not expand on whom the staff comprise other than 84% were nurses; professional groups were not analysed

individually. On this basis it was difficult to draw any conclusions about the influence of prior training on attitudes towards self-harm but the study found that staff who had not had previous training but had a longer period of working in A &E had higher levels of anger towards patients attending with self-laceration with unhelpful attitudes noted, particularly around attention seeking.

Dickinson et al (2009) examined attitudes towards young people who self-harmed in a secure unit setting, using the self-harm antipathy scale. The study participants were primarily registered nurses (n= 34) and nursing aides (n=19), but also included three nursing students, one dental nurse, and three level 2 (enrolled) nurses. The findings revealed no significant difference in scores between qualified and unqualified staff, but did find that staff who had received training in self-harm displayed less antipathy than those who had not received training. The relationship between access to education and training and qualification is not explored, but Dickinson et al (2009) note that unqualified staff have more difficulty accessing training/study days.

Overall a number of studies identify the need for education and training. Mc Cann et al's (2006, 2007) study of 43 A&E nurses found that 'most nurses' had received no education and training specific to self-harm, while Sun et al (2007) found that the nurses who had a higher level of education (at initial preparation) were statistically more likely to have positive attitudes. Most recently Conlon & O'Tuathail's (2012) study using the self-harm antipathy scale, found that while the nurses had positive attitudes, the nurses reported a deficit in mental health knowledge and skill, with those who had studied approaches to self-harm recording lower antipathy; those who had not undertaken additional study believed they did not have the skills to nurse patients who attended following self-harm. The earlier study by McAllister (2002a & b) while not specifically measuring attitudes within the context of education also noted that where staff perceived they had less ability to assess and refer patients following self-harm, the more negative attitudes they possessed. McCarthy & Gijbels (2010) similarly found that nurses who had undertaken self-harm education were more likely to receive higher scores on the empathy dimension of the 'Attitude towards Deliberate Self-harm Questionnaire' used in their study.

4.11 Influence of Gender

As noted above Mackay & Barrowclough's (2005) study identified that male staff held less positive attitudes than female and that doctors held less positive attitudes than nurses. These differences might co-exist in that female staff are more likely to be nurses given the gendered composition of the nursing workforce, as reflected in Sun et al's study (2007) in which only 1.3% (n=2) of the respondents (all nurses) were male; Sun et al's (2007) study revealed positive attitudes. Dickinson et al's (2009) study which focussed specifically on nurses and unqualified aides also found that males held less positive attitudes, but they do not give information on the gendered breakdown of the study's participants, although as the study occurred in secure units and young offenders institutions it is likely that a high proportion of the 60 participants were male, again due to the gendered nature of the workforce in these settings.

Overall the picture in respect of gender is unclear. Anderson et al (2000) found that females were less likely to agree that the suicidal patient is attempting to 'cry for help'; 70% of their sample was female, but no analysis of whether gender and role is influential has been determined. Law et al (2009) in their study of undergraduates' attitudes found that female students were more likely to have a more positive disposition, whereas Suokas et al (2008) and McCarthy & Gijbels (2010) found no association between gender and attitudes.

4.12 Influence of Age and Length of Experience

Age and length of experience have been found in some studies to make a difference to attitudes, although as with gender there is inconsistency in the research findings.

McLaughlin's (1994) study initially identified a relationship between age and length of experience. Using a modified version of the SOQ she surveyed 200 nurses working across 11 casualty departments in Northern Ireland gathering responses from 95 nurses, of whom 42% were aged under 30 and 49% had less than five years experience; the older more experienced nurses were found to hold more positive attitudes. Twelve years later McCann et al (2006) also identified that older and more experienced nurses had more supportive attitudes than less experienced and younger

nurses. This study was undertaken in Queensland Australia, and involved 43 nurses working in one A&E department, and used a modified version of the SOQ as adapted by McLaughlin (1994). It is therefore of note that the findings of this study support that of McLaughlin (1994), although sample size and distribution of age and length of experience across the two studies are not comparable.

Although not reaching statistical significance similar findings were noted in Anderson's (1997a) study in respect of A&E nurses, but he found that community mental health nurses who had more experience had lower scores than their less experienced counterparts, moreover, the older community mental health nurses also had lower scores, which similarly was not apparent in the A&E nurses. Whether an interaction between age and length of experience existed was not assessed. Anderson et al's (2000) later study found no difference in respect of age but did find that those with more experience were more likely to see self-harm as normal behaviour in young people.

McAllister et al (2002 a) undertook a survey of 352 nurses working across 37 emergency departments in Queensland Australia, using a tool specifically designed for their study (Attitudes towards Deliberate Self-Harm Questionnaire – ADSHQ). They found that while length of experience in nursing did not have a correlation with a more empathetic approach, nurses who had worked in A & E for longer periods did show more empathy, suggesting that exposure to patients who had self-harmed resulted in more positive attitudes, a finding reflected in Sun et al's study (2007). Other studies that also noted a positive correlation between length of experience and positive attitudes were Suokas et al (2008) and Conlon & Tuathall (2012). Freidman et al (2006) found that staff who had previously received little training but had a longer period of working in A&E felt more inadequate and expressed more anger towards patients who self-harmed. McCarthy & Gijbels's (2010) study adds to the inconsistency in findings relating to length of experience; they found that age and length of experience produced a trend where positive attitudes increased, reached a peak and then declined, this decline being evident in those with more than 16 years of experience.

4.13 Explanation for Attitudes.

In terms of differences between and within occupational groups and gender differences, no explanations are proposed that might explain any differences observed. With regards to age and length of experience, a number of explanations exist, such explanations being dependent on whether age and length of experience positively or negatively influenced attitudes. An explanation for the positive association between age and or length of experience is that exposure over a period of time to patients who present with self-harm can be a contributing factor in bringing about or reinforcing positive attitudes (Mc Laughlin 1994, McCann et al 2005). McCarthy & Gijbels (2010) propose that the integration of mental health triage and integration of triage scales might explain why more experienced nurses have more positive attitudes, but are puzzled as to why there is a dip post 16 years of experience. Conversely where more negative attitudes are associated with increasing experience and age, distress resulting in desensitisation (McAllister et al 2002a) and stress and burnout has been cited as possible explanations (Friedman et al 2006).

As already noted most of the studies cited above measured attitudes using a range of scales, and as indicated by the variations in explanations for the (variations in) relationship(s) between and age and length of experience, these are largely speculative. There were though two studies that attempted to explain why staff might exhibit given attitudes.

In an attempt to explain what might influence nurse and doctors attitudes MacKay & Barrowclough (2005) based their study on Weiner's attributional model of helping behaviour (Weiner 1980, 1986) and hypothesised that 'where staff attributed precipitants of the act of deliberate self-harm to controllable, internal, and stable patient factors, then staff would display greater negative affect, less optimism, and less willingness to help the patient'. They used a vignette as the basis of their study where a 27-year-old woman has taken an overdose; aspects of the vignette were changed to provide four hypothetical scenarios, but they all related to the same 27 year old woman. They found that A&E nurses and doctors were less likely to feel motivated to help and had more negative responses towards the young woman when they attributed controllability towards the patient – i.e. the cause of the self-harm was

within the individual's control. Although not explored in Mackay & Barrowclough's (2005) study it is possible that other research that has identified negative attitudes by staff in respect of self-injury and laceration might be because the staff' attribute more controllability to those who self-injure, a finding that was evident in Law et al's study (2009).

Law et al (2009) employed Corrigan et al's (2003) attribution model of public discrimination. They also used a vignette which in this case described a young female who self-harmed, having self-lacerated; the vignette was similarly manipulated to give different motives for the young girl's self-harming behaviour, providing two different hypothetical scenarios. The participants in Law et al's (2009) study were final year undergraduates in nursing, medicine, clinical psychology and physics. They found that consistent with Corrigan's model, students who believed the young person to be responsible for their self-harm (laceration) were more likely to display negative attitudes.

As discussed above Ghodse's (1978) study which looked at three kinds of overdose patients found that staff viewed the patients who overdosed through drug addiction most negatively, which on the basis of these studies (Law et al 2009 and MacKay & Barrowclough 2005) might suggest that staff in Ghodse's study held those with a drug addiction as more responsible for their overdose, due to their involvement with drugs in the first place.

McKinlay et al (2001) also used two vignettes, one that portrayed a nurse with a positive attitude and one a negative. Using the theory of reasoned action a questionnaire was designed to ascertain nurses' behavioural responses to the vignettes, with 74 nurses working in both acute medical admissions and A&E recruited to the study. The questionnaire contained 15 behavioural beliefs associated with self-poisoning patents with distinct differences between nurses who are more prone to adopt a positive behavioural orientation towards self-poisoning patients and those who are not, emerging. Nurses who were more prone to adopt a positive orientation valued empathy and emotional involvement with the patient, and valued the challenging nature of such work, although paradoxically these nurses also valued spending the minimal amount of time with patients. No analysis was undertaken to

determine if there were differences between the A&E nurses and those working on acute admissions, as by the nature of A&E work, nurses spend less time with patients and tend to have shorter emotional involvement.

The two qualitative studies provided more insight into the basis for the attitudes observed in the quantitative studies. Anderson et al (2003) used semi-structured interviews to analyse through grounded theory the experiences of 45 nurses and doctors working in A&E, paediatric medicine or CAMHS. Two main categories emerged, 'experiences of frustration in practice' and 'strategies for relating to young people'. Central to the first category was the lack of time and resources the staff felt they needed in order to enhance their relationships with the young people who had self-harmed. For those working in A&E and paediatric medicine ensuring that the young people were no longer physically at risk was the main priority, the value of spending time with the young person of secondary concern. For those working in in-patient CAMHS the frustrations centred more on how the suicidal behaviour of one young person can influence the behaviours of others on a unit.

As well as being frustrated by lack of time the staff also felt frustrated by the fact that often (they perceived) their interventions did not work, partly because for those in A&E it was not a physical illness, but partly because the staff felt that what they did was unlikely to make a difference due to the repetitive nature of self-harming behaviours. The staff also found it difficult to understand why young people would self-harm given that, in the eyes of the practitioners, the reasons the young people gave for their self-harm seemed trivial, and as the staff viewed it – 'a potential waste of a life'. The desire of a young person to potentially take their life was at odds with what the staff viewed as a key aspect of their role – the preservers of life.

In terms of the second theme, strategies for relating to young people, the staff recognised that specialist skills were required in order to ascertain and understand the motives for self-harming behaviour, with nurses working in paediatric medicine and A&E realising that they were less able to offer specific skills, partly due to lack of education on the basis of their initial qualification (adult or children's nursing), but also post-qualifying education. The nurses and doctors were also found to separate themselves from the young people who had self-harmed as they themselves had not

had to resort to such extremes in order to cope – as coping was recognised by the staff as a motive for the self-harming behaviours. Anderson et al (2003) observed that the nurses and doctors felt sympathy towards young people who self-harmed, as the family life and or other circumstances that the young people found themselves in were so different from their own. Reflecting on these differences enabled the staff to understand the behaviours young people who self-harm.

Hadfield et al's (2009) phenomenological study involved in-depth interviews with five doctors working in A&E. Three main themes emerged, 'treating the body', 'silencing the self' and 'mirroring social and cultural responses'. Similar to the findings of Anderson et al (2003) the first theme illustrates how doctor's main priority is to treat the physiological aspects of the patients' needs, the doctors reporting that they felt 'helpless' to address the emotional needs of patients who self-harm. Feelings of frustration and despair were also expressed as, similar to participants in Anderson et al's study (2003), it was felt by the doctors that their interventions would be futile. The doctors also expressed frustration with mental health services and felt unsupported and 'abandoned' by them.

In respect of 'silencing the self' the doctors identified that patients who self-harmed challenged their motivations for working in A&E i.e. self-harm patients did not conform to the notions of (immediate) cure and crisis resolution they expected of A & E work. Doctors and other staffs' responses were couched (by the doctors) as defence mechanisms, as they protected them from their feelings of powerlessness. Doctors also identified that they were reluctant to discuss the emotional basis of patient's self-harm, as it would seem, they were fearful that they might lose their own sanity, and therefore they distanced themselves. However where a doctor had personal experience of self-harm through family members or friends they felt more empowered and able to help.

The third theme reflected how the doctors' responses mirrored social and cultural responses. The doctors on the one hand felt constrained by the culture of being a doctor and specifically the culture of A&E work and on the other were critical of UK culture in respect of, as they saw it, over protecting vulnerable people by disempowering them.

4.14   What Do The Studies Tell Us About Attitudes Towards Young People Who Self-Harm?

As noted above only six papers reported on studies relating to attitudes towards young people, one of which assessed attitudes towards staff working in young people's forensic units and youth offending institutions (Dickinson et al 2009), one study involved undergraduate students (Law et al 2009) and the remainder related to A&E Anderson et al 2000, 2003, Crawford et al 2003, Anderson & Standen 2007). While each of these papers clearly focuses on self-harm, their striking feature is the absence of young people from the discussion and to this end the papers could have been discussing attitudes towards self-harm in any age group.

For example Crawford et al (2003) assess knowledge and attitudes, and while the introduction of the paper contextualised the research in terms of increasing prevalence of self-harm amongst young people and the researchers have tailored the data collection tool to focus on young people, the results in terms of knowledge and attitudes are discussed from a mental health perspective, with the (paediatric) A&E departments benefiting from access to and expertise of the psychiatric services, which the authors propose explain their findings. The only reference that Law et al (2009) make to young people is within the vignettes used as part of the study's data collection tool. No rationale is provided as to why they opted to use a young person who self-harmed, a factor that could have been pertinent given that their sample were undergraduate students, and thus their likely age was close to the age group used for their study.

Two of the papers published by Anderson and colleagues are drawn from the same study, one reporting on qualitative data arising through semi-structured interviews (Anderson et al 2003) the other reporting on quantitative data derived using the SOQ (Anderson et al 2007), neither paper is though reported in the context of mixed methods. The latter paper similarly focuses on self-harm, with young people almost entirely invisible in the discussion, other than a brief acknowledgement that the findings suggest more recognition and understanding of the social and psychological problems faced by young people. However the paper adopting a grounded theory approach (Anderson et al 2003) provides some insight into how the doctors and

nurses experienced caring for young people with a sense that the practitioners saw self-harm in young people as a potential waste of a life – a finding not mirrored in the wider review. The staff's lack of confidence in respect of issues relating to young people's competency and rights also came through in this qualitative data, issues not explicitly reported on elsewhere.

4.15   Young People's Reported Experiences of Attitudes Encountered

Not only are young people largely invisible in the studies outlined above, but their own perspectives on how they view the care received and associated attitudes of staff has not been considered; indeed none of the studies consider attitudes encountered from a service user perspective. On that basis a further search was undertaken to ascertain what research has been undertaken which specifically ascertains young people's experiences of emergency care. Similar search terms were used as outlined previously, but the terms experiences, self-reports, and service users were added.

The search revealed that there is a substantial body of research that has examined service users' perspectives, most of which reports on adults' experiences which have been found to be variable. In relation to A&E services common themes include being treated differently, being made to wait longer, perceived threats, e.g. withholding anaesthetics, being processed, lack of information, lack of privacy and negative attitudes of staff, who are seen to avoid physical contact and interaction. Positive experiences are associated with staff who make time, are non-judgemental and listen to the perspective of the service user (National Collaborating Centre for Mental Health 2004, Horrocks et al 2005, Taylor & Hawton 2007, Taylor et al 2009).

As McDougall et al (2010) highlight, there is a plethora of research that has focussed on the views and opinions of young people who self-harm. This body of research has provided insight into why, from their perspective, they self-harm, what led them to start and cease their self-harming behaviours and their experiences of and interactions with caring professions. Within this literature there are anecdotal accounts of service users, with mixed reports of young people's experiences. For example McDougall et al (2010:175) include a narrative from a 16 year old who had attended A&E following an overdose. The young girl reports her blood pressure having been taken on arrival and then being left in a cubicle for two hours unattended. Staff attended to her when

she started head banging the wall, but only to move the bed away from the wall; she acknowledges that she was difficult to manage but found the staff on this occasion to be uncompassionate and uncaring.

Overall the reports of adolescents' experiences of hospital services following self-harm are inconclusive. Although not specific to A & E, Dorer et al (1999) in a study involving 43 young people admitted to Birmingham Children's Hospital over a 15 month period, found that there was roughly an equal split between those who perceived admission following self-harm to be positive or negative. Moreover the reasons for negativity relate more to having to stay in hospital, rather than treatment and care received. Similarly a study undertaken by Burgess et al (1998) reported generally positive feedback in respect of services received and the understanding shown by both family members and professional carers.

As part of a wider national cohort study, Nada-Raja et al (2003) examined help-seeking behaviour in a sub-group of 25 individuals (aged 26 years) who had previously reported self-harming behaviours; the experiences they reported were therefore retrospective. Overall they reported positive experiences in their interactions with health service personnel, but were least satisfied with the help they received from emergency services. Although the study was conducted using semi-structured interviews, the authors acknowledge that they did not pursue why emergency services were viewed least favourably, but speculate that possibly the limited resources and staffing and the need to triage may cause the level of dissatisfaction reported.

Harris (2000) undertook a correspondence study with five women who had self-harmed, their self-harm having commenced in their teenage years. The (retrospective) accounts of the women in this study confirm the presence of negative attitudes amongst A&E staff, the women having undergone 'traumatic and unpleasant incidents' in A&E departments. The women reported hostility and lack of sympathy, with staff attempting to embarrass the women by indicating that they were 'time wasters'. Harris noted that there was widespread anger amongst the women, which stemmed from their 'ritual humiliation', humiliation that was based on the paternalistic attitudes of the staff, paternalistic attitudes that young service users widely report (McDougall 2010).

The most recent and wide ranging study of young people's experiences is presented in an inquiry undertaken for the Mental Health Foundation (Brophy 2006), which reviewed published research evidence, and heard evidence from more than 350 organisations and individuals concerned with young people who self-harmed. The voices of young people were also represented, through consultation groups, online questionnaire and direct testimony. The report noted that in order to be treated in A & E departments young people often found themselves having to disclose their self-harm, some for the first time; the testimonials from young people about the care they received was largely negative, both in respect of hospital emergency departments and the ambulance service. The following are two quotes from the report, which illustrate the negative attitudes encountered:

> *"On the occasions I have been admitted to an A & E department they have concentrated on medically patching me up and getting me out. Never have I been asked any questions regarding whether this is the first time I have self-harmed or if I want to again or how I intend to deal with it."*

> *"A & E isn't usually a positive experience. The last time I had a blood transfusion the consultant said that I was wasting blood that was meant for patients after they'd had operations or accident victims. He asked whether I was proud of what I'd done..."* (Brophy 2006:50).

4.16   Summary

Self-harm in young people is frequently cited as a serious public health concern as an increasing number of young people are engaging in self-harming behaviours, with a correlation between self-harm and subsequent suicide evident (Hawton et al 2003a, 2003b, 2006, Hawton & James 2005). Despite these patterns and trends, the numbers of young people who attend for emergency care following an episode of self-harm remains comparatively low (Nadkarni et al 2005) as many young people who self-harm do not seek help from emergency and other health services (Hawton & Rodham 2006).

As discussed earlier in this chapter there is debate within the literature about what constitutes self- harm, but it is normally used to explain a range of behaviours from

self-injurious behaviour such as cutting, burning or bruising, to self-poisoning. In the UK it is preferred to the terms attempted suicide, para suicide or suicidal behaviour as while there are some similarities the interrelationship is not straightforward; moreover self-harm activists have been highly critical of terminology that assumes that suicidal intent was a motive for their behaviour. However, intent has been an important consideration within the literature around suicidal behaviours, as there is evidence that those who attempt suicide are adversely judged when compared to those who complete suicide, or whose intention was to complete suicide; self-harm is associated with failed suicide attempt and not being seen as serious.

The National Institute for Health and Clinical Excellence acknowledged such concerns, concluding that the attitudes (of practitioners) towards self-harm are problematic (NICE 2004). This is an important consideration as young people themselves have identified that *"the reaction a young person receives when they disclose their self-harm can have a critical influence on whether they go on to access supportive services"* (Brophy 2006:3). Consequently, as attendance at an emergency department might provide the first opportunity for a young person to disclose their self-harming behaviours (whether through choice or not), it is imperative that staff working in these services respond appropriately, as the response received might influence a young person's subsequent health seeking behaviour and subsequent management of their self-harm. Consequently, A&E departments are viewed as playing a central role in England's suicide prevention strategy (Department of Health 2002).

This literature review reported on research that has examined attitudes of emergency care practitioners towards patients who self-harm; with the exception of three papers, this literature has been published over the past decade. The vast majority of the research located is quantitative, mostly employing the SOQ to measure attitudes. The results reveal that when measured in terms of overall scores, the attitudes practitioners hold towards self-harm are seemingly more positive that those reported in earlier studies (prior to the 1990's), and do not represent attitudes encountered (as reported) by service users. There is also some evidence that negative attitudes are more prevalent when patients have harmed through self-injury or self-laceration, possibly,

in line with Corrigan's (2000, 2003) attribution theory, as these individuals are held to have more control over their actions.

While there has been a fairly substantive interest in attitudes towards self-harm, some of which focuses on A&E staff, the extent to which these attitudes have been examined in relation to adolescent self-harm is comparatively minimal. Moreover, those studies that purport to examine attitudes toward adolescent self-harm render the young person almost invisible. Another group invisible from the research specifically relating to accident and emergency care is the ambulance crews/services, with only one study located that has included these personnel (Ghodse 1978).

The research reviewed has noted relationships between gender, age and length of experience and attitudes; however these findings are inconsistent with no definitive pattern emerging. Moreover as the majority of the research is quantitative, employing survey methods, the explanations for the observed attitudes are either not explored or are speculative. The two qualitative studies do provide insights into the tension that A&E staff face, the focus on the physical as well frustration at the limited extent to which they feel they can make a difference. Testimonies from young people and young adults reflecting on their earlier experiences of emergency care reveal some positive attitudes but overall paternalistic attitudes seemingly prevail.

4.17   Research Aims & Research Questions

On the basis of the above it is apparent that there are gaps in the current research that has examined attitudes towards young people who-self harm, gaps that this study intends to address, and which represent the originality of this PhD thesis.

Firstly as noted above while young people might have been the subjects for a minority of the studies reviewed, the focus remains on self-harm, rather than contextualising young people as self-harming individuals. The above studies reported either quantitative or qualitative approaches to the study of attitudes; none employed mixed methods in order to triangulate their findings. Finally, none of the studies involved the perspective of young people as service users, and only one included ambulance personnel. This thesis intends to address this by adopting a mixed methods approach, including young people who have self-harmed and paramedic/ambulance personnel,

as participants. On this basis the research aims and questions for the study have evolved and are as follows[8]:

Aims of the Study

- Identify the attitudes of staff working in emergency departments in relation to young people (aged 12− 18 years) who self-harm and how these impact on practice
- Explore young people's attitudes towards self-harm and their motivations in relation to seeking medical care and treatment
- Explore young people's experiences of emergency care following an attendance at an emergency department

Research Questions

i)   What are the attitudes of emergency care staff towards young people?

ii)   What are their attitudes towards young people who self-harm and is there a relationship between these and their attitudes towards young people?

iii)   What are the attitudes of young people participating in the study in relation to self-harm?

iv)   What were the factors that led to the young person seeking help from emergency services?

v)   From the perspective of young people, how do they experience the care received from emergency care staff following an attendance with self-harm?

Managing data in a mixed methods study has proved to be challenge, particularly given the need to integrate the two data sets in order to determine clearly where the data sets converge and or provides corroboration (or not). The process of data analysis has been outlined above, and results from this analysis are presented in the subsequent chapters.

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[8] As noted in chapter one, as the study progressed the research questions were adapted. This was largely due to the difficulties encountered in accessing young people who have self-harmed that had visited the A&E departments, which had agreed to participate in this study (PRUH, QMS). This is further discussed in the following chapter where the revised research aims and questions are identified.

CHAPTER FIVE

METHODOLOGY

5.1   Introduction

In this chapter I consider the methodology employed in my thesis a mixed methods approach, using a triangulation convergent design (Creswell & Plano-Clarke 2007:73). The rationale for adopting a mixed methods approach will be considered within the context of the epistemological and ontological debates and how it 'fits' with my field research and the research questions asked. It is widely recognised that key to a mixed methods study is clearly articulated research questions, the research questions driving the need for a mixed methods approach; thus the development of the research questions and how they influenced the study design are outlined, as is the development of the data collection tools.

I collected and analysed both quantitative and qualitative data. Quantitative data were obtained using a survey approach through the use of self-administered questionnaires and involved staff in four emergency departments in South East London and five London Ambulance complexes that served these departments. Qualitative data were obtained through semi-structured interviews with 12 practitioners, seven nurses and five paramedics; the nurses worked in a local children's A& E department[9] the LAS personnel worked in the LAS complexes. The processes for selecting and accessing research participants and obtaining their informed consent to participate is outlined and discussed. The proposed inclusion of young people required careful planning and consideration due to their heightened vulnerability being both young, and 'self-harmers'. Ethical approval to involve young people in the study was obtained, approval having been sought through the (then) National Research Ethics Service (NRES). However although approval was granted, it was not possible to recruit young people; failure to recruit was largely down to issues related to access, thus the chapter also reviews the ethical requirements relating to accessing participants and specifically participants who by virtue of their age are not able to consent to participate in research. The contribution of research ethics in influencing the progress

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[9] The children's A&E was an annexe to the hospital's main A&E department. Staff in the department, including the children's nurses, formed part of the survey sample.

of this study is therefore evaluated and the changes to the study that occurred as a result of failure to recruit young people and interview participants in one A&E department are outlined.

The chapter provides an overview of the approaches adopted for data analyses. This involved statistical analysis of survey data, and thematic analysis of data obtained from the interviews. The basis of the statistical tests and their underlying assumptions are outlined and my role and influence as an 'insider researcher' is considered. In line with a mixed methods approach the data were integrated. The process and approach used for data integration is therefore outlined.

5.2   Research Design

5.2.1   Background to and Definition of Mixed Methods Research

Research reported in this thesis adopted a mixed design and utilised a mixed methods approach to look at within and between groups factors. Mixed methods are increasingly used, notably in health care research (O'Cathain et al 2007, O'Cathain 2009). Historically two approaches had guided and informed researchers in their approach to research design and data collection; research was identified as being either qualitative or quantitative, with an almost polemic stance evident when examining debates as to the rigour and value of each approach in relation to the advancement of knowledge, policy and practice. These debates are well rehearsed and outlined in much of the literature around mixed methods research, partly because protagonists have proposed that a mixed methods approach can for example, bridge the divide or constitute a paradigm in its own right (Greene 2006, Morgan 2007, Creswell & Tashakkori 2007, Bryman et al 2008, Creswell 2009, and Wooley 2009). Indeed it is evident that to a large extent mixed methods research has evolved as a result of the so called 'paradigm wars' (Doyle et al 2009, Feilzer 2009).

Creswell defines mixed methods research as,

> *an approach to inquiry that combines or associates both qualitative and quantitative forms. It involves philosophical assumptions, the use of qualitative and quantitative approaches and the mixing of both approaches in a study. Thus it is more than simply collecting and analysing both kinds of*

data; it also involves the use of both approaches in tandem so that the overall
strength of a study is greater than either qualitative or quantitative research
(Creswell 2009:4)

As Johnson et al (2007) note, mixed methods research is also referred to as blended research, integrative research, multi-method research, triangulated studies, ethnographic residual analysis and mixed research. Notwithstanding this, whichever term is adopted, mixed methods research (the term used for this study) can be exemplified by the adoption of either two differing approaches to research – i.e. quantitative and qualitative (Creswell 2009) or two different research methods within the one approach for example two qualitative methods (Morse 2009). Johnson et al (2007:129) emphasise that a mixed methods approach recognises the importance of both quantitative and qualitative approaches to research and propose that mixed methods research is *'an intellectual and practical synthesis'* of these two research traditions, while Sandelowski concludes that mixed method research is a *'dynamic option for expanding the scope and improving the analytic power of studies'* (Sandelowski 2000a:254).

5.2.2   Mixed Methods Approach – Epistemological and Ontological Debates

A paradigm is defined as *'a collection of logically connected concepts and propositions that provides a theoretical perspective or orientation that frequently guides research approaches towards a topic'* (Field & Morse 1996:199), Conventionally, the paradigm adopted for a given research study has been determined by the researcher's epistemological and ontological stance, which in turn influences the methodological approach.

The paradigmatic choice made by a researcher is based on philosophical assumptions concerning the nature of truth, based on beliefs about the basis of knowledge (epistemology) and reality (ontology). Qualitative research is typically located within an interpretive or constructivist paradigm and is concerned with explanation, construction of theory, and generating understandings at the 'micro-level', whereas quantitative research is based on the philosophical stance of positivism which is based on the notion that there is a universal truth, researchers therefore seeking to test theory, establish causal relationships, being interested in relationships and structures

at a 'macro'-level and involving precise measurement (Field & Morse 1996, Brannen 2005, Mason 2006, Bryman et al 2008). As a consequence of these divisions qualitative research, due to the small sample sizes and lack of randomisation when selecting a sample, is often seen as 'soft' and lacking in rigour and too context specific. Conversely while quantitative research is perceived as being 'hard science', it is viewed as lacking in context, with failure to address the everyday meanings that individuals ascribe to their individual situations and life events, seen as an inherent weakness of this approach.

There is much debate within the literature as to whether a mixed methods approach constitutes a paradigm in its own right (Johnson et al 2007), can successfully transcend approaches to research that are based on paradigms which are fundamentally opposed (Creswell 2009) or constitutes an alternative paradigm (Feilzer 2009). Moreover some advocates of mixed methods approaches challenge theoretical/ philosophical divisions on the basis that applied researchers *pay little attention to paradigm differences in actual research practice, and different methods are not treated as exclusive to a particular perspective* (Moran-Ellis et al 2006:49). Notwithstanding this, it would appear that the prevailing view is that mixed methods can transcend the two paradigms, by adopting a pragmatic perspective, pragmatism defining for many mixed methods researchers the epistemological and ontological basis for a mixed methods approach.

5.2.3 Pragmatism

Pragmatism arises from a theoretical stance that emphasises the application of theory to practice, drawing as it does on a need to problem solve (Johnson & Onwuegbuzie 2004, Muncey 2009). It has a number of characteristic/forms but its centrality lies in its position on 'taking the middle ground,' rejecting philosophical dogmatism and scepticism, and traditional dualisms (e.g. rationalism versus scepticism) (Johnson & Onwuegbuzie 2004, Creswell 2009). Of particular relevance to this study is its

> *'high regards for the reality of and influence of the inner word of human experience in action', its endorsement of 'practical empiricism as the path to determining what works', and the fact that 'knowledge is viewed as being both constructed and based on the reality of the world we experience and live in'* (Johnson & Onwuegbuzie 2004:18).

Creswell (2009:10) defines pragmatism *as 'a worldview (which) arises out of actions, situations, and consequences rather than antecedent conditions'*. Based on his own work and that of Morgan (2007) and Cherryholmes (1992), Creswell has outlined the key philosophical tenets of pragmatism and how these relate to mixed methods research, a summary of which is presented in Table 5.1

TABLE 5.1 A Summary of Creswell's (2009:10) Pragmatic Worldview

Philosophical Basis	Application/Implications for Mixed Methods Research
Pragmatism is not committed to any one system of philosophy and reality	Mixed methods researchers draw liberally from both quantitative and qualitative assumptions
Individual researchers have a freedom of choice	Researchers are free to choose the methods, techniques and procedures of research that best meet their needs and purposes
Pragmatists do not see the world as an absolute unity	Mixed methods researchers look to many approaches for collecting and analyzing data rather than subscribing to only one way
Truth is what works at the time. It is not based on a duality between reality independent of the mind or within the mind.	In mixed methods research, investigators use both quantitative and qualitative data because they work to provide the best understanding of a research problem
The pragmatist looks to the 'what and how' to research, based on intended consequences – where they want to go with it	Mixed methods researchers need to establish a purpose for their mixing, a rationale for the reasons why quantitative and qualitative data need to be mixed in the first place
Pragmatists agree that research always occurs in social historical, political and other contexts	Mixed methods studies may include a post-modern turn, a theoretical lens that is reflective of social justice and political aims
Pragmatists believe in an external world independent of the mind as well as that lodged in the mind and believe that we need to stop asking questions about reality and the laws of nature	For the mixed methods researcher, pragmatism opens the door to multiple methods, different worldviews and different assumptions, as well as different forms of data collection and analysis

Brannen (2005) proposes that:

> *in the paradigmatic vision of the world the researcher is more interested in ideas and their origins, in the ideas which drive the research and ideals upon which research should be founded. The concerns of the pragmatist is more to open up the world to social enquiry and hence to be less purist in terms of methods and preconceptions about theory and methods.* (Brannen 2005:10)

On the basis of the above I determined that the pragmatic stance underpinning mixed methods research was appropriate to this study, as while I considered that staff working in emergency care settings would have attitudes towards young people and young people who self harm that could be measured, measuring these attitudes does little to illustrate what has and does influence the development of these attitudes and whether these attitudes are fixed. Moreover, I was not only interested in how emergency care staff perceive young people and young people who self harm, I was also interested in the social processes that are inherent within emergency care work, as well as the perspectives of young people in terms of how they experienced emergency care. Thus pragmatically I needed to adopt different approaches within the study in order to identify and measure attitudes, explore the social processes that may influence attitudes and care provided/received as well as ensuring that the perspectives of young people were represented.

5.2.4 Mixed Method Approach

It is widely recognised that there are a number of typologies and classifications that represent the varied designs that mixed methods research may take (Collins & O'Cathain 2009, Creswell 2009, Kroll & Neri 2009). Essentially though there are two key decisions the mixed methods researcher needs to make, firstly whether to collect data concurrently or sequentially. Secondly whether the design is triangulation, embedded, exploratory or explanatory (Cresswell & Plano-Clark 2007). A summary of the four most commonly cited designs is provided in Table 5.2, drawing on Creswell & Plano-Clark's (2007) widely cited classification.

TABLE 5.2   Characteristics of Mixed Methods Design drawn from Creswell & Plano-Clark (2007:59 – 79)

Approach/ Features	Purpose	Strengths	Challenges
Triangulation	• To obtain different but complementary data • To compare and contrast quantitative results with qualitative findings • To validate or expand quantitative results with qualitative data • Four variations – convergence, data transformation, validating quantitative data, multilevel	• Most widely used as efficient (data collected roughly at same time) • Data can be analysed separately and independently facilitating team research	• Need to resolve what to do if quantitative and qualitative results do not agree • Having two different samples and sample sizes (convergent) - difficult to integrate the data in a meaningful way • Need to have procedures for transforming data (transformation)
Embedded	• One data set provides a supportive secondary role to another. • Numerous variants, most common experimental & correlational	• Logistically more manageable thus more accessible for less experienced researchers and appealing to funders	• Must specify the purpose of collecting qualitative data in a largely quantitative study • Few examples of embedding quantitative data in qualitative designs • Difficult to integrate results when two methods are used to answer to different questions – data is purposefully kept separate • Clear rationale for when and why qualitative data to be gathered/included • Potential for treatment bias in experimental approach

Table 5.2   Characteristics of Mixed Methods Design drawn from Creswell & Plano-Clark (2007:59 – 79) cont/

Approach/ Features	Purpose	Strengths	Challenges
Explanatory	• Qualitative data helps explain or build on quantitative results • Can be used to follow-up groups through subsequent qualitative research or use quantitative participants characteristics to guide purposeful sampling for qualitative phase • Two variations – follow-up explanations and participant selection.	• Two-phase structure makes it easy to implement and report on • Design lends to single and multi-level mixed methods studies • Appeals to quantitative researchers as often begins with strong quantitative element	• Time consuming as normally sequential study – qualitative phase can be lengthy • Decisions need to be made about whether to use same individuals across both phases and criteria for selection in qualitative phase • Obtaining ethical clearance more difficult as the second phase approach might not be clear as will be determined by results from first phase. • Decisions needed about which quantitative results will be further explained
Exploratory	• The results of first methods (qualitative) help or inform the second (quantitative) – typically used to develop measurement instruments or taxonomies	• Separate phases make the design straightforward to implement • Attractive to quantitative researchers due to inclusion of quantitative component • Design can be applied to multi-phase or single studies	• Time consuming to implement • Difficult to specify procedures of the quantitative phase when applying for ethics approval • Decisions about whether same participants will be used across both phases • Decisions about which data to use from qualitative phase to build quantitative instrument • Procedures need to be developed to determine validity and reliability of the tool that emerges

A triangulation model of data collection was employed in this thesis using the convergent model, as represented by Creswell & Plano-Clark (2007) and replicated below in Figure 5.1.

FIGURE 5.1 Triangulation Design: Convergence Model
(Creswell & Plano-Clark 2007:63)
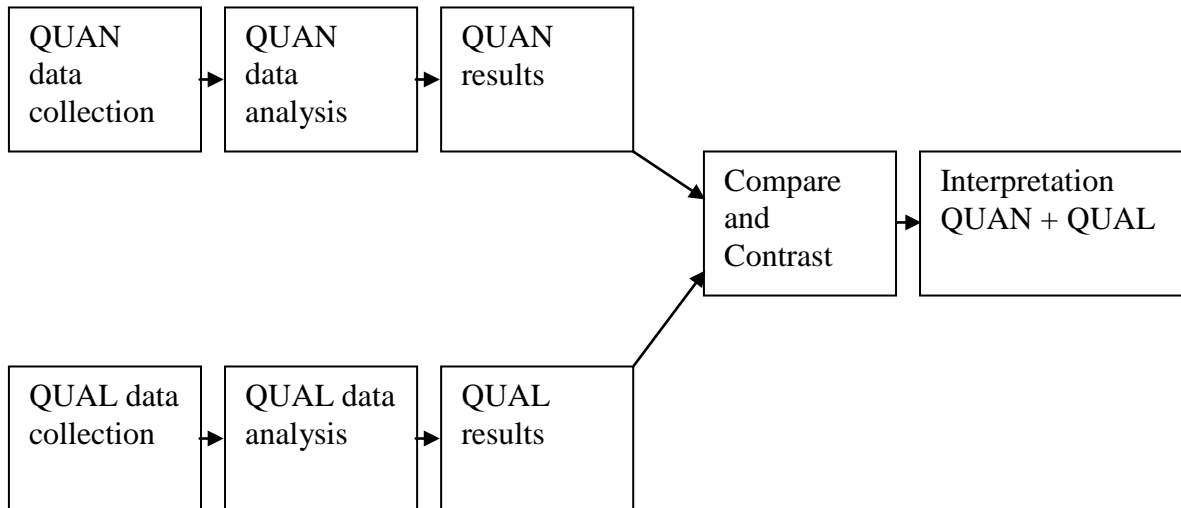
This model was selected as it enabled me to collect (separately) quantitative and qualitative data and analysis of the two data sets could be compared and contrasted. Data was collected concurrently, and involved a survey to obtain quantitative data that aimed to examine and measure attitudes towards young people and young people who self-harm, and to determine whether there were relationships between gender, age, occupation, length of experience and education and training on the respondents' attitudes. The collection of qualitative data enabled me to explore practitioners' experiences of caring for young people who self-harm and their general attitudes and towards young people who self-harm as well as their attitudes and towards self-harm that they had encountered. Analysis of both types of data allowed me to look at relations, similarities and differences in themes arising from the qualitative findings and survey results (Creswell & Plano-Clark 2007:137).

5.2.5 Mixed Methods Design and the Relationship with the Study's Research Questions

Muncey (2009:21) notes that fundamental to pragmatism is the belief that the research questions should be the impetus for choosing the research design not a method or paradigm. Indeed it is widely recognised that a strong mixed methods research study should start with a strong mixed methods research question (Tashakkori & Creswell 2007, Creswell 2009). The questions should therefore address both the quantitative and qualitative elements of the study. Moreover, more latterly it has been advocated that a specific mixed methods question should be explicitly stated; the suggestion for a triangulation design using convergence is as follows: *To what extent do the quantitative and qualitative data converge? How and why?* (Creswell & Plano-Clark 2007:106).

My research questions did not comprise an overarching mixed methods question as advocated, although the extent to which the data converged has been addressed at the level of analysis and will be discussed in the concluding chapter. Initially the research questions for my study, as detailed in chapter 4, were as follows:

vi)   What are the attitudes and emergency care staff towards young people?

vii)   What are their attitudes towards young people who self-harm, and is there a relationship between these and their attitudes towards young people?

viii) What are the attitudes of young people participating in the study in relation to DSH?

ix)   What were the factors that led to the young person seeking help from emergency services?

x)   From the perspective of young people, how do they experience the care received from emergency care staff following an attendance with DSH?

My research questions were formulated at an early stage of the process, due to the need to obtain ethical approval through NRES to undertake the study. It was not the intention or purpose of the study to determine from emergency care practitioners how they perceive the care provided to these young people, rather its purpose was to identify and explore with them how they organize and manage their work in respect of young people who self harm, and through an analysis of the data obtained from the

different phases of the study, determine the attitudes participants hold towards self harm, and how these impact on both the delivery and receipt of emergency care. My research questions were thus aimed to address these multifaceted issues and were worded such that some addressed explicitly the measurement of these attitudes, while others reflect the more exploratory nature of the study in terms of young people's experiences. As a consequence the research questions were refined to address this and the following question emerged:

- *How does the practice of emergency care work influence young people's experiences of emergency care following an episode of self-harm?*

Figure 5.2 provides an illustration of the different debates underpinning the study and how through mixed methods research these influenced the design of the study.

Figure 5.3 illustrates how the different debates translated into research questions and the kind of data to be elicited in order to address each of the questions.

Figure 5.2   **An Illustration of the Rationale for the Mixed Methods Approach Adopted in order to explore the Emergency Care of Young People who Self-harm**
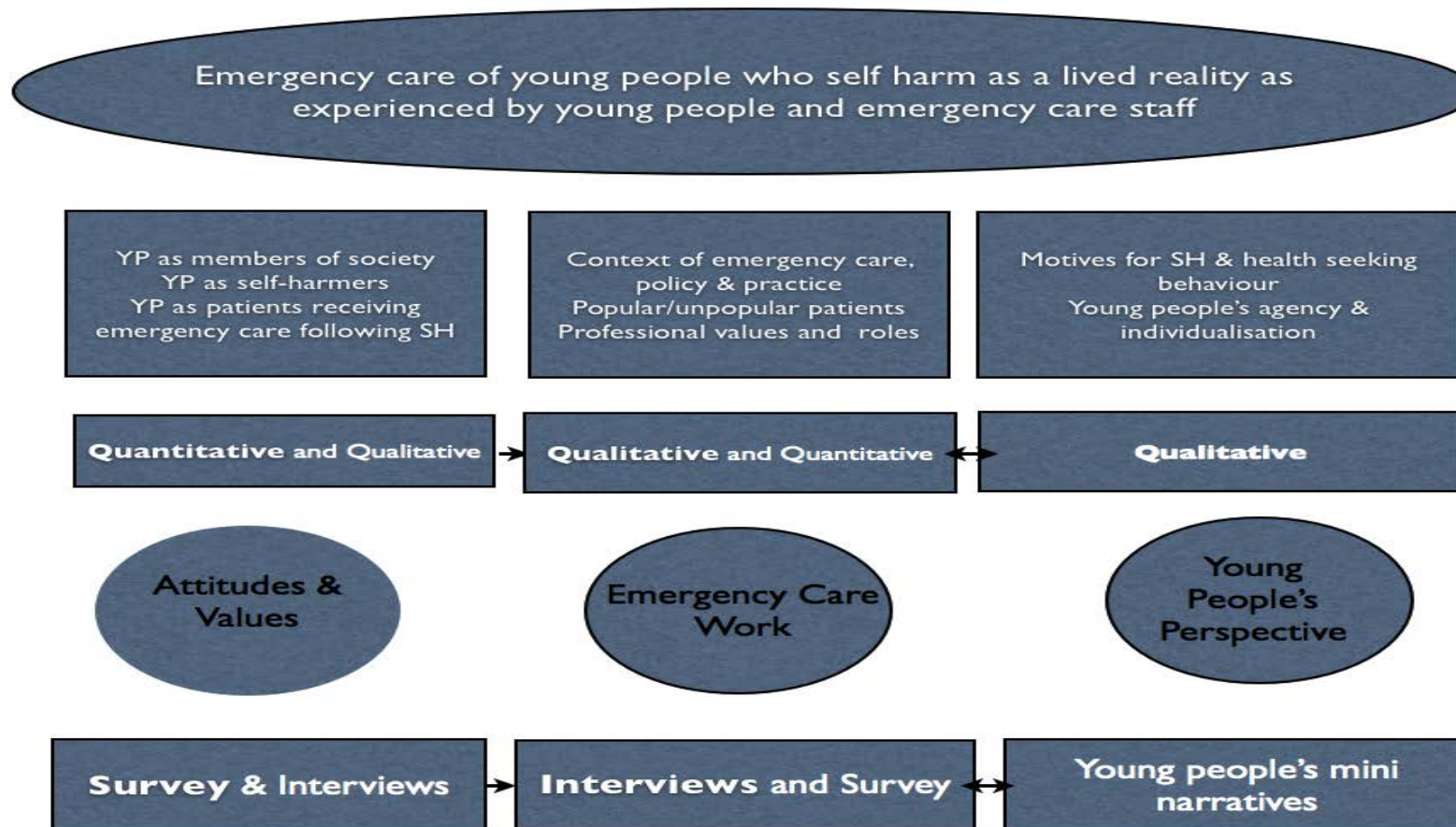
Figure 5.3 An Illustration of the Interrelationship of Research Questions to Methods and Data Collection
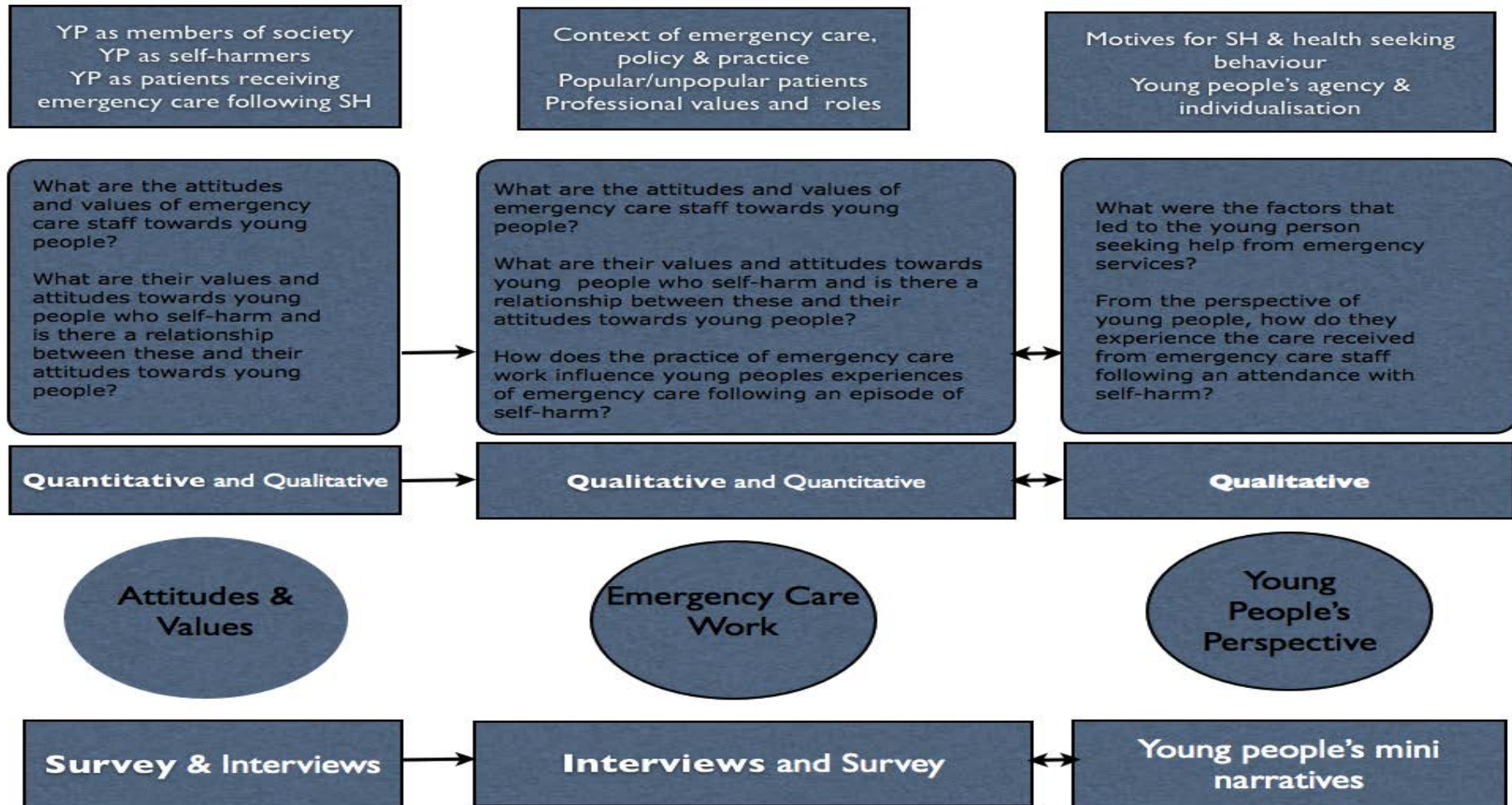
5.3   Study Participants

5.3.1   Sampling

There are a number of debates within mixed methods research as to the role of sampling, including questions around sample size and comparability across the two elements of the study (Cresswell & Plano-Clark 2007). Onwuegbuzie & Collins (2007) note that in mixed methods research, decisions around sampling design are normally based on two criteria, a time orientation, i.e. whether data is collected concurrently or sequentially, and the relationship between the quantitative and qualitative samples. With regards to the latter, samples can be identical, parallel, nested or multilevel. An identical sample is, as would be expected, the use of the same participants in both elements of data collection, whereas parallel samples are different samples but drawn from the same underlying population. A nested sample involves participants in one element representing a subset of the other; a multilevel sample involves two or more samples that are obtained from different levels of the study i.e. different populations (Collins & Onwuegbuzie & 2006, Onwuegbuzie & Collins 2007).

My study adopted a concurrent approach to data collection. However in respect of the typology outlined above, my sample design does not neatly fit into any of the categories. On the one hand I have adopted what would be typified as a nested design in that my sample for the qualitative element of the study in respect of emergency care practitioners represent a subset of the larger sample identified and used for the survey component of the study. However the intention had also been to interview young people and as such they did not form a subset of the initial sample, thus an element of multi-level typology was evident in my proposed sample design.

5.3.2   Survey Sample

Participants for the survey were selected largely on a convenience basis, being drawn from four local A&E services and their corresponding LAS complexes, of which there were five. This was a pragmatic decision as the locations were geographically close to my area of work/home address, which made distribution of questionnaires easier.

At the planning stage it became apparent that it would not be possible to obtain a

random sample of staff from the four emergency departments and five LAS complexes, partly as this would have required the respective managers providing me with a full list of details of all staff employed within the nine settings, which wasn't feasible. Indeed obtaining information on the actual number of staff employed in each setting was problematic. However I ascertained with the respective managers their perspective on how many staff in total there were in each department/complex and I distributed the number of questionnaires accordingly, in effect adopting a census approach to the survey across these nine settings.

5.3.3 Identifying Participants for Research interviews.

It had initially been the intention to interview doctors and nurses from one A&E department, (Hospital A), as well as a small sample of young people who had attended that department following an episode of self-harm, ultimately however, I was unable to recruit doctors or young people as study participants. The background to this is discussed further in section 5.4.3.

Purposive sampling was used to select participants for the interviews. Initially practitioners were alerted to the interviews via the covering letters distributed with the questionnaires, (see appendix 2) and in line with information contained in the letter, I posted notices in the A&E department (Hospital A). However recruiting staff from this department was problematic, primarily because of a lack of children's trained nurses. One interview was conducted at this site, but the nurse, who was not a children's nurse, was unable to offer any significant insight, as she did not have experience of the central phenomenon being explored[10] (Creswell & Plan-Clark 2009). I therefore gained agreement to conduct the interviews at the department where I fulfil the role of link teacher (Hospital B); this site had also been involved in the survey element of the study. The department in Hospital B included a dedicated children's A&E, providing a 24-hour service; the nursing staff were experienced children's nurses.

A further change to the selection of interview participants resulted from the iterative process of data collection inherent within a mixed methods approach. As reported in

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[10] This nurse's interview transcript was not included in the thematic analysis.

the literature review, only one previous research study (Ghodse 1978) had considered ambulance personnel in the context of attitudes of emergency care staff towards self-harm. Secondly, the comment on a returned questionnaire from a paramedic was particularly revealing, the term case hardened was enlightening to me and reflected I thought an element of frustration, which was also evident in other qualitative comments from the questionnaires, particularly in relation to locating or discharging young people who self-harm; I came to recognise that my omission of LAS staff in the qualitative element of the study was an oversight that weakened the study.

As a consequence of the above I sought and gained NRES, R&D and UREC approval for an amendment to involve LAS staff in the qualitative element of the study and to change the study site for the qualitative component of the study to Hospital B (see appendix 3 for correspondence confirming NRES approval). Nursing and LAS staff were invited to participate through both posters and personal contact (amongst participants). Recruiting LAS personnel to the study in the approach identified through NRES proved difficult (indeed overall response rates from LAS personnel were low in respect of the survey); only one technician who responded came forward (as per the instructions on the covering letter accompanying the questionnaire) to be interviewed. The School of Health & Social Care offers a Foundation Degree in Paramedic Science thus permission was given to approach paramedics through this route, the lead for the programme using his networks to promote the study. This resulted in a further four paramedics being recruited who all were currently working in Outer South East London.

Ultimately seven nurses and five LAS personnel (one ambulance technician and four paramedics) participated in the interviews. Four of the five LAS staff were male, and three of the nurses were also male, thus over half the interviewees were male. The length of experience of the participants ranged from 3 – 26 years; five practitioners (three nurses and two paramedics) had more than 18 years experience; this provided unexpected consequences in that these five practitioners were able to provide detailed accounts and insights into their 'self-harm work', borne from their many years experience

5.4   Overarching Ethical Principles that Guided the Study

Greig et al (2007:169) propose that

> *'ethics is the one part of the research process that should **never** be learned in practice and that the would-be researcher should have ensured that all the potential ethical dilemmas have been considered before embarking upon the research'*.

This was a principle I aimed to adopt, although acknowledging that one can never foresee fully what might arise during the process of undertaking research with human subjects (Guillemin & Gillam 2004, Holloway & Jefferson 2000).

Mishna et al (2004) point out there are three primary principles that underpin the conduct of ethically sound research, these being respect of the participants and their right to autonomy; the research should do the person no harm (beneficence and by implication non-maleficence) and principles of justice. In order to adhere to these principles and thereby conduct ethically sound research, the researcher must ensure that appropriate measures are taken in considering how participants are selected, with a sound rationale for a particular group's inclusion; that participants informed consent is sought, and that measures are taken to ensure the research minimises harm and discomfort, and on balance, brings about good (Mishna et al 2004). As a consequence, I spent considerable time in planning the study to ensure that issues around access, informed consent, anonymity and confidentiality were considered, and, as far as was possible, ensuring that potential ethical issues which might arise, for example disclosure of poor practice, or distress at recounting experiences, were anticipated prior to commencement of data collection.

5.4.1   The Purpose, Costs, and Hoped-for Benefits of Involving Young People and Practitioners.

Guillemin & Gillam (2004) distinguish different dimensions of research ethics – 'procedural ethics', which as the term indicates is concerned with the process of obtaining ethical approval, and 'ethics in practice', a term used to describe the issues which arise while undertaking the research. They also make reference to professional

codes of ethics, viewing these as being limited in their application to research ethics. I would propose that professional ethics, like procedural ethics, provides a framework for the novice researcher, setting out as they do a code of practice for researchers within the context of a professional role (Medical Research Council 2004, Royal College of Nursing 2004, Nursing & Midwifery Council 2007).

The involvement of young people who had self-harmed meant that I had to particularly consider, given the actual and perceived vulnerability of this group, whether the benefit of their participation outweighed any potential costs, both to them as young people in terms of potential distress, and the 'costs' to me as the researcher. In respect of the latter the potential cost to me were neither financial, nor related to my own potential harm, rather it was more of a 'pragmatic' nature. As the study was being undertaken to fulfil the requirements of a PhD on a part-time basis, time and other resources were limited and constrained; the additional amount of time that was required to plan for the involvement of young people as well as ultimately their recruitment into the study, was a factor that I had to consider. Notwithstanding this, I determined that the benefits from my perspective outweighed the costs.

In relation to a cost-benefit analysis from the perspective of the gains (or not) for the young people themselves, I initially reflected on what had been the key factors that had led me to identify this as a legitimate and original piece research. As reported in the literature review, no research was located which, within one study, obtains the perspectives of both practitioners and service users. Moreover, by exploring the experiences of young people, it was hoped that the research would provide a basis for reviewing and enhancing the provision of emergency care for these young people, which might then encourage a higher level of attendance and consultation. It was hoped that this in turn would result in securing, at an earlier stage, appropriate mechanisms for support to assist young people in managing their self-harming behaviours. On this basis I decided that the potential benefits outweighed the potential costs, the latter being concerned with potential distress and inconvenience for the young person, which is discussed further below.

Obtaining the perspective of practitioners was important to me as their perceptions of young people in general and young people who self harm were central to the study

aims. Unlike children and young people practitioners were not considered to be especially vulnerable, although I was wary that given the broad basis of A&E work and the range of patients seen in this setting, staff working in A&E departments are often subjected to surveys. To this end practitioners in this setting can suffer 'survey fatigue'. Nevertheless I considered that a survey represented the most effective and efficient way of obtaining the views of a wide range of practitioners across a total of nine NHS settings.

A key consideration for local R&D committees was the amount of time that responding to the survey and participating in interviews would take, as the Trusts did not want staff removed from front-line care to participate in the research. This did not pose a significant problem in respect of the survey, as questionnaires were left for staff in their work pigeon holes. Although, I couldn't militate against the possibility that staff would complete them in the department, in all likelihood staff completed during their break time, or took the questionnaires home for completion. Through the peer review process when developing the questionnaire, it was evident that it took no longer than 15minutes to complete.

 The interviews posed more of a problem as, for the convenience of both practitioners and staff, it was easier to undertake the interviews on NHS Trust premises. I therefore negotiated with each interviewee to conduct his or her interview at a time that suited him or her in terms of shift start and end times. I also gave interviewees the option of being interviewed on campus in off-duty time if they so preferred. Five interviews were conducted on campus, the remaining seven occurred in interviewees' workplaces prior to or on completion of a shift. .

5.4.2   Decisions about Selection - Justification for Inclusion and Exclusion of Participants

As outlined in Chapter One there are two discourses associated with young people, who, paradoxically, are seen as vulnerable or deviant, the latter discourse having driven much research and subsequent debates in relation to youth. However when undertaking research with young people that requires NRES approval, it is the vulnerable discourse, which prevails. This is evident in that when initially completing

the NHS NRES form, a filter question asks will any of the participants be children under the age of 16, which if affirmative, requires a justification as to their inclusion.

When planning the study I had determined that the age range for young people who were to be the focus and participants in this study would be 12 – 18 years of age. The lower age limit had been determined on the basis of research evidence from prevalence studies, which indicate that the onset of puberty is associated with onset of self-harm (Hawton et al 2003a and 2003b, Hawton & Harriss 2008). The upper age limit was based on the fact that paediatric units do on occasions admit young people up to the age of 18 years of age, transition from paediatric to adult services is generally recommended at this stage, and youth/ adolescent services are generally geared towards the 19 and under age range (Department of Health 2004b, 2008b). Nevertheless, while the age range of 12 – 18 in generational terms is narrow, there is a significant difference between a 12 year old and an 18 year old, which has had a bearing on how I negotiated and planned access to young people.

The debates concerning age are significant as if children and young people are perceived as being particularly vulnerable, well-meaning attempts by adults to protect them from harm could adversely impinge on their right to participate and as Alderson (1995) argues, a balance needs to be struck in relation to protecting children from harm while not excluding them and thereby failing to seek their views. Indeed Stalker et al (2004) report on difficulties they personally encountered when trying to access hospitalised children for the purposes of their research, experiences which they propose was shared by other social researchers, as evidenced through personal communications and previously published papers.

Morrow & Richards (1996:96) point out that,

> *'arguments about ethics of social research with children can effectively be reduced to the question of the extent to which children are regarded as similar or different from adults...... in turn (these debates) can be reduced to two related descriptive perceptions that adults hold of children, that is, children as vulnerable and children as incompetent.....conceptualisations that are reinforced by legal notions of childhood as a period of powerlessness and irresponsibility'.*

The inherent vulnerability of children reflected in these conceptualisations are based on epistemological assumptions (or indeed constructions) of the category 'child' which are arguably based on historical conceptions and constructs which have, until recently, been reflected in adult orientated approaches to research on children, who were already deemed 'vulnerable' or 'damaged', and who were, more often than not, the 'objects' (rather than 'subjects') of research (Morrow & Richards 1996). As a consequence, the notion of children and young people as being inherently vulnerable was thus promoted.

These constructs of the 'child' are not congruent with the position adopted by the proponents of the sociology of childhood, which is fundamentally concerned with children's experiences of childhood as they experience it, although as Morrow & Richards (1996) note, there has been little discussion within sociology in relation to potential or actual ethical dilemmas encountered when undertaking 'child orientated' research. However, it is now recognised as good practice that, instead of doing research on children or about children, where practitioners or parents and their family members give proxy representations of children's views of the world, children and young people should themselves, have their voice heard. This view is evident in government policy as reflected in the Department for Education and Skills (2001) guidance – Learning to Listen: Core Principles for the Involvement of Children and Young People, and illustrated in research terms through the ESRC Children 5 – 16 programme (Prout 2001, 2002). As a consequence, an increasing body of social science research has been generated, which gathers, listens and incorporates the views, perspectives and experiences of children and young people, and as Prout (2001) notes, the children in this programme were, contrary to what sceptics might have proposed, *'keen, constructive and thoughtful commentators on their everyday lives at home, at school and in the wider community.... their contribution having been overwhelmingly positive'* (Prout 2001:195).

Thus it is evident that, despite what might be viewed as adult prejudices in relation to the significance and potential for children's contributions to research, children and young people, despite their immaturity (and by implication their vulnerability and perceived 'incompetence'), are able to make a contribution. However as noted above,

while medical and psychological research on children and young people has historically been focussed towards those already deemed 'vulnerable' or 'damaged', much social science research explores with children and young people their perspectives on what might be considered their normal everyday lives, and as such the children and young people who participate in such studies are 'ordinary children', asked, for example, to give their views on 'quality time', their experience of divorce, their engagement with morality and values, and views on justice and punishment (Prout 2002). The children in these studies are not selected because they have necessarily experienced divorce, or have working parents, or have particular experiences of justice and punishment, they are selected on the basis that they are children and young people. This is not the case for this study; young people were being invited to participate because they had self-harmed, and thus they were (potentially) more vulnerable than the 'ordinary' child or young person.

As noted in Chapter 4 there are a range of predisposing factors which increase a young person's risk of engaging in self-harming behaviours, each of which are themselves associated with additional vulnerability; i.e. difficulties in relationships with families and peers, the association of self-harm with alcohol and substance abuse, and the association with depression, all add to a young person's vulnerability. As a consequence I determined that I needed to be selective about the young people I might include in the study, and also needed to consider how and when I would approach them, thereby ensuring that I minimised risk and the potential to do them harm.

Although there is clear evidence that an episode of self-harm predisposes a young person to further self-harming behaviours, not all young people go onto to repeat this behaviour, have psychiatric morbidity or complete suicide (Hawton & Harriss 2008). Moreover my preliminary investigations when looking at the feasibility of undertaking this study revealed that the A & E departments often saw young people who self-harmed on an occasional or one-off basis, and while there were a minority of young people who were repeat attendees and who had an associated psychiatric history, these were comparatively small in number. Nevertheless some young people who self-harmed were likely to be more vulnerable than others, and on that basis I determined inclusion and exclusion criteria as identified below in Tables 5.3 & 5.4.

TABLE 5.3   Criteria for Inclusion – Young People who had Self-harmed

Inclusion Criteria	Rationale
Aged between 12 − 18 years	This is the age group who are initially vulnerable to self-harm and reflect the age group associated with the 'paediatric' patient
Attended and discharged directly home from hospital emergency department	It is considered important to obtain the views of these young people as it is possible that they will form the largest proportion of young people receiving emergency care
Were conscious on arrival and during their stay in the emergency department	They would be able to recall and recount their experiences
Were either accompanied by, or subsequently joined by, the resident parent(s)when attending the emergency department	To ensure that when communication from the researcher arrives via the post, the parent(s) will have already been aware of their child's attendance
Have given their full informed consent (assent if under 16 years of age) to participate in the study and where appropriate their parents (or those with parental responsibility) are willing and have given full informed consent for them to participate in the study	To avoid coercion and ensure that the young person is fully informed and willing to discuss their experiences

TABLE 5.4   Criteria for Exclusion – Young people who had self-harmed

Exclusion Criteria	Rationale
Unconscious when initially admitted to the emergency department due to related alcohol ingestion or poisoning from drugs	Memory of the experience would be minimal and possibly distorted. It would also suggest that their attendance was initially life threatening which could suggest suicidal intent
Required intensive care and/or admission to a specialist CAMH service following episode of deliberate self-harm	Would suggest that the young person was critically ill and a potential suicide risk, and or may have an associated psychiatric disorder
Any associated child protection concerns	These cases will be complex and also indicate increased vulnerability

Although the inclusion of NHS staff did not pose such difficulty from an ethical stance, it remained an imperative that careful consideration was given to criteria for selection of NHS Personnel. Inclusion criteria for NHS staff for both the survey and interview elements are detailed in Table 5.5 below. of the study were as follows:

Table 5.5 Inclusion Criteira for NHS Personnel – Survey and Interviews.

Inclusion Criteria for Survey	**Rationale**
• Nursing, medical, clerical/administrative and London ambulance personnel working in/attending the 4 departments concerned, and who are employed on a substantive basis.	• All these personnel are likely to come into contact with young people who self-harm when they attend an emergency department for care and treatment. No staff in the these categories will be excluded
Inclusion Criteria for Interviews	**Rationale**
• NHS staff who have expressed willingness and have consented to participate in interviews and are employed on a substantive basis in their respective NHS site	• Will have willingly volunteered to participate and are likely to have experience of caring for young people who self-harm experiences that they would be willing to share, following the informed consent process. • Bank staff excluded unless simultaneously employed in the NHS setting concerned, on a substantive basis, as the interviewees need to have experience of emergency care work which an agency or bank member of staff might not have.

5.4.3   Accessing Research Participants for Interviews

5.4.3.1 Accessing Children and Young People

Because of concerns around children and young people's actual and perceived level of competence, and because children and young people are indeed vulnerable to exploitation, researchers undertaking research with children and young people

necessarily encounter an additional layer of gate-keeping. Hood et al (1996) investigated how risks to children are understood and managed by parents and children; their study focussed upon the daily lives of children in and around the home at the ages of three, nine and twelve, living in one neighbourhood. The researchers approached a health centre, community organisations, primary schools and youth clubs in order to gain access to families, but report how they met with a hierarchy of gate-keeping, which ran from *'an organisational level to the parents and finally to the child'*. So for example, when approaching the health centre, the GP's and practice managers identified that they would need to gain parents' informed consent prior to being contacted by the researchers. The practice sent out letters to families who met the selection criteria explaining the study with a tear off slip, which stated "I agree" or "I do not agree" to being contacted. As the researchers noted, this placed them at the end of a long chain of negotiation, and most potential participants did not reply. Similarly when approaching children through the schools the researchers had to navigate their way through a similar 'chain of negotiation', which included the head teacher, school secretary and class teacher.

I personally experienced similar gate-keeping difficulties. It had been agreed with parties concerned that the study site for conducting interviews with staff and selecting young people to participate would be one of the four hospitals participating in the survey (Hospital A). Originally I had hoped to obtain the records of young people who having self-harmed had attended the designated emergency department, to determine potential participants, based on the study's inclusion and exclusion criteria. I had then planned to write to eligible young people providing them with information about the study. The letter was to invite them to contact me to find out more about the study if they were interested in participating. Permission had been gained from the relevant Trust's Caldecott Guardian to access the records. However, the LREC advised that it was unhappy for me to contact potential young people directly, as they felt this was a breech of data protection.

As a consequence I was required to revise my approach to making initial contact with young people. I therefore constructed a letter on Trust headed paper, which was ultimately sent out by the A&E department and signed by the Consultant in Emergency Medicine. This letter was sent to young people who had attended

following an episode of self-harm. The letter gave information about the study and advised the young person to make contact with me if they were interested in participating. The difficulty for me was that the letters sent out by the department necessarily had to go to all young people who attended with a discharge diagnosis of self-harm, as the department did not have the resources to filter potential participants based on my inclusion and exclusion criteria. Consequently the letter from the Consultant also explained to the potential participants that if they responded to indicate potential interest, they would also need to confirm that they were happy for me to access their attendance record (thereby allowing me to check if they were suitable for inclusion). Trying to explain this in a letter to a young person and retain their interest and potential engagement was a challenge. Moreover, for those young people under the age of 16 I had to construct a similar letter for their parents, also explaining that I had written to their son/daughter.

A further challenge I encountered was that (as noted above) to be eligible for inclusion the parent of the young person had to have attended at some stage during their stay in the hospital. I had previously checked the A&E attendance record to ascertain whether information on who accompanied a patient was routinely gathered. There was a section on the form where this information was recorded, but as I commenced the study the Matron of the department, in respect of the 16 – 18 year olds, raised a concern. She pointed out that with this age group they might not have had an adult accompany them, and that while in theory this information should have been recorded, she could not guarantee that staff did routinely fill in this section of the record. She was therefore concerned that if letters were sent to retrospective attendees with a discharge diagnosis of self-harm, and the young person was still living at home, but had not disclosed this to their parents, this could potentially breach their confidentiality, which of course was correct. This therefore meant that within the department I had to obtain the cooperation of all staff to ensure that once the study commenced they were vigilant about recording who attended with the young person, regardless of age. Information sheets were only sent if this evidence was available, but it remains possible that more young people attended with parents, who could initially have been approached, than was apparent from the records.

Being at the end of a long chain approach undoubtedly affected the recruitment of young people to the study; a total of 33 letters were sent to young people over a three-month period; only one young person responded. Unfortunately she did not meet the inclusion criteria as she was admitted to an in-patient CAMH unit as a result of her attendance. As Hood et al (1996) observe, adult gate keepers have arguably given priority to the adult duty to protect over the child's right to participate. Cree et al (2002) experienced similar problems in their research, which examined children's experiences of living with a parent or carer with HIV. They were also reliant on a chain of gate- keepers, and they report finding it difficult living up to the principles of informed consent in practice. They note that parents are more likely to consent to their child's participation in the study when a trusted professional has introduced the researcher. I could draw parallels here with my study in that had I been personally introduced by a member of staff from the A & E department at some stage, for example by inviting the parents back to meet me, then this might have made the parents feel more reassured about who I was and my legitimacy. However, this would have added to the burden of the A & E department staff, as well as time demands on the parents and myself and wasn't therefore feasible.

Given that this strategy for recruiting young people was clearly not effective I then gained approval via the University's Research Ethics Committee to post an on-line request on 'thesite.org.uk', a web site that provides on-line support across a range of issues, including health and wellbeing. Three responses were posted in response to my own but were not sufficient to undertake any meaningful analysis. Consequently I accepted that given the time constraints that I would have to forgo obtaining the young person's perspective.

5.4.3.2 Accessing Practitioners for interviews

In terms of gaining access to interview practitioners, as noted in 5.3.3 above, prospective interviewees were invited to contact me in the letter accompanying the questionnaire and through posters left in the A&E department and (subsequently) LAS complexes. However as noted above initially I encountered difficulties in recruiting participants for interviews; this was due to two different issues, my relationship as an 'outsider' to the A&E department selected and indeed LAS

complexes, and re-configuration of local A&E services, both of which are briefly discussed below.

In my work at the University of Greenwich I fulfil the role of 'link teacher', a role that requires me to visit and support student nurses and their mentors in designated placement areas. My 'link' is based on my professional expertise – children's accident & emergency; at the time of the study, my 'link' was at 'Hospital B' and the staff working in this department therefore knew me. Consequently initially I decided that it might be more appropriate for me to base the study elsewhere as I didn't want to blur the boundaries between my role as a link teacher and my research. I was also concerned that I might be more inclined to 'go native' as a researcher in a setting I was familiar with, be less able to be detached, and may have difficulty in 'withdrawing' from the setting (Morse & Field 1996) given the relationships I had already established. I therefore opted to undertake the qualitative element of the study at the 'Hospital A', another local hospital but one that I have little involvement with.

Alderson & Morrow (2004) summarise the debates around the advantages of being an insider versus an outsider and certainly in terms of being an outsider, required me to be more thorough in my planning, which undoubtedly benefited me in thinking through a whole range of areas during the initial stages, particularly relating to what should be contained on the participant information sheets. However, overall being an outsider did in-fact make the process for recruiting NHS staff more difficult.

Negotiating access to a department where I had no history and therefore no relationships with the staff concerned proved to be difficult and time consuming. Although the lead consultant was always very supportive and willing to meet to discuss and help in the planning of my study, this was not always reflected with other members of staff. However two key factors influenced my change of approach. The department where I had intended to undertake the qualitative element of the study lost a number of staff due to local service re-configuration, some of who were children's nurses. The response rate overall from children's nurses in the survey was low, which does though reflect the workforce in that fewer children's nurses are required. However as noted above, I conducted my first interview with a nurse who was an adult nurse and she was unable to give me an informative perspective on the care of

young people who self-harm, as this was out-with her experience. On that basis I realised that I needed to interview children's nurses for this element of the study, as they would be better informants (Morse & Field 1996).

Gaining access to interview these members of staff proved to be much easier due to my relationship with them. They were happy and willing to participate, and having a relationship with them made them feel at ease when discussing the care they witnessed and provided to young people who self-harm. Their answers to my questions were, I think, honest and frank. Having experience and therefore insight into the provision and management of children's accident and emergency care provided me with what Corbin & Strauss (2007) call sensitivity. Throughout the interviews I was mindful of the need to be sensitive to how I as a researcher with a background as a practitioner and author (Cleaver & Webb 2007) in children's A& E nursing shaped the data collection and analysis (Andrew & Halcomb 2009). My approach to self-reflexivity is discussed below in 5.6.5).

5.4.4   Obtaining Informed Consent from Participants

In order to obtain consent for the survey component of the study, the questionnaire was accompanied by a letter that outlined the purpose of the study and defined the parameters of age and self-harm. Respondents were assured of confidentiality, the questionnaires being anonymised. The letter made it clear that the practitioner was not obliged to respond, thus by returning a completed questionnaire, consent was implied (A copy of letters distributed with questionnaires can be found in Appendix 2.)

Practitioners who participated in the interviews were made fully aware that their participation was voluntary and that my role in conducting the research was a postgraduate student; this was particularly important given that I knew some of the participants due to my role as a link lecturer. I was also aware that in their interviews practitioners might raise issues of concern with regards to their experiences of caring for young people who self-harm with potential for the disclosure of information that could indicate that aspects of care have been inadequate and of concern. The participant information sheet (see appendix 4) made explicit to participants the action they and I would need to take should such a situation arise, as the primary concern to

me as a nurse researcher is, in accordance with the NMC (20067) code of conduct and RCN (2004) guidelines, patient safety and wellbeing.

To protect participants' rights for confidentiality and anonymity I also advised on both the participant information sheet and consent form that while comments from them as interviewees would be included in the study and any subsequent publications, any comments lifted from the interview transcripts would not be attributable to them as individuals, either in publication(s) or through discussion at supervision. Having been provided with the information about the study, all interviewees gave informed consent and were advised that the could withdraw from the interview at any time; a copy of the consent form is attached as appendix 5

5.5 Review of Research Questions

Given the difficulties outlined above as well as my oversight in initially excluding LAS personnel from the qualitative component of the study, the research questions were necessarily revised to account for the fact that young people would not be involved. This also gave me an opportunity to include a specific mixed methods research question as advocated by Muncey (2009) and Creswell (2009) and thus as suggested for a triangulation design using convergence, a question concerning the convergence of quantitative and qualitative data was also included (Creswell & Plan-Clark 2007:106). The revised research questions were thus as follows:

i.   What are the attitudes of emergency care staff toward young people generally and young people who self-harm specifically?

ii.   Is there a relationship between emergency care staff attitudes towards young people generally and young people who self-harm specifically?

iii.   How does the practice of emergency care work as undertaken by nurses and paramedics influence attitudes towards and perceptions of young people who have self-harmed ?

iv.   To what extent are the findings from the qualitative data consistent with the findings from the quantitative data?

The first three questions are used as basis for the discussion chapter and the final question is addressed in the conclusion of the thesis.

5.6   Data Collection

5.6.1   Survey

As Creswell (2009:145) notes, a survey design provides a quantitative or numeric description of trends, attitudes or opinion of a population, from which generalisations can be made. Oppenheim (1992) identifies two types of surveys, descriptive and analytical. The former describes the proportion of the population being studied (derived through random selection) that have certain opinions, characteristics or attributes – they are essentially fact finding and therefore descriptive. Analytical surveys are more concerned with identifying relationships, i.e. cause and effect and as such explore associations between particular variables.

The purpose of a survey is to provide inferences of a population's characteristics, attitudes and or behaviours (Babbie 1990); in relation to this study the purpose was to explore and measure the attitudes towards young people and attitudes towards young people who self harm, specifically to determine if a relationship between attitudes towards young people in general and attitudes towards young people who self-harm existed. In addition to this I was also interested to determine if there were relationships between occupations, gender, age, length of experience and education and training on attitudes towards young people and attitudes towards young people who self-harm.

Surveys generally involve the use of questionnaires, which can be self-administered, interview surveys, web-based or telephone. As Babbie (2007) notes, self-administered questionnaires allow the researcher to capture a wide range of respondents, which for this study involved nurses, doctors, paramedics and ambulance technicians, who were based across a geographical location in Outer South East London, a population that I would otherwise have been unable to access individually due to time and resource constraints.

It is widely acknowledged that self-administered questionnaires have a range of strengths and weaknesses. While a key strength of a self-administered questionnaire is the potential to access a wide range of respondents, low response rates are also a feature of this approach. Survey methods also ignore the social context and processes

of the respondents, which as noted above, is my rationale for adopting a mixed methods approach. Moreover, while data obtained using survey methods are standardised and therefore reliable, they are generally seen as being weak on validity (Babbie 2007).

5.6.2   Questionnaire/Tool Development

In developing the questionnaire I planned to include statements that aimed to explore attitudes towards young people in general and attitudes towards young people who self-harm, with the ultimate aim of exploring whether attitudes toward young people per se had a bearing on attitudes towards young people who self harm. In line with previous studies that had used measures to ascertain attitudes towards self-harm I also decided to obtain data relating to participants' occupation, gender, age, and length of experience as previous studies (see appendix one) had specifically examined the presence or not of an interaction between these variables and the (various) scales used to measure attitudes. Similarly the influence of education and training and use of guidelines have also been explored and given that (at the start of the study) the NICE guidelines (NICE National Institute of Health and Clinical Effectiveness 2004) had been published I felt that that ascertaining awareness, accessibility and use of guidelines was relevant to this study. Finally the questionnaire also included a scenario, an approach that had similarly been adopted by McCann (2006, 2007).

In order to explore attitudes towards young people in general and attitudes towards young people who self-harm, two scales were devised, the AYP scale (Attitudes Towards Young People), which aimed to ascertain the attitudes of respondents towards young people in general, and AYPSH (Attitudes Towards young People who Self-Harm), which aimed to ascertain attitudes towards young people who self-harm.

5.6.3   Attitudes to Young People – Devising the AYP Scale

An extensive review of the literature revealed that only one study had measured attitudes towards young people (Anderson et al 2005), albeit attitudes towards young people were measured as part of a wider study that examined public attitudes towards young people and crime. Anderson et al's study was undertaken on behalf of the Scottish Government and was part of the 2004 Scottish Social Attitudes Survey; the survey addressed five areas as follows:

- How much contact is there between young people and other sections of the population?

- Do problems associated with young people and youth crime feature prominently in adults' accounts of the main problems facing their communities?

- What are the main themes in the way that young people are viewed by adults?

- What are the main features of adult perceptions of and anxieties about youth crime and disorder?

- To what extent are such views grounded in experience?

For the purpose of my study the third area was pertinent to my research. As part of the study the researchers developed a series of attitudinal statements which examined broader views of young people (aged 11 – 24 years) in an attempt to determine *'whether the current generation of young people is seen as different from its predecessors, and the extent to which positive and negative constructions coexist in prevailing adult views'* (Anderson et al 2005:2).

The statements included in the Scottish Office study were brief, unambiguous, and as per Oppenheim's (1992:179) advice appeared meaningful, and interesting. I therefore included the following statements:

- The behaviour of young people today is no worse than it was in the past
- The views of young people aren't listened to enough
- Girls are more badly behaved than boys
- Most young people are responsible and well behaved
- Young people today have no respect for adults
- Most young people are helpful and friendly
- Adults have no respect for young people

In addition I also included three further statements as follows:

- Young people today are not disciplined by their parents
- Young people today don't get enough care and attention from their parents
- Young people today have more stress in their lives than they did before.

The questions, 'young people today are not disciplined by their parents' and 'young people today don't get enough care and attention from their parents' were included because whilst it is accepted that parents are responsible for their child's health and wellbeing, it is also increasingly accepted that parents must take responsibility for when their child's behaviour does not subscribe to societal norms. Thus for example as parents are legally responsible for their child's school attendance, persistent truancy can now result in penalties also being applied to parents, which can include custodial sentences (DirectGov 2010). Such measures reflect debates about who is responsible in any perceived or actual decline in young people's behaviour, which as outlined in Chapter 3 is reflected in the debates that surround the 'death of childhood' (Heath 1997, Aitken 2001, Darbyshire 2007). Moreover, as is evident in research that has discussed moral evaluations of young people as patients, (Dingwall & Murray 1985, White 2002) it is parents who are the focus of any negative evaluations, rather than their children. Thus inclusion of these questions was deemed appropriate to determine if similarly parents are adversely judged when young people's behaviours are evaluated.

The question, 'young people today have more stress in their lives than they did before' was included because as noted in Chapter 3, historically a discourse has been constructed of young people's behaviour as deviant. Although this discourse still prevails, more recently, an alternative framing of young people as stressed, unhappy, and vulnerable has increasingly been portrayed, and emphasised in reports published by UNICEF (2007) and The Children's Society (2008). Research undertaken by Green et al (2005) and the aforementioned concerns about the death of childhood (Buckingham 2000, Aitken 2001, Abbs et al 2006, Darbyshire 2007) also make reference to the additional stressors and tensions that young people face. This question was therefore included to determine whether respondents subscribed to the view that young people do have more stress in their lives than previous generations.

Respondents were required to state their level of agreement on a five-point 'Likert'-type scale. Scores for the following negatively worded items were reversed for the purposes of analysis:

- Girls are more badly behaved than boys

- Young people today have no respect for adults
- Young people today are not disciplined by their parents
- Young people today don't get enough care and attention from their parents

5.6.4 Attitudes Towards Young People who Self Harm – Devising the AYPSH Scale Derived from the Suicide Opinion Questionnaire

In contrast to the dearth of pre-validated measures to assess attitudes to young people, there is a wealth of literature that has examined attitudes towards suicide and in so doing a number of measurement scales have been devised. A systematic review undertaken by Kodaka et al (2010) illustrates this; having undertaken a search of 2210 publications the authors narrowed down published scales to 18 (included as they had unique names used to measure attitudes towards suicide and suicidal behaviours). From these 18 scales the authors further narrowed down to three identified scales, the Suicide Opinion Questionnaire, the Suicide Attitude Questionnaire and Attitudes Towards Suicide Questionnaire. Although these scales have all been developed to measure attitudes towards suicide it is evident that, despite the debates around self-harm as being distinct from suicide (see Chapter 4) these tools formed the basis for measuring attitudes to 'self-harm', with the Suicide Opinion Questionnaire (SOQ) being the most frequently used tool (Anderson et al 2008).

The SOQ was originally developed and piloted by Domino in collaboration with his graduate students and entailed Domino and his team undertaking extensive searches of the literature and noting 'anything and everything' on suicide, developing a total of 3000 statements relating to suicide. These were subsequently refined following input from a range of experts in the field, followed by content analysis, which subsequently narrowed the number of statements down to 138; ultimately, having excluded items with low test-retest reliability the tool comprised 100 items (Domino et al 1980, 1982, Domino 2005).

As identified in the literature review seven of the twelve studies which examined attitudes towards self-harm, had employed the SOQ, (McLaughlin 1994, Anderson 1997, Anderson et al 2000, Anderson & Standen 2007, McCann et al 2006, McCann, 2007, Sun et al 2007), three the self-harm antipathy scale (Patterson et al 2007,

Dickinson et al 2010, Conlon & O'Tuathail 2012), two the attitudes towards suicide questionnaire (McAllister et al 2002a, McCarthy & Gijblels 2010), and Soukas et at used the understanding suicidal patients questionnaire. The remainder developed their own tool based on reviews of the literature (Ghodse 1978, McKinlay et al 2001, Crawford et al 2003, Mackay & Barrowclough 2005, Friedman et al 2006, Law et al 2009). Given that the Suicide Opinion Questionnaire was the most frequently used, I decided to adopt this tool as the basis for this study.

The eight clinical scales that comprise the SOQ instrument are as follows:
1. Mental illness (suicide reflects mental illness)
2. Cry for help (suicide threats are not real they represent a cry for help).
3. Right to die (people have the right to take their own lives)
4. Religion (lack of religion has a role in suicide)
5. Impulsivity (deliberate self harm and suicide are impulsive acts)
6. Normality (everyone is potentially capable of suicide)
7. Aggression (suicide is an aggressive act)
8. Moral evil (suicide is a morally bad action).

(Anderson et al 2000:4)

McLaughlin (1994) included 14 statements from the original SOQ; her basis for selection was that the variables chosen pertained to attempted suicide only and were those that had been proven to yield highly significant effects (DeRose & Page 1985). The items selected by McLaughlin (1994) and subsequently by McCann (2006, 2007[11]) are as follows:

- Most people who try to kill themselves don't want to die
- Once a person is suicidal he/she is always suicidal
- Suicide attempts are typically preceded by feelings that life is no longer worth living
- People who attempt suicide are trying to get sympathy from others
- Those who bungle suicide attempts really did not intend to die in the first place

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[11] Professor McCann was approached and provided me with a copy of the questionnaire used for his studies, and permission to use it – see appendix 6.

- Those who attempt suicide and live should be required to undertake therapy to understand their inner motivation

- Suicide attempters as a group, are less religious

- Those who attempt suicide using public places (such as bridge or tall building) are more interested in getting attention

- Those who threaten to commit suicide rarely do

- Improvement following a suicidal crisis indicates that the risk is over

- Once a person survives a suicide attempt the probability of her/her trying again is minimal

- Those with no roots or family ties are more likely to attempt suicide

- The majority of suicide attempts result in death

- Most people who attempt suicide fail in their attempt

However neither of these studies were specifically addressing young people and self-harm; moreover, as Anderson et al (2008) note society's attitudes towards religion and suicide have changed, and characterising suicide as an 'evil act' or a 'moral transgression' may represent outdated attitudes, a viewpoint recently confirmed in a research study by Witte et al (2010). Thus in order to determine the items to include in the tool I reviewed the above papers to identify the items from the SOQ scale that most commonly featured and that were relevant to my study. The outcome of this mapping can be found in appendix 7.

Listed below in Table 5.4 are the items that comprise the attitudinal element of the SOQ used in my questionnaire, column 2 represents the wording most commonly used in other studies, and column 3 shows the number of these published studies that have used the given item. As can be seen from Table 5.4, no statements from the SOQ were used by all the studies. When considering which statements to select I was mindful that my study was focussing on young people aged 12 – 18 years of age, consequently, for statements 1 – 8 the wording was amended to reflect the study's concern with young people. Statement nine was amended to reflect the research findings that relationships with family members is a key risk factor for self-harm in young people (Webb 2002, Evans et al 2004, Fox & Hawton 2004); statement 10 was included due to the research findings that the media and youth sub-culture are

influential in self-harm in young people (Fox & Hawton 2004, Young et al 2006), and could therefore be seen as a 'normal' rite of passage for young people who subscribe to the values and ideals of a given youth sub-culture, such as 'Goths' and 'EMO's'. Statements 11 – 14 were included as young people have themselves identified these as motives for self-harm (Hawton & Rodham 2006) and with the exception of statement 12 there was some correlation between these statements and those from other studies that have adapted the SOQ.

TABLE 5.6 **Items Comprising Suicide Opinion Questionnaire**

Statements used in this study	Correlating statements used in the 7 published studies relating to nursing	Number of these studies using the statements
1. Most young people who deliberately harm themselves don't want to die	1. Most people who try to kill themselves don't want to die	N= 3
2. Young people who deliberately harm themselves are trying to get sympathy from others	2. Those people who attempt suicide are usually trying to get sympathy from others	N= 3
3. Young people who deliberately self-harm are in desperate need of help	3. Suicide threats are not real they represent a cry for help	N= 3
4. Young people who attend having deliberately self-harmed themselves are likely to repeat this behaviour	4. Once a person survives a suicide attempt the probability of his/her trying again is minimal	N= 2
5. Young people who deliberately self-harm are attention seekers	5. Those who attempt suicide using public places (such as bridge or tall building) are more interested in getting attention.	N= 4
6. Young people who deliberately self-harm should be required to undergo therapy	6. Those who attempt suicide and live should be required to undertake therapy to understand their inner motivation	N= 3

TABLE   5.6 /cont   Items Comprising SOQ

Statements used in this study	Correlating statements used in the 7 published studies relating to nursing	Number of these studies using the statements
7. Young people who deliberately self-harm are more at risk of successfully completing a suicide attempt	Once a person is suicidal he/she is always suicidal	N= 5
8. Young people who deliberately self-harm are mentally ill	Suicide reflects mental illness	N= 2
9. Young people who deliberately self-harm are more likely to have difficult relationships with their families	Those with no roots or family ties are more likely to attempt suicide	N= 3
10. Deliberate self-harm is a normal part of youth culture	Everyone is potentially capable of suicide; suicide in young people is unacceptable	N= 2
11. Young people who self harm do it to show how desperate they are feeling	Suicide attempts are typically preceded by feelings that life is no longer worth living	N= 3
12. Young people who self harm do it because they want to frighten someone	No correlating statement	0
13. Young people who self-harm do it because they want to find out if someone really loves them	Often if feels as though suicide attempters are trying to make someone else sorry	N= 2
14. Young people who self-harm do it because they want to get their own back on someone	Suicide is a selfish behaviour	N= 4

As with the AYP scale, respondents were required to state their level of agreement on a five-point Likert-type scale. The negatively worded items reverse scored – which applied to the following:

- Young people who deliberately harm themselves are trying to get sympathy from others
- Young people who attend having deliberately self-harmed themselves are likely to repeat this behaviour
- Young people who deliberately self-harm are attention seekers
- Young people who self harm do it because they wanted to frighten someone
- Young people who self-harm do it because they want to find out if someone really loves them
- Young people who self-harm do it because they want to get their own back on someone

Throughout the process of developing the survey instrument the statements and questions were refined following internal and external expert review. This was facilitated through supervision with my PhD supervisors, and specifically drawing on the external expertise of Dr Bill Young, a child and adolescent psychiatrist who had both clinical, subject and methodological expertise in relation to self-harm in young people. The survey instrument was not formally piloted and given the relatively low response rates (see chapter 7) this iteration of the instrument and the results herein are considered a pilot. The reliability of the scales in terms of internal consistency was assessed using principal component analysis (PCA) the results of which are discussed in chapter 6.

5.6.5   Obtaining Qualitative Data – The Research Interview

As Kvale (1996:11) notes, '*in qualitative methods the basic subject matter is no longer objective data to be quantified but meaningful relations to be interpreted*'. In so doing he draws on two metaphors, the miner who is digging for nuggets of 'meaningful data' and the traveller who is constructing stories, these nuggets and stories being uncovered through the process of interviewing. Kvale, (1996) like Mishler (1991) presents the research interview as a form of discourse, where '*the interview is a situation of knowledge production in which knowledge is created*

between the views of the two partners in the conversation.... the construction of knowledge is not completed by the interaction of the researchers and their subjects, but continues with the researchers' interpretations and reporting of their interviews' (Kvale 1996:296).

Corbin & Strauss (2008) reveal that that for them, unstructured interviews provide the densest data, however as Morse & Field (1996) note unstructured interviews are frequently used when the researcher has little knowledge or insight into the topic area, and can also cause consternation with funding bodies and (ethics) committees as there are concerns about the effects on participants who may be discussing and disclosing information of a sensitive and traumatic nature (potentially a consideration in my study). On the other hand, semi-structured questions are used when the researcher has some knowledge of the topic area but 'cannot predict the answers', with respondents having the potential (dependent on the expertise of the interviewer) to tell their stories, thereby similarly providing a rich description (Morse & Field 1996:76). As semi-structured interviews involve the use of a topic guide, funding bodies and ethics committees are able to ascertain in advance the broad areas to be addressed by the researcher and thereby ensure that their requirements are addressed. In my case I have knowledge of the topic area as well as the research setting, and was also mindful of the need to secure ethical approval in a timely way, thus I opted for a semi-structured approach to my research interviews.

5.6.6   Reflexivity in the Research Interview

Having experience and therefore insight into the provision and management of children's accident and emergency care provided me with what Corbin & Strauss (2007) call sensitivity. Corbin & Strauss define sensitivity as being in contrast to objectivity, in that it requires the researcher '*to have insight, being tuned into, being able to pick up on relevant issues, events and happenings in data'*. They identify that insight doesn't occur in isolation, with theories and professional knowledge likely to inform our research in a number of ways. Indeed they go on to propose that *'professional experience can enhance sensitivity ... it can enable researchers to understand the significance of some things more quickly... as they do not have to spend time gaining familiarity with surroundings or events"*, however they caution *'that researchers must remember to compare knowledge and experience against the*

data, always work with concepts in terms of their properties and dimensions and it is what the participants are saying or doing that is important not the perceptions of the researcher' (Corbin & Strauss 2007:32), a factor I was mindful of both during the interviews and data analysis.

Being knowledgeable about a topic area as well as the research setting does raise some questions about subjectivity and the consequent interpretations of qualitative data. Debates abound in relation to the researcher as 'insider/outsider', as although interviews give participants an opportunity to 'tell their story', concerns arise in relation to the effects of the interaction between researcher and interviewee and the effect of the resultant social interaction, embedded within the interview process, on interview data (Melia 1997, Finlay 2002, May 2003, Lambert et al 2010). In order to review and reflect on researcher effects on the data, qualitative researchers undergo a process of reflexivity.

As Finlay (2002) observes, reflexivity can be understood in a multitude of ways, ranging from a confessional account of methodology, to an examination of the researcher's own personal and possibly unconscious reactions; it involves exploration of the researcher –researched relationships, or can review how the research is co-constituted and socially situated (Finlay 2002:224).

In collecting qualitative data I adopted Sandelowski's (2000b) viewpoint that qualitative description is the method of choice when 'straight descriptions of phenomena are desired, in order to get to know the, '*who, what* and *where* of events' (Sandelowski 2000b:339). To this end, and in line with the principles of pragmatism, the paradigm that underlies mixed methods research, my data collection and analysis was not guided by a qualitative paradigm such as ethnography, phenomenology or grounded theory and similarly was not guided by a 'theoretical lens' (Creswell 2009). Nevertheless as Sandelowski (2010) notes, qualitative descriptive research requires researchers to 'make something of their data' and in so doing Sandelowski (2010) advises that researchers make explicit where they were when they began their studies in order to enhance the interpretation (as opposed to 'mere celebration') of qualitative data (Sandelowski 2010:83).

May (2003) notes that 'the identity of the researcher is at the heart of reflexivity' (May 2003:21). Arguably, as individuals, we all have a number of identities, whether within our private (family domains) or in our professional/work domains. With regards to the former and of relevance to this study I have an identity as a mother to a teenage daughter, who has emerged through puberty into young adulthood as this thesis progressed. While she hasn't formally contributed to my processes of reflexivity, her observations as to, "why would someone my age want to talk to you, especially about self harm, if they have been self-harming" was an insightful observation that caused me to reflect on this as a possible reason why I had failed to recruit young people to the study, and similarly how I might present myself/be perceived by the practitioners I did interview.

Within my professional/work identity I consider myself to be a nurse sociologist, having professional registration as a children's nurse and having completed an MSc in Sociology of Health & Illness. As outlined in chapters two and three the theoretical basis of this study is a sociological analysis of the organisation of accident and emergency work, and the construction of adolescence as a life stage and how young people's behaviours have been theorised sociologically. These two positions were relevant as there remain questions as to whether young people are adversely judged in the same way that adults are, when they present to emergency services with diagnoses that attract labels of 'trivia' and 'rubbish', labels associated with 'unpopular' patients, as some patients, including those who self-harm, pose challenges to the organisation and negotiated order of, emergency services, challenges that I had personally encountered when working as a practitioner.

I was also mindful that as children's accident & emergency nurse, who has published in the field, my previous (scholarly) work, as well as my role within the university as a link lecturer to local children's A&E departments would have a bearing on the social interaction which occurs during the interview process.

I was aware of all the above when commencing both (interview) data collection and analysis. I employed both reflective writing and opportunities in supervision to analyse how my role and professional/academic background may influence and shape the data collected and how I might interpret this. Thus for example while I was

conscious that interview participants were unlikely to make explicitly negative comments or express negative attitudes towards young people and young people who self-harm, given my role, I was also conscious of not foisting a sociological interpretation/analyses of self-harm and young people's behaviours on what to the participants, was day to day practice experience.

I was also able to reflect with my supervisors on the merits (or not) of being an outsider to one A&E department and the difficulties this caused in terms of access, and being an insider in another, and the relative ease this gave in gaining access to this department. I also reflected on whether my (possibly perceived) credibility as a children's A&E nurse meant that the interviewees were more readily willing to 'tell their stories', as while I am an experienced interviewer, the interviewees spoke freely and at length of their experiences, which I decided on reflection was not solely down to my interviewing skills.

A key element of what I consider to be a success in obtaining the interviewees stories was the topic area I covered within the interviews themselves. My insider perspective allowed me to navigate easily into the language of emergency care work (for example I readily understood the terms 'revolving doors' and 'frequent flyers'). I was able, if required, to contextualise the topic areas identified on the interview schedule or clarify if required, given my knowledge of emergency car work.

5.6.7   Topic Guide for Interviews

Within the context of a mixed methods approach, the topic areas for the interviews needed to both address the specific research questions (as previously discussed) as well as provide an opportunity to explore whether the findings from the qualitative data were consistent with, and/or added to findings from the quantitative data. Creswell & Plano-Clark (2007) advise that many researchers do not always consider what element of the quantitative analysis will be followed up in the qualitative component of the research. It is difficult however to predict at the planning stages of a study what elements might need to be pursued in the qualitative element of the study, and thereby provide the research ethics committee with an accurate account of the topics that will be covered in the interviews. Consequently the topic areas were suitably broad to encompass a range of issues that were pertinent to the research

questions while enabling me to further explore any similarities and differences, which might emerge (Creswell & Plano-Clark 2007:137) (see appendix 8 for topic guide).

Notwithstanding this, it became apparent from qualitative comments on the returning questionnaires that respondents experienced difficulty in locating ongoing help and support as exemplified by the following:

> *"With reference to your final question, the problem with self-harm is that it is constantly being laid at the door of A & E Departments. Every day I see persistent failures from social services and mental health authorities who use the line, just phone 999 on a daily basis. Crews just become case hardened"* (LASC1 5 068)

> *"The guidelines are applicable to adolescents presenting with clear mental health issues as opposed to self-harm, although, most children and adolescents have very poor provision made for them as paediatrics are very reluctant and inexperienced, as too are the psychiatric services - CAMHS are more often than not too busy to see new patients in the A & E"* (QM37 64 RN Child)

> *"It's always difficult to refer to psychs with the12 – 18 age group. Our guidance is that all self harm are referred to paediatric registrar for admission until CAMH's can assess (usually not until 24 hours later). If a child is aggressive the paed reg does not want them on children's ward and always difficult to find child psych placement if that is more appropriate"* (QH 81 114 RN).

Thus, as the interviews progressed the emphasis placed on the challenges the participants faced in caring for young people who self-harm became more orientated towards the difficulties staff faced in 'moving young people on'.

5.7   Data analysis

In keeping with the mixed methods approach adopted for this study data analysis was undertaken with a view to ensuring that both sets of data were treated equally and that each data set informed the other, thereby integrating the data. It is acknowledged by a

number of writers (for example, Bryman 2006, Bazeley 2009a Bazeley 2009b Woolley, 2009) that the subject of integration of data with mixed methods approaches is problematic, partly due to epistemological concerns and debates, and partly because there have been, in what is seen as a relatively new approach to research, few good quality papers that have been published that demonstrate to others how integration might occur. As a novice researcher I found this to be the case myself.

As Bazeley (2009a) notes, many published papers treat the data sets separately, with lack of integration resulting in lost opportunities for richer and deeper analysis. Notwithstanding this, Moran-Ellis et al (2006:54) identify that '*the challenge of an analysis that is integrated in any sense lies in developing some form of common analysis of a diverse set of data without losing the characteristics of each type of data*', a challenge that I personally wrestled with. Bearing this in mind, the approach adopted for the analysis of the two sets of data was in alignment with the paradigm associated with each method. Thus the quantitative data were analysed statistically to provide an overall description of the sample and to explore relationships between the variables, thereby providing a measurement perspective on practitioners' attitudes towards young people and young people who self-harm and factors that might interact with and influence the relationships between the variables. The qualitative data was subjected to thematic analysis thereby providing a 'rich description' of nurses and LAS personnel's experiences in relation to caring for young people who self-harm, in the context of emergency care work.   Finally the qualitative data was further interrogated aligning narrative descriptions as allocated to a theme, with the statements associated with the two scales used in the quantitative element of the study. Details of the data analysis for each component are discussed in more detail below.

5.7.1   Analysis of Quantitative Data

Quantitative data was analysed using SPSS. Having entered the data onto the database it was initially screened to check for errors. The reliability was assessed using the reliability analysis facility on SPSSS, the measurements produced from this analysis providing an indication of a scale's internal consistency. The most commonly used indicator used from this SPSS output is the Cronbach Alpha score (Pallant 2007)

which tests the internal consistency of items within a scale to ensure that they are all measuring the same thing (Bland & Altman (1997).

Factor analysis was also undertaken, which as Pallant (2007) advises, is widely used to evaluate tests and scales; it also allows for a large set of variables or items from a scale to be condensed, thereby enabling a smaller more manageable number of dimensions or factors for the purpose of analysis (Pallant 2007). Factor analysis encompasses a range of techniques including principal component analysis (PCA), the technique adopted for this study; PCA involves the transformation of the original variable into a smaller set of linear combinations, with all the variance in the variables being used (Pallant 2007:180). Following factor analysis, items were removed from the initial scales (AYP reduced from 10 items to 8, AYPSH, reduced from 14 items to 11). As a consequence minimum and maximum scores were adjusted accordingly.

Having ascertained the internal consistency within the two scales, the 'normality' of the two dependent variables (AYP & AYPSH) was assessed, as many of the parametric tests rest on the assumption that there is a normal distribution of responses within the variables under scrutiny. This test was undertaken using the 'Explore" feature on SPSS. In reviewing the output the mean scores were compared with the trimmed mean score to determine whether extreme scores influenced the mean score. Skewness and Kurtosis values were also reviewed to determine whether/where there was any clustering of scores. The Kolmogorov statistic was reviewed to ascertain the normality of the distribution (Pallant 2007).

Once the degree of consistency and normality of distribution of the scales had been determined, Pearson product-moment correlation was performed to provide a summary of the strength of the relationships between the AYP and APSH scales and items on them. Pearson product-moment correlation coefficient can range from -1 to +1. Pallant (2007:120) advises that the size of the absolute value provides an indication of the strength of the relationship, with a perfect correlation of 1 or -1 indicating that the value of one variable can be determined exactly by knowing the value on the other variable, whereas a correlation of 0 indicates no relationship between the two variables. The relationship between variables can be inspected visually on a scatterplot, which also provides information on both the strength and

direction of the relationship. Details of the process and outcome of PCA, the distribution within and relationships between the scales are reported on in Chapter 6.

Having ascertained the degree of consistency and normality of distribution of the scales, descriptive statistics were carried out in order to determine the level of concordance between each item on both scales and mean scores for each occupational group. Having computed mean scores, and ascertaining the level of internal consistency, normality of distribution and correlation between the scales, analysis then focused on comparing mean scores of the two scales (dependent variables), with independent variables (e.g. occupation). One and two-way between groups Anova and t-tests were then performed; data met the requirements for such tests as:

- Dependent variables were obtained from continuous scales and were not categorical

- Responses ere independent of each other (this was assured as the survey was completed by individual participants)

- Normality (of distribution) was confirmed

- Levene's test for equality of variance was performed and confirmed that I had not violated the assumption of homogeneity of variance; the **Sig** value of the Levene's test was greater than 0.5 (Pallant 2007).

The only assumption not met was random sampling, however Pallant (2007) confirms that 'this is often not the case in real-life research' (Pallant 2007:203).

A one-way between groups ANOVA was used to compare mean scores of both scales, with one independent variable. This test was selected as I was aiming to determine whether there was a difference in scores on the two dependent variables [AYP & AYPSH] with each one of the independent variables (occupation, age and length of experience). In addition to the above, an ANOVA test also assumes that variances are equal (Fowler et al 2002) with samples obtained from populations of equal variances (Pallant 2007).

After conducting the one-way between groups ANOVA I employed post-hoc comparisons, as I wanted to conduct a set of comparisons, exploring the differences between each of the groups, while ensuring that the risk of a type 2 error (failing to

reject a null hypothesis) was minimised (Fowler et al 2002, Pallant 2007). Where the result of the final *F-* test in the ANOVA indicated that there was a significant difference post-hoc 'Tukey' tests were applied, this test assuming equal variance, to determine which means were significantly different from the other.   Where a statistically significant difference was noted, I also calculated the effect size (*eta* squared) to further establish the strength of the relationship between the variables under scrutiny.

Having performed the one-way analysis of variance I also where relevant, conducted a two-way between groups ANOVA. This allowed exploration of more than one independent variable against the dependent variable(s), in order to look at the individual and joint effect of two independent variables on one dependent variable, because as Pallant (2007:257) noted, 'the advantage of using a two-way design is that it is possible to test the *main effect* for each independent variable and also explore the possibility of an *interaction effect'*. As with the one-way between groups ANOVA I ascertained that the variance across groups was equal using Levene's test of equality of error variances.

Where the independent variables were not suited to analysis of variance using a one-way between groups ANOVA, an independent samples t-test was performed. This applied to the following independent variables:
- Gender
- Attendance at training that addressed self-harm (or no training)
- Witnessing the scenario (or no experience of the situation represented in the scenario)

The purpose of this test was to ascertain whether I was testing the probability that the two sets of scores (male or female, attended training or not, witnessed the scenario or not) came from the same population (Pallant 2007).

Findings from the data analysis of trends and interactions relating to scores across the two scales are presented in Chapter 7 with figures used to illustrate results.

5.7.2 Thematic Analysis of Qualitative Data

Data from the interviews was transcribed and subjected to thematic analysis. Thematic analysis is defined as '*a method for identifying, analysing and reporting patterns (themes) within data (*Braun & Clarke 2006:79) When undertaking analysis of the qualitative data I was guided by the principles outlined by Creswell (2009), Howitt & Cramer (2008) and Braun & Clarke (2006), who note that while thematic analysis is widely used and cited as a method of qualitative data analysis it has received little attention in respect of how it should be undertaken. Given that thematic analysis is not associated with any particular theory or method and its flexibility means that it can be used within different theoretical frameworks (Howitt & Cramer 2008, Braun & Clarke 2006), it seemed appropriate to adopt this approach to analysing my qualitative data, as a mixed methods approach can be independent of theoretical approaches such as grounded theory, phenomenology, conversation or discourse analysis.

Themes can be generated from the data by adopting either an inductive or deductive approach (Howitt & Cramer 2008:337 Braun & Cramer 2006). The former is associated with themes being closely related to the data, bearing little relation to the research questions, nor informed by the area/topic of the research, with no pre-existing coding frame devised, codes wholly arising from the data itself, the approach being data driven. Conversely, a deductive approach is theory driven in that it is based on the researcher's theoretical or analytical interest, which according to Braun & Clarke (2006) means that the analysis tends to provide less rich description and a more detailed analysis of some aspect of the data. The focus on some aspect of the data occurs because the analysis may focus on specific research questions, which was a relevant consideration given that the mixed methods approach enables the researcher to adopt different approaches to address different research questions. As noted earlier in this chapter, the qualitative element of this study sought to explore both the attitudes of participants towards young people in general and young people who self harm, as well as seeking additional insight into how the care of these young people is managed within the context of emergency care work; thus the data analysis arising from the semi-structured interviews needed to take account of the research questions which pertained to this element of the study.

Braun & Clarke (2006) and Howitt & Cramer (2008) both suggest six clearly defined stages to the development of themes; these stages were adopted for my thematic analysis as follows:

1. Familiarisation - whereby I transcribed the data, getting a sense of the whole. This also involved writing notes (or memos) as I began to make some interpretations.

2. Generating and listing initial codes, then applying these across the data set, thereby allowing suggestions as to what is happening in the data.

3. Searching for themes – through reduction of categories and collapsing together the coding in a meaningful way

4. Reviewing themes – revisiting the data to check to see if the themes work against the coded extracts and then the whole data set.

5. Defining and renaming themes – determining how one theme is differentiated from another, generating clear definitions for each of the themes.

6. Writing up – reflecting on the data and using extracts to illustrate the meanings ascribed to the themes (this will be presented in the results chapter)

The twelve interviews were conducted over a six-month period. As the interviews were undertaken they were transcribed into written (word processed) form, thereby allowing me to familiarise myself with the data as it was collected. As I transcribed I would continually reflect on what I was learning from the participants, writing memos and asking questions. Thus for example coincidentally I conducted two interviews with female nurses both within the same week; both reported that they had noticed changes over their years as nurses in respect of how self-harm was viewed by their peers. This led me to note on the transcripts a question about whether self-harm was becoming more 'problematised' or 'medicalised' thereby making it more acceptable to practitioners, and if this was the case why was this happening? These initial thoughts would as Braun & Clarke (2006) suggest reflect the fact that the transcription of the interviews is a key phase of the data analysis, recognised as an interpretive act, as the researcher actively begins to make sense of and construe meanings from the data.

Once all transcribing had been completed the transcripts were reread several times, this allowed me to further immerse myself into the data; however, while I became increasingly familiar with data I found that I would forget key points raised by an early respondent by the time I re-read the transcript from a later participant, as the data revealed numerous key issues that to begin with were difficult to make sense of. I therefore produced a descriptive summary of each transcript and added further memos to self as each script was further reviewed. This process assisted me in beginning to get a sense of possible codes; by the time I summarised the 10th transcript I noticed that my memos were beginning to reflect possible codes, as similar issues were being noted across the transcripts.

As noted above the identification of codes can be inductive or deductive, but as I am familiar with both the theory and practice of emergency care work with children and young people and, following the literature review, aspects of self-harm in young people, I adopted an inductive theory led approach. I was therefore anticipating that some of the codes would be around attitudes towards young people, and attitudes towards young people who self harm. Similarly some of the codes would reflect A&E work such as physical assessment, and moving patients through, but as disused in an earlier chapter, attitudes are multi-faceted, and emergency care work is complex. The number of codes that were initially generated reflected this complexity.

The data analysis was managed using 'Word' documents. As codes were identified they were given a colour coding and the text ascribed to the codes was highlighted on the transcribed Word document accordingly. Initially 31 codes were identified, although not all transcripts contained all codes, and some elements of the transcripts were assigned more than one code, as indeed there was overlap amongst the codes - these codes were therefore collapsed providing 26 codes, the collapsed code retaining the title of the dominant element of the group of codes. Thus the code 'Fix" was moved to 'Focus,' the codes 'ADJ', and 'Good/Bad [patient]' were moved to 'Good/Bad [young person], and the code 'Rpt' was moved to 'Privacy'. Tables 5.7. a and b provide details of the codes ascribed.

Having coded all the transcripts the text ascribed to each code was lifted into 26 different Word documents, each document reflecting one of the codes. I then read

through each of the 26 code documents to get a further sense of the data and to begin to search for themes, as Howitt & Cramer (2008:345) suggest that *a theme can be seen as a coding of codings.* While I had begun to get a sense of the possible themes I still found it difficult to manage the array of data within each code; I therefore summarised each of the 26 codes identifying the repeating patterns within each code, which provided me with more clarity. I then put these onto separate pieces of paper and laid them out on the kitchen table. This enabled me to (literally), move my codes around. Ultimately three themes emerged as follows:

- 'Positioning Self-Harm in Young People'
- "Good" and "Bad" Young Self-Harmers'
- 'Self-harm work in A&E' [working with contradictions].

Tables 5.7a &b show coding categories, Figure 5.4 below shows the interrelationship with the codes and themes.

TABLE 5.7 a Codes for Qualitative Data (1)

Code	Explanation	Code	Explanation
	Expressed or observed example of an attitude	DESCRIPTIONS OF SELF-HARM	Examples provided by practitioners of injuries etc which constitute self-harm
INTENTION -	How practitioners perceive the YP's intentions when harming	TIME/TIMING	Not enough time, or speed needed, time spent
CONSEQUENCES.	For YP – fear of parents, care etc	UNWANTED	YP not wanted in a service – could have been nowhere to go.
UNDERSTANDING	Level of understanding practitioners demonstrate in relation to SH motives		YP as vulnerable or YP as problematic
FOCUS	Focus on the physical or focus on the emotional needs of YP	DESCRIPTIONS	Descriptions of young people who have self-harmed or responses to self harm
MOVING ON	Having to move patients through the service(s) to final destination		Defining a cry for help distinguishing from attention seeking
JUDGEMENT	Judgements made by practitioners, which are not based on a clinical measure	PT Mnt	Processing patients through A&E
ACCESS TO EXPERTISE	Access to a HCP/service who has expertise required for either the patient or practitioner		Needing to get more information;
ALCOHOL	Discussion of alcohol in context of YP's lives (normal) and SH	ENGAGEMENT	Level of engagement with YP – clamming up
PARENTAL REACTIONS	Observed reactions (by practitioners) of parents		Invoking authority – the role of uniform
RISK	At risk from harm – YP or practitioner YP = risk of further attempts and suicide, practitioners at risk of missing this and also at risk if YP aggressive.	ADJ	Adjectives describing approach to YP who SH
GD/BAD	Good/bad patient	COMP DEM -	Competing demands placed on practitioners how balanced and effect;
RPT	Having to repeat the story	CONFIDENCE	Reference to having (or not) confidence/experience
FIX	Emphasis on fixing/mending/cure	DOC	Documentation (inc guidelines, policy, action plans)
PRIVACY	Needing somewhere private – and confidential	PAEDS	Benefits of paediatrics (training, staff = better care, or not)
IMPOTENT	Unable to do anything for YPSH due to barriers, treat to the best of ability		

TABLE 5.7b   Codes for Qualitative Data (2)

Code	Explanation	Code	Explanation
	Expressed or observed example of an attitude	DESCRIPTIONS OF SELF-HARM	Examples provided by practitioners of injuries etc which constitute self-harm
INTENTION -	How practitioners perceive the YP's intentions when harming	TIME/TIMING	Not enough time, or speed needed, time spent
CONSEQUENCES.	For YP – fear of parents, care etc	UNWANTED	YP not wanted in a service – could have been nowhere to go.
UNDERSTANDING	Level of understanding practitioners demonstrate in relation to SH motives	GD/BAD ADJ	YP as vulnerable or YP as problematic Good/bad patient Adjectives describing approach to YP who SH (gentle etc all denote vulnerable)
FOCUS FIX	Focus on the physical or focus on the emotional needs of YP Emphasis on fixing/mending/cure	DESCRIPTIONS	Descriptions of young people who have self-harmed or responses to self harm
MOVING ON PT Mnt	Having to move patients through the service(s) to final destination Processing patients through A&E		Defining a cry for help distinguishing from attention seeking
JUDGEMENT	Judgements made by practitioners, which are not based on a clinical measure		Needing to get more information;
ACCESS TO EXPERTISE	Access to a HCP/service who has expertise required for either the patient or practitioner	ENGAGEMENT	Level of engagement with YP – clamming up
ALCOHOL	Discussion of alcohol in context of YP's lives (normal) and SH		Invoking authority – the role of uniform
PARENTAL REACTIONS	Observed reactions (by practitioners) of parents	RISK	At risk from harm – YP or practitioner – risk adverse as at risk
IMPOTENT	Unable to do anything for YPSH due to barriers, treat to the best of ability	COMP DEM -	Competing demands placed on practitioners how balanced and effect;
CONFIDENCE	Reference to having (or not) confidence/experience	PRIVACY RPT	Needing somewhere private – and confidential Having to repeat the story
DOC	Documentation (inc guidelines, policy, action plans)	PAEDS	Benefits of paediatrics (training, staff = better care, or not)

Figure 5.4   Interrelationship Between Codes and Themes.

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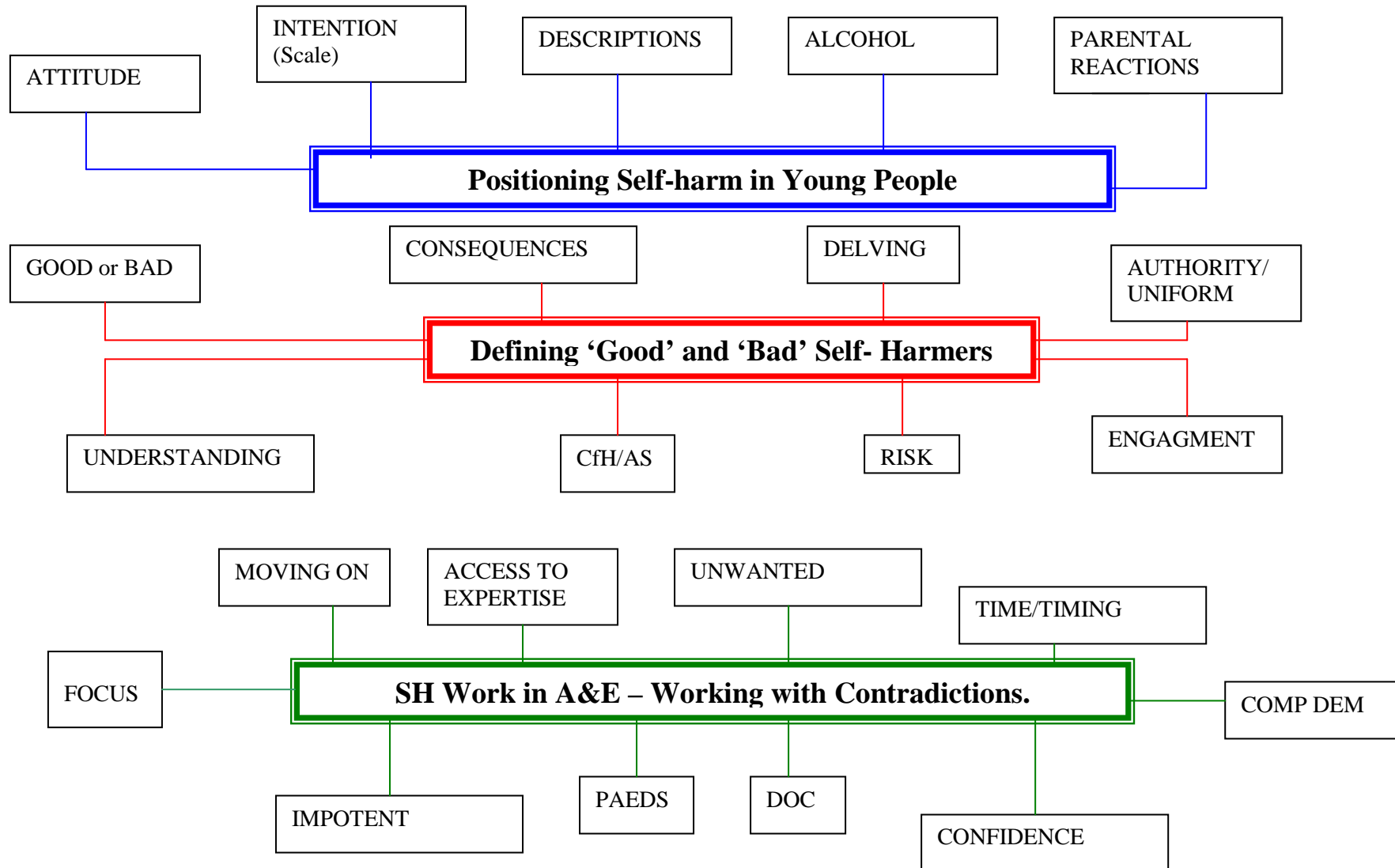
5.7.3 Integration of Quantitative and Qualitative Data

As noted above there is debate within mixed methods literature as to when, where and how integration of data within mixed methods research occurs. Moran-Ellis et al (2006:51) argue that integration 'denotes a specific relationship', this relationship referring to the use of two or more methods which retain their distinct paradigmatic basis but which are 'intermeshed with the purpose of knowing more'; they propose that integration can occur at any point, albeit on a continuum, with integration occurring at the conceptualising point being referred to as integrated methods, while acknowledging that integration might occur at later stages. They distinguish integrating methods from combining methods; the latter while using two distinct methods normally employs one only as an adjunct, the distinction being therefore that integration requires an equal weighting to be given to both methods and their analysis. Creswell & Plano-Clark (2007:64) identify variations of the triangulation design, which include the convergence model; this model involves the comparison of the results across the two data sets, and occurs during the interpretation stage. This was the approach adopted for this study, an approach that Moran-Ellis et al (2006:55) refer to as interpretive integration, '*where an explanation is generated from the empirical work which incorporates the knowledge produced by the different methods, blending it into a coherent account*'.

The type of mixed method approach selected influences the approach to integrating the data, with data merged or embedded in concurrent approaches, whereas in sequential designs the data from the first element of the research is used to inform data collection and thus analysis in the second phase (Cresswell & Plano-Clark 2007). Thus, in a triangulation design, it is generally qualitative data will be used to inform, complement, add to and directly compare and contrast, quantitative statistical results, and in doing so, data from the two data sets are merged.

A number of approaches to analysing merged or embedded data in mixed methods research are apparent. In concurrent strategies Creswell (2009) identifies data transformation, which involves transforming numerical data to textual data or vice versa; examining multiple levels by (qualitatively) exploring particular phenomena with specifically identified participants who took part in a survey; and the creation of

a matrix or matrices which combine information from both quantitative and qualitative elements of the study.

As noted above, the interviewees were unable to be matched to the quantitative element of the study due to the anonymity assured to participants when completing the questionnaires; it was not possible therefore to compare interview transcripts of respondents with their results from the questionnaire. Indeed not all the interviewees had undertaken the survey element of the study, and with the benefit of hindsight, where this applied I could have started the interviews by administering the questionnaire - this was an opportunity lost. Thus the approach adopted for integrating the data following the separate (statistical and thematic) analysis was the use of case analysis and matrices.

As identified in Figures 5.2 & 5.3 (see pages 113-114), there were two areas where both quantitative and qualitative data would inform the findings of the study, 'attitudes', and 'emergency care work', these areas are therefore explored through the matrices (see appendix 9-12).

The first matrix (see appendix 9) is presented as a précised summary of each interviewees' accounts. In the matrix the key messages from each transcript were assigned to one of three columns representing the two scales, AYP AYPSH and emergency care work; these are represented on the horizontal axis, with each interviewee accounted for on the vertical axis. The précised accounts were colour coded according to which final theme the statement reflected, with red denoting Theme 1 (Positioning self-harm in young people), blue, Theme 2 (Defining 'good' and 'bad' young self-harmers), and green, Theme 3, (Emergency care and self-harm work).

The second set of matrices (appendix 10) included the codes from the interview transcripts on the vertical axis and the participants' code on the horizontal. The number of times each code appeared in their transcript was listed. The matrix was replicated four times and analysed by occupation, gender, age and length of experience; a column was included entitled 'analyses where my observations on trends were made.

The third set of matrices (Appendix 11 & 12) employed the statements from the AYP and AYPSH scales (respectively), with the means scores[12] and percentage level of agreement from nurses and Paramedics & Ambulance Technicians (PAT) identified alongside each item from the scale; these were placed on the horizontal axis. The participants' transcripts were then re-reviewed and relevant phrases that applied to the statements were inserted onto the matrices with the respondents code included so that each interviewee's responses could be reviewed against the statements from the two scales. The phrases were compared to determine whether they were in alignment with the scores against each statement. The respondents who had the most responses against each statement were then selected for case analysis, their transcripts being reviewed specifically for further comparisons.

The matrices were then reviewed and analysed to determine patterns in order to identify where the two data sets were consistent and whether/where discrepancies existed. For example, during the thematic analysis it was apparent that the LAS personnel did not seemingly feature in the data relating to the 'unwanted' category and were overall less represented during the third theme than the other two. The analysis of the matrix containing précised accounts confirmed this, and percentages applied to the number of responses by occupation were identified. Thus for example, on the AYHSH scale item '*Most young people who deliberately harm themselves don't want to die*' was matched against the qualitative comments '*More of a "I'm very upset for whatever reason, I'm going to swallow a handful of pills and that will be that" (P006).* Similarly on the AYP scale *item, most young people are responsible and well behaved* was matched with, *definitely I would say yes I've been intimidated before* (P008).

Using the matrices to further explore the data sets encapsulates the essence of a triangulation design, as through the matching of the data a further data set arises, the resultant comparisons that arise both informed by, and supporting, the two initial data sets. Matching the comments to the items on the scale in the 3rd sets of matrices

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[12] The mean scores for ambulance technician and paramedics were added together and divided by 2 as equal number of paramedic and technicians participated in the survey whereas only one technician participated in the interviews. Consequently the ambulance technician who participated in the interviews was for the purpose of coding assigned the code of paramedic.

(appendix 10 & 11) enabled me to determine where similarities and contrasts arose. Thus for example on the item, *most young people are responsible and well-behaved,* 67% of the survey respondents agreed with this item, however the comments from the interviewees did not fully support the score obtained, although as discussed in section 10.4 the interviewees tended to discuss young people's behaviour in the context of alcohol and its (adverse) effects. Whereas in relation to the item '*Most young people who deliberately harm themselves don't want to die',* 85% of survey respondent agreed with this statement and comments from the interviewees similarly supported this view.

5.8   Summary

In this chapter I have detailed the methodology used for this study: a mixed methods approach using a triangulation convergent design to look at within and between groups' factors. As has been discussed, the basis of good mixed methods research is clear signposting through clear articulation of mixed methods research questions. The nature of the research questions evolved as the study progressed; this required re-working of the questions to account for the need to explicitly consider the organisational processes which are fundamental to emergency care work, and whether/how they might influence staff attitudes and perceptions of young people who self-harm. Secondly, it was not ultimately possible to recruit young people to the study, thus this element of the research as initially planned was not undertaken. This similarly led to a revision of the research questions for the study.

Given that the SOQ has been the most commonly used instrument to ascertain attitudes towards self-harm in previous studies, this was used as the basis for the AYPSH scale in this study. However modifications were adopted, with adaptations to account for the fact that this study was measuring attitudes towards young people and self-harm and also included statements that represent young people's motives for self-harm, thereby ascertaining participants' knowledge of these. THE AYP scale was based on research that had examined public attitudes towards young people in the context of young people and crime (Anderson et al 2005), with relevant statements employed for this study. To this end the survey instrument was a pilot, as the combination of the scales and the extent to which they measured what they set out to measure has not previously been ascertained.

Qualitative data was obtained using semi-structured interviews, although not as initially planned in terms of the research setting. This similarly changed as the research progressed due to issues around access and the expertise of staff working in the department concerned. Paramedics were also involved in the interviews, again this was not initially planned and as such this was an oversight in the initial planning stage. Throughout the study amendments to the design and data collection were agreed through both the University and local (NHS) research ethics committees.

Managing data in a mixed methods study has proved to be challenge, particularly given the need to integrate the two data sets in order to determine clearly where the data sets were consistent or not. The process of data analysis has been outlined above, and results from this analysis are presented in the subsequent chapters.

CHAPTER SIX

PRELIMINARY DATA ANALYSIS

6.1   Introduction

At the commencement of the study a methodological decision was made to use two scales to determine if there was a relationship between attitudes towards young people generally and attitudes towards young people who self-harm. Thus, as outlined in Chapter 5, two scales were devised (1) the Attitudes to Young People Scale (AYP) and (2) the Attitudes to Young People who Self-Harm (AYPSH). The AYP scale drew statements from a survey, which examined public attitudes towards young people; the AYPSH scale included items that derived from the work of Domino et al (1980) in the widely used suicide Opinion Questionnaire (SOQ), a scale that has been widely used and adapted, this iteration also reflecting further adaptations. The resultant scales had not therefore been previously tested in their current format. In this chapter I will describe how the two scales (AYP & AYPSH) were validated and present the findings of tests undertaken to assess their internal consistency, normality and the correlation between them.

6.2   Validity and Reliability of the AYP Scale

As discussed in Chapter 5, the items that comprised the AYP scale arose from a subs-section of the survey instrument devised by Anderson et al (2005) with three additional items included reflecting debates about young people's behaviour and the changing nature of childhood/adolescence. Ten items were listed and comprised this scale as follows:

- The behaviour of young people today is no worse than it was in the past
- The views of young people aren't listened to enough
- Girls are more badly behaved than boys
- Most young people are responsible and well behaved
- Young people today have no respect for adults
- Most young people are helpful and friendly
- Adults have no respect for young people
- Young people today are not disciplined by their parents

- Young people today don't get enough care and attention from their parents
- Young people today have more stress in their lives than they did before.

Respondents were required to indicate whether they 'strongly agreed', 'agreed', 'neither agreed nor disagreed' 'disagreed' or 'strongly disagreed' with each statement on the scale; strongly agreed attracted a score of 5, whereas strongly disagreed attracted a score of 1. Negatively worded items were reverse scored – which applied to the following:

- Girls are more badly behaved than boys
- Young people today have no respect for adults
- Young people today are not disciplined by their parents
- Young people today don't get enough care and attention from their parents.

Although logistic regression was used to analyse the variables used in the survey on Public Attitudes towards Young People and Youth Crime, (Anderson 2005), only seven statements used in Anderson's (2005) survey were relevant and used in this study. As such they were not within the 'block of variables" (Pallant 2007) which formed the basis of that analysis. In order to check the reliability of the scale I undertook the Cronbach Alpha test, which as Bland & Altman (1997) note tests the internal consistency of items within a scale to ensure that they are all measuring the same thing.

I undertook the test twice, firstly on the initial seven statements only and then I repeated the test adding the three statements devised specifically for this study. The former construction yielded a Cronbach Alpha of 0.46, the latter 0.52. It is advised that a scale has a minimum of 10 items in order to perform the Cronbach Alpha and ideally the score should be 0.7 or above (Pallant 2007), although there is some debate around what is acceptable as a minimum score, with some writers proposing that 0.6 is adequate, particularly if the scale has a small number of items (Garson 2008). Pallant (2007) advises that where scales have a small number of items, the mean inter-item correlation value should also be examined. In the case of the former (Anderson's items only), the mean inter-correlation is 0.1 with a range of -.154 to .399, which suggests a weak correlation between the items. Where the scale included my

additional items the mean inter-item correlation was .94 with a range of -.317 to .793 demonstrating a wider range and evidencing a weak correlation between the items.

The inter-item correlation matrix (using the ten item scale) identified two items demonstrating negative values, 'girls are more badly behaved than boys nowadays', and 'young people don't get care and attention'. Removing these two items resulted in a Cronbach Alpha of 0.56 (which rounded up is equivalent to 0.6). The mean inter-item correlation of .13 is lower than recommended; Pallant (2007) reports that this should be between 0.2 & 0.4. Consequently, *in order to identify a small set of factors that represent the underlying relationships among a group of related variables* (Pallant 2007:185) factor analysis using principal component analysis (PCA) was undertaken on the revised version of the scale, which excluded the above two items.

Pallant (2007:185) advises that there are a number of assumptions that need to be met as follows:

- Ideally a sample size of 150+ although my sample size was 143, the Kaiser-Meyer- Olkin Measure of sampling adequacy was 0.65 and meets this assumption (Pallant 2007).
- The correlation matrix should show some correlations of *r=.3* or greater, the Bartlett's test of sphericity should be statistically significant at *p <.05*
- The relationship between the variables is linear
- Extreme outliers should be removed as factor analysis is sensitive to this (my data was checked for the effect of outliers and found not to have any that had a significant effect as evidenced in the trimmed mean scores)

Consequently, prior to performing Principal component analysis (PCA) the suitability of the data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of coefficients of 0.3 and above, as noted above the Kaiser-Meyer-Olkin value met the required level suggesting an adequate sample size. The KMO and Bartlett's test reached statistical significance, *p=.000* thereby supporting the factorability of the correlation matrix (Pallant 2007:197).

Principal component analysis (PCA) revealed three components with Eigen values

exceeding 1 explaining 25.8%, 17.9% and 13.1% of the variance respectively. On the basis of this information and the scree plot a forced two-factor component analysis was undertaken. The two-component solution explained a total of 43.8% of the variance. Oblimin rotation was performed which revealed a simple structure, generally variables loading only on one component. The pattern and Structure Matrices are presented respectively in Tables 6.1 and 6.2 below.

TABLE 6.1 AYP Scale Pattern Matrixes

	Component	
	1	2
YP have no respect for adults	.811	
YP not disciplined by parents	.783	
YP responsible and well behaved	.598	
YP's behaviour is no worse today	.547	
YP's views aren't listened to		.715
Adults have no respect for YP		.703
YP have more stress than before		.531
YP are helpful and friendly		.375

TABLE 6.2   AYP Scale Structure Matrix

	Component	
	1	2
YP have no respect for adults	.816	
YP not disciplined by parents	.749	
YP responsible and well behaved	.631	.310
YP's behaviour is no worse today	.554	
YP's views aren't listened to		.726
Adults have no respect for YP		.672
YP have more stress than before		.536
YP are helpful and friendly		.387

When interpreting the results from the two-component PCA it is difficult to draw comparisons with previous findings because as noted above the statements were not previously used as items on a scale. When looking at emerging patterns from the above structure and pattern matrices, in both components the first two factors represent a possible cause of behaviour, the second two items an effect – i.e. in component one, 'young people have no respect for adults' and 'adults do not discipline young people' could be seen to be paired, while the outcome, young people are responsible and well behaved as well as their behaviour being no worse today are also closely matched. Similarly in component two 'young people's views aren't listened to' and 'adults have no respect for young people' could similarly be paired, while the outcomes, 'young people have more stress' and 'young people are helpful and friendly' could be seen as outcomes.

Overall the factor analysis using PCA demonstrates that by employing eight items the AYP scale hangs together reasonably well, although the relationships within the two components are to some extent open to interpretation; the scale warrants further refinement and testing in future research, this manifestation of the AYP scale being employed as an initial pilot. Consequently, for the purpose of this study, the following two items were removed from the scale (but retained within the survey tool) 'girls are more badly behaved than boys nowadays', and 'young people don't get care and attention'. Minimum and maximum scores were adjusted from 10 – 40 to 8 - 40

6.3. Validity and Reliability of the AYPSH scale.

Despite its frequent use, it is widely acknowledged that there have been debates about the validity and reliability of the SOQ (Kodako 2010) with a number of variations of the tool subsequently developed (Domino 2005, Anderson et al 2008, Kodaka 2010) with no consensus on factor structure achieved (Kodaka 2010). The SOQ has previously entailed 15 factors with 100 items (Domino et al 1982), 5 factors with 52 items (Rogers & Deshon 1992), both of which Anderson et al (2008) propose are not supported by factor analysis – they therefore proposed a two factor model with 32 items, which similarly was not supported through confirmatory factor analysis. The internal consistency of the scale and its variations have also evidenced low reliability scores, with 'most α coefficients lower that 0.7' with no consensus on the

reproducibility of the SOQ sub-scales (Kodaka 2010). Moreover both Kodaka (2010) and Anderson (2008) note the complexity of the SOQ, which combined with its length means, they suggest, that it is not suitable for clinical use.

It is perhaps not therefore surprising that my adaptation of the tool has also revealed a relatively low Cronbach Alpha reliability score of 0.52. It is difficult to determine whether this has been a feature of the adaptations used in studies examining nurses' and other health professionals' attitudes as only McLaughlin discusses the reliability score, which in her study was 0.7. In the light of the low Cronbach Alpha score I reviewed the Inter-Item correlation matrix; two items demonstrated some negative scores, 'young people who self-harm should be required to undergo therapy' and 'self-harm is a normal part of youth culture', these were therefore removed from the scale (but retained in the questionnaire), which resulted in a Cronbach Alpha score of 0.62.

As with the AYP scale factor analysis using PCA was performed, the AYPSH scale meeting the suitability requirements as indicated by the Kaiser-Meyer- Olkin Measure of Sampling adequacy (0.65) the presence of many coefficients of 0.3 and above; the Bartlett's and KMO test reached statistical significance *p = 0.000* thereby also supporting the factorability of the correlation matrix. Similarly a two-component extraction using PCA was undertaken. Both the pattern and structure matrices revealed that the two components represented positive statements (component one) or negative (component two). However the item, 'most young people who harm themselves don't want to die' did not feature in either component and was consequently removed from the scale for analysis purposes. Removing this item resulted in a Cronbach Alpha score of .62. Tables 6.3 & 6.4 present the pattern and structure matrices arising from the PCA.

TABLE 6.3   AYPSH Scale Pattern Matrix

	Component	
	1	2
YPSH want to frighten someone	.781	
YPSH to get their own back	.771	
YPSH want to find out if someone loves them	.758	
YPSH are trying for sympathy	.678	
YPSH are attention seekers	.624	
YPSH are more at risk of suicide		.637
YPSH are likely to repeat this behaviour		.632
YSPSH are in desperate need of help		.624
YPSH are more likely to have difficult relationships with families		.580
YPSH are mentally ill		.551
YPSH do it to show how desperate they are feeling		.486

TABLE 6.4 AYPSH Scale Structure Matrix

	Component	
	1	2
YPSH want to frighten someone	.779	
YPSH to get their own back	.770	
YPSH want to find out if someone loves them	.760	
YPSH are trying for sympathy	.679	
YPSH are attention seekers	.625	
YPSH are more at risk of suicide		.636
YPSH are likely to repeat this behaviour		.631
YPSH are in desperate need of help		.621
YPSH are more likely to have difficult relationships with families		.580
YPSH are mentally ill		.553
YPSH do it to show how desperate they are feeling		.488

In summary removing three items from the AYPSH scale and performing PCA on the remaining 11 items revealed that both components showed strong loadings, the interpretation from the two components matches with the positively and negatively

worded items and the revised scale therefore hangs together well. As with the AYP scale, items removed from the scale were analysed separately; the minimum and maximum scores with these items removed ranged from 11 – 55.

6.4   Assessing Normality

As noted in Chapter 5 prior to fully analysing the data I needed to determine if there was a normal distribution of scores across the two scales as the parametric tests used to explore variations are based on the assumption that a normal distribution is present.

As noted above the range of possible scores on the AYP scale was 8 – 40. Results from the exploration of normality revealed that on the AYP scale the minimum score recorded was 13, the maximum 33; the mean score for all participants was 23.91 with the 5% trimmed mean 23.93 which indicates that extreme scores have not influenced the mean (Pallant 2007). The values for Skewness and Kurtosis were -.052 and .396 respectively. As Pallant (2007) notes, negative Skewness indicate a clustering of scores at the higher end of the scale and 'if distribution were perfectly normal you would expect a Kurtosis value of 0', therefore my value of .397 indicates a reasonably normal distribution. Finally, the Kolmogorov-Smirnov statistic, which assesses the normality of the distribution, was .001; Pallant (2007) advises that the Sig value must be more than 0.05 to indicate normality, thus the assumption of normality has been violated, which Pallant (2007) advises can be expected in larger sample sizes.

Possible scores on the AYPSH ranged from 24 - 54; the mean score for all participants was 37.81 with the 5% trimmed mean 37.51. The values for Skewness and Kurtosis were .697 and 1.71 respectively, which for this scale indicates more of a cluster towards the lower end of the AYPSH scale; notwithstanding this, the histogram and Q plot indicated a reasonably normal distribution.

6.5   Relationships between AYP & AYPSH

As discussed in Chapter 5, I was interested in possible relationships between participants' attitudes towards young people generally and towards young people who self-harm, in light of this I examined whether there was a relationship between scores across the two scales. Scores from the two scales were reviewed on a scatter plot. The

scatter plot demonstrated a concentration of data points with the potential to draw a straight line through the main cluster points; there was therefore an indication that high scores on AYPSH are correlated with high scores on AYP. Pearson's product moment correlation coefficient confirmed that there was a strong positive correlation between scores on the two scales, (r= .84, n= 139, p <.000,) with high scores on the AYP scale being related to high scores in the AYPSH scale.

Mean scores on the two scales were analysed by the independent variables (occupation, age, length of experience, gender, training and witnessing scenario); trends were found across the two scales with similar patterns with the exception of attendance at training, where the pattern is reversed (attendance at training giving higher mean scores on the AYPSH scale but lower on the AYP). These results are presented in figures 6.1 & 6.2 below. There is also a correspondingly larger dip on the age scores for those aged 31 – 35 on the AYP scale than the AYPSH scale. Similarly scores for participants with 16 years plus experience showed a larger dip on the AYPSH compared to AYP. These findings were interrogated further and are reported in chapter 7.

Figure 6.1 Mean Scores on the AYP and AYPSH Scales by Participant's Occupation, Age and Length of Experience
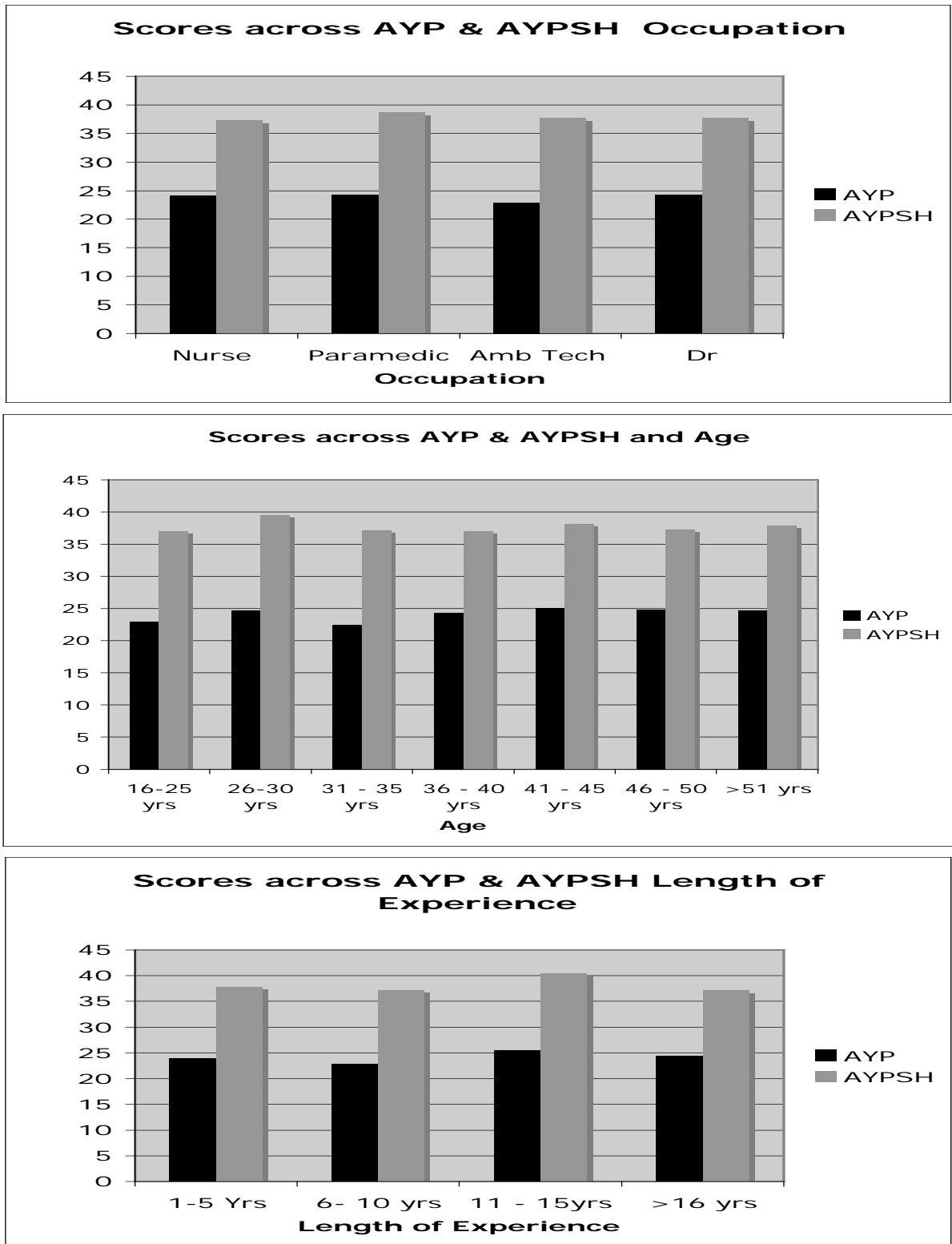
Figure 6.2 –Mean Scores on the AYP and AYPSH Scales by Gender, Training and Witnessing Scenario.
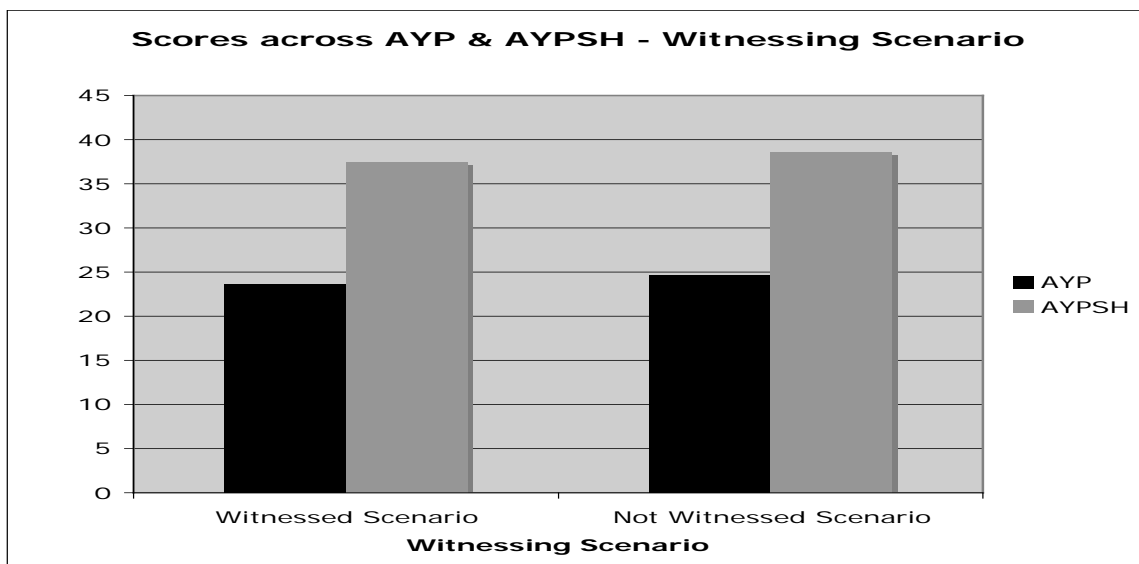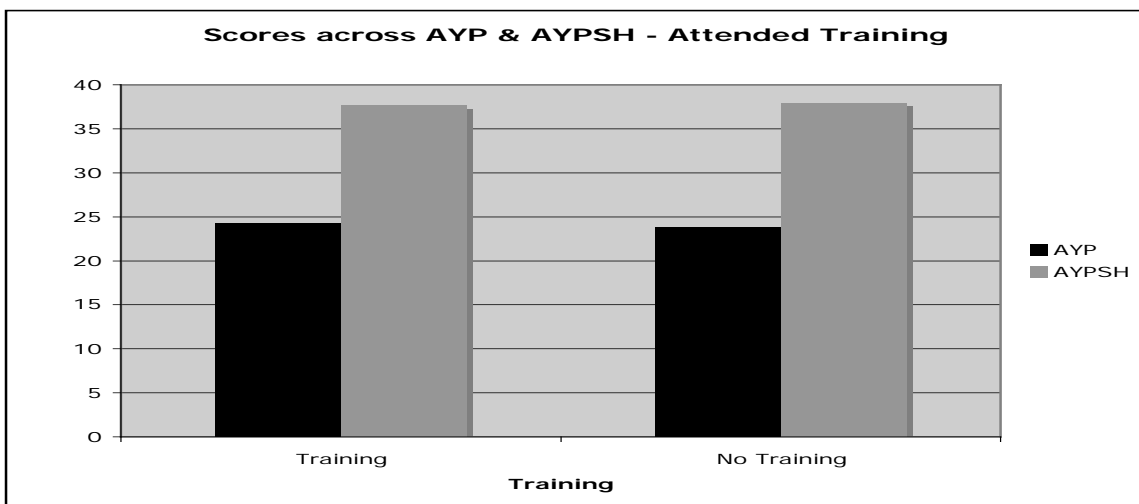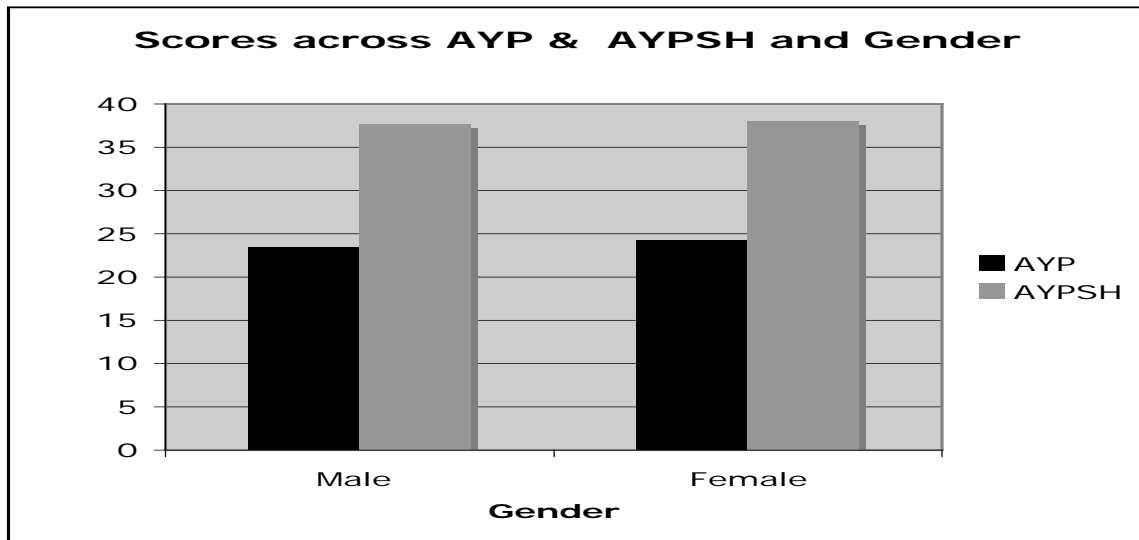
6.6   Summary

Prior to analysing whether any interactions were evident between the dependent variables (AYP & AYPSH scales) and the independent variables, it was necessary to determine whether the scales met the assumptions required for parametric analysis. Factor analysis was carried out to test the internal consistency of each of the scales (AYP and AYPSH). As a consequence a small number of items were excluded and the number of items on the AYP was reduced from 10 to 8 and from 14 to 11 on the AYPSH scale.

Following adjustments to the scales the distribution of scores was reviewed; reasonable distribution curves were evident on both sales, the scales therefore meeting this assumption for parametric testing.

The Pearson's product-moment correlation coefficient test was undertaken; the results demonstrated a strong positive correlation between scores across both the AYP and AYPSH scales thus indicating that the attitudes that practitioners hold towards young people generally have a relationship on their attitudes towards young people who self-harm, with individuals who have a more positive attitude towards young people per se, more likely to have a positive attitude towards young people who self-harm.

Having determined that the scales met the assumptions required for parametric testing, and that a correlation between the two scales exists, further analyses were undertaken to determine whether there were significant differences in the mean scores on the dependent variables (AYP & AYPSH) across the dependent and the independent variables, occupation, length of experience, age, gender, training and witnessing the scenario. This is reported on in the following chapter.

CHAPTER SEVEN

FINDINGS FROM THE QUESTIONNAIRE SURVEY

7.1   Introduction

In this chapter findings from the survey component of the study are presented. A total of 610 questionnaires were distributed across five London Ambulance (LAS) complexes and four emergency departments in Outer South East London. The LAS complexes employed large numbers of staff and the numbers of questionnaires delivered to these sites represented 67% (n=408) of total questionnaires distributed. Overall the response rates were low (n=149) with 24% of questionnaires distributed returned; this was in part due to low response rates from the LAS complexes (17% response rate n=68), whereas response rates from the four emergency departments were higher at 40% (n=80). Receptionists had been included in the initial sample, but ultimately only six receptionists returned questionnaires, three of which were incomplete; hence this group was excluded from the data analysis. The final number of participant responses analysed was 143, 96% of the total questionnaires returned.

As outlined in Chapter 5 my aim in undertaking the statistical analysis was to determine whether there were differences in mean scores on the independent variables. One and two-way between groups ANOVAs were performed to look at the independent variables, occupation, age and length of experience and the dependent variables of AYP and AYPSH. Independent sample t-tests were used when the independent variable was a categorical variable i.e. gender (male/female), training (attended or not) and the scenario (witnessed or not).

The null-hypothesis was that the population means would be equal, i.e. there would be no difference between means scores on the main independent variables. A one-way-between groups ANOVA was used to look at the variation amongst the independent variables on an individual basis, a two-way between groups ANOVA was used to examine the presence of an interaction between two independent variables and the dependent variable, for example AYP and age and occupation. Where the result of the F test was significant, the null hypothesis (that population means are equal) was rejected and post-hoc Tukey tests were applied to determine where the differences were significant.

The chapter begins by presenting results relating to frequencies to provide an overview of the survey sample and its characteristics. This is followed by an analysis of means scores against each of the items across the two scales with a specific focus on the items that were excluded from the scales following PCA. A chi-squared test for independence was employed to determine whether two categorical variables were related (Pallant 2007), i.e. the item from the scale and means scores against that item according to occupation. Findings from analyses are reported and summarised in relation to the underlying hypotheses at the end of the chapter.

7.2   Analysis of Sample

The final sample contained reasonably equal group sizes in terms of occupational group. Figure 7.1a provides a breakdown of participants by role, and Figure 7.1b provides a breakdown following the collapsing of the categorical variable of role into four revised 'role' variables, (renamed occupation), nurses, paramedics, ambulance technicians and doctors; these were the variables subsequently used for comparative purposes as the group sizes were more equal.

Figure 7.1a Respondents by Role

Figure 7.1b Respondents by Occupation
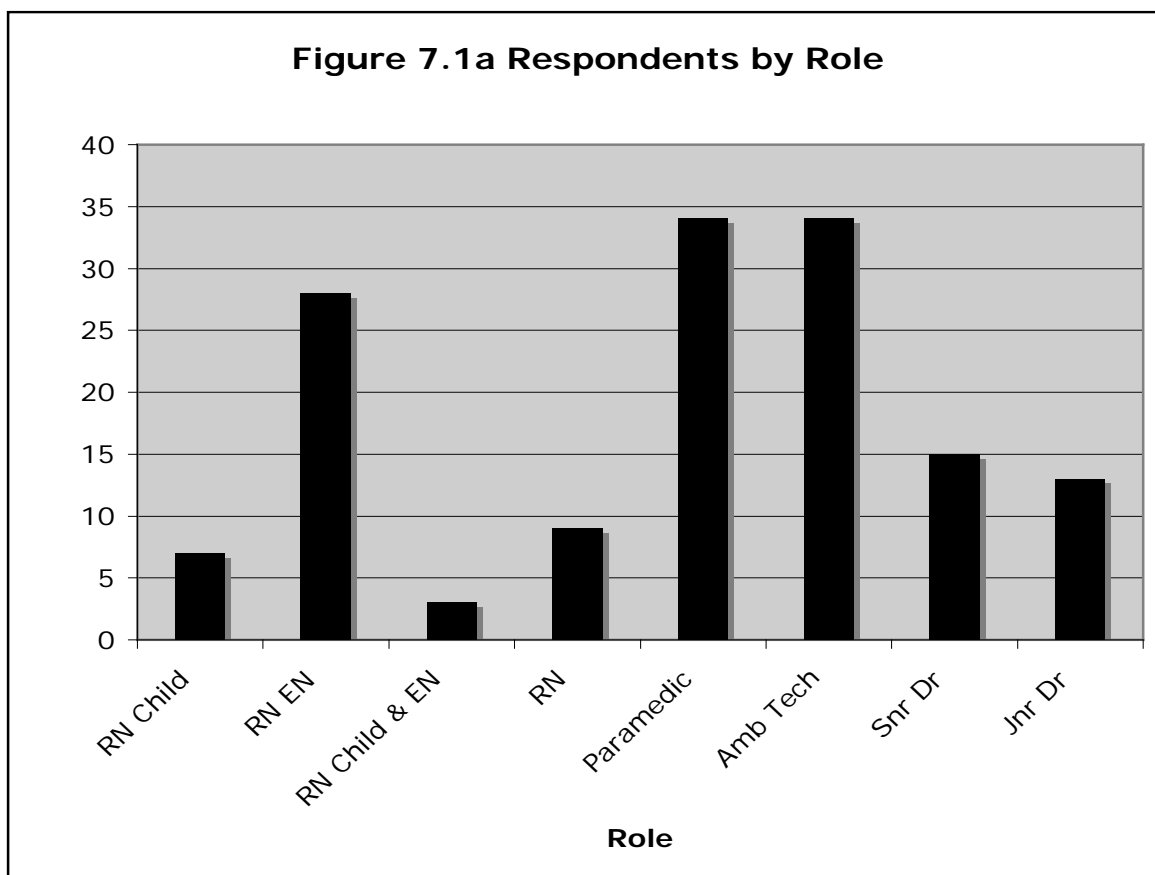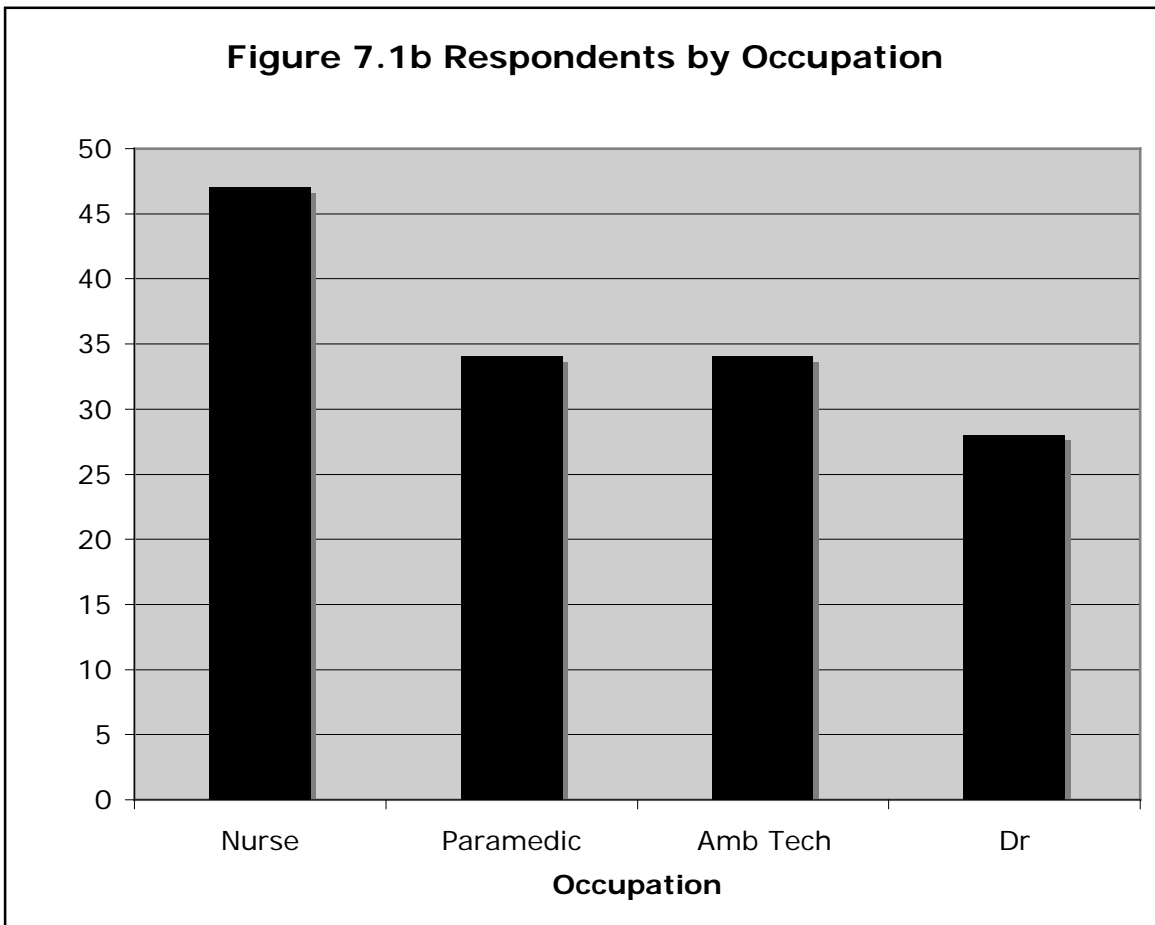
At the request of the LREC information was collected on the number of respondents employed as agency or bank staff, (three respondents did not answer this question). The data revealed that 15% (n=21) were currently employed in this capacity, the majority, 29.5%, in nursing (n=13) with 8% of LAS staff (n= 5) and 11% of doctors (n=3) employed on the bank or agency.

A similar number of male and female respondents completed the survey (47% male, 51% female); nurses were overrepresented by females compared with the other occupational groups although this reflects trends in nursing generally. There were a similar number of male and female respondents in the remaining occupational groups which all had more males than females (see figure 7.2).

Figure 7.2 Occupation and Gender
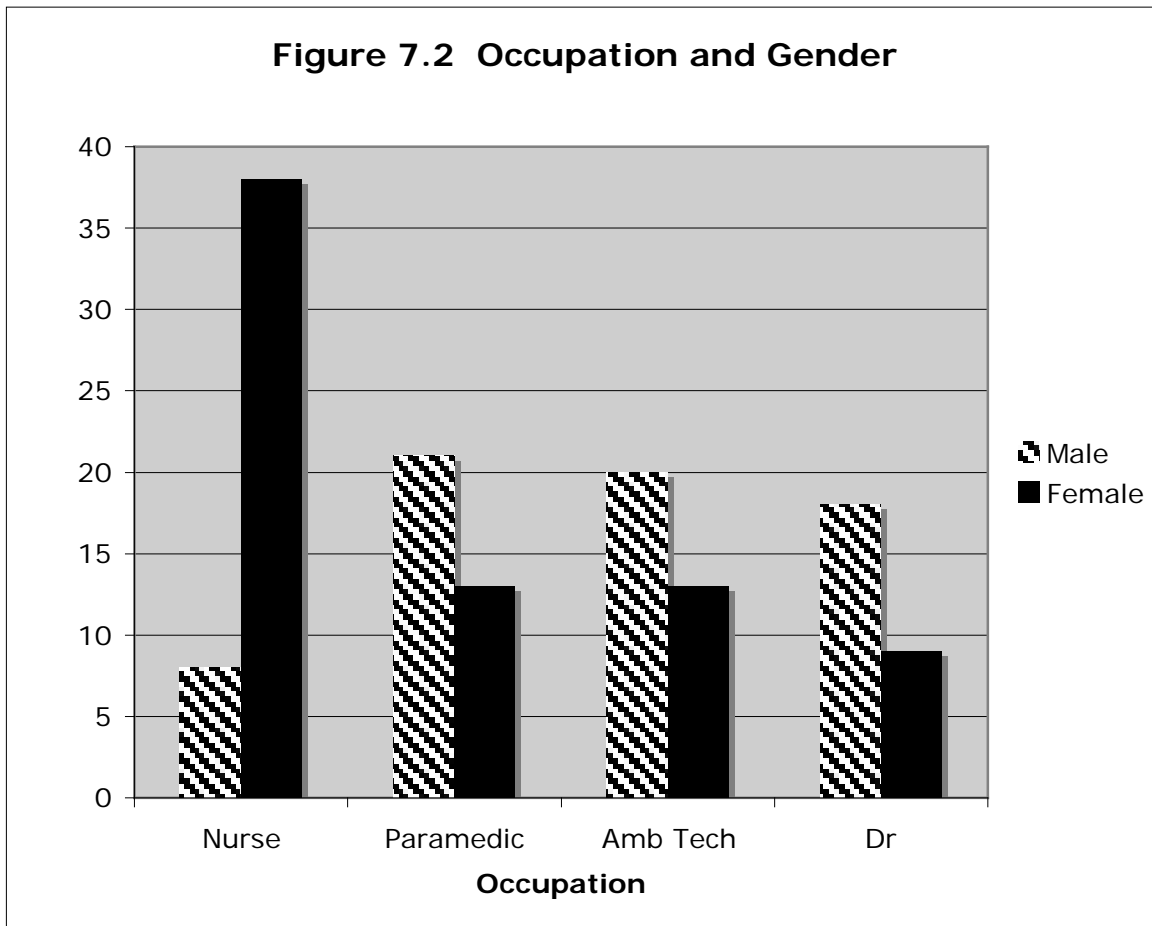
Almost half of the respondents (n=70) were aged 31-40 years of age; doctors were proportionally younger than their colleagues across the other occupational groups.

Overall the respondents were relatively inexperienced with nearly half (48%) having had between 1 – 5 years experience or working in emergency care. Paramedics as an occupational group had more years experience with 64% (n=21) having more that 11 years experience; doctors were the least experienced with 89% having less than 5 years experience. The lack of experience by doctors is possibly a refection of their younger age and stage in their career; almost half the doctors who responded were 'junior doctors'.

Respondents were asked whether they had attended training in relation to self-harm; only 29% (n=41) of the overall sample had attended training; 50% (n=14) of doctors had received training compared with 27 % nurses (n=13), 26% paramedics (n=9) and 15% ambulance technicians (n=5). Of these 41 respondents, 71% (n=29) attended for a half-day study day or less. Only 34% (n=14) of these respondents had undertaken training in self-harm that included aspects specifically related to young people and self-harm.

Respondents were asked whether their department/service had practice guidelines on self-harm, and if they did, the degree to which staff were familiar with and followed these. Half of the respondents (n=73) reported that their department/service had guidelines, however responses suggested that doctors and nurses were far more likely to report this guidance than LAS staff. Those respondents who reported the presence of guidelines were largely familiar with them, although only 23% (n=23) always followed them, and 6% (n=9) rarely or never followed them.

7.3   Mean Scores against the Individual Statements Comprising AYP & AYPSH Scales

Preliminary analysis found that participants had less positive attitudes towards young people per se than they did for young people who self harm. Notwithstanding this, it is worth noting that although there were differences between quantitative ratings of young people, most scores were over 2.5 on a 5-point 'Likert'-type scale and were as such positive. The mean score for one out of the ten statements on the AYP was over four (young people are helpful and friendly), and mean scores for five items on the AYP were less than three. Young people were rated by respondents as helpful and friendly, generally responsible and well behaved, they were not seen as having respect for adults, and young people's behaviour was rated to be worse than it was in the past, although participants generally agreed that young people had more stress in their lives, and that young people's views were not listened to. Table 7.1 provides mean scores by occupation of respondent for each of the statements on the AYP scale.

TABLE 7.1 Mean Scores by Occupational Group for Each Item Relating to Attitudes towards Young People (AYP).

	Nurse (n=47)	Paramedic (n=34)	Ambulance Technician (n=34)	Doctor (n=28)	Overall mean (n=143)
The behaviour of young people is no worse than it was in the past	2.45	2.06	2.03	2.64	**2.30**
The views of young people are not listened to enough	3.23	3.44	3.18	3.04	**3.23**
Girls are more badly behaved than boys nowadays[13]	3.21	3.15	3.09	3.14	**3.15**
Most young people are responsible and well behaved	3.20	3.47	3.00	3.29	**3.23**
Young people today have no respect for adults #[14]	2.81	2.65	2.59	2.75	**2.71**
Most young people are helpful and friendly	4.00	4.35	4.18	4.21	**4.17**
Young people today are not disciplined by parents#	2.49	2.06	2.03	2.25	**2.23**
Adults have no respect for young people	2.51	2.82	2.68	2.50	**2.62**
Young people today don't get enough care & attention from their parents	2.68	2.44	2.71	2.50	**2.59**
Young people today have more stress in their lives than they did before.	3.28	3.44	3.36	3.57	**3.39**

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[13] Italicised statements were removed from the scale following factor analysis.

[14] # Denotes negatively worded statement, scores therefore reversed.
NB This also applies to Table 7.2

Conversely on the AYPSH scale only mean scores for three out of fourteen statements were less than three. Overall the mean scores on the AYPSH suggest that respondents viewed young people who self harm as being in need of help, participants' responses suggested that they recognised that young people who self-harm were likely to repeat this behaviour, but that it was not a young person's intention to kill him or herself. Respondents did not generally agree that young people who self-harm were mentally ill, nor that self-harm is a normal part of youth culture. However, it is of note that the mean score for ratings of the negatively worded statement 'young people who self harm are trying for sympathy' was less than 3 suggesting a level of agreement with this statement, while the statement relating to attention seeking, also a negatively worded statement, scored more than 3 suggesting a level of disagreement with this statement, and therefore a more positive attitude. Table 7.2 below provides mean scores by occupation of respondent for each of the statements on the AYPSH scales.

TABLE 7.2   Mean Scores for Each Item Relating to Attitudes towards Young People who Self-Harm (AYPSH)

	Nurse (n=47)	Paramedic (n=34)	Ambulance Technician (n=34)	Doctor (n=28)	**Overall mean (n=143)**
Most young people who self-harm don't want to die	3.83**(p=0.05)	4.26	4.32	3.96	**4.08**
Young people who self-harm are trying to get sympathy from others#	2.74	2.71	2.55	2.57	**2.65**
Young people who self-harm are in desperate need of help	4.00	4.35	4.18	4.21	**4.17**
Most young people who attend having deliberately harmed themselves are likely to repeat this behaviour	4.08	4.27	4.32	4.29	**4.22**
Young people who self-harm are attention seekers#	3.13	3.18	3.21	2.82	**3.10**
Young people who self-harm *should be required to undergo therapy*	3.89	3.79	3.73	3.43	**3.74**
Young people who self-harm are more at risk of successfully completing suicide	3.42	3.74	3.29	3.71	**3.55**
Young people who self-harm are mentally ill	2.85	2.97	3.12	3.00	**2.97**
Young people who self-harm are more likely to have difficult relationships with their families	3.61	3.88	3.56	3.96	**3.73**
Self-harm is a normal part of youth culture	1.96	1.62	1.85	1.89	**1.84**
Young people who self-harm do it because they want to show how desperate they are feeling	3.52	3.68	3.65	3.71	**3.63**
Young people who self-harm do it because they want to frighten someone#	3.47	3.15	3.12	3.25	**3.27**
Young people who self-harm do it because they want to find out if someone really loves them#	3.13	3.18	3.06	2.96	**3.09**
Young people who self-harm do it because they want to get their own back on someone#	3.63	3.59	3.35	3.21	**3.47**

7.4   Comparisons of Mean Scores by Occupation

A one-way between groups analysis of variance was conducted to explore whether there was a variation between the mean scores of the four occupational groups. Findings on the AYP scale showed no significant differences between the four groups; ambulance technicians had the lowest score – 22.99, with nurses scoring 24.13, doctors 24.25 and paramedics scoring 24.29. Similarly, there was no significant differences between the four occupational groups sores on the AYPSH scale; on this scale nurses had the lowest mean score (M 37.29), with ambulance technicians scoring M 37.69, doctors M 37.71 and paramedics scoring M 38.68 F (3, 135) = .708, P = 0.54. Thus across both scales the null hypothesis is confirmed, the population means are equal; i.e. there was no significant difference between the occupational groups.

As discussed in chapter 5, following factor analysis two statements were removed from analysis of the AYP scale and three statements were not included in the analysis of the AYPSH scale. These statements were each analysed separately using the Chi-square test for independence to determine if there was a relationship between them and the independent variable of occupation, and in relation to girls' behaviour, gender.

The two statements excluded from the AYP scale were '*girls are more badly behaved than boys nowadays' and 'young people today don't get enough care & attention from their parents'*. Analysis revealed there was little variation between the occupational groups in respect of their views on girls' behaviour, the overall mean of 3.15 indicating a more positive attitude towards girls' behaviour, although 50% of respondents neither agreed nor disagreed with this statement, suggesting an element of ambivalence in relation to this statement. When analysed against the independent variable of gender the cross-tabulations revealed that 24% of male respondents compared with 12% of female respondents agreed that girls were more badly behaved, although the results of this test were not statistically significant (P = 0.43). There was general agreement that '*young people don't get enough care and attention'* (48% agreement) with little variation amongst occupational group observed.

The three statements excluded from the AYPSH scale were, '*Most young people who self-harm don't want to die'; 'young people who self-harm should be required to undergo therapy' and 'self-harm is a normal part of youth culture'*. Analysis of the AYPSH scale showed that 50% of nurses disagreed with the statement '*most young people who self-harm don't want to* die' compared with 17% of paramedics and 33% of doctors (no ambulance technicians disagreed with the statement), this difference being statistically significant ($P = 0.05$). There was general agreement that young people should be required to undergo therapy (71% overall agreed with this statement); although doctors were less likely to agree (53%) this was not statistically significant ($P = 0.27$). Similarly across the occupational groups there was general agreement that self-harm was not a normal part of youth culture; only 14% of respondents agreed with this statement ($P = 0.28$).

7.4.1 Comparison of Mean Scores within Nursing

Within the occupational groups studied nursing was unique in that, 10 of the 47 nurse respondents (21%) had undertaken specific training to register as children's nurses and were working in emergency care. Paramedics and ambulance technicians do not have this level of specific training and the doctors surveyed were, by virtue of working in A&E, either A&E specialists (consultants) or training to be specialists, surgeons, or GPs and with the possible exception of GP trainees, would not have had specific training in the needs of children and young people. The children's trained nurses would have studied the specific needs of children and young people including children and young people's physical/developmental, psychological, social and emotional needs. In light of the unique position of nursing, it was useful to look at differences between the two groups of nurses: those that had and had not had specific training leading to registration as a children's nurse. An independent-sample t-test was therefore conducted to compare the overall scores of registered nurses with a children's nursing qualification (n=10) with those without (n=37) on both the AYP and AYPSH scales.

The significance level of Levene's test for the AYP was $P=0.03$ thus the data violated the assumption of equal variance, however as Pallant (2007) points out SPSS provides an alternative t value, which was therefore used for this analysis. Although children's

nurses had a higher overall mean score than the registered general/adult nurses on the AYP scale, the difference in scores was not statistically significant; (RN = M 23.68, SD 4.52, RN Child = M 25.70, SD 4.52); t (11.00) = 1.34, P =0.208).   The magnitude of the difference in the mean scores (mean difference = 2.01, 95% CI: -1.39 to 5.32) was moderate (eta squared = 0.06).

In contrast, equal variances for the AYPSH scale were assumed. An independent-sample t-test analysis showed that children's nurses had statistically significant higher scores (RN Child = M 40.22 SD 6.57) than registered adult nurses (RN= M 36.54, SD 3.71); t (42) = 2.24, P = 0.03. The magnitude of difference in the means (mean difference = 3.68, 95% CI: .36 to7.00) was large (eta squared = 0.1). Thus in relation to differences between registered children's nurses and non-registered children's nurses the null hypothesis was rejected; i.e. there was a significant difference between the scores of the children's trained nurses and the registered adult nurses.

7.4.2   Comparison of Mean Scores for Bank/Agency Staff

As noted above, the question relating to bank or agency staff was inserted at the request of the LREC. Bank and agency staff can be temporary staff that are transitory, although many staff on a substantive contract undertake agency and bank work in their off-duty hours in their place of employment, and in my experience this is frequently the case for emergency care staff. On that basis I postulated that there would be no difference between scores of those identified as bank/agency and those who were not. An independent-samples t-test was performed to compare scores, which confirmed that there was no significant difference between scores for bank/agency staff and non-bank/agency staff across both the AYP and AYPSH scales.

7.5   Comparisons of Scores by Gender of Respondents

An independent-samples t-test was performed to compare scores from the two scales in relation to gender. There was no significant difference in scores in AYP for males (M= 23.44, SD = 4.11) and females (M= 24.26, SD 3.36), P = 0.20, with a similar pattern evident in AYPSH with scores for males (M= 37.64 SD = 3.83) and females (M=37.95 SD = 4.61) P = 0.66; indeed overall male and female scores were very similar

A two way ANOVA was performed between gender and occupation of participants and scores on the AYP & AYPSH. There was no significant interaction effect between occupation and gender on the AYP scores ($P = 0.37$) however, with the exception of nurses, female practitioners had more positive attitudes towards young people than their male counterparts on this scale. The same trend was seen in relation to AYPSH. As with AYP, with the exception of nurses, female respondents had higher scores than males; conversely male nurses scored more highly than their female counterparts. The difference between gender on the AYPSH scale was statistically significant, $F(3, 128) = 3.16$, $P = 0.03$, the effect size was moderate with a partial eta of 0.6. The variations in scores can be seen below in Figures 7.3 and 7.4 and are explained by the difference between scores when comparisons are made between paramedics and nurses.

Figure 7.3. Gender and Mean Scores by Occupation AYP

Figure 7.4 Gender and Mean Scores AYPSH
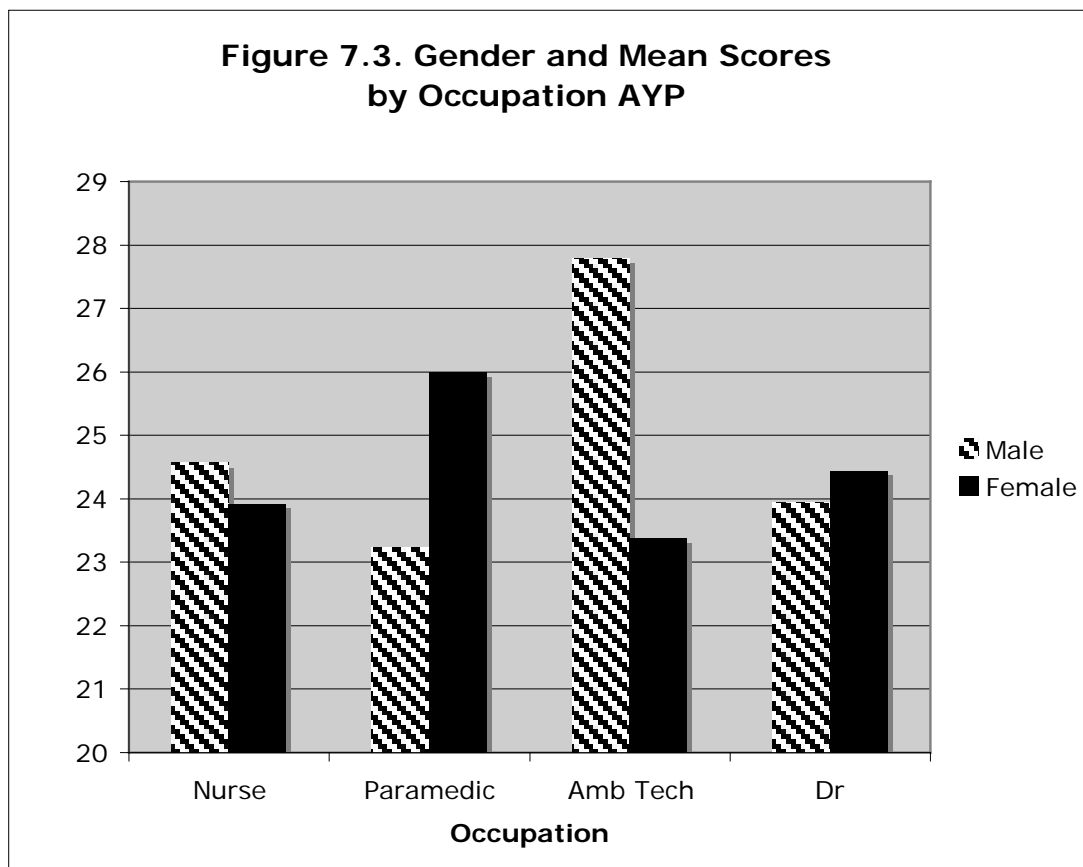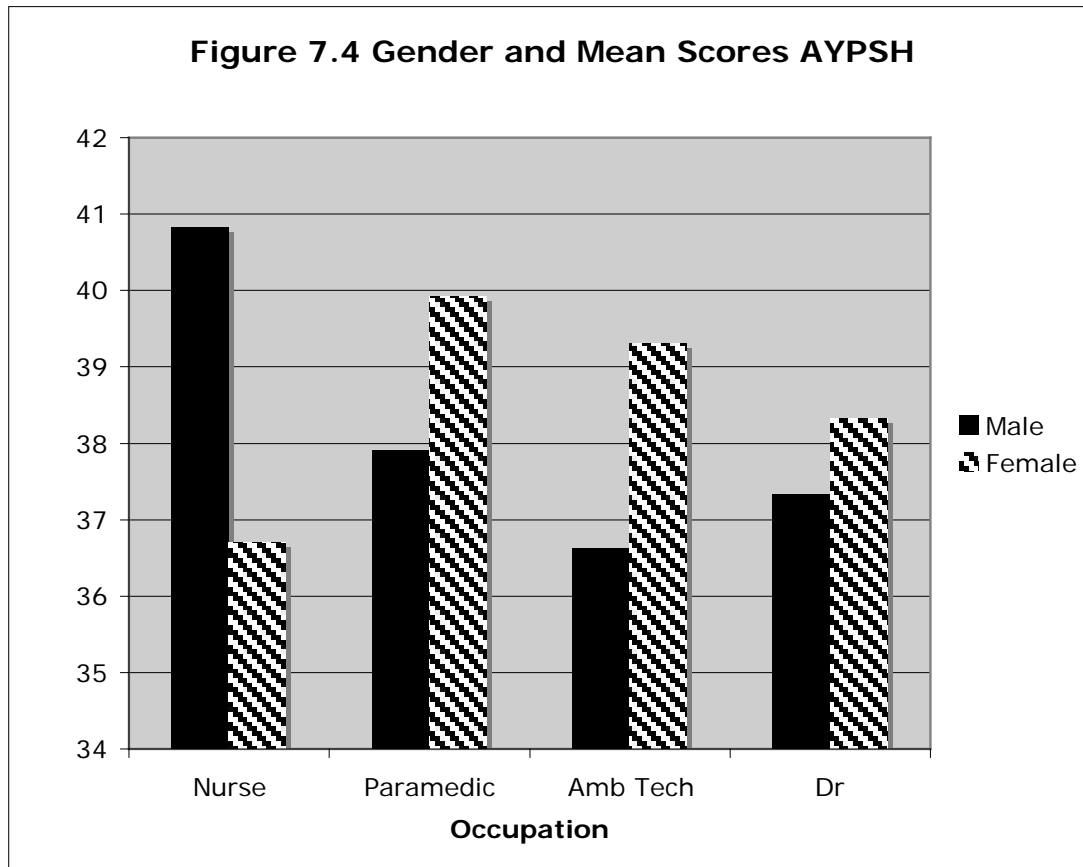
7.6 Comparison of Scores by Age

A one-way ANOVA was conducted to look at potential age differences in respect of participants' scores on the two scales, AYP and AYPSH. This variable was grouped into seven age categories: 16 – 25, 26 -30, 31- 35, 36-40, 41-45, 46-50 and over 51 years of age.

Findings from analysis show that 31-35 year olds had the least positive attitudes towards young people on the AYP scale (M = 22.46, SD = 4.25) whereas those aged 41-45 had the highest scores (M = 25.08, SD = 3.44), these differences were not statistically significant ($P = 0.08$). Similarly the 31-35 year old group also had a comparatively low score (M = 37.20, SD = 3.65) on the AYPSH and those aged 41-45 higher scores (M = 38.17, SD = 4.80) although those aged 26-30 had the highest scores on this variable (M = 39.50, SD = 3.81) and those aged 16-25 the lowest (M = 37.00, SD = 2.16). However these differences were not statistically significant.

Two-way between groups ANOVAs were conducted to ascertain whether there was an interaction of age and occupation and age and gender on the dependent variables AYP & AYPSH. In relation to AYP the interaction effect for the independent variables age and occupation and age and gender were not statistically significant (age and role $P = 0.10$, age and gender $P = 0.06$). No obvious trends were apparent in relation to age, indeed analysis of age and occupation show that the scores were similar across groups (see Figure 7.5).

Figure 7.5 Mean Scores by Age and Occupation AYP
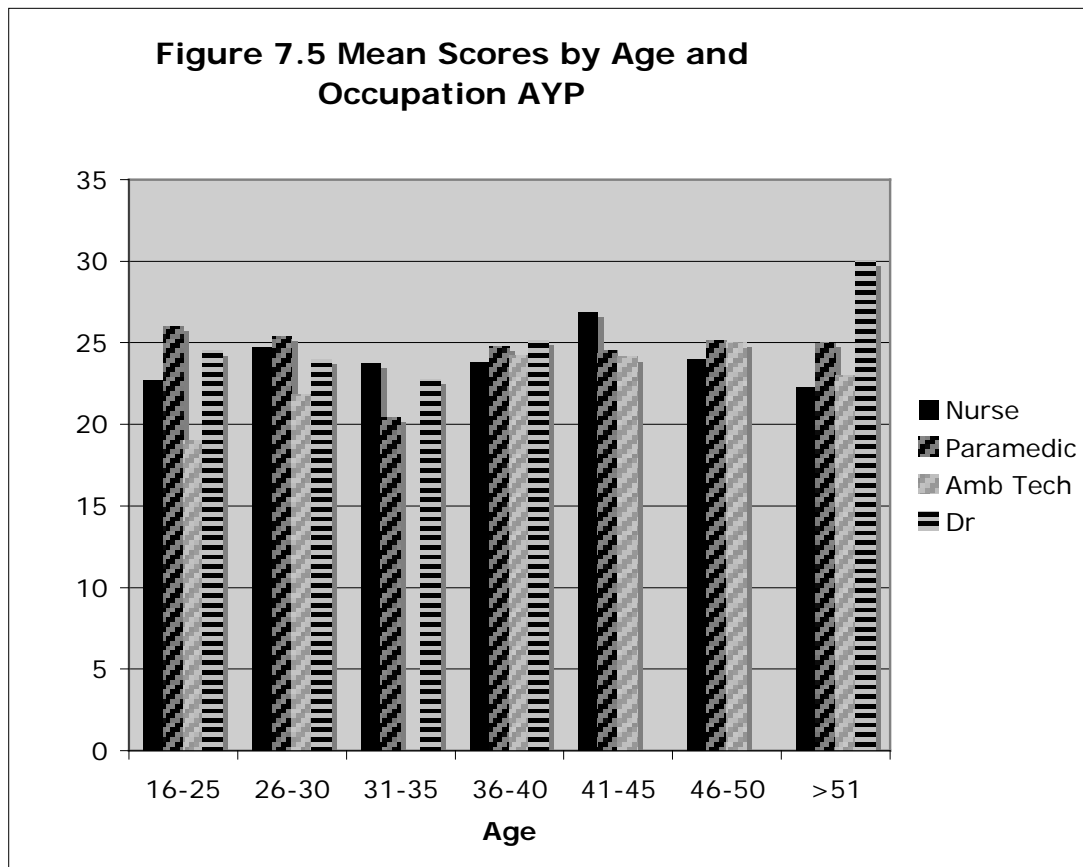
In relation to gender, males in the 16- 25 and 31-35 aged group had lower scores than females in the same age group, whereas the scores of males in the over 51 age group were higher than females in this age category, the only age category where this was the case. Figure 7.6 below provides an illustration of this interaction.

Figure 7.6 Mean Scores by Age and Gender AYP
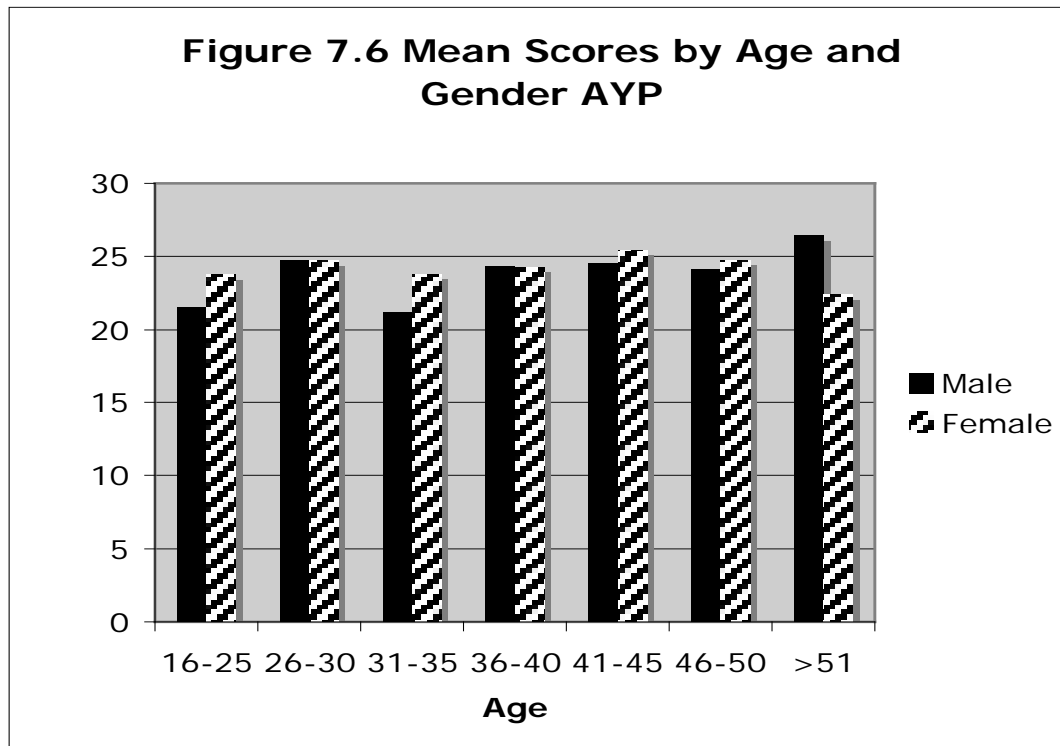
Similarly as with AYP, no discernable trends in relation to age and role on the AYPSH scale were observed ($P = 0.15$). The findings showed that nurses aged 46 – 50 had the lowest scores (M = 33.33 SD = 8.08) and doctors over the aged of 51 the highest (M = 43.00 SD = 5.65).

When gender and age were examined findings showed that males in the 16-25 year category had comparatively low scores, whereas males in the 26-30 category had the highest scores (see Figure 7.8 below for comparison), however while these variations were statistically significant ($P = 0.02$) the Levene's test of equality of error variances was significant at $P = 0.03$. Pallant (2007) suggests therefore than a more stringent significance level of 0.01 be applied. It was also evident that the Tukey HSD did not show any significance in multiple comparisons, and on closer inspection it was evident that there was only one male respondent compared with 8 females hence the statistical significance of this result is not reliable.

Figure 7.7 Mean Scores by Gender and Age AYPSH
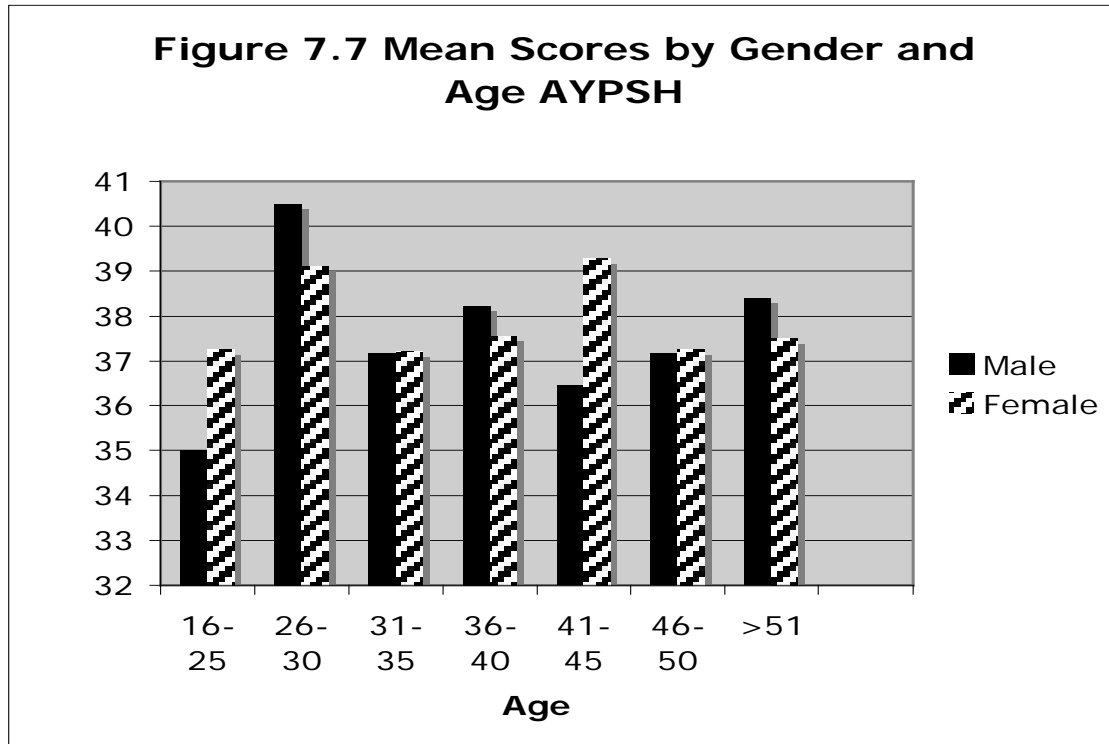
7.7 Comparison of Scores by Length of Experience

In line with past research, a one-way ANOVA was conducted to examine whether more experienced practitioners had more positive attitudes towards young people who self-harm than their less experienced colleagues. The categorical variable, length of experience, was collapsed into four categories, 1-5 years, 6-10 years, 11- 15 years and more than 16 years experience. A one-way ANOVA revealed a similar pattern for both scores on the AYP and those on the AYPSH. Practitioners with 11-15 years of experience had higher scores than other groups across both scales. This variation was not statistically significant in relation to AYP. It was however significant for AYPSH scores at the $p <.05$ level between those with 11-15 years experience when compared with those with 6- 10 years and more than 16 years experience: $F (3, 133) = 3.09, P = .030$. The effect size calculated using eta is 0.06, which is a moderate effect size (Pallant 2007). The variations in length of experience are shown in figure 7.8 below.

Figure 7.8 Mean Scores by Length of Experience AYP & AYPSH
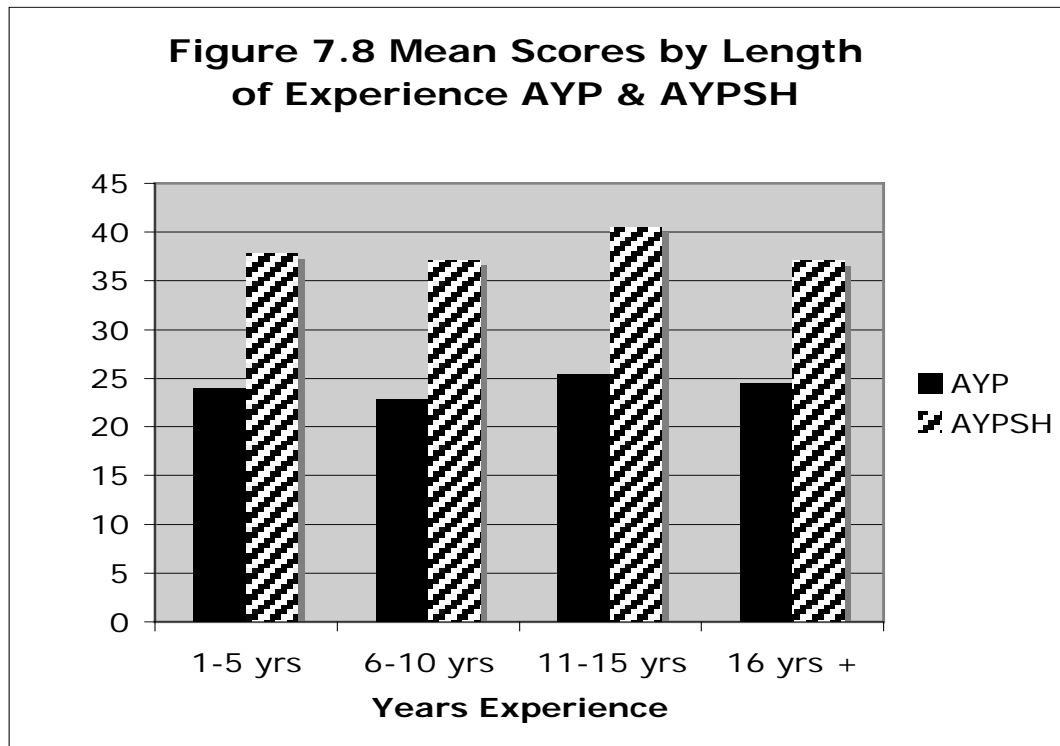
It is of note that while the scores of practitioners with 11-15 years experience are high in comparison with their peers, there is a drop in scores (particularly in AYPSH) for those with more than 16 years experience.

Having ascertained that there was a variation in scores based on length of experience I conducted a two-way between groups ANOVA to determine if, in relation to AYPSH, there was an interaction between length of experience and occupation, and gender. The findings revealed little variation in respect of gender and length of experience. In relation to occupation, there was noticeable variation in respect of nurses who have 11-15 years of experience when compared to other practitioners, notably ambulance technicians. This was not however statistically significant. Figure 7.9 illustrates this latter finding.

Figure 7.9 Mean Scores by Occupation and Length of Experience
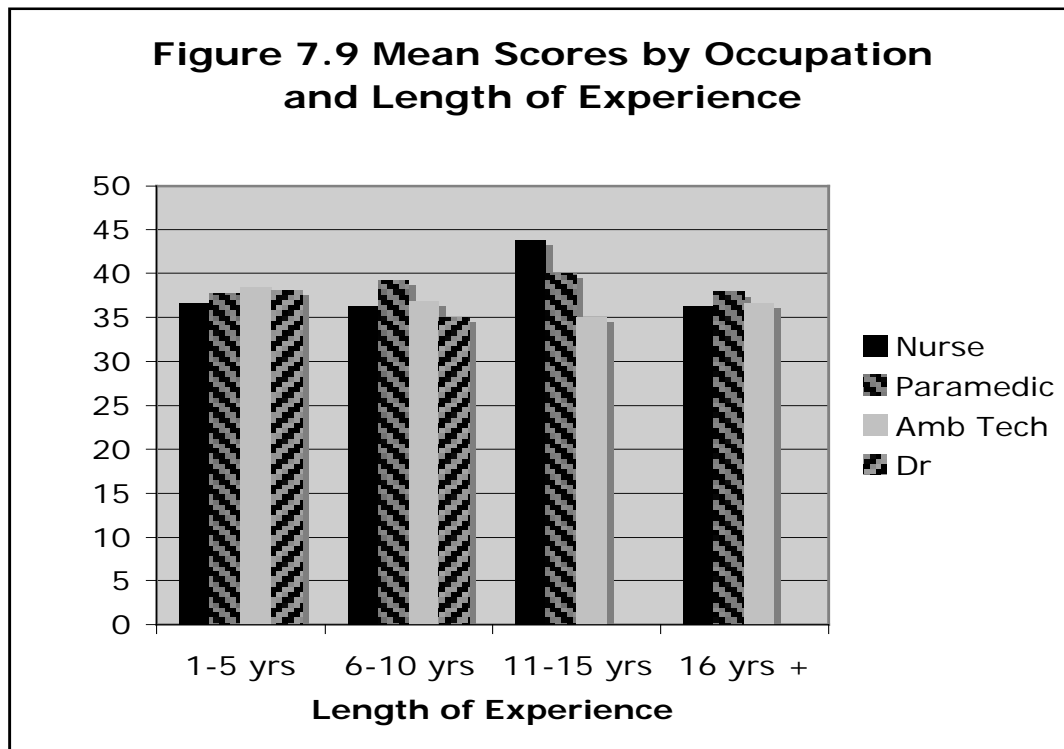
7.8 Participants' Scores on the AYPSH Scale and their Access to Continuing Professional Development (CPD) on Self-Harm.

An independent-samples t-test was performed to compare occupational groups' scores on the AYPSH scale in relation to their access/uptake of CPD relating to self-harm. There was no significant difference in scores for those who had undertaken CPD and those who had not ($P = 0.73$), however it is of note that scores were marginally higher for those who had ***not*** accessed CPD (M=37.88, SD 4.19) than for those who had (M= 37.62 (SD= 4.30).

Given that practitioners with more experience are more likely to have had access to CPD opportunities I examined whether there was a link between experience and amount of CPD undertaken. Overall there was little difference in the percentage of respondents accessing CPD by length of experience, indeed, a higher percentage of practitioners with 1-5 years experience reported undertaking CPD relating to self-harm (29%) than their colleagues with more than 16 years experience (26%). Practitioners with 11- 15 years of experience had the highest level of access to CPD with 33% of respondents in this category accessing CPD related to self-harm.

As noted above, in relation to the AYPSH scale respondents who had 11-15 years experience were more likely to have more positive attitudes than their peers, it was interesting to note that this group had undertaken more training in relation to self-harm than respondent in other categories of length of experience. I therefore examined this interaction using a two-way ANOVA. Although there was a statistically significant effect, Levene's test of equality demonstrated a significance of 0.04 which suggested that variance of the dependent variable across the groups was not equal (Pallant 2007:261), thus a more stringent significance level was set (0.01) and at this level the results were not significant. The results did though confirm that those with 11-15 years experience who had attended CPD demonstrated more positive attitudes than respondents in the other categories, as illustrated below in Figure 7.10

Figure 7.10 mean Scores by Length of Experience and Attendance at Training AYPSH
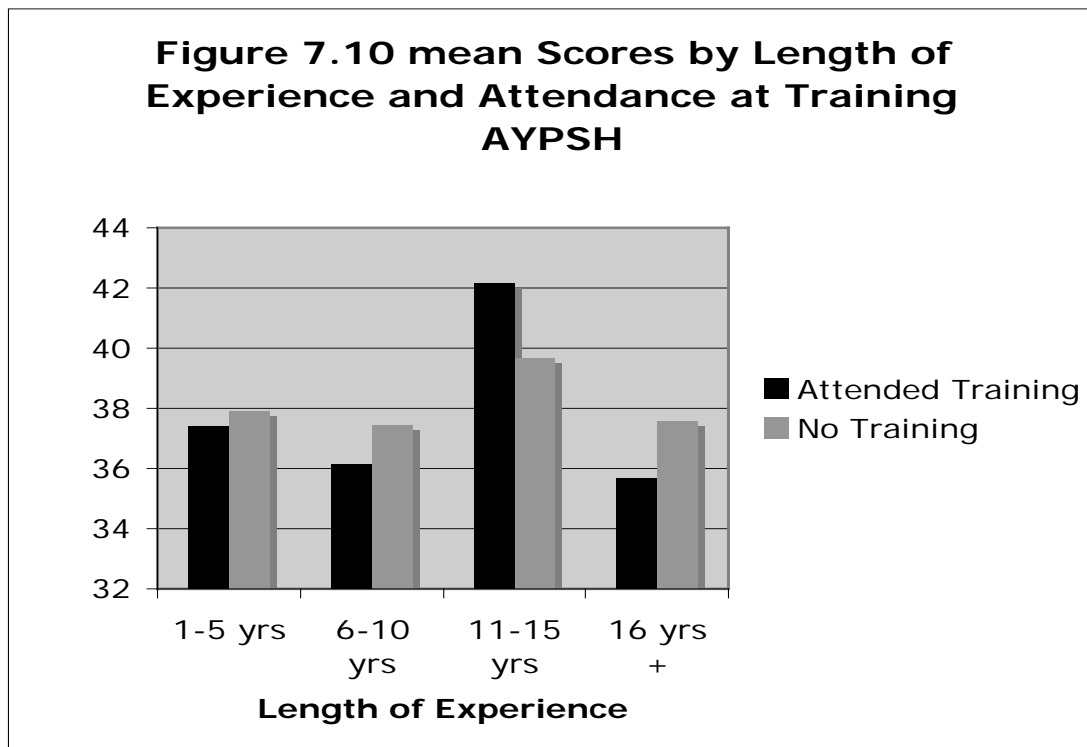
7.9   Response to Scenario

At the end of the questionnaire respondents were provided with a scenario with a description where a colleague was overheard talking about a 16 year old girl who had attended for the tenth time with self-harm, the colleague saying "why didn't she do it right this time and save us a lot of trouble". Respondents were asked to indicate ('yes' or 'no') as to whether they had ever heard other colleagues say something along those lines. Respondents who answered 'yes', were given 5 options as to how they would (have) respond(ed). Seventy-one percent of all respondents (n=101) reported hearing something along the lines of the scenario. When broken down by occupation 68% (n=32) of nurses, 76.5% (n=26) paramedics, 73.5% (n=25) ambulance technicians and 64% (n=18) doctors reported hearing such a comment. Practitioners overall chose one of the first two options – 13% (n= 19) advising that they would 'provide more care than I [they] would normally give' and 56% (n=80) said they would 'provide the same level of care that I [they] would normally give to patients'.

An independent t-test was performed to determine whether there was a relationship between witnessing/overhearing the scenario event and attitudes towards young people who self-harm. There was no significant difference in scores for those who had witnessed such a scenario (M 23.65, SD = 3.60 and those who hadn't (M 24.60 SD = 4.13, P = 0.16). I also examined whether there was a relationship between occupation and witnessing the scenario by conducting a two-way ANOVA. Results from the two-way ANOVA revealed the same pattern in that for all occupations (with the exception of ambulance technicians, where the difference was minimal) the mean scores were lower in the groups where such a scenario had been witnessed compared with those who hadn't. However although this difference was largest for nurses, this interaction was not statistically significant (p = 0.422). Figure 7.12 illustrates the differences encountered.

Figure 7.11 Mean Scores by Occupation and Witnessing Scenario
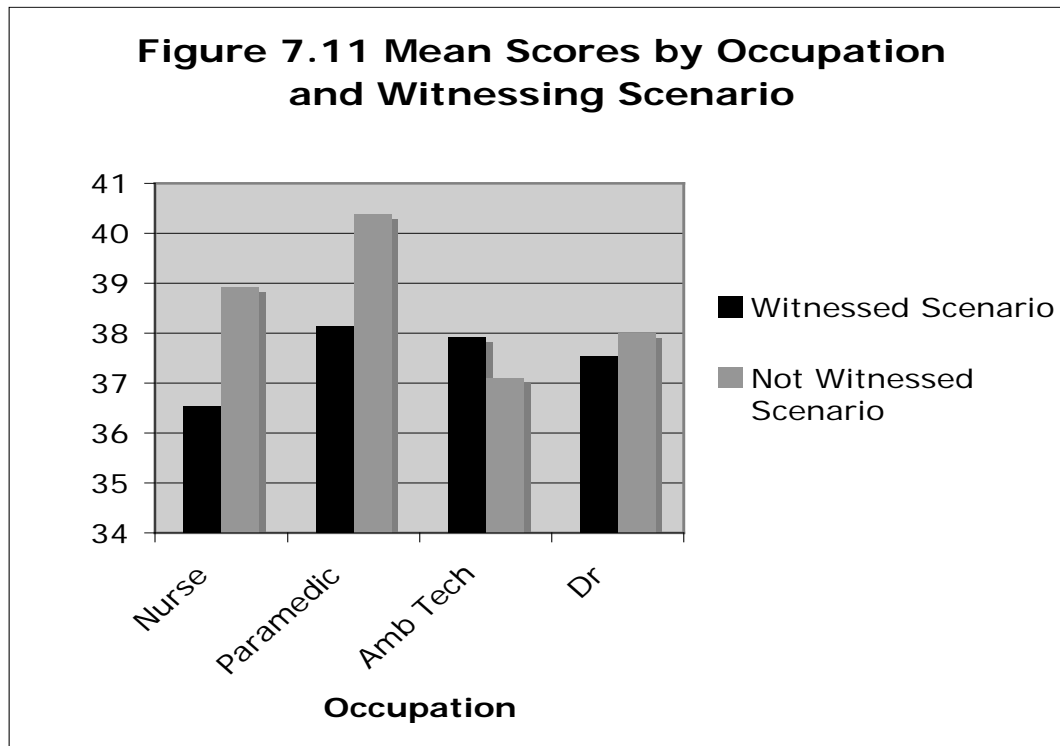
A one-way ANOVA was performed to ascertain whether there was a relationship between response to scenario and AYPSH to determine whether the practitioners who identified that they would provide more care would have more positive attitudes. Subjects were divided into three groups: if they had witnessed the scenario, the effect this had on the care they gave, i.e., they provided more care (n=19), or the same care (n=80) compared with those who had not witnessed the scenario (n=44). Despite the relatively small difference between the scores, there was a statistically significant difference at the $p < 0.05$ level (F 2, 136= 3.61, $p = 0.03$) the effect size calculated using eta was 0.05. Post-hoc comparisons using the Tukey HSD indicated that the scores for those who provided more care (M 39.611, SD = 4.11) and those who provided the same care (M 37.03 SD = 3.85) were significantly different, with higher scores evident in those who 'provided more care' in response to the scenario.

7.10   Qualitative Comments

18 participants added comments on the returned questionnaires, of which 10 came from LAS respondents (three technicians and seven paramedics), four were from registered children's nurses, two from an adult emergency care nurse, and two doctors (one consultant and one junior doctor). Twelve of the comments referred to the use of guidelines, reflecting the fact that respondents had been given an opportunity to comments at this point on the questionnaire. Of the remaining six comments, one referred to crews becoming 'case hardened', one noted that, 'I have worked with young people in the community and a lot of them crave adult attention', three made reference to the difficulties associated with making onward referrals and gaining admission for young people who self-harm, and one (an ambulance technician) made reference to the scenario as follows:

> '*this phrase is only said in the company of crewmates and to lighten the nature of the call. Also the fact the health service has let the person down*'.

This comment was assigned to code of 'attitude' as the respondent had witnessed the attitude expressed in the scenario; the code of attitude reflected attitudes witnessed, described or represented by the interviewees.

Each of these comments were collated as part of the thematic analysis of the qualitative data and assigned to a code as follows (see Table 5.7a P166):

1. Case hardened   =   Competing demands (n=1)

2. Guidelines   =   Guidelines/Documentation (n=12)

3. Crave Adult Attention =   Good or Bad (n=1)

4. Onward referral   =   Unwanted (n=3)

5. Scenario   =   Descriptions (n=1)

7.11   Summary of Key Findings from Quantitative Analysis

Overall practitioners demonstrated more positive attitudes towards young people who self-harm than was evidenced in their attitudes towards young people; respondents tended to perceive young people as having little respect for adults and view their

behaviour as being worse today, although paradoxically they also saw young people as being helpful and friendly. The respondents (correctly) recognised that young people who self-harm are likely to repeat this behaviour, and are more at risk of completing suicide, but were unsure as to whether young people who self-harm are mentally ill. They recognised that the young people need help, and generally did not see them as being attention seeking, although there was a high level of agreement that young people who self harm are trying to get sympathy from others.

As reported in Chapter 6, Pearson's product moment correlation coeefcient demonstrated a strong correlation between scores on the two scales; this is further illustrated in the presentation of results in this chapter; the analysis of relationships between the two dependent variables (AYP and AYPSH) and respective independent variables demonstrated similar patterns. Thus for example, practitioners with 11-15 years of experience had more positive attitudes towards both young people and young people who self harm than those with 6- 10 years experience. Similarly with gender, female practitioners displayed more positive attitudes across both scales than their male counterparts, and similar patterns in terms of age of practitioners and scores across scales was also evident, although not as consistent. However using two-way between groups analysis facilitated a more detailed analysis of possible interaction(s) between the dependent and independent variables.

Analysis of scores by role demonstrated that although there was generally little variation between groups, scores indicated that across both scales paramedics had the most positive attitudes towards young people and young people who self harm. Ambulance technicians had the least positive attitude towards young people, nurses the least positive towards young people who self-harm. In terms of AYP the scores of nurses, doctors and paramedics were more closely aligned. Given that nurses' scores were lower in the AYPSH scale than their peers from other professional groups, the scores of nurses were examined separately as this is the only occupational group (involved in this study) who could specialise in the care of children and young people. These scores revealed that children's trained nurses had generally more positive attitudes towards young people than registered general/adult trained nurses. This was not statistically significant for young people generally but was significant in relation

to young people who self harm, where registered children's nurses had higher scores than nurses who had not specialised in this field.

A high proportion of respondents from across all occupational groups indicated that they had overheard or witnessed a negative reaction to a young person who had self harmed within the emergency care environment, and while not statistically significantly different between paramedics, nurses and doctors, scores on the AYPSH for those who had witnessed such an event were lower than their colleagues who hadn't.

With the exception of the nurse group, where females predominated, there was generally an even spread of males and females. This is of note as while scores for female practitioners were generally higher across both scales, there were differences in respect of gender and occupation. Nurses as an occupational group recorded lower scores on the AYPSH scale which is noteworthy given that a high percentage of the nurses (83% n=38) were female; nurses' scores on both scales do not reflect the gender patterns recorded in the remaining three occupational groups, with male nurses demonstrating more positive attitudes to both young people and young people who self harm than female nurses, the latter variation being statistically significant. Conversely, male paramedics recorded lower scores than their female paramedic colleagues, female paramedics recoding the highest scores on the both scales (See Fig 7.3 & 7.4). When analysed by age this trend largely remains across the age ranges, however some variations were noted, with male practitioners over the age of 51 having more positive attitudes than their female counterparts across both scales, and men in the 26 – 30 category also demonstrated higher scores on the AYPSH than their female colleagues.

Practitioners with 11-15 years experience demonstrated more positive attitudes across both scales, with nurses recording the highest scores in this category. In relation to an interaction with attending CPD/training and length of experience, practitioners with 11-15 years experience were more likely to have attended training. This may have influenced their attitude towards young people as, while not statistically significant, those who had undertaken training had higher scores on AYP than those who had not. Conversely, those who had had training recorded lower scores on AYPSH, although

again this was not statistically significant, but as with scores on the AYP scale, practitioners with 11-15 years of experience who had not witnessed the scenario also demonstrated higher scores.

Overall few significant differences were noted, confirming the null hypothesis that there would be no variance in sample means, for example, in relation to scores for dependent variables on the independent variables occupation, age, gender, access to training and witnessing the scenario. This was also the case in relation to AYP and the independent variable length of experience. In contrast, the null hypothesis was rejected in respect of the dependent variable AYPSH for which statistically significant differences were found. Post-hoc Tukey HSD tests demonstrated that differences amongst groups lay with those who had 11 – 15 years experience compared with those with 6 – 10 years and 16 years experience or more. A two-way between groups ANOVA showed that this effect was more evident in nurses than other occupational groups, although this was not statistically significant.

The next chapter provides a description of the findings from the interviews. The findings from the questionnaire and interviews are explored in more depth in Chapter Nine.

CHAPTER EIGHT

DESCRIPTION OF FINDINGS ARISING FROM THE INTERVIEWS

8.1   Introduction

This chapter will provide a 'rich description' of how the care of young people who self harm are managed within the context of one accident and emergency department, and in so doing will provide insight into how the paramedics[1] and nursing staff make sense of and manage their work with young people who self-harm. The chapter begins with a description of the A& E department where the nurses in the study worked, and includes a brief discussion of how patients are received and managed and thus the nurses' relationships with paramedics. The findings from the research interviews will be described within the context of the three themes identified following thematic analysis, 'positioning self-harm in young people', 'defining "good" and "bad" young self-harmers' and 'self-harm work in A&E'. The accounts of the nurses and paramedics will be drawn on to illustrate the basis of these themes.

8.2   Description of the Setting

The nurses who participated in the research interviews worked in a paediatric accident and emergency department in South East London, which provided 24-hour care for children and young people up to the age of 18 years[15]. Although next to the adult department (and sharing the resuscitation facilities) the nursing staff (all children's trained nurses) were managed by the children's services, whereas the medical input was largely provided by medical staff employed to work in the (adult) A&E department. Paediatricians (F1's & F2's) would see children in the department if the A & E medical team made a referral. However, the following would be referred directly to paediatricians:

- Direct GP referrals
- Babies under the age of one year

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[1] The term paramedic is used throughout although one participant was an ambulance technician (see page 190)

[15] The provision of accident and emergency services changed including departmental opening hours whilst the study was being undertaken. The description provided is as the department operated at the commencement of the data collection.

- Children and young people who required immediate resuscitation
- Any child where there was a child protection concern
- Any child or young person who had self-harmed.

With regards to the latter, if the young person had self-injured then any wound would initially be assessed and treated by a doctor from the emergency department and then referred to a paediatrician, otherwise the referral (for overdoses and alcohol/drug related attendances) would be direct.

At the time of the study there were normally two registered children's nurses on a shift, drawn from a skill mix of two band seven, four band-six and two band-five nurses who were overseen by a children's emergency nurse practitioner who is a band eight. The hospital concerned had one children's ward with 18 beds and six cubicles, a paediatric assessment unit, outpatient department and a continuing care unit for young people with cancer.

As with all accident and emergency departments, patients can access emergency care via referral from a GP, by calling out emergency services or self-referral, thus as with most departments the workload was unpredictable, with attendances in the department averaging between 45 – 65 children/young people a day, with around 21,000 attendances annually. Many children attended after 5pm having either returned from school unwell, or as a result of a GP referral. As was evident from the interviews with the nurses working in the department, many of the young people who self harmed attended during 'out of hours' i.e. over weekends and late in the evening, when child and adolescent mental health services (CAMHS) were unavailable. The department has an average of 8- 12 attendances with a diagnosis of self-harm per month, although A&E records are compiled on the basis of discharge diagnosis; thus while on average only 6% (an average of 1 per month) of all self-harmers were recorded as self-injury the actual numbers might be higher than this.

Three LAS complexes, one in Bexley and two from adjacent London Boroughs, served the department, although paramedics make a judgement as to which A&E department to deliver patients to based on timing and factors surrounding bed

occupancy and expertise. When transferring a critically ill child ambulance crews delivered the patient directly into the resuscitation room of the main department, the department having received advanced warning that a child or young person was coming on a 'blue light', Otherwise children and young people arriving by ambulance were delivered directly to the paediatric department and the ambulance crew would then book the patient in at the A&E reception.

The space available in the department was limited, accommodating a triage cubicle and four treatment cubicles; each cubicle contained equipment required for assessment and treatment of minor injuries and acute illness in children and young people. At the centre was a 'workstation' where nurses and doctors completed notes and other administrative tasks. Paramedics provided the nursing staff with a handover, normally by the workstation, which given its proximity to the cubicles, often meant that others within the department could overhear what was being said; issues of confidentiality in respect of receiving handover for young people who self harm were raised during the research interviews.

8.3   The Research Interviewees

As noted in chapter 5 a total of 12 accounts from 13 interviewees were thematically analysed; one account was omitted as the experience of the nurse, (who did not have a children's nursing qualification) was limited. The remaining 12 interviewees had varied experience, covered a range of ages and were mixed in respect of gender. A breakdown of the participant's characteristics is provided in Table 8.1 as follows.

TABLE 8.1   Overview of Research Interviewees.

Participant identification	P001	N002	P003	N004	N005	P006	P007	P008	N009	N010	N011	N012
Role	P[16]	N	P	N	N	P	P	P	N	N	N	N
Gender		M		M	F				F	M	F	F
Age Range[2]	>51	36-40	46-50	46-50	31-35	36-40	>51	26-30	41-45	31-35	36-40	26-30
Length of Experience	16 years +	16 years +	16 years +	16 years +	11-15 years	6-10 years	16 years +	1-5 years	16 years +	6-10 years	6-10 years	1-5 years

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[16] [16] One ambulance technician participated in the interviews. To protect anonymity the technicians' data is coded as a paramedic. This technician fulfilled the same role as the paramedics, paramedic training only recently having become regulated.
One paramedic was female. To protect this participant's anonymity, details re paramedics' gender have also been omitted from the table.
[2] Age and length of experience are categorised as per survey categories.

8.4   Theme 1: Positioning Self-harm in Young People

As discussed in chapter 5, three themes emerged (see Figure 5.7). Each theme is discussed individually.

8.4.1   Overview of Theme

All the interviewees were able to recount numerous examples of young people who they had encountered who had self-harmed, both as overdoses and self-injury, as well as more serious cases, including suicide. The first theme, 'Positioning Self-Harm' arose from interviewees' accounts of their experiences of caring for patients who had self-harmed, the attitudes they had observed as well as comments they made which revealed their own attitudes.

Reporting on this theme begins with interviewees' accounts of attitudes observed, and discusses how the more experienced interviewees have noted a change in attitude over the past decade. Part of the changes that have occurred has been the increase in self-harm, an observation made by interviewees with experience, and in those with less experience in their reports of how retrieving and caring for young people who self-harm has become a regular feature of their emergency care work.

Although self-harm is increasingly a routine element of their work the interviewees do not see it as a normal response or behaviour. Their own reactions to self-harm have also been mirrored to some extent by parental reactions that they've observed; responses, which though varied, indicate that in some instances parents like the interviewees find it a 'difficult concept to grasp'. On the other hand the fact that teenagers often drink alcohol to excess and thereby render themselves in need of 'medical' care is seen as concerning, but is viewed (unlike self-harm) to some extent as being normal, as there is an expectation that young people will drink alcohol and drink to excess.

In discussing their experiences of caring for young people who self-harm, the interviewees often framed these within a context of 'serious' suicide attempt. In so doing they distinguished self-harm from suicide on the basis of 'scale', for example the number of tablets taken, or the seriousness of the wounds inflicted. These accounts are reported as well as how the label of self-harm is applied to young people by the interviewees and their peers.

8.4.2. Reports and Recollections of Attitudes Towards Self-Harm

At the beginning of the interviews I introduced the subject area of my research and emphasised the age range that I was interested in as well as the broad definition of self-harm adopted for the study. It was apparent that interviewees had witnessed or 'heard about' negative attitudes as is typified by the following response from a nurse:

> ***In your experience how do you feel people's attitudes are to young people who self-harm?***
> *Fairly appalling in most A & E departments* [instant response]
> ***What sort of attitudes have you come across?***
> *You do get the comments that are made - how many tablets did they take and its only 8- 10 paracetamol and its like that's not nowhere going to touch the sides tell them to take a decent dose next time, I've heard of people who, I've never actually witnessed it thankfully, who've said um for cutters and things like that they need suturing so no need to give Lignocaine because they enjoy the pain anyway, that's what they're in there for, and those sorts of things* (N011).

Another nurse with less experience to draw on, provided an account which involved an unusual presentation of self-harm, which also indicated that in some circumstances negative attitudes prevail:

> *I know it sounds like not a good thing to say but I remember two teenage girls one each day had come from a secure unit who had inserted light bulbs it seemed to be the trend of the home that they were in - one was lucky it was intact the other, it broke, not quite so lucky, and that was deemed as a joke job, an injury as opposed to self-harm, as they were already where they were resident (in-patient CAMHS), it kind of didn't get necessarily the true, it got the medical input they deserved, whether they got the input as per normal I'm not so sure* (N010)

A number of the interviewees had more than 16 years experience, and all bar two had more than five years, which provided an unexpected outcome in that these interviewees reflected on how attitudes had changed. For example one nurse recalled that:

> *I think certainly when I started in A&E people were quite dismissive about young people.... I remember a student nurse in my first A&E coming in having taken a, you know, a physically inconsequential overdose but a cry for help sort of and it was just, it was, I think most of the staff in A&E were, who had dealings with her, were just "oh this is, you know, this is stupid and just a waste of time" and that sort of attitude* (N002)

This interviewee recognised that although the dose was inconsequential the intentions of the young person had to be considered and that by adopting such an attitude he wondered *"whether we missed some of the actual intents at the time"*.

Similarly another nurse questioned whether self-harm was now being recognised as a 'problem', a problem not in a problematical sense, but in the sense of a problem in need of treatment.

> *Well I think it's changed, quite drastically over the last few years really, I think going back, bearing in mind I've been qualified 20 years, there was, I can't really explain the attitudes really, but there was a negative response if you like towards self-harm and overdoses, whereas now, I think people are seeing it as much more of a problem and they're received better within A&E, and I think there was a cliché years ago when they were seen in A&E, not treated badly but people's attitudes toward them was you've done this yourself you're not a priority, now it's completely different and its looked at completely differently* (N009).

That self-harm is viewed differently is also mirrored in another participant's reflection on the re-positioning of care and management from punishment to treatment:

> *When I first started in A&E it was put the tube down and, you know, kind of you know it was almost seen as a punishment routine and not seen as a help thing* (N004).

All the accounts from the more experienced nurses, suggest that there has been a move to a 'help' mode, and in so doing interviewees are looking beyond the harm i.e. are not merely focussing on the overdose or wound, but taking into consideration wider factors which might explain their behaviour and therefore attendance, a facet that is returned to when discussing the final theme.

8.4.3. Self-harm, Increasingly a Routine Component of Emergency Care Work

One thing that became clear from the interviews was the extent to which self-harm in young people has increasingly becoming a routine element of the interviewees' workloads:

> *And in my early days of my health career, I didn't really have many people who self-harmed but now, it's part and parcel of our daily workload.... On the road in the 80s ... I'd probably count that on one hand. And I joined in '84, so from '84 through till '90, I would be able to count the amount of young people on the one hand of five, of course, who I would say had actually self-harmed, taken an overdose, etc. In the 90s, that probably changed and went into tens and up towards hundreds and in this decade, it is a daily occurrence* (P007).

As is the case when pathology increases, the question becomes, to what extent has it actually increased or is it better recognition, as reflected by this respondent,

> *There does seem to have been a rise, as I said, whether that rise is due to the actual numbers or whether we're just getting better at recognising it, as attitudes have changed* (N004).

Whichever is the case, and in reality it is likely to be both an increase as suggested by prevalence studies as well as better recognition, the outcome remains that self-harm is for paramedics an almost 'daily occurrence', and for nurses a frequent (and unanticipated) element of their workload.

> *I think in general terms if you included things like drugs and alcohol as self-harm, I see it every day. **What about overdoses?** If we're talking about people who take overdoses, self-harm as overdoses are I'd say are relatively common, I think if you're talking recreational drugs and alcohol l see that every day* (P008)

> ***Was it your expectation that when working in A&E you would have to manage young people who self-harm?***
> *Yes, but not the number, that surprised me, that has surprised me, because coming from the ward and student days to A&E you don't see that many necessarily on the wards* (N010).

The increase in prevalence of self-harm in young people was also echoed in the accounts of some interviewees who reflected on the fact that in their own personal lives it wasn't something they'd encountered but which was something which young people were increasingly turning to and as such it had become more of a 'societal' norm:

> *I can't imagine it being sort of you know, your grandparents' age and then 50 and 40 yr olds now I don't think it was so prevalent with them, I think it's got an easier option, I don't quite know how to word it, I think kids turn to it now sooner than they did it before... In my life experiences I've come across kids who've been in tough situations and self harmers were then in the minority, if I had my life experiences now, I think most of the kids I've ever met, grew up with, would have been self harmers, but that's just my interpretation* (N010).

> *I'm in my 50s; nobody at my school did that, an overdose? You probably didn't even know about, well, there were aspirin in those days, you didn't have paracetamol, but the difference is, nobody did that, you only ever took medicine when you were ill. Whereas, now it's a societal thing whereby young people use self-harm as a way of relief for whatever their problem is* (P007).

8.4.4 Self-harm – A Difficult Concept to Grasp

While self-harm was evidently an increasingly prevalent component of these practitioners' workloads, this hadn't normalised self-harm; it was still seen by the interviewees as an abnormal response or behaviour. A nurse discussing the reactions of junior less experienced colleagues said,

> It's a difficult concept to grasp, why someone would cut and harm themselves and what release they get from that, it's not an easy concept to grasp...(N011)

Other comments ranged from seeing it as an unhealthy approach to life to something that was 'horrendous',

> But no healthy teenager with a healthy lifestyle and healthy friends and family and everything, normally come into A&E having taken an overdose (N005)

> Unless of course you're a masochist, would you really want to do that - I might cut myself on a bit of wood or a glass, Ooh, Aargh, but actually cutting and doing it yourself, that's horrendous! If they get to that stage, that is horrendous, and even to take drugs and medication, call it what they like, it's' still, well I couldn't do that. (P001)

This personal reaction of some respondents towards self-harm is possibly a reaction that some parents themselves share. Although not explicitly explored as a topic on the interview schedule a number of interviewees made reference to parental reactions, which included embarrassment, the embarrassment arsing from the stigma associated with self-harm. One respondent made the point that the family might try to hide what's happened, possibly because of the stigma attached to self-harm, giving this example of her recent experience:

> There was a girl who came in last week who'd taken an overdose and she said she'd tried to cut her wrists once before but her parents found her and patched her up at home and she had not actually attended anywhere so you don't know how many the family is keeping going and keeping going without seeking help (N011).

One of the nurses observed that while there was a 'taboo' associated with self-harm, this wasn't associated with other behaviours such as drinking and smoking, even though these behaviours are also associated with stress relieving strategies in the same way that people who self-harm report it as a coping mechanism:

> I've noticed a change of attitudes, there's a big taboo around the fact that it's self-harm whereas if you look at people that drink or people who smoke I mean you know these are all stress coping strategies that people, a lot of people drink too much because they're

stressed or because they've got problems, a lot of people don't really look at that in a frowned upon manner like they do self-harm (N009).

8.4.5. It's the Norm for Teenagers to Drink

As N009 observed, excessive drinking amongst teenagers, whilst a concern, didn't invoke the same kind of response from the interviewees in terms of it being abnormal, or indeed masochistic, with evidence that inebriated adolescents were the norm in their daily work. As identified above, one paramedic reported that *if you included things like drugs and alcohol as self-harm, I see it every day*. One paramedic in particular graphically recounted the following:

> *And then the classic one is Saturday afternoon in Bromley, a bus stop. Now when you arrive, the person can't even sit on the bench, they're actually on the floor, there is vomit everywhere, the person is like a young teenager, 13 or 14 years of age, and totally incapable, at the moment, of even… in that sense, if they rolled on their back, they wouldn't be able to maintain their own airway. Literally, the people standing at the bus stop have a concern because they know that they don't know what to do, but at the same time, I can't leave this human being laying on the pavement on a sunny Saturday afternoon in the middle of Bromley town centre while I'm waiting for my bus. So they dial 999* (P007).

Overall it was the paramedics who provided the accounts of inebriated young people, nurses on the whole made passing reference to teenagers being drunk, normally in the context of their behaviour as being abusive. In their accounts some of the paramedics indicated that they thought alcohol was a normal part of growing up, or a normal aspect of our lifestyle(s) as illustrated in the following comments:

> *The drink, the drink you can get over the counters, and they go wha hey, and you wake up with a headache, that's nothing, that's life.*
> ***Do you think you distinguish differently between those who go out and get drunk, those who cut themselves, and those who overdose?***
> *Ooh yes, yes,*
> ***How – in what way?***
> *Drinking, is kind of normal, I mean you've gone out and got drunk?* ***Hmm***
> *I have – you've gone to a party and I mean I never did drugs, but everyone gets drunk, it's a normal part of growing up* (P001).

Not only is the above interviewee clearly indicating that he sees it as normal for young people to go out and get drunk, he is also intimating that it's a normal part of our lives, and in so doing tries to affirm this with me. The fact that we as adults and interviewees, might drink was also reflected in another comment from a paramedic,

I mean partly for my own interest in human behaviour what, you know, because not having done it (self-harm) myself I wonder what provokes somebody else into doing it. Well I suppose I self-abuse with alcohol [laughter] (P003).

Another paramedic comments,

What I'd say is recreation - it's the norm to go out for a few drinks, it gets a bit silly after exams (P008).

Overall the interviewees tended to ascribe adverse behaviour associated with drinking to females as illustrated in the following extracts:

And it does tend to be ladies that fall over (drunk) (N002)

And we're seeing lots of them who are coming in who are out drinking at the age of 13, 14, and they think, they come in and think they may have slept with some boy but they don't remember if they did or not as they were so wasted - it's a dreadful way to be at such a young age (N011)

And the reason was is the fact that the parents had actually found their daughter who had been with her friends, she'd drunk over a litre of vodka, her friends had used her lipstick to write over her forehead who she was and across her, and then left her, took her mobile phone and left her in the car park (P007)

However for some alcohol was also seen as a symptom of something else, i.e. an underlying problem, in the same way that self-harm was viewed:

I mean even getting drunk is termed as just "oh don't worry, they're just getting drunk" but actually if you look at the history, how often it's happened, what are the contributing factors, what's the home background, that's more important than looking at just an isolated case of being drunk, you know (N004).

I would argue that the alcohol and drugs it's in the same way, is that they are still trying to hide or get away from what's making them upset (P008).

8.4.6   Suicide and Self-harm – A Matter of Scale.

It was apparent from the accounts of the interviewees that how self-harm was defined and thus how a person who self-harmed was perceived was partly dependent on the scale of their self-harm, with suicide being seen as the extreme,

I've seen a few cases of physically self-harming, cutting and stuff or remnants of stuff.... but um I've not seen the extreme (suicides) ... you hear about it, it's

> *a very sad case and you hear about a young person who's hung them self*
> (P008).

Generally though self-harm was not seen as being a 'serious'- as described above, a nurse respondent refers to a student nurse, who had taken a *'physically inconsequential overdose'* and later says,

> *Okay, from our point of view it's not serious, it's only ten or whatever, and let's say six paracetamol, it's not a big deal* (N002).

Similarly another interviewee indicates that taking two or three tables would be seen differently (assuming the young person is telling the truth) to taking 50 tablets,

> *A lot of the time they say they've taken 50 plus tablets but only taken two or three* (N012).

It was evident however that a number of interviewees had encountered young people who had completed or nearly completed suicide, which clearly saddened them

> *I've seen self-harm in young people especially like potential attempted hangings and stuff who've ended up intubated and poorly from that, from hypoxic injuries* (N012).

> *At least one girl here came in with recurrent overdoses and ended up succeeding in committing suicide and that's not what we're aiming for at the end of the day, it's sad isn't it* (N011).

One paramedic recounted two cases where he'd attended where suicide had been completed, one involving a 'glue sniffer' and one an overdose, he compares other cases of self-harm he's encountered with these two suicides,

> *I mean those are only two; yeah those were the only two that self-harmed to the point of killing themselves. A lot of the others it's, you know, it's just been a handful of pills or an aborted attempt to slash your wrists or something you know (P003)*

His use of the words, its just been a 'handful of pills' or 'aborted attempt to slash your wrists' suggest that to him, when comparisons are made, the latter are relatively inconsequential when compared to the two suicides he had recalled.

As with any traumatic event these cases clearly 'stuck in the minds' of the respondents, and it is quite possible that they used these as reference points for making judgements about what did or didn't constitute a serious attempts. For example, another paramedic recalled that,

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> *I've had one very traumatic case, which was a 10 year old who hung themselves* (P006).

It would be unusual to encounter a ten-year old who had died from hanging, as indeed self-harm let alone suicide is rare at this early age, which perhaps explains her use of the word 'traumatic', but this paramedic goes on to say,

> *I have been in, not to, not wanting to sound cold or anything, but more what as I would describe as cries for help than serious suicide attempts, so whether they truly believe that what they've taken will cause them to die or not I don't know, but it's not been anything significant* (P006)

Many of the comments in relation to scale referred to an overdose and the number of tablets taken, but comments were also made about young people who had self-injured which also alluded to scale, one comment from a paramedic was particularly edifying:

> *Yeah. Yeah, yeah, I've had the occasional, a couple where they've tried to slit their wrists but you know, they've done it Hollywood style and they don't know how to do it so, you know, it's just skin wounds rather than anything significant, yeah, yeah* (P003).

While a nurse provides a somewhat graphic (and probably inaccurate), account of how a young person who self-injures might go about causing the injury

> *I particularly remember seeing, even last week, there was a young lady who's got a big, massive, she has been a cutter for some time now and she's got her own file now and it's, you know, like a door stop ... it's about 3 or 4 inches thick, you know, and she regularly chops herself up* (N002)

8.4.7 Self-harm as a Label

Although the respondents used suicide as a reference point when defining self-harm, it was evident that self-harm itself wasn't necessarily viewed as a mental illness as reflected in these two extracts:

> *and I think that therefore there was probably a tendency to look at the patient size wise and just brand it as an adult with a self-harm or mental health issue* (N004).

> *I think it's any children's A&E must have these issues all the time, because you can't treat them like adults, they are incredibly distinctive and you know obviously, you do get the very rare few teenagers that may have legitimate mental health issues* (N005).

It would seem from these nurses' accounts that self-harm wasn't seen as a mental illness. Moreover N004 questioned whether in-fact some cases labelled as self-harm might, in another

setting be considered a different kind of behaviour; he cites his experience as working as a school nurse where he observed the pressures young people in school faced. He noted that often their reactions to these pressures might result in aggression for example punching a wall or punching and shattering a window. He didn't necessarily see this as self-harm, but commented,

> *Other people, the other professionals, they think of that as self-harm but I think it can be self-harm, or it can be, not self harm, but just anger management or a combination of both* (N004).

The nurses in the A&E department frequently encountered difficulties when securing an admission for a young person who had self-harmed, usually because it was not possible to access CAMHS directly, consequently the young people had to be admitted to the children's ward. The ward was though unwilling to accept these young people as they were perceived as being disruptive and or aggressive. This is explored in more depth in the final theme; however, two of the nurses questioned the assumptions that staff on the children's ward made about young people who self-harmed, as follows:

> *I mean, there are disruptive young people, or families with young people with mental health problems, but there's also disruptive children that don't have mental health problems and families with children that aren't having mental health problems which are all disruptive as well so I wouldn't class them as all disruptive* (N004)

This respondent is suggesting that it is the label of self-harm and perceptions of the behaviour of young people who self-harm that causes the young people to be perceived as a problem, i.e. the diagnostic label. Another nurse also noted this:

> *Teenagers wouldn't normally be turned away from the ward if they say come in with appendicitis, it's because they've self-harmed, and they're 'stroppy'. I mean they could be an asthmatic teenager and 'stroppy' - but they could have a head injury masked by alcohol or something and then... but it's because of medical diagnosis that fits under that remit you know, asthma is paediatrics, that sort of makes it acceptable whereas because it's self-harm it makes it slightly different. I think so, yeah. And so no one wants to deal with it because it's difficult and a problem* (N002).

8.5   Defining 'Good" and "Bad" Young Self-Harmers

8.5.1   Overview of theme

This theme focuses on young people as 'self-harmers'; in so doing it reviews how the accounts' of the interviewees indicate that they were more sympathetic towards young people (when compared with adults) who self-harm, and explores based on their accounts, why this should be.

However, although young people who self-harm were seen more benignly due to their immaturity, the accounts of the interviewees also reveal how they hold contradictory views of young people themselves, these views usually articulated by paramedics and framed in their experiences of seeing them in the local community/society. Notwithstanding this, young people's immaturity was recognised by the interviewees, this immaturity also being reflected in how, in their experiences, young people did not appreciate the consequences of their self-harming behaviours, and were also fearful of the consequences, this fear further emphasising their immaturity and vulnerability.

The interviewees' perspectives on attention seeking were ascertained during the interviews, as the label of 'attention seeking' is frequently associated with people who self-harm. It was apparent that the interviewees distinguished between attention seeking and a cry for help; the former were more likely to be seen as repeat attendees who could demonstrate manipulative behaviours. Those who were deemed as attention seeking were also more likely to be seen as 'Frequent Flyers' and 'Revolving Doors'. As the interviewees' accounts demonstrate, they understood and were sympathetic towards the young people who self-harmed in respect of their motives, but simultaneously they found their behaviour frustrating as young people were invariably difficult to engage. Engagement was necessary if the interviewees were to get to the bottom of their current presentation and thereby help them, in a therapeutic sense; there was therefore a sense of exasperation at young people's reluctance to engage. This sense of exasperation was heightened by the fact that the interviewees worried that by not being able to engage the young person they might miss something serious, and that as a consequence the young person might come to further harm. The interviewees consequently welcomed young people who were active in seeking help and who engaged and provided their history.

8.5.2 'Being More Accepting' of Young People (who self-harm)

One nurse while acknowledging that some of the cases he encounters are 'sad' admits that,

> *There are some that really pull at the heart strings and some just you don't feel so quite so warm to, the job is the same, you do what you've got to do, but yea, they are not my favourite patients* (N010).

However interviewees were generally sympathetic to young people who self-harmed as illustrated by this reflection from a paramedic:

> *I think it's always that people can be more accepting of children, you know or young people sort of like, you know you've got your whole life ahead of you*

whereas someone who's older it's a case of "pull yourself together, sort yourself out girl" isn't it, you know so I think it's a bit more sympathetic.
And that's because they're younger?
Yeah, yeah and it's not like, you know, it's more... you do, you sort of think well what's pushed you to this point at your age, you know when you're a bit older sort of like, you know, and you maybe put yourself in situations you've got more option to make your own choices I think so maybe from that point of view (P006).

The above account indicates that comparisons with young people and adults who self-harm are made, with young people who self-harm viewed more benignly due to their immaturity, a perspective that was evident in other respondents' thoughts as follows:

> *I think the younger they are the more sympathy I tend to feel for them which right or wrong is just the way I react* (N005).

> **Do you think people have different attitudes towards young people as opposed to adults who self-harm, are they seen in a different way?**
> *Yeah I think so to be honest, I think they do. I think there's a certain, well certainly speaking for myself, there's probably a view that they don't understand the implications of what they're doing... they haven't really cottoned on to the implications whereas you kind of assume that by the time you get to adulthood you should know better or, you know, what you're doing is a deliberate action* (P003).

Moreover, as the latter and the next respondent suggest, due to their immaturity children and young people are seen as being unable to fully distinguish between behaviours or responses that are right or wrong,

> *A lot of adults overdose because they simply can't afford to miss time off work, or I've got an illness or I've got problems – but children a lot of them are too inexperienced too immature, they haven't experienced life to know the difference between what you do and what you don't* (P001).

8.5.3   Perspectives on Young People Borne from Experience

It is evident that the interviewees felt that they and their colleagues did or should treat young people who self harm differently than adults and in effect this was acceptable or expected because young people lack maturity. However some ambiguity about young people's status was evident as is illustrated in the following extract of an interview with one of the paramedics:

> *But if I talk about where I work ... young people are seen as, it's probably not fair to generalise, but they have a bad reputation, they have a reputation that if they're not in school they are troublemakers, and probably around my areas as well where I work a lot of them are expected or seen to be in gangs and that's the expectation they (the police) have ... and that's a real big part of it, they (young people) all talk about respect, I think a lot of people where I work*

don't respect them at all so I think it's a very poor outlook from what I've seen...

However, he goes on to say,

I see a very skewed version as the young people I tend to see have either been in an accident themselves or unfortunately, a lot of it is gang related violence, but, I also see a lot of people who are young carers, the family are very unwell, I see a lot of young people who grow up incredibly young for other reasons... and perhaps they are acting in this gang nature as you see in the media representation but in the ambulance it's a very different environment they're scared, hurt, they tend to revert back to being a child (P008).

This paramedic had clearly witnessed the pressures that some young people face, a perspective also shared by a nurse:

I think they've got a lot more pressure nowadays, more than we did even at school and with peer pressure and things like that there is so much in the media, and on TV programmes and things like that about, the way they should live, and all the magazines, supposed teen magazines aimed at young girls which are all about sex and boys and this that and the other, from such a young age now that they're being hit by shops who are selling thongs and bras for 6 yr olds it's just awful the whole way society is hitting and putting a lot of pressure on girls especially (N011).

Another contradiction in how young people are viewed was apparent from this interviewee's account, on the one hand he suggests that he needs protecting from young people,

On the whole, young toddlers, now they're very, very vulnerable; then 12 – 18's if someone starts up they're probably a bit like adults, most teenagers now, as you probably know are taller than me and I wouldn't take them on...

But in the next sentence he agrees that there are differences between attitudes towards adults and young people, who self harm, he says,

Maybe because they're adults they've learnt how to cope with it, children, young people, might not be able to cope with it, you've got to protect them (P001).

The contradictory way in which young people are seen was also highlighted by a nurse who, when discussing difficulties over finding a bed for young people who self harm pointed out the following:

But I've always, funnily enough, I've always wondered why it's okay for them (16-18 year olds who've self-harmed) to go on adult ward when you've got confused old ladies in beds, huh, why is it okay for the nurses up there to accept them and not the children's ones (N002).

In other words it's fine to expose elderly people to potentially abusive young people, but it's not appropriate to expose other inpatient children or young people as they themselves are vulnerable – the assumption being therefore that the elderly are less vulnerable than children and young people.

8.5.4   Knowing (or not) the Consequences

The vulnerability of young people came across in terms of young people's fear of the consequences of their self-harming behaviour; interviewees identified for example that they either lack awareness of or fear, the physical consequences, and that this is down to their own immaturity and thus lack of knowledge and understanding of the consequences,

> *Some young people take the over the counter, take the paracetamol, usually it's paracetamol, genuinely thinking they're going to die or not really knowing what the consequence is going to be and they just do it and then they go "oh no, what have I done?"... I don't think they worry about the consequences physically of what they've taken* (N002)

> *If it is a self-harm in the sense of wounds, sometimes they look at the blood and it's like too much.... and then they look at it and go, and well, they get a little bit frightened* (P007).

This lack of understanding resulted in the respondents being more acceptable of their self-harming behaviours:

> *There's probably a view that they don't understand the implications of what they're doing, you know they take a handful of paracetamol because it's handy and it's there and it's easily available, they don't understand the implications of what paracetamol can do to you in excessive doses. You know things like that so I think there is a sort of, a more tolerant attitude towards children who self-harm because you sort of think they, you know they don't really, they haven't really cottoned on to the implications* (P003)

The interviewees also described the young people as being fearful of the consequences, in terms of fearful of what their family might say and fearful of the 'authorities':

> *They're too frightened, too frightened. **So they want help?** Yes, and they're too frightened to say, too frightened, because they think to themselves I'm going to be separated... A lot of them are frightened they've done something and they don't know how, if it's the first time, their mum and dad's going to react* (P001).

> *I think it's a more of a them thing at that time, am I going to get in trouble am I disrespecting my family should I be doing this and some of them see calling ambulance as fine but for some it's a huge, huge thing that you've called out medical help* (P008).

They're scared of uniforms and service provision... and there is a fear of next steps, and what we're going to do and what they can say and can't say... There is a big fear a big fear about being separated, some want that, but they're still afraid, there is fear from both the child and the family about next steps, what's going to happen next (N010)

8.5.5 Defining a 'Cry for Help'

It is evident that, although young people who self-harm are initially viewed by the interviewees with compassion and understanding, there were circumstances when these views could be challenged. Interviewees were specifically asked if they'd encountered the term attention seeking, as (negative) perceptions of self-harm as attention seeking behaviour has been widely reported. All the interviewees had heard of the term, however many interviewees couched attention seeking in terms of 'a cry for help'; thus the differences between a cry for help and attention seeking were explored.

It was evident that a cry for help was associated with little forward planning, the young person wanting to be found:

I use this thing whereby does the person really want to take an overdose or is it a cry for help? When I say 'cry for help' it's the fact that maybe somebody who's taken an overdose, who contacts a friend, who dialled 999 and the door happens to be open. And ... Okay, you've gone to suicides and that's exactly what you find [a body and a locked door]. Now that is then somebody who actually wants to commit the act and has the will to commit the act, no ifs, no buts, they may leave a note or whatever. Whereas others, when I say the cry for help, they don't really want to or intend to do that to themselves and they will contact friends who are concerned about them and who know what's going on in their life at the moment and you arrive. And in fact, you don't find a locked door, you actually find an open door, and then you're able to ascertain in talking to the person, well, this is what they say they want to do, but they don't really mean it and they don't... because if they had wanted to have done it, nobody would have got any phone calls, nobody would have left their door open, etc. So that, to me, is the kind of call that I've been to where it's a cry for help (P007).

I guess if it was a cry for help and they've timed it so the parents come home or something like that or someone expects someone to come past or they've taken whatever it is and then panicked and called an ambulance themselves (N004).

Sometimes it's a cry for help sometimes, it's just like I think of one the other day, at the time it was a good idea so wasn't pre-empted, I think it depends how much pre-empting and how much kind of thought and planning goes into

it as to how much of a cry for help it is and if it's happened before or if it's a regular occurrence or a once off (N012).

Thus, a cry for help was more likely to be seen in a positive way, as it was seen as an active attempt by young people to draw attention to themselves and the problems they were facing, as the following extracts illustrate:

> ***Is there a difference between cry for help and attention seeking do you think?***
> *A cry for help is like someone asking for help, whereas attention seeking, it intimates that they don't necessarily need help but they want attention* (N010).

> ***Have you heard the term 'attention seeking' used in relation to self-harm?***
> *I have heard people say that, I don't know it's always meant in that they're wasting time, people will use that and say, sometimes people self-harm, the adolescents for example, they're not intending to commit suicide and it's a cry for help, sometimes it's a cry for help and I think that that's probably just mis-worded, some people I don't think mean it, that its attention seeking, because a cry for help is sort of attention, you are seeking attention to get yourself sorted if that makes sense* (N009).

In actively seeking out help, there is also an element of the interviewees perceiving that the young person, having tried to deal with their self-harm, has recognised that they want help, but don't know what to do,

> *More to the point of they don't know what else to do, not to be... it's not to be taken seriously or anything like that, not sort of like to crave the attention, it's to try and, well they don't know what else they can do because they're at that point that they don't, they don't see how they can rebuild it so they don't know what else to do* (P006).

It is possible that the respondents were reluctant to label young people as attention seeking, as they were themselves wary of the consequences of 'missing' something,

> *And then you have ones where they've tried to keep it to themselves, that's not attention seeking as they haven't sought any attention it's someone else bringing them into hospital, or mum's found them or they've told one friend because they're a bit scared or one teacher, they maybe told, I don't think that's attention seeking. I think there are probably ones that you put under the bracket of attention seeking but then still you have to be a bit wary of that because why are they attention seeking?* (N005).

Overall interviewees had concerns about 'missing something', and to this end young people who self-harmed were viewed as a risk, both to themselves, but also to the interviewees as their

professional judgement might be questioned should they miss something, particularly if it was missed due to an underlying perception or attitude. This aspect of how young people are viewed is returned to below when discussing engagement.

8.5.6   Attention Seekers - 'Frequent Flyers' and 'Revolving Doors'.

While most interviewees couched attention seeking within the context of a cry for help, there was an element of young people who are perceived to be frequent attendees being seen as attention seekers, as illustrated in the accounts below:

> *And you know, and a lot of the frequent ones are, it's they see it as, you know, like an attention seeking or it's a way of getting emotional support when they haven't got it or something like that, you know* (P003).

> *I think that you can quite easily pick out a few faces that I've seen here which clearly is attention seeking, where they've taken maybe a few paracetamol few Ibuprofen, have gone into school and told all their friends and then come in* (N005).

Young people who attended frequently were referred to as frequent flyers and revolving doors, the accounts suggesting that these young people might not receive the same level of time and attention:

> *I can see how if you're repeatedly having to deal with somebody, you know you could end up becoming dismissive of what they're doing because it's "oh no, it's X again, here we go", you know, "doesn't really mean it, what's she done this time". And I think that would be, the thing is with the ambulance service and the paramedic thing is you could have frequent fliers, and as an individual you might not encounter them, but certainly within the mess room it gets known, you know because people will start to recognise the address and things like that* (P003).

> *With some patients, but you can't pigeon hole every one, um but some of these kids are revolving doors... Yea I've had a girl who was well known revolving door, constant fake procedures, fake unconscious, self-harm, every sort from overdose to wounds, admitted and discharged immediately* (N010).

This participant (N010) was however at pains to point out that it wouldn't make any difference whether a young person was deemed to be attention seeking or a cry for help in respect of how he judged the patient, however in so doing he ascribes negative values to attention seeking:

> *As a service provider, when you come to my door, a 16 yr old girl who's taken an overdose for the first time is it a cry for help? If you've done it 15 time is it attention seeking? Am I going to value judge that and change my approach? No. Yes you can say it's different, but for me it's easier to keep it the same. I*

don't want to put a plus as a cry for help and a negative for attention seeking because ultimately it's the same thing (N010).

Distinctions were also made in respect of those young people who were seen as being problematic by being drunk, abusive and or aggressive, for example:

I think it depends what condition in they come in, if you get some of the young people particularly teenagers that come in maybe have been drinking, out with friends, had an argument with boyfriend then take either an overdose or cut themselves or take an overdose of tablets or things like that, I think the sympathy is not necessarily there as much... I'm not a saint I've probably been guilty of that as well (N005).

Occasionally young people who had self-harmed were seen as being manipulative, using self-harm to get what they wanted whether that was attention, or services,

Sometimes, sometimes, the cause [of the self-harm] is very apparent, other times it's crowded and shrouded in them not talking to you and manipulative behaviours. **What are these?**
They quite often know things to say, take the girl who broke her hand she knew that if she was unconscious she was likely to be booked so she came in faking unconsciousness; they know certain buzz terms, certain terminologies to use that triggers red flags and things and with the Pathos tool for example the Pathos tool, do you feel any hope that sort of thing, you ask them certain questions three or four times, the fifth time they know the answer, so they know next time what to say, they say no, after you've used it a few times they know the questions and know next time what to say and you see that, you get to know regulars (N010).

Say they've had a meeting with their counsellor and they feel they want particular housing or particular outcome to that meeting and it doesn't happen, then the counsellor will ring you and say and like, I know they're distressed because they wanted this and couldn't have it blah de blah, so you know, because their stress levels are raised, their way of coping with that is invariably to hurt themselves and you know they're going to come in because of that (N005).

8.5.7 Understanding and Exasperation

Despite some cynicism in respect of young people's perceived manipulative and attention seeking behaviour, the interviewees were generally sympathetic and understanding to the causes/motives for young people's self-harming behaviour, citing a range of reasons why, from their perspective, young people self-harm, which they recognised as being legitimate.

Again this is personal opinion, but I don't think that they want to die but they just don't want to carry on with things as they are, so it's a way of almost stopping this bit happening and then maybe moving on (P006).

To me it's an act of desperation they don't know where to go next (P008).

Interviewees' concerns were often couched in terms of understanding self-harm as a coping strategy,

> *I think she'd had argument with somebody, you know, and it was just a, you know so, the patient's way of coping or something* (P003).

> *Self-harm is kind of, it's a coping mechanism, not life threatening usually, but the cutting, but just you know, needs help they suffer... It's an addictive behaviour like smoking and drinking, that's why it becomes a problem* (N009).

Similarly other motives (as identified in research studies) were also cited

> ***From your experience, why do young people self-harm?***
> *Family break up, not liking new partners so family break-up is the original thing but not liking the new partners they're living with, not being able to see the other partner it's another separate thing, drug use, I'd say depression, it sounds very stupid but really depression... family break up is quite a big one, umm... There has been sexual abuse but that's, it's not the most frequent one, but that has come up as well* (N010).

> *It doesn't always have to be abuse or it could just be that they are feeling very out of their depth or think who are their crowd or are their crowds are moving onto this and that and they don't want to move that way, but they will feel very isolated if they don't, and teenagers do have a very big tendency to blow things out of proportion as well, so you know, sometimes a timely spat with boyfriend or mum or step-mum or dad can result in this type of behaviour* (N005).

> *I've done a lot on self-harm, and self-harm in adolescents is very different to self-harm in adults and it's not always with the intention of suicide, sometimes it's a release of their bad feelings and we need to be recognising the difference between the two and be able to offer support* (N009).

While interviewees understood and recognised the motives behind self-harm they almost universally reported difficulties in communicating with the young people who self- harmed:

> *I think by and large, they don't go into in depth conversations, yeah there might be a glib answer or something like that that you'll get "because I felt like it", that kind of thing, you know* (P003).

> *A couple of times they've just not wanted to communicate because they don't want to be part of it, ... they're not very happy with the situation, with whoever's called or what have you* (P006).

> *The biggest challenge is to get them to open up and talk to you* (P008).

It's extremes they're either very talkative and just glad someone's listening or they're not very talkative at all full stop. I guess that the talk doesn't matter to them so much (N010).

It can be difficult with some of the adolescents they don't, they've got a lot going on with themselves anyway they don't tend to want to walk into A&E and disclose what's going on in their mind to some strangers... sometimes they're completely closed down they won't tell you anything at all, won't answer any question and their history and everything else is coming from a parent or friend or whoever is with them so you're not getting a true idea of what's going on (N011).

However it was evident that the interviewees attempted to engage the young people, in an attempt to gain their trust and because they recognised that it was important to get as much information as possible from the young people:

Initially quite a lot of them are, they're either, you know I think they're abusive because they're defensive, you know, because they perceive that they're in trouble and, or they just want to be left alone or something like that. But normally, normally I find the best approach is to take it and just, you know, not rise to the abuse because it's very difficult to maintain aggression against somebody that's not kind of feeding it back and so they run out of steam and eventually once they've calmed down a bit you can get to sort of chat with them....And then maybe once you've gained their trust maybe engage them in a conversation that might start something, so you know like "is this the first time you've done it", you know "what provoked you in doing this" and you know, you know "why did you pick those particular tablets as oppose to something else" or you know, just try and engage them in a conversation and kind of eke it out of them, you know (P003).

Because you do have to delve and you have got to get history and that's important otherwise you're not going to be able to touch on what's happened (N009).

It was also recognised that the ability to engage a young person often depended on the ability of both parties to interact with each other, and if engagement occurred this was highly valued,

You know, you can see that [personal feelings] in how patients react to you, or the nurses react to certain patients. Some nurses can build a rapport with a certain type of patient and other nurses don't and vice versa (N004).

I've had a child open up to me as, through communication we've connected, and he told me more than he spilled to other people, I felt flattered but that was luck, my personality and his gelled on that day (N010).

As noted above a respondent displayed some anxiety in relation to labelling a young person as attention seeking in case applying such a label meant that a more serious outcome might occur or

be overlooked. Similarly, interviewees focussed on trying to get the young person to 'open up', as they were concerned that they might miss something, and that a young person would succeed in completing suicide:

> *Also of course what you get is you get your repeat calls, you know that's the other ones you know where they, you know they frequently do it, you know, but then again, you know, there's always the argument that if they're serious they'll succeed eventually* (P003).

> *But if there's nothing visible, you think hang on, then bells should start ringing, if I've done, or missed something and I'm concentrating on the wrong side there* (P001).

The 'fear factor' of young people not opening up was evident in this comment:

> *And then you have ones where they've tried to keep it to themselves and they're the ones who are really very dangerous because I think if you release them too soon as if you let them back home or back into that environment again what are they going to do next ... and the ones who come in alone I'm always an awful lot more frightened about* (N005).

Consequently it was pleasing when young people opened up or presented themselves, and as with those young people who were seen as presenting as a cry for help, there was a sense of the young people taking an active responsibility for what they'd done, and are being seen (in the eyes of the interviewees) to be apologetic:

> *Some do come and say um, I took this, this morning and just whatever - its normally the overdoses rather than those who cut, they say - at the time I wanted to kill myself and now I don't and I'm sorry I did it and I've told my mum and I want help or whatever else* (N011).

> *You know, so if they've taken an overdose and they're refusing any help, you know that's different from somebody who's sort of taken an overdose and then thought "oops I've done a silly thing, what's happened here", you know (P003).*

> *The ones that I've seen here have been quite open and we had one the other day it was a boy who self referred himself to come in for like depression so the potential to do other things, but he had kind of walked in himself and asked for that help, which was quite reassuring really, that there are some young people out there who will try and get help before self harming or taking anything further* (N012).

> *Some of them do actually ask for help themselves don't they, some of them they've gone to someone and say this what I've done, then I think that's the*

first step in the fact that they're recognising that they need some help themselves (N009).

As well as valuing young people who were more active in seeking out help, interviewees also distinguished between how they reacted to young people based on their aggressive or disruptive behaviour:

> *I have to say I think its easier to feel sympathy for someone who isn't being abusive and it's easier to feel sympathy for someone who is very quiet and seems very frightened and quite young* (N005).

> *I mean some, you know sometimes they're, you know just abusive, you know, and there is a, you know, I suppose there's a danger that you sort of slip into lecturing them about what they've done which doesn't really help the situation* (P003).

> *I would say I've been intimidated before.... I would definitely thought that I've reacted in a certain way by accident, especially situations which are, when we arrive, can be so explosive I'd say it's happened, it's hard to generalise but in my experience I would have thought that that's had an effect on the way I've seen young people because of something perhaps they've just done* (P008).

8.6 Emergency Care & Self-Harm Work

8.6.1 Overview of theme

This theme emerged out of the interviewees' accounts of their work with young people who self-harm, within the wider context of emergency care work. When encountering young people who self-harm it was evident that the initial focus was on assessment and ensuring physical safety, and this was a given. The focus on the physical element of care reflected the interviewees' focus on 'fixing', i.e. treating and discharging (either home or through admission). However the interviewees identified that self-harm wasn't something that was amenable to a quick fix, partly due to the fact that it isn't a short-term physical problem, but also partly due to young people's aforementioned reluctance to engage. This reluctance to engage made it difficult for interviewees to ascertain their needs, a frustration which was further compounded by elements of time and timing.

The accounts of the interviewees all conveyed the need to move these young people on through their respective services, and that time was a factor in doing so; this was particularly evident in the accounts of the nurse interviewees. They reported that although these young people no

longer waited hours for admission, the imposition of the four-hour target created additional pressures. These pressures arose due to the amount of time needed to assess the young person, and were exacerbated if the young person didn't cooperate in the assessment process. The time pressures in respect of the four-hour target were also further compounded by the fact that frequently there was nowhere for these young people to go with inpatient services (both psychiatric and paediatric) reluctant to accept them.

8.6.2 Treating the Physical – A Quick Fix

Managing risk is an inherent part of emergency care work, and it is therefore unsurprising that the priority for all interviewees when caring for a young person who had self-harmed was to ensure their safety, through an initial assessment of their physical wellbeing. This initial emphasis on physical assessment was particularly evident with the paramedics with the routine element of this apparent:

> *We just have the standard medical information that we start off with so it's like base line observations, pulse, blood pressure, respiratory rate, pulse oximetry* (P006).

Indeed reference to 'obviously' and 'the usual stuff' reiterates that as far as the respondents were concerned, as a nurse with a background in children's accident and emergency, I would be aware of this, so not much detail is given.

> *Umm, find out what they've taken, obviously I'd do the ABC - Obviously airway breathing that kind of thing does attract priority* (P001).

> *Basically its, well you know, obviously make sure that the area's safe and you know, do all the usual stuff* (P003).

The nursing staff also identified treating the physical as the first line of care, and were similarly brief in these accounts,

> *The crew will bring them to nurses station, where they've been transferred on a trolley bed we'll get a brief handover, and we'll do just a very quick assessment general colour and can make sure they're safe* (N012).

> *Well the initial assessment, doing the obs...The rescuing sort of thing, the assessment* (N004).

As outlined in the description of the setting, with the exception of self-injury, self-harm was not seen as a 'physical problem', it was classified as a 'medical problem' and therefore within the paediatric as opposed to the A&E domain; a nurse respondent summarises it thus,

> *There is a difference in management and if there's a injury then they need to be seen by A&E because there is a physical injury that needs to be patched up or brought together or whatever it is but if it's just drugs or alcohol or whatever it is, then you can do it on a medical side so there's perhaps little or no need for A&E to get involved, for any of their medics to get involved with that* (N002).

In this description the nurse makes reference to the physical injury needing to be 'patched up' and 'if it's just drugs or alcohol', which emphasises the differences in how these presentations are seen and illustrates the division between A&E and paediatrics/CAMH, the former more of a 'quick fix'. As highlighted in the (earlier) description of the setting, the nurses were contracted to, and managed by, the children's services; however their accounts of 'patching up' or 'fixing' subscribe more closely with the immediacy of emergency care work as evidenced in the above and the following:

> *I just think it's [self-harm] like any condition in A&E, any nurse is very focused on the here and now and getting a bit done, you know if it requires more input than that they're, everybody seems to kind of deal with the critical moments and get through the critical moments and mental health wise, the critical moment is, it's at that moment, they've just done it [self-harmed]* (N004).

> *We're just in trying to help them through whatever they're experiencing if it's a reaction to medication they've taken, or pain from the wounds they've got or anything like that, just try to treat what we can* (N011).

8.6.3   Self-harm – Difficult to Fix

While these accounts acknowledge that within initial emergency care the focus is on assessment and treating the physical, it was recognised that A&E wasn't the location where these young people could be treated, or 'fixed'

> *It's [self-harm] also something that you can't put a bandage on and fix at the end of the day, and they are, they are the ones who often need a lot of input and lot help if they are to actually move forward and have decent lives at the end of the day* (N009).

For some nursing staff being unable to 'fix' or patch them up was frustrating, for both nurses and patients:

> *I think it is a medical thing of wanting to be able to fix people, and be able to do something even with long term medical problems at least you've got something, you can give them medicine and whatever else, you can and you feel in yourself you've done some good, whereas with self-harm its not something where you can hand someone a tablet and say you'll be better tomorrow* (N009).

I mean they quite often come to us expecting the world to be put to rights, a magic pill or sticking plaster or something, the new presentation I'm talking about, and when they quickly realise you can't actually offer a magic sponge or cold spray, they kind of get disillusioned quite quickly (N010).

Two paramedics encapsulated this dichotomy; one when he made the observation that,

From what I've seen sometimes A&E care and physical and probably the mental health care don't always coexist (P008).

The other noted that,

It's much harder to cure emotional pain than it is physical pain (P001).

Although there was an emphasis for all the respondents on the physical side of care, they did as noted above, make attempts to engage with the young people, partly as they see this is necessary to obtain further information, and partly as they have concerns that they might miss something. This was not always easy as young people were themselves not always easy to engage. Engagement was though undertaken within the context of carrying out the routine emergency care work, and was also dependent on time:

So normally most of the information I'll get is in the ambulance as we've left or on our way to hospital so 15 minutes at home having a chat and then in the ambulance (P008)

if it's not time critical we've got a little bit more time about asking them a little bit more (P001)

Notwithstanding this, the emphasis often remained on the physical,

But I suppose the important thing is, is trying to find out what they've taken, if it's an overdose, what they've taken, how much they've taken and when they took it and then try and find, we do a bit, you know, you do a bit of kind of like detective work, have a scan of the area, see if you can find any packets and all that kind of stuff (P003).

Lack of cooperation by young people was acknowledged by some nursing staff who when discussing their interactions with paramedics did so with reference to the physical, as exemplified by the following:

I think they're [paramedics] generally good about the actual situation, so where they were and what was around them and what drugs they were carrying, who they were with, you know, and perhaps even some social history about family. But I think it's difficult because often the young person is unwell, not cooperative, won't communicate so I think the difficult thing they find is the history of their medical history, their social history, you know,

and getting a bit more in depth... as I say they're usually pretty good on where it happened and when it happened, what happened but perhaps not the stuff behind it (N004).

Thus young people's reluctance to engage, as noted above, caused exasperation amongst the interviewees, this exasperation further exemplified in that without information their attempts to 'fix' were made more difficult. Moreover, getting this information was important as it assisted the nurses in moving the patient on through the department, a factor that paramedics recognised,

> *You know, and sort of try and get enough information just to kind of highlight and maybe sort of point the nursing staff into a direction as to what might have provoked them or what might have caused it* (P003)

8.6.4   Moving Young People on Through (the Respective Services)

The care of young people who self-harmed cut across three boundaries, pre-hospital care, hospital emergency care and inpatient paediatric/CAMH care. As indicated by the above comment from a paramedic, the nurses were central in negotiating these boundaries on behalf of the young person who self-harmed, in terms of both receiving and then transferring them on through these services. However each service had different priorities, which affected how effectively the nurses could manage their care. While young people themselves contributed to difficulties in obtaining information, there were organisational factors that also played a part; the first of these factors is time.

A key element of the work for both nurses and paramedics was ensuring that patients were moved through the (emergency care) system. For paramedics this involved transporting young people to hospital with a sense that having made an initial physical assessment and obtained any additional information they could, it was then down to the hospital to determine the onward course for the young person:

> *First of all let's treat the patient, take them onto hospital treat the patient and let the hospital decide* (P001)

> *You know it is really just a case of deal with the immediate situation, find out whether it's life threatening or not life threatening, do what you can and get them to a place of, you know, like an A&E department or somewhere like that that's more appropriate* (P003).

Moreover, if the young person was drunk, it was evident that there was more haste in delivering to the hospital, with minimal attempt at engagement, as these two accounts reflect:

I had a patient the other morning, who had a serious problem with drink and I say to myself okay they're 14 so they know what they've done, a quick job, a quick five minute job (P001).

The amount of calls that I've been to where youngsters have been involved in drink, either in homes, having parties while the parents are not there, or in public places. And as soon as it's a youngster, my colleagues are like, it's like "well it's a youngster and I don't want to know. It's not that I don't want no involvement, it's let's just get them onboard, let's get them to the hospital and let's get it done and out the way with" (P007).

From a nursing perspective there was, as with the paramedics, a sense of urgency in respect of getting a drunken teenager out of the department, even when policy dictated a young person should be admitted, as this account reflects;

So if someone comes in and they're absolutely, you know, drunk and incapable and flat out on a trolley and then the parents turn up and they're mortified and we give them some fluids and they wake up and they're hung over but there's nothing else, they're supposed to come in as well but they often don't, they often go home (N002).

8.6.5 Moving Young People on Through – Pressures of Time & Competing Demands

By virtue of the fact that the interviewees all worked in emergency care, a fundamental element of their work involves an element of speed. This speed is needed in order to both manage the volume of patients, but also in the case of the critically ill, speed is of the essence is terms of ensuring safety and possibly, survival. However, the paramedics' accounts indicated that they could if required spend time at a call, even though their accounts indicated that they would have likes more time, as the following examples illustrate:

I think our problem... and when I say 'our problem', I'm talking about the ambulance service and the hospital thing - we don't have long enough with the person. You might spend half an hour to an hour on the scene and talk to that person (P007).

I think people would argue that we're not (under time pressure) because what they [ambulance control] time is how long we're at hospital and how long we take to get to a call, what they don't time is how long we spend on scene with the patient which I think is fair to an extent, but there is also limits on how long we spend there, which I think is fair enough, so the expectation is you'll be with the patient unless it s a very serious call they'll check if it's an hour or so, they'll start to worry – they'll question where you are – that's a sort of silent expectation, are we under pressure? No, but I think everyone is aware to spend hours and hours is not appropriate, more we're under pressure at hospital to hand the patient over quickly - they're saying now 25 minutes... I'm very aware of the amount of time I do spend (P008).

Both these accounts indicate that, while more time might be desirable, they can spend between half and hour to an hour on a call to (one) young person who has self-harmed. This is in stark contrast to the accounts of the nurses, who were quite clearly under time pressures,

> *They do take up a lot of time, which is frustrating within an A&E dept if you have got someone, when it's very busy, and you know that you're going to get involved with them for a long time, because you do have to delve and you have got to get history and that's important otherwise you're not going to be able to touch on what's happened* (N009),

The above comment confirms that the nurses also recognised the need to 'delve' and that this takes time, however this nurse's frustration is evident, and was also evident in other nurses' accounts, as they often felt torn between spending the time needed with a young person who had self-harmed, but being unable to, due to the other pressures and competing demands they faced within the setting, as one nurse recounted:

> *But I didn't physically have the time [to spend with a teenage girl who was a regular self-harmer] with triage and assessment and I had a septic baby and other things going on at the time.. And when you've got lots of patients that are sick around you, that is quite difficult because you know it's going to take you a long time, but that's the same as a social issue, paediatrics is going to take you a long time so it's frustrating as you know its going to take you away from what is perhaps an already busy department* (N009).

> *Is it annoying? Yes it can be when you've got an asthmatic that can't breathe and you're on your own and struggling with 30 patients, is it any less worthwhile? Not really, she is someone who needs help* (N010).

> *We're not in an ideal situation when its busy shift you can't spend time with them you're not the right person to spend time because you're not going to be there long term, you've got a maximum of four hours with the person before they're off and you're not going to see them again until next attendance, which you might not be there for anyway* (N011).

This respondent (N011) makes reference to the fact that an A&E nurse will only be with the patient for a maximum of four hours. Indeed the four-hour target was another significant factor that influenced the amount of time the nurses could spend with these young people as is evident in the following accounts:

> *The four-hour targets have had an impact on their care, because at times if you are trying to do an assessment you are going to get interrupted as people are coming in and needing you to do things or needing your advice, for example I had an adolescent who was regularly self-harming, I knew her story I knew her background as I'd seen her before, but we were so busy and I*

knew, I know how much time she takes, but I had to get someone from the adult side to assess her (N009).

They get pushed through a lot quicker, it is a conveyor belt system nowadays for all patients, and it's, those are the patients that we struggle the most with that, where they possibly could do with being seen for a bit longer... as often you can't get the doctors down immediately to do the interview or assessment - if the paed registrar or SHO, whoever is coming down to see them, isn't going to be quick, and if they've been busy upstairs or busy downstairs with patients then by the time they get to this one they've [the young person whose self-harmed] been here more than two hours already and then you're like right you've got to push through, get your notes written up photocopied and get them upstairs in this four hours breach time it doesn't help anyone (N011).

Notwithstanding this, the four-hour target was seen as a benefit for young people who self-harmed by virtue of the fact they took time, thus assessment and onward referral was, if possible, mobilised early:

We've got four-hours to do it (assess and treat), and because of the psychiatric input that we're supposed to offer for them, that often, which has been a big problem and that's probably the impetus that's made that happen anyway (admission to the children's ward) because we've regularly had breaches, four hour breaches when patients haven't managed to be seen because the psych's haven't got to see them (N002)

It's [four-hour targets] probably made us focus on the fact that we do need, because I think in the past patients with self-harm would have sat in the department for hours and hours and hours with no one making an effort to actually, you know, do anything, so I think it has impacted on actually quickening up the process about the referral process. And also along with the four-hour target, you know, the bed, the length of stay target on the wards because we try now, we want them seen within 24 hours by CAMHS and that's been happening as well, probably because of those targets (N004).

It was acknowledged that the four-hour target could affect how the nurses viewed the young people who self-harmed, a stressor that was intensified when the nurses were unable to locate beds; the senior nurse summarises it thus,

They're probably regarded as patients that are difficult to sort out because getting an admission bed for them or them wanting to admit, all those kind of issues are very difficult, it's not, sometimes it's not a straightforward aspect to get them on a bed and the reluctance perhaps of ward staff to accept them and people even to admit them and even a decision to be made to admit so probably that's.... they've probably been classed as a hard type of patient to deal with because of the four hour target (N004).

8.6.6   Moving Young People On – Issues of 'Ownership'

The accounts of the nurses illustrated the difficulties they encountered in moving these young people on.

> *It's my point of view they're the nightmare umm, because generally they are adolescents they fall into that grey area and no one wanting to take ownership...they are just tricky heart breaking patients because no one wants them... It's very different between adults, yes it's, for adults its geared up, but for the kids it's an absolute nightmare to get someone to take ownership and get them managed* (N010).

This nurse's comments about how it's set up for the adults, referred to the fact that with adult patients they could be seen and assessed by the Duty Assessment Nurse (D.A.N) who was called from the on-site inpatient (adult) psychiatric unit. The 'DAN' could undertake a risk assessment and if the adult patient was deemed safe they could be discharged home, with a referral to the community made. However, the policy of the children's services, as per the NICE (2004) guidelines was that all young people with a diagnosis of self-harm had to be assessed by the CAMH service; this policy was a further factor in the nurses' difficulties in moving patients on. As the charge nurse explained,

> *We have a CAMHS on call person and in office hours there is somebody on the end of a phone but out-of-hours there isn't and we find that it's just very problematic* (N002).

The reason it was problematic was in part due to the organisation of health services with CAMHS being managed and located in mental health services separate from children's services, but partly due to the young people themselves, who mostly attended out of hours, an issue which featured in most nurses' reflections (one nurse estimated that 95% attended out of hours). Additionally, as one nurse said,

> *I think our main barrier to helping them a lot of the time, is time, invariably these people come in when its busy, they just seem to have an antenna for that* (N005).

As one nurse pointed out while there might be policies to support and guide practice, the policies are of little benefit if there is no-one accessible to operationalise the policy,

> *They always come out of hours, you'd think they provide for them, it's heart breaking, absolutely heart breaking, you've got someone, a cry for help whatever, and what can you do, what can you do, you try and follow these flow charts that don't then work as no one can come it's Friday night, and they can't come till Monday afternoon at best* (N010).

Ultimately however, it was age that was the major determinant of how easy or not it was to move the young person on and discharge them from the department, with both research and policies used to inform and justify:

> *For the paediatrics we have the 16-17year olds, and the adults keep 17-18, it's a big black hole for those two years, no one really wants them one way or another and they're the ones who we really struggle with.*
> ***Why does nobody want them?***
> *It's that cross over, it's who decides they are a child and an adult, and different places do it at different ages, XX [the inpatient adult psychiatric unit] will quote all the time the studies out there that have shown if you put adolescents between 16-18 on a mental health ward with adult patients they have a very poor prognosis, which I can well believe is the case, but it's not the 17-18yr olds fault that that's the age group and we don't provide better care for them (N011).*

> *I think the problem is about the middle group, not the young children and not the adults but the ones in between because of the guidelines of where they fall, there's lots of confusion about who's responsible for them, you know what services are appropriate for them (N004).*

The problem arose as young people were, or were perceived to be, disruptive,

> *If a child is, a young person is very disruptive the child won't get admitted onto the ward and then we've got a real problem in terms of management from our perspective because they can't go to the ward because they're too disruptive to the other children, they're too young to go on adult ward so where do they go? And they won't take them on the psych ward because they're under 18 so we've got a real issue and that does cause us a lot of problems in terms of managing a disruptive young person (N002).*

> ***What kind of reaction do you get from ward staff when admitting?***
> *They generally get a bit of a groan from everyone umm, but then they're another patient no one fights not to, they accept them because they have no other choice so, the only thing that they're concerned about is any patient who might be aggressive which tends to be the older ones, and that's where we have our issues with the 16-17 yr olds as well if they the slightest bit aggressive we don't want to get them on a children's ward either so it's not appropriate so we try and find them an adult ward but trying to find them a ground floor ward adults don't want to put any patient who self-harms or who is suicide risk on a higher floor, despite the fact that the kids ward is on 3rd floor with opening windows, that's never been a concern for anybody else, yeah but they all say we haven't got any ground floor that's available (N011).*

As this last extract indicates, the location of the ward is a factor, and as with other nurses, they shared the view that a children's ward was not necessarily the right place to admit these young people to. These difficulties led to a sense of frustration and at times impotence in that they were

unable to do anything about it, with both nurses and paramedics recognising that it's the service provision for these young people that needs to be addressed:

I find it frustrating as its completely inappropriate to take someone to A&E for what is essentially a mental health issue or an issue around their wellbeing, when its more appropriate to take to another service (P008)

But I think the problem is that perhaps children with acute psychiatric episodes aren't identified early and aren't transposed to specialist services, and there's a shortage of those specialist services (N004).

I mean again the collaboration of departments [could be improved]. For example like paeds and psych because they are so separate; it would be nice to have a paed psych, but I think you know, having more availability to the CAMHS would be fantastic, but again they're under huge pressure there's a huge wait for one of them to come and assess (N005).

I think there should be more access to CAMHS and I think there should be more flexibility with getting patients assessed by CAMHS, I mean on the adult side they have a psych assessment nurse that can come in and see these people and I think that should be something that we can do with for adolescents (N009).

8.7   Summary of Findings

The first theme arising from the interview data was concerned with how the interviewees located self-harm within their emergency care work, with a picture emerging of how they constructed self-harm, as a behaviour, within the context of their everyday emergency care practice. In so doing they located self-harm in the context of their experiences of actual suicide in young people, with comparisons made in terms of 'scale'. Alcohol intoxication was considered an element of self-harming behaviour, although contradiction was evident as the interviewees viewed alcohol consumption within teenagers as normal, its misuse a concern. The interviewees did not see self-harm as a normal response, and the actions associated with self-harm were not seen as normal behaviour.

This second theme was concerned with how the interviewees ascribe young people's behaviours when presenting to emergency services following self-harm, and how as a consequence, categorisation of 'good' and 'bad' young self-harmers are constructed. The interviewees generally displayed sympathetic attitudes towards young people who self-harm, with little evidence of moral judgements being made. Their (perhaps more benign) attitudes arise from the notion that young people don't know any better and don't realise the implications of what they are doing, thus it would seem that age is a factor that potentially influences attitudes towards self-

harm. However the interviewees did discern between some aspects of young people's behaviours that made them more challenging to care for, with traits emerging that caused some interviewees to differentiate between those young people who self-harm for whom they feel more compassion and those they don't. Within this context the interviewees distinguished between those young people they perceived as 'attention seeking' and those whose attendance represented a 'cry for help'. There was some frustration expressed, particularly in relation to the difficulties they sometimes encountered when trying to engage with the young people attending following an episode of self-harm.

This final theme focussed on how the interviewees reported that they managed self-harm within the context of their emergency care work. The accounts of the interviewees conveyed a sense of rapid assessment both during pre-hospital and in hospital (A& E) care. This sense of urgency in undertaking an assessment reflects in part the concerns around risk as well as the need to move patients through the emergency care system, in order to maintain 'shape' (Sbaih 2002). In undertaking and making an assessment the initial focus was on physical care/risk, reflecting the priorities and arguably, norms (or 'maxims', Sbaih 1997 a & b) of emergency care work. However the nurses were often frustrated in their attempt to 'move patients on' due to the reluctance of paediatric in-patient services to admit young people following self-harm, a reluctance that was exacerbated if the young person was drunk and or aggressive. Lack of access to and support from CAMHS also compounded the interviewees' sense of frustration especially as the nurses in particular were under pressure to 'move the patients on' due to the four-hour target. The nurses viewed the target as both a hindrance and help in meeting the needs of young people who had self-harmed.

CHAPTER NINE

DISCUSSION OF THE FINDINGS OF THE DATA SETS

9.1 Introduction

As noted in Chapter 4 an inherent element of mixed methods research is the integration of data. In line with a triangulation approach, following individual analysis of the survey and interview data, the two data sets were compared and contrasted (Creswell & Plano-Clark 2007). This discussion will therefore draw on both data sets to provide analyses of the study's findings. As noted earlier, the presence of a mixed research question is advocated in the methodology literature and was included in the study. This research question, 'to what extent are the findings from the qualitative data consistent with the findings from the quantitative data' is addressed in the final chapter of the study. For the purpose of this chapter the remaining research questions provide the structure and focus for this discussion. As such the headings for this chapter are as follows:

- What are the attitudes and values of emergency care staff towards young people

- What are practitioners' attitudes towards young people who self-harm and is there a relationship between these and their attitudes towards young people?

- How does the practice of emergency care work as undertaken by nurses and paramedics influence attitudes towards and perceptions of young people who have self-harmed?

The first two questions draw on both quantitative and qualitative data, the third question draws only on the qualitative data (see Figure 5.3 Page 114). While the qualitative data was organised into three themes, there is some overlap across the themes in terms of the research questions, with the exception of the third research question, which is predominantly based on the descriptions from theme three.

9.2 What are the attitudes of Emergency Care Staff towards Young People?

The results from the analyses of the quantitative data indicate that the practitioners held slightly more positive attitudes towards young people who self-harm than were evidenced in their attitudes towards young people in a general sense, with a correlation between attitudes towards young people and young people who self-harm evident. Data from the interviews illustrated how through their daily interactions with young people, the interviewees constructed their perspective on young people's behaviours, young people being seen as both vulnerable and problematic.

9.2.1 Contradiction and Ambiguity

The survey data identified that on the one hand young people are seen as helpful and friendly, with 44% of respondents agreeing with this statement, but on the other, only 19% thought young people's behaviour had not got any worse, with 69% perceiving that their behaviour had indeed got worse. Moreover 49% agreed that young people had no respect for adults[17]. There also appeared to be some ambiguity around girls' behaviour, as while only 17% agreed that girls were now more badly behaved than boys, fifty percent of the respondents nether neither agreed nor disagreed with this statement. The survey data indicates that parents are held responsible for their children's behaviours; 70% agreed that young people are not disciplined by their parents and almost half (45%) agreed that young people don't get enough care and attention from their parents.

These somewhat contradictory and ambiguous views were reflected in the qualitative data, which mostly emerged from paramedics' (individual) accounts, as illustrated below:

- *Young people are seen as, it's probably not fair to generalise, but they have a bad reputation*

- *A lot of them are expected or seen to be in gangs and that's the expectation*

- *They're scared, hurt, they tend to revert back to being a child* (P008)

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[17] In respect of 'not receiving care and attention from parents' and 'having respect for adults' there was a level of ambiguity in responses to this in that 34% and 30% respectively neither agreed nor disagreed with these statements.

Similarly P001 is contradictory:

- *Most teenagers now, as you probably know are taller than me and I wouldn't take them on*

- *Young people, might not be able to cope with it, you've got to protect them*

Participants' accounts also acknowledged how difficult the teenage years can be, and to that end indicated that they understood teenagers and their behaviour:

- *I think also having, you know, been through teenage years I, you know I understand the emotional roller coaster it can be (P008)*

- *Its, very difficult for them and it's getting worse than rather better for teenagers (N011)*

- *Teenagers I think are very vulnerable people, they're like little sponges half the time, they absorb their environment (N005)*

While there is a dearth of literature that has examined and measured attitudes towards young people, there is conversely a plethora of literature that has examined attitudes towards older people, with evidence that ageist attitudes exist (Bytheway 2005, Kite et al 2005), ageism seen as a form of oppression which is applied almost exclusively to older but not young people (Thompson 1997). This perhaps reflects why, with the exception of the study undertaken by Anderson et al (2005), there was no literature located which had specifically examined attitudes towards young people as an age related population group.

As noted earlier in this thesis, Anderson et al's study (2005) was concerned with public attitudes towards young people and youth crime, and as discussed in Chapter 4 provided the basis for the attitudinal statements for the AYP scale in this study. It is difficult therefore to compare the findings generated from this study on attitudes towards young people to a body of other published research. Notwithstanding this, Anderson et al's (2005) study also found that adults held contradictory views on young people, or their attitude was ambivalent. While it is acknowledged that the sample from my study cannot be matched or compared, it is interesting to note that when reviewing responses to the seven statements incorporated from Anderson et al's

(2005) research into my study, similar patterns emerge. Table 7.1 below provides details of results against each statement across both studies.

TABLE 9.1

Comparison of responses from Anderson et al (2005) and this study to the seven statements comprising (in this study) the AYP scale

Statement/Author	Agree/ Strongly Agree (%)		Neither agree or Disagree (%)		Disagree/ Strongly Disagree (%)	
	Anderson et al	Cleaver	Anderson et al	Cleaver	Anderson et al	Cleaver
The behaviour of young people is no worse than it was in the past	30	19	9	12	61	69
The views of young people are not listened to enough	59	48	19	27	21	25
Girls are more badly behaved than boys nowadays	38	17	32	50	28	33
Most young people are responsible and well behaved	57	47	18	27	25	26
Young people today have no respect for adults[18]	45	45	18	30	37	25
Most young people are helpful and friendly	53	44	25	32	22	24
Adults have no respect for young people	35	16	22	36	42	48

As noted above, across both studies there are contradictions in respect of the participants' views of young people's behaviour and as can be seen from the above table, the same pattern of attitudes is generally evident (with the exception of girls' behaviour). The main difference between the results of the two studies is that in my

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[18] Anderson et al (2005) used the term older people

study there are more 'neither agree nor disagree' responses. This difference could be due to sample size and selection, but may also reflect more ambivalence in my sample. Respondents might also have been reluctant to score negatively and thus opt for the neutral position, a possibility given that they were responding as health care professionals rather than members of the public, a reflection of the presentation of 'moral self', a concept that is further discussed below.

Anderson et al (2005) propose that age and circumstances (e.g. whether a person has their own teenage children) might be a factor that influences these contradictions, as they had previously noted that while adults can be highly critical of young people, they maintain a different perspective of their own children, grandchildren and neighbours' children, i.e. children they know well and relate to (Anderson 1997b). Indeed, one of the key findings emerging from Anderson et al's (2005) study was that adults who had most contact with young people were more likely to have benign views on young people and were therefore less likely to judge them in respect of their behaviour. This contact was not dependent on age, as the 18-24 year olds were more likely to have negative attitudes than the older respondents (65 years and over), despite often still residing with young people. Rather, they propose, it is the extent of people's contact with young people, degree of rurality and in particular the level of deprivation in an area that influences attitudes.

It is difficult to compare the findings of this study in terms of age with Anderson et al's, as different age categories were employed; however similar trends are evident. In this study the age group of 31-35 years had the lowest scores on the AYP scale followed by the 16-25. The scores for participants aged 35 years and over then increased, peaking for the 41-45 year olds and remaining higher than the younger age groups thereafter. It is quite possible that this reflects (in my sample) participants' personal interactions with young people as the older age groups are more likely to have teenage children; aspects relating to rurality are unlikely to apply given the location of my study, whereas deprivation might. An acknowledged weakness of my study is the lack of demographic data available from which to draw such analyses.

The interview data indicates that both nurses and paramedics have encountered two problematic elements of young people's behaviour, their propensity to be abusive, and

their reluctance to engage. Their reluctance to engage was ascribed to their self-harm and associated problems, rather than them being difficult teenagers per se, or simply because they were young people:

- *They're just very withdrawn and sullen upset kids, that are just very down for whatever reason, on life (N010)*

- *Sometimes they're completely closed down they won't tell you anything at all won't answer any questions ... but again I'm a stranger to them, so why should they be responding to me (N011)*

- *Sometimes it's realising that they're not going to talk to you and I'll make a note of that, it's quite common practice (P008)*

Young people's abusive behaviour was almost universally associated with drunkenness, and attracted disapprobation and for paramedics a desire to transport them swiftly to A&E and for nurses to similarly move them out of the department as soon as possible even if (as discussed in 8.2.3 below) this was contrary to Trust policy. However, although young people's aggression/inebriation caused particular problems for the nurses it was evident that the interviewees held contradictory views on alcohol and young people.

9.2.2 Contradiction and Ambiguity – Alcohol and Young People: A Case in Point

The interview schedule did not explicitly seek information about the practitioners' attitudes towards young people in general. For the most part therefore the interviewees' accounts described young people's behaviour in the context of self-harm, and included within this was alcohol, with numerous references made to young peoples' excessive drinking habits. Here again there was evidence of contradiction, on the one hand alcohol rendering the young person abusive, on the other, acknowledgement that young people don't realise the dangers of alcohol, as evidenced by the following observation from P003: '*They know that like vodka is alcohol they just don't understand the implications of drinking a litre of it*'.

The frequency with which the interview participants encountered young people who were drunk is possibly a reflection of the apparent rise in alcohol consumption by

young people (Harrington 2000), a rise that has been widely reported in the literature, with significant concerns, bordering on panic, in relation to young people's (underage) drinking habits (Newburn & Shiner 2001). These concerns are fuelled amid fears of the damage that excess alcohol intake in young people does to local communities, their economies and geographies, and young people's health and wellbeing (Measham 2008). Such concerns are evident in the self-harm literature, with evidence of a link between alcohol misuse and self-harm in young people (Evans et al 2004, Sinclair & Green 2005) a link that was made by one experienced nurse interviewee who observed that

> *'I mean even getting drunk is termed as just "oh don't worry, they're just getting drunk" but actually if you look at the history, how often it's happened, what are the contributing factors, what's the home background, that's more important than looking at just an isolated case of being drunk, you know'* (N004).

Indeed the comments from this nurse have resonance with the accounts of participants in Sinclair & Green's (2005) study who recognised that alcohol was a factor in their self-harm, their use of alcohol being a means by which they attempted to escape from the emotions and feelings that also precipitated their self-harm.

Nevertheless, the interviewees in this study generally considered alcohol use a normal element of adult life and indeed underage drinking a normal part of growing up; P003 joked that he'd been drunk, and P001 sought to confirm with me that I also drink, stating that, *'drinking, is kind of normal, I mean you've gone out and got drunk'*? Similarly P008 observed that it was the norm for young people to have a few drinks admitting that it *'got a bit silly after the exams'*. The fact that adults determine what constitutes acceptable/unacceptable behaviour on behalf of young people is evident in the case of alcohol use (Johnson 2009). As noted in Chapter 3, in a UK context drinking alcohol is not always seen as deviant (Newburn & Shiner 2001, Demant & Ostergaard 2007, Measham 2008).

The interviewees in this study, notably the paramedics' experiences with alcohol intoxication, reflect Turp's (2002:200) observation that, *'practitioners who work in the community frequently encounter hidden self-harming behaviour, much of which is associated with lapses and lacunae in self-care rather than active self-directed violence'*. Turp (2002:207) building on Favazza's (1996) earlier work which had

drawn attention to 'culturally accepted forms of self-harming behaviours', proposes that some behaviours have a specific role and meaning, serving as a rite of passage citing as an example body piercing in UK youth sub-culture. The interviewees in this study similarly saw drinking alcohol as part of 'normal growing up'. Notwithstanding this, they also had views about how much alcohol was acceptable reflecting the findings of Ostergaard's (2009) study whereby adults (parents) sanction 'controlled loss of control'.

As noted above, there was a perception amongst the survey respondents that girls are more badly behaved than boys. It was therefore interesting to note that the qualitative data revealed that where a gender was ascribed to a recollection of a specific patient, or a generalisation was made, it was normally a female, and often in the context of a drunk female. Such recollections were more likely to be made by the male nurses and paramedics, and overall the quantitative data analysis revealed that male practitioners were more likely to have negative views on the behaviour of young girls when compared to their female peers. This could reflect an element of sexism on the part of the respondents, as studies that have examined A&E attendance and underage drinking reveal that boys are as likely as girls to attend with alcohol related disorders (Thom et al 1999, Michalis & Charalambous 2002).

The ascription of alcohol problems to girls by the (male) practitioners could similarly be a reflection of the social stereotypes generated through media accounts of girls' behaviours – based on the norms and values of society and thus expectations of how young girls should behave (arguably still largely determined from a male/patriarchal perspective). Indeed as Newburn & Shiner (2001) observe, gender differences in underage drinking have provided an important focus for research in this field, with concerns emerging that young girls' drinking habits are increasingly similar to young males; they cite a range of studies that have questioned this (seeming) trend, and a later review by Measham (2008) confirmed that alcohol intake and 'binge drinking' remain more prevalent amongst males in both teenagers and young adulthood. However, it is of note that Shaw (2004) has provided an historical analysis of girls' and women's 'self-injury, while Scourfield et al (2011) similarly found that their research participants, when discussing self-harm, provided gendered accounts,

participants in their study also being more likely to ascribe self-harming activities to females.

9.2.3 Contradictory Views on Parental Influence

Data from the questionnaires suggests that the respondents do hold parents responsible for young people's behaviour; as noted above, 48% of survey respondents felt that young people don't 'get enough care and attention from their parents', and (possibly as a consequence) 90% agreed that 'young people are not disciplined by their parents'. The accounts of the interviewees indicated that parents were often absent; this was particularly and graphically evident in paramedics' descriptions of being called to inebriated young people, a finding supported in other research that has examined underage drinking (for example Harrington 2000, Demant & Ostergaard 2007). However although the survey respondents tended to view parents as absent and not providing discipline, the interviewees also reported that, in their experience, young people were themselves fearful of their parents' reactions to either their drunken or self-harming behaviour.

In both the interview accounts and survey data it is apparent that practitioners recognise that young people who self-harm have difficult relationships with their families, with 69% agreeing with this statement on the questionnaire. These difficulties were acknowledged and reflected by the interviewees as illustrated by the following:

> *Some of them [parents] just do sit back and don't say much and are quite argumentative with the teenagers (N011)*

> *I have seen parents upset and angry about the child or the situation or express they're angry to the child (N004)*

> *We don't always involve them (parents) in the initial triage as to why its [self-harm] gone on... sometimes they're the cause (N012)*

One nurse admitted that how the parents behaved influenced his views towards them:

> *I've had the full range [of parents] from abusing the child verbally, not abusing but belittling, so yes abusing the child umm, to shocked, stunned, frightened, embarrassed, umm, they're the worst ones the embarrassed ones, I'm not particularly taken warmly to those parents...(N010)*

It was clear that on occasions (subjective) judgements about parents were made; this was illustrated when a nurse reported that despite departmental guidelines, they might on occasions not admit a teenager who was drunk, providing they could sober them up in the department, and the parents were available and willing to take them home, the parents having been deemed as being 'sensible', as the following extract from the interview data illustrates:

> *KC) How do you think people decide as to whether or not parents are sensible?*
> *N002) I think there's a very middle class medical and nursing sort of view point on it and if the healthcare practitioner feels that sort of empathy towards the parents and, "that could be me", then they're thinking "that's okay," and if they don't have any empathy with the parents then, well that's terrible and you know, it happens, and I don't know, that sort of a thing [trails off]][1]*

Research that has examined the judgements made by health care staff about children and young people has identified that where adverse judgements might be expected these have not been passed on to the children and young people (Strong 1979, Dingwall & Murray 1983, White 2002), instead the parents are adversely judged. Indeed White observed that 'normative judgements of parents are a routine part of the (paediatric) work' (White 2002:428). The findings from this research confirm that normative judgements of parents continue to be a feature of paediatric work, as although there wasn't a sense that the interviewees blamed the parents for their child's drunken or self-harming behaviours, their absence was noted. It was also evident that the study participants held a clear view that parents failed to discipline their children, thus by their omission perhaps, the parents were held responsible, and judged accordingly.

9.3 What are Practitioners' Attitudes Towards Young People who Self-harm and is there a Relationship between these and their Attitudes Towards Young People?

As reported in Chapter 6 (6.5) there was a strong correlation between scores on the two scales (AYP & AYPSH), thereby confirming that individuals who hold more positive attitudes towards young people would hold more positive attitudes towards young people who self-harm. Further interrogation of the survey and interview data

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This extract had been coded under judgements but ultimately did not become incorporated into an overarching theme

confirmed this, while indicating that some nuances are evident, which the interview data illustrated, particularly in respect of age as a factor in ameliorating attitudes.

Overall the study participants held generally positive attitudes towards young people who self-harm, as reflected in overall mean scores on the AYPSH scale and the accounts of the interview participants, which clearly indicated that encounters with young people who self-harm were now a common, indeed almost routine aspect of their emergency care work. Two of the paramedic participants recounted how during the late 1980's their caseload had involved retrieving young people who had abused solvents, but this was rarely the case today. Instead their caseload of young people who had self-harmed had increased, initially with self-injurious behaviour and more latterly with young people who had overdosed or abused alcohol. The (experienced) nurses who participated in the interviews similarly identified that the numbers of young people who self-harmed had increased, and all the nurses also tended to make reference to young people who had taken overdoses or misused alcohol. Where self-injury was discussed this was in reference to specific and unusual cases.

As noted in the description of theme one (Positioning Self-harm in Young People), particularly from a paramedic perspective, transporting inebriated young people was a daily and routine element of their work. The interviewees spontaneously cited alcohol intoxication as an element of their self-harm work. Indeed, one paramedic (P008) commented that if alcohol was included then he saw young people who had self-harmed on a daily basis, and generally most accounts made reference to young people who were drunk (normally in the context of them being abusive), thereby indicating the extent to which these practitioners are involved with young people who drink to excess. However alcohol intoxication or abuse, while recognised as a risk factor for adolescent self-harm (Evans et al 2005), is not recognised as a self-harming behaviour and does not correspond with the medically orientated definition of self-harm used in this study.

The definition I used (see page 63) was derived from the World Health Organisation's (WHO) multi-centre study (Schmidtke 1996), and as with the wider medical literature reference is made to a range of acts that constitute self-harm. For example Skegg (2005) provides a list of 'candidate behaviours', which range from highly lethal

behaviours such as hanging, to 'other self-harmful behaviours without visible injury', such as excessive exercise; no reference is made to alcohol misuse constituting a self-harming behaviour. Indeed Skegg's list of behaviours has some resonance with Pattison & Kahan's (1983) earlier work which had presented a case for obtaining a DSM classification for self-harm (see page 55 for further discussion), which exemplifies psychiatry's attempts at medicalising self-harm. The medicalisation of self-harm and latterly adolescent self-harm is apparent in the plethora of literature that attempts to explain self-harming behaviours, explanations that take a bio-medical perspective by examining risk factors for self-harm in young people as well as seeking causal relationships between self-harm and completed suicide (Redley 2003). It is acknowledged that the definition I adopted for this study is a 'medical' definition and as such draws on categories of behaviour that are medically defined as self-harming, whereas the interviewees adopted what might be termed a more culturally bound definition of self-harm, including as they did alcohol intoxication within their own descriptions of self-harm.

Although the interviewees in this study associated alcohol intoxication with self-harming behaviours in young people, it was, as noted above, also seen as 'normal' i.e. normal for young people to go out and get drunk – a 'rite of passage'. Conversely, self-injury or other forms of self-harm were not seen as a normal response, for example one interviewee viewed self-harm as 'masochistic' and 'horrendous' (P001). As discussed earlier in this chapter, self-harm has featured in people's array of behaviours, culturally or otherwise, long before it was officially recognised by the medical profession (Favazza 1996, Turp 2002, Adler & Adler 2007) and correspondingly, there was evidence of some ambiguity in terms of how the interviewees in this study perceived self-harm, with a sense of shifting perspectives, not only in terms of how the interviewees came to define and assess (rather than judge) adolescent self-harm, but also in terms of recognising self-harm as 'legitimate', thereby reducing the stigma associated with this presentation to emergency services and thus the moral judgements ascribed.

This shift in the interviewees' thinking arguably reflects the de-medicalisation of self-harm, as outlined in chapter 4 (4.2) of this thesis. This is relevant as whilst medicalisation theories can be seen as adopting a critical stance towards medicine,

medicalisation in itself isn't entirely negative from a patient perspective; indeed some activist groups have actively campaigned for their 'condition' to be medicalised (i.e. Gulf War Syndrome, Chronic Fatigue Syndrome), as medicalisation can be seen to bring legitimacy (Broom & Woodward 1996). Self-harm 'survivors' and activists have though resisted psychiatry's attempts to label and treat their experiences as medical cases (Creswell 2005a & b). Nevertheless, the survey participants in this study were conversant with risk factors and motives associated with self-harm, which was further illustrated by the interviewees, who drew on this knowledge to make sense of why a young person might self-harm, and to this end the findings of this study demonstrate that the medicalisation of self-harm in young people has ameliorated negative attitudes towards self-harm as a behaviour. The interviewees recognised that young people who self-harm had legitimate problems, problems that were deserving of their input, even if, at times, this posed problems for them in their day-to-day work, as discussed later in this section (9.3.12).

9.3.1   Making Sense of Self-Harm

As outlined in Chapter 4 initially the term 'attempted suicide' was used to describe behaviours where an attempt at suicide was made, but not executed (Stengel 1952, 1956, Stengel & Cooke 1958). Stengel and Cook were key advocates in distinguishing suicide from attempted suicide, because as they observed, *'the survivor of a suicidal attempt is regarded by the public as having either bungled his suicide or not being sincere in his suicidal intention'* (Stengel & Cook 1958:19). It is therefore of note that all the paramedic interviewees and 50% of the nurses spontaneously made reference to young people they had cared for who had completed suicide. Moreover, and possibly in light of this, 56% of the survey respondents recognised that young people who self-harmed were at an increased risk of suicide, although this level of insight was less than the participants in Crawford et al's (2003) study where 66% of respondents recognised the link between self-harm and suicide.

As outlined in the description in theme one (chapter 8), the interviewees found self-harm a *'difficult concept to grasp',* and as noted above, did not perceive it as a normal (behavioural) response. Possibly because of this, when discussing self-harm they made reference to the suicides they had either encountered or heard about and in so doing it was apparent that they judged the seriousness of individual cases of self-harm

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by making reference to their own experiences of suicide, i.e. in the context of other actual (young) suicide patients they had cared for. For example one participant (P006) overtly made comparisons with a suicide case and used this as a reference point for considering and discussing young people who had self-harmed, the latter having not *'been anything significant'*. So while suicide was seen as being 'the extreme', self-harm was variously described as being 'physically inconsequential', 'not serious', 'not a big deal'.

Jeffery (1979) similarly observed that A&E staff ascribed intention on the basis of the scale of an overdose, and argues that distinguishing patients thus is the basis of moral judgements made by the A&E staff in his study. For example one of his participants makes reference to 'symbolic overdoses'; the phrase suggested to Jeffery (1979) that to this respondent the patient wasn't serious in their attempt – it was a gesture. Similarly another of Jeffery's respondents commented that, *'Most of the people I've met, they've either told someone or they have done it in such a way that someone has found them. I think there's very few that really wanted to, you know* (Jeffery 1979: 96). This latter comment also has resonance with a comment made by one of the paramedics (P007) in this study. He commented that:

> *They don't really want to or intend to do that to themselves [commit suicide] and they will contact friends who are concerned about them and who know what's going on in their life at the moment, and you arrive, and in fact, you don't find a locked door, you actually find an open door'.*

Arguably this is the basis on which this paramedic distinguishes between someone who intends to commit suicide and someone who self-harms, and thus from the perspective of the interviewees there were 'clues' as to intent; these clues – an open door, contacting friends, serious versus inconsequential wound, number of tablets taken, are the basis of a clinical/risk assessment rather than moral judgement.

Creswell and Karminova (2010) propose that 'moral' [judgements] and 'values' go together, because when individuals make judgements about human behaviours, we ascribe a 'value' in terms of whether the behaviour is 'praiseworthy' ' or 'blameworthy', the latter resulting in disapprobation, attracting negative evaluations. They further propose that in so doing the behaviour(s) being negatively evaluated (self-harm) is compared with another behaviour that attracts more positive evaluation

(suicide). There is clear evidence that the interviewees in this study drew distinctions between young people's presentations in terms of self-harm, by drawing on their experiences of suicide in young people, however there was no sense that self-harm in young people was adversely judged when compared with suicide. Suicide was seen as 'tragic', it was memorable to the participants who recounted individual cases they had cared for where young people had completed suicide. However their comparisons did not result in young people who self-harmed being negatively evaluated; both patient groups were seen as vulnerable and generally (in the case of self-harm) spoken about compassionately.

While there was a clear distinction between suicide and self-harm, the distinction between mental illness and self-harm was not so clear-cut. The survey data identified uncertainty over the statement, 'young people who self-harm are mentally ill'; 38% neither agreed nor disagreed with this statement, and 29% (wrongly) agreed. Nurses were least likely to agree (23%) compared with paramedics (26%), doctors (32%) and ambulance technicians (38%). This finding contrasts with those of Crawford et al (2003); while 83% of respondents in their study (correctly) identified that the statement, *'young people who self-harm are usually mentally ill'* was false, non-psychiatric nurses were more likely than non-psychiatric doctors to wrongly identify the statement as 'true' (Crawford et al 2003). Anderson and Standen (2007) report that the participants in their study (doctors and nurses) *'supported the notion that suicidal behaviour reflects mental illness'* but go onto say that they *'were more cautious when asked to classify suicide as a product of mental illness'*. They proposed that practitioners *'may be less willing to attach a label of mental illness to the young people they meet'* (Anderson & Standen 2007:474).

As noted in chapter 4, mental illness is a risk factor for self-harm (Evans et al 2005, Hawton & James 2005, Fortune 2007) although Healy et al (2002) found that in 107 consecutive attendances at a specialist CAMH emergency service following self-harm (by young people), only 50% were considered to have a mental illness. Participants in both Anderson et al (2000) and Hadfield et al's (2009) study drew distinctions between those who self-harmed who were deemed to have a mental illness and those who did not, the doctors in Hadfield et al's (2009) study perceiving the former as having more valid reasons for engaging in self-harm than the latter. It would seem

therefore that, given the participants in this study did not generally associate self-harm with mental illness, the absence or presence of mental illness did not influence attitudes of participants in this study, towards self-harm.

Notwithstanding this, 71% of the survey respondents agreed that 'young people who self-harm should be required to undergo therapy'. There was some evidence of disagreement amongst the nurses as to how well placed they were to therapeutically manage self-harm as the following two extracts illustrate:

> *There's a shortage of those specialist services, so I think that then colours or clouds the whole situation and I think the straightforward, if there is such a thing as straightforward, but self-harm we can support that child in that (paediatric) environment, and underlying other psychiatric issues, I think they should be, you know, dealt with in perhaps a more specialist area (N004).*

> *We're not trained or set up for it (self-harm), it needs to be specialist psychiatric and psychological help that they get, which is where CAMHS come in, but we don't see CAMHS very much - not at all in A&E, to get any advice from them or learn any techniques, or anything like that which would help (N011).*

The participants in Anderson et al's (2003) grounded theory study regarded young people who self-harmed as requiring specialist skills; the comments of the paediatric A&E nurses in their study echoed the comments above from N011, rather than the views of N004. It is of note that N004 was an experienced children's nurse and perhaps both because of experience and role this participants' expectations are seemingly different.

9.3.2   Influence of Occupation and Gender

The findings from the quantitative data indicate that there was no significant difference between occupational groups and their attitudes towards young people who self-harm, although nurses had the lowest mean scores on the AYPSH scale. These findings are consistent with other studies that specifically examine attitudes towards young people who self-harm (Anderson et al 2000, Crawford et al 2006, Anderson & Standen 2007), although Crawford et al (2003) found doctors to be more knowledgeable than nurses and in the one study where occupational comparisons are made when self-harm is considered in a general (non adolescent) context, doctors

were found to have more negative attitudes than nurses (Mackay & Barrowclough 2005).

The quantitative data from this study indicates that female practitioners held more positive attitudes towards young people who self-harm than their male colleagues. However, as McCarthy & Gijbels (2010) note from their review of the literature, the relationship between attitudes and factors such as gender (and age and experience) remain unclear, although, in line with the findings of my study, both Law et al (2008) and Mackay & Barrowclough (2005) also reported more negative attitudes amongst male respondents. In many of the attitudinal studies, correlations with gender are not explored even where data on gender is available; this could be because many of the studies only examine nurses' attitudes, thus genders will be unequally distributed given the gendered division of the nursing workforce, and the data therefore less amenable to statistical analysis.

It is of note that in this study male nurses had more positive attitudes than their female counterparts, a finding also reported by Anderson et al (2000) who observed that male nurses were more likely than females to agree that self-harm was a cry for help. Anderson et al (2000) comment that their findings contrast with other studies, but subsequent to their study Patterson et al (2008) also found that female nurses reported greater antipathy towards self-harm. The findings that male nurses demonstrate more positive attitudes than female nurses could be seen as surprising, particularly given that overall males have more negative attitudes, but it is also of note that the male nurses, unlike their male counterparts in other occupational groups, had more positive attitudes towards young people on the AYP scale, suggesting that there might be an inherent attribute within male nurses that influences their attitudes.

Notwithstanding this, and as noted above, the qualitative data revealed that where a gender was ascribed to a recollection of a specific patient, or a generalisation was made, it was normally a female, which was more likely to be made by the male nurses and paramedics. However as previously noted, Scourfield et al (2011) also observed a gendered account of young people and self-harm, although arguably this might be considered unsurprising given that self-harm is more prevalent in young females, particularly in those aged 15 and under where the female/male ratio is 6.5:1 (Hawton & Harriss 2008).

9.3.3 Influence of Age and Length of Experience

Findings from the survey data showed that there were no discernable patterns evident on the AYPSH scale in relation to age. Practitioners aged 26-30 years had the highest scores on the scale, whereas the age groups either side (16-25 and 31-35) had the lowest scores. Similarly there are no discernable patterns evident in studies that have reported on an interaction between age and attitude. For example Anderson (1997a) found that the younger community mental health nurses (aged 30-39 years) were more positive than their older (49 years plus) peers, whereas where the age range was broad (21- 40 and 41-60) older nurses demonstrated less antipathy towards self-harm (Conlon & O'Tuathail 2012). McCarthy & Gijbels' (2010) recent study identified that respondents in their 40's were more positive than those in their 30's and 50's. However, part of the problem with age (and indeed length of experience) is that different studies (including mine) categorise age groups differently therefore making comparison more difficult.

In relation to years of experience, those with 11-15 years experience had (statistically) significantly higher scores on the AYPSH scale, with a notable dip in scores for those with more than 16 years experience. This trend (experience equating to more positive attitudes) has been reported in other research studies (McLaughlin 1994, Anderson 1997, Freidman et al 2006). Moreover as noted above Patterson et al (2007) noticed that after 10 years this trend ceased, a factor also reported by McCarthy & Gijbels (2010) who also found a positive correlation with experience and attitudes, with the same dip as is evident in this study, in terms of lower scores post 16 years experience.

It could be postulated that there might be an association between length of experience and stress and associated burnout, a factor that Friedman et al (2006) also considered and which had been observed in an earlier study by Suokas & Lonnqvist (1989) and further explored by Glasberg et al (2007). Glasberg et al's study (2007) confirmed earlier findings that staff that had little support, worked long hours, were older, and had low resilience were more prone to 'stress of conscience'[19], and that this was associated with having to lower aspirations to provide good care (due to competing demands). These factors could be associated with the survey participants in this study

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[19] Glasberg et al define stress of conscience as *'a product of the frequency of the stressful situation and of the perceived degree of troubled conscience as rated by health care professionals'* Glasberg et al (2007:393).

(particularly nurses) with more than 16 years experience. These practitioners are more likely to be in senior positions, probably older, and because of their seniority may not attract the same level of support and supervision than their more junior colleagues do.

Six of the interviewees had more than 16 years experience (P001, N002, P003, N004, P007, N009). Due to the findings that emerged form the survey component of the study, these practitioners' accounts were specifically reviewed to determine whether negative attitudes were evident and whether factors such as stress or role/responsibility (given their experience) might have a bearing on their attitudes. Three of these practitioners were nurses (all senior grades), two male one female; two were paramedics and one an ambulance technician, all male. However there were no particular patterns in their accounts that would indicate a prevailing attitude, although the accounts from these practitioners were more reflective. For example as noted above (9.3) paramedics (P003, P007) had observed a change in their caseloads. Similarly the more experienced nurses (N002, 004, 009) also reported how they had observed a change in attitudes during their years of working in emergency care; changes for the better, because, as noted above, self- harm is now more recognised as a 'legitimate' (medicalised) concern.

The experienced nurses also tended to demonstrate more insight into self-harm as a behaviour. For example N004 questioned whether self-harm had actually increased or whether the increase was due to better recognition; he also questioned whether behaviours such as punching a wall might be construed in another setting at another time as anger management difficulties rather than self-injury, this participant's self-analysis analogous with a 'self-harm activist's' perspective that self-haring behaviours are a form of expression and a coping strategy, as reflected in information provided by Young Minds (2001) a charitable organisation who support young people who self-harm. Similarly N009 noted how self-harm, unlike drugs and alcohol remains a taboo area, and N002 observed that abusive young people can be admitted to an adult ward with vulnerable elderly patients but not to a children's ward. Both N002 and N004 also questioned whether the wards' reluctance to accept young people who self-harm was due to perceptions about self-harm, the ward nurses assuming all teenagers who self-harm to be problematic but not making such assumptions with other teenage patients, who, they argued could (in theory) be equally problematic.

Although factors relating to stress, support and supervision were not explicitly explored in this study, it was evident from the interview accounts that for nurses there was particular stress associated with 'moving' these young people on, and engaging with CAMH services. These difficulties clearly influenced these practitioners' working practice with stresses and tensions evident, which could explain more negative attitudes. This is further explored below.

9.3.4 Expertise and 'Exposure'

There was an assumption made by some of the interviewees in this study that having specialist resources, including trained staff and a separate paediatric A&E, would lead to better care. Due to this recurring proposition a code (expertise) was identified, and although this code did not feed into a final theme it does add a dimension to the quantitative data around experience.

Both nurse and paramedic interviewees identified that they thought that having a specialist qualification (in the care of children and young people) was beneficial, these staff being seen as more receptive to young people who self-harm, because of their experience.

> *But again, at times, if you go into a paediatric A&E, I think the attitude is slightly different because they're used to the youngster and used to people of those age groups having particular problems* (P007).

> *If you look at the skill sets to look after a young person or a child [who've self-harmed], paediatric nurses, although they're not mental health trained, have probably got a lot of skill sets to look after that young person* (N004).

As indicated by these comments, there appears to be an expectation that nurses who have specifically received training around the needs of children and young people and have opted to work in this speciality may have more knowledge and skills and consequently more positive attitudes than their peers who have chosen non-paediatric specialties. This assertion is supported by the findings of the survey data from this study. When analysing whether a qualification pertaining to the care of children had an interaction with attitudes towards self-harm, scores on the AYPSH scale were found to be higher in children's trained nurses compared with those without a children's nursing qualification, a finding which was statistically significant.

Few previous studies have made comparisons between occupation groups and where these have been undertaken inconsistency is evident. Anderson (1997a) found that while there were slight variations between community mental health and A&E nurses' attitudes, these were not statistically significant and both groups were accepting of suicidal behaviours. Patterson et al's (2007) study indicated that when assessing level of antipathy towards self-harm, mental health nurses demonstrated lower levels of antipathy (thus a more positive attitude) than their general nursing peers (a difference that was statistically significant). The difference in levels of antipathy was explained by differences in the nurse's knowledge base and educational preparation for caring for patients who self-harm. Crawford et al (2003) found that non-psychiatric nurses had less knowledge of self-harm than their peers working in mental health, less knowledge was not though associated with more negativity towards self-harm

Notwithstanding this, preparedness is only one of many factors that can impinge on attitudes. Sun et al (2007) found that nurses who had been exposed to more than ten suicidal patients[20] had fewer positive attitudes than those who had been exposed to less than ten; Sun et al (2007) do not put forward explanations for their findings, which were contrary to the earlier work of McLaughlin (1994) and Anderson (1997) who propose that exposure to suicidal behaviour explains the more positive attitudes found amongst nurses with more experience when compared with their less experienced peers. Two studies have indicated that having exposure to individuals who self-harm either personally (Law et al 2009) or professionally (Patterson et al 2009) influences attitudes, with more exposure correlated with more positive attitudes. Moreover, as noted earlier in this chapter, Anderson et al (2005) propose that public attitudes towards young people are influenced by their day-to day contact with them. It could therefore be postulated that increased length of experience as a practitioner would equate to increased exposure and therefore possibly more positive attitudes towards self-harm in young people. The more positive attitudes noted in this study of children's trained nurses to young people and significantly, young people who self-harm, could be explained by virtue of the fact that they have had initial education and training in caring for young people, and have more regular exposure to and experience with young people who self-harm.

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[20] Sun et al's (2007) study did not involve young people

One qualitative comment in a returned questionnaire from a paramedic made reference to becoming 'case hardened'. Although this was only one comment it led me to question whether length of experience and exposure to negative attitudes might in due course cause practitioners to become 'immune', ultimately rendering less empathy in the individual practitioner. As noted above, 71% of the participants had witnessed the (negative) scenario relating to a 16 year old girl who has been admitted to the A&E department following an overdose with paracetamol. Data analysis revealed that those who had not witnessed such a scenario were more likely to have higher scores compared with those who had witnessed the scenario, this finding being statistically significantly. However an assumption that longer exposure to emergency care practice would increase likelihood of witnessing such a scenario proved unfounded, with no association noted through the chi-square test. Indeed, as the findings suggest, if witnessing such a scenario is fairly common practice, it is likely that practitioners new to the field (whether paramedics, nurses or doctors) would encounter this attitude, thus there would be no association with length of experience. It is also of note that practitioners with 16 years plus experience also showed the same dip in respect of their attitudes towards young people as they did to young people who self-harmed, thus overall the findings in this respect are inconclusive.

9.3.5 Influence of Education and Training

A recurring theme throughout the studies that have examined attitudes towards self-harm is the need for education and training, these recommendations initially being made by McLaughlin (1994) and reinforced numerous times subsequently. However, only one third of the respondents in this study had undertaken any training in relation to self-harm, with doctors far more likely to have received training than any of the other occupational groups. Moreover this training was short, 71% having been delivered over the equivalent of a half-study day, and only 14 participants (reflecting 10% of total sample) had received specific input in relation to young people and self-harm. An analysis of whether training had an effect on attitudes revealed no interaction between training and attitude scores on the AYPSH scale; indeed those who had attended training obtained lower scores, an unexpected finding.

It might be assumed that those with more experience would have had more opportunity to attend training, however this was not the case and indeed those with 16 years plus experience had had less training than their peers who had had 1-5 and 11-

15 year's experience. The interviewees, regardless of length of experience, identified a need for education and training, which like expertise was not ultimately incorporated into a theme. However this code also illustrated how more experienced practitioners felt confident and able to draw on their experiences (P001), whilst others who were less experienced did not (N011), as illustrated in the following comments:

> *if you notice any concern, you go there and think – what do you reckon, and think could it be this and could it be that and if you don't like it if the answers are more negative than positive, then I'll take a stance and I can't prove it, but I'll think this or think that, so it might not be written down but it's experience, its experience of life and it's the experience of the crew, you think ooh, there are too many negatives, and not enough positives* (P001)

> *I do feel myself that I don't know enough about it and I'm, you do want to help at the end of the day and its one of those things that that's it very difficult to get help from people with when you're in A&E and I think it's something we're all pretty much lacking in* (N011).

Moreover, the emphasis of physical care in the emergency care setting means that the focus of training also rests with physical care and resuscitation, which therefore re-enforces that physical care is the priority. However it was evident from the perspective of some participants that the prioritisation of physical care was seen as a shortcoming, and more emphasis needed to be placed on mental health issues, in order to reflect more accurately the nature of A&E work:

> *but my worry would be that especially for us, we get limited training, I think it could be better yes, we could have more training and more understanding about these sort of aspects, especially as the problem (self-harm) is commonplace, as we'll learn all the physical aspects but limited in mental health, but a lot of what we go to are mental health issues* (P008)

> *There's no mental health components, no counselling component which I think would be very good in an A&E course, and very good in a paeds nursing course, yes, it's required as far as I'm concerned it should be mandatory in training* (N010)

These comments have resonance with the findings of Crawford et al (2003) who found that 42% of their participants wanted further training as they had had little or no training related to self-harm in young people; they felt it was very important to be trained in the appropriate pathways of referral to psychiatric services particularly out of normal working hours. Indeed lack of training is a recurring theme across previous research studies (McCann et al 2005, Friedman et al 2006, Sun et al 2007, Conlon & Tuathail 2012) with these and other studies (Anderson et al 2003, MacKay &

Barrowclough 2005, McCann et al 2007, Anderson & Sanden 2007, Hadfield et al 2009, McCarthy & Gijbels 2010) recommending further education and training.

9.3.6 Young People & Health Seeking Versus Attention Seeking Behaviour

Both the survey and interview data suggested that the participants in this study did distinguish between behaviours whereby young people were actively seeking help, versus attention seeking.

The interviewees made frequent reference to self-harm being a 'a cry for help'. When exploring this with them, it was apparent that a cry for help was associated with a young person's distress, distress that the young person wanted to draw attention to, and to this end they were (actively) 'seeking attention' (Anderson et al 2000). Wanting to be found or actively seeking out help and treatment voluntarily was therefore viewed more benignly as these young people were seen to be taking responsibility for their problems, a viewpoint that is encapsulated in the following comment from one of the interviewees:

> *The ones that I've seen here have been quite open, and well, we had one the other day it was a boy who self referred himself to come in for like depression so he had the potential to do other things, but he had kind of walked in himself and asked for that help which was quite reassuring really that there are some young people out there who will try and get help before self harming or taking anything further* (N012).

Previous studies have identified that attention seeking is recognised by health care practitioners as a derogatory term (Anderson et al 2000, Friedman et al 2006), which the interviewees in this study might have been attuned to and taken into in their 'moral presentation of self' (discussed further in 9.3.7 below). However the interviewees in this study clearly identified that a cry for help was a means by which young people sought attention for their (genuine) problems, and that as such they were deserving of attention, and to this end attention seeking did not always have a negative connotation. Such findings are in line with Dickinson et al's study (2009), which found that while staff working in secure environments felt that the young people in their care self-harmed to both gain and compete for attention, they nonetheless noted that the self-harm behaviours of the young people were primarily driven by a need for attention –

the participants in Dickinson et al's study similarly drawing a distinction between 'needing attention' and 'attention seeking'. It is also of note that lack of attention is a reason given for young people resorting to self-harming behaviours (Fortune et al 2008).

Nevertheless, 28% of the survey respondents indicated a level of agreement with the statement that young people who self-harmed were attention seekers, with 40% neither agreeing nor disagreeing with this statement. Some interviewees used the terms 'inconsequential' and 'insignificant'. While this was in the context of a clinical assessment, the terms were also used linked with attention seeking. In this context, inconsequential and insignificant were associated with repeat attendance following a self-harm event, and under these circumstances this behaviour was more likely to be negatively evaluated; this group of young people were more likely to be referred to as 'frequent flyers[21]', or 'revolving doors', both terms being widely used in emergency care, and often associated with inappropriate attendances/calls.

The term 'attention seeking' has long been associated with negative attitudes towards self-harm, and has been much criticised by 'self-harm activists', notably Pembroke (1994, 1998), with the label attention seeking viewed as the basis for discriminatory behaviours, particularly by staff in A & E departments (Pembroke 1994, 1998, Harris 2000, Jeffery & Warm 2002, Cresswell & Karimova 2010). However a recently published study (Scourfield et al 2011) reveals that it is not just health practitioners who perceive self-harm behaviour as potentially attention seeking; young people themselves[22] distinguish between self-harming behaviours that are 'private' and 'public'. The former suggests 'emotional pain' which is genuine; the latter undermined the credibility of young self-harmers as publicising their self-harm was seen to be a self-indulgent attempt to seek attention.

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[21] The term frequent flyer is one used widely by ambulance personnel, but in official documentation patients who repeatedly call ambulance services are referred to as frequent callers (see for example London Ambulance Service 2011)

[22] Scourfield et al's (2011) study involved young people aged 16 – 25. Some participants had self-harmed but it was not a prerequisite to have a history of self-harm to be included in the study.

9.3.7 Ascribing Negative Attitudes to Others

As noted in Chapter 4 research that has looked at attitudes towards self-harm reveals somewhat contradictory findings. Most recent studies indicate that attitudes are more positive (McCann 2007, McCarthy & Gijbels 2010, Conlon & O'Tuathail 2012) and studies that have specifically examined attitudes towards adolescents who self-harm reveal more positive attitudes (Crawford et al 2003). The general consensus amongst the studies reviewed is that attitudes towards patients who self-harm, irrespective of age group, are complex (Anderson et al 2003, Anderson & Standen 2007, Patterson et al 2007), and practitioners' feelings of frustration are a recurring element of earlier studies.

The AYPSH scores and accounts of the interviewees in this study revealed generally sympathetic attitudes towards young people who self-harm. Examples of negative perceptions of self-harm were evident from the interviewees, which were often stated in a general sense, and were either ascribed to other departments, or all staff in general. As noted in Chapter 7, one interviewee (N009) when asked, *'In your experience how do you feel people's attitudes are towards young people who self-harm',* immediately responded, 'Fairly appalling in most A & E departments'. Similarly N005 remarked that, *they're still really treated like the pariahs of A & E. As soon as they come in everybody are like you know oh no, what are we going to do with this one'.* Patients who repeatedly self-harmed were also described as *'frequent flyers'* and *'revolving doors'*, but interviewees either framed such comments as gallows humour, or comments they had witnessed others saying; for example when referring to 'frequent flyers', this was generalised to the mess room as follows: *'within the mess room it gets known [a frequent flyer], you know because people will start to recognise the address and things like that'* (P003). Moreover as noted in Chapter 6, 71% of the respondents (n=101) reported witnessing a similarly (negative) scenario to that presented in the questionnaire.

The more positive attitudes in the survey data, as largely borne out by the qualitative accounts, possibly reflect participants' wish to be viewed in a more positive light, particularly given that the subject area of the research is one where practitioners would be aware that pejorative attitudes towards self-harm have been widely reported to be

prevalent amongst A&E staff. The presentation of self is widely recognised both within sociological and social psychology literature as having the potential to introduce bias into research (Nederhoff 1985, Ajzen 1988), this tendency being increased when the behaviours being discussed are 'sensitive' (Ajzen 1988). Green et al (2006) and May (2008) draw on Goffman's (1959) perspective of presentation of self as a 'moral actor', to highlight how through 'story telling' (May 2008) individuals present 'moral' accounts of self, as a means by which (good) impression management is maintained in order to protect an individual's moral identity (Green et al 2006). Similarly, social psychologists have identified how respondents' awareness of societal norms and values influences responses based on 'social desirability' whereby respondents tend to deny socially undesirable traits while claiming socially desirable ones, in order to place them in a favourable light (Nederhof 1985). It is likely therefore that these factors explain in particular why the interviewees were likely to ascribe negative traits to others, while presenting themselves in a more favourable light, particularly because, as noted in Chapter 5, many of the respondents knew me within my professional role, and might therefore have been more concerned about presenting themselves in an unfavourable light than they might have been to a researcher who was totally unknown to them.

9.3.8 Age And Agency: Influence on Attitudes Towards Self-harm in Young People

It is evident from the qualitative data that the interviewees viewed young people as both vulnerable by virtue of their age, but problematic as a result of some of their (age-related) behaviours. The acknowledgement that being a teenager is not an easy period of the lifespan is probably one factor that contributes to more benign attitudes towards them as self-harm patients, but another factor is also likely to be their perceived immaturity and thus lack of (life) experience, which engenders feelings of sympathy amongst the practitioners:

- *I think it's always that people can be more accepting of children (P006)*
- *I think the younger they are the more sympathy I tend to feel for them (P005)*
- *But children a lot of them are too inexperienced too immature, they haven't experienced life (P001)*
- *It's heart breaking for the families as well as it's a child (P010*

The interviewees in this study made reference to young people who self-harm as being *inexperienced* and *immature*. A paramedic encapsulates these views as follows:

> *I think there's a certain, well certainly speaking for myself, there's probably a view that they [young people] don't understand the implications of what they're doing, you know they take a handful of paracetamol because it's handy and it's there and it's easily available, they don't understand the implications of what paracetamol can do to you in excessive doses. You know things like that so I think there is a sort of, a more tolerant attitude towards children who self-harm because you sort of think they, you know they don't really, they haven't really cottoned on to the implications, whereas you kind of assume that by the time you get to adulthood you should know better or, you know what you're doing is a deliberate action rather than a kind of attention seeking* (P003).

Chapter 4 considered the contribution of attribution theory to an understanding of how factors associated with controllability influenced practitioners' willingness to help (Weiner 1983, 1985, Corrigan 2000, Corrigan et al 2001, 2003, 2005), with two studies identified which had drawn on this perspective to examine attitudes towards self-harm (Mackay & Barrowclough 2005, Law et al 2008). Mackay & Barrowclough had applied the attribution model of helping behaviour to 89 medical and nursing staff in A&E, finding that staff were more motivated to help where the self-harm (an overdose) was attributable to the death of a friend (as opposed to financial debt). Mackay & Barrowclough (2005) speculate that age and gender of the patient might influence attribution, but are unable to draw any conclusions. Law et al (2008) used a vignette of a young girl (aged 15) who had self-harmed, the self-harming behaviour attributed to either abuse, or drug misuse. Similarly, the participants were more motivated to help the young person who harmed following abuse; however the findings are not discussed in the context of the hypothetical patient's age, thus no consideration of the interaction of age and controllability, is considered.

The qualitative data from this study indicates that in terms of causal attribution practitioners attribute low controllability and thus more willingness to help as age is seen as a factor which both to some extent explains and 'excuses' their self-harming behaviours, young people being held less responsible than an adult would be. It is evident from the interviewees' accounts that (although not expressed as such) young people lack agency, and, it is lack of agency that also renders the young person more vulnerable. For example the interviewees reported that young people are fearful of the

consequences of their self-harming behaviours. They are fearful of parental reactions as well as fearful that they might, against their will, be taken away from their parents/family, with several interviewees making reference to the fact that young people were fearful of 'authority'.

The interviewees were also sensitive to the risk factors associated with self-harm in young people, reflecting as they do the pressures, difficulties and challenges that young people face. This was also apparent in the quantitative data whereby respondents demonstrated broad level of agreement with the statements that constituted young people's motives for self-harm. Redley (2003, 2010) similarly noted that practitioners were very conversant with risk factors and motives associated with self-harm; individuals who self-harmed were described with reference to the recognised risk factors and motives which both served to illustrate lack of agency (Redley 2003) and practitioners' reluctance to engage in a meaningful way in order to see beyond (the individual's) predefined motives for self-harm (Redley 2010).

The interviewees acknowledged that some young people were proactive in seeking help whilst others were reticent, their presence in the ambulance or in the A&E department not always through their choice. Research has indicated that young people are most likely to seek support from friends and family rather than health professionals, irrespective of what their health problem is (Rickwood 1995, Boldero & Fallon 1995, Fallon & Bowles 2001, Rickwood et al 2007). However while young people who self-harm do seek support from family and friends (Hawton et al 2002, Brophy 2006, Fortune et al 2008), many do not access any support (Brophy 2006, Fortune et al 2008), although those that do are more likely to present to hospital (Hawton et al 2009).   Reasons for not seeking help and support for their self-harm are varied, but notably, in line with the perceptions of the interviewees in this study, adolescents report that they are concerned about both creating more problems for themselves, and hurting the people they care about (Fortune et al 2008).

Kite et al (2005) noted that when social role theory was applied to explain perceptions of older people, it was evident that the more information an individual possessed about an older person the more likely they were to view them more positively, as they were no longer defined merely by age; instead they were more likely to be defined

according to the roles they fulfilled. Thus although Kite et al (2005) found a bias against older adults, they confirmed that perceptions of older people are complex and multi-dimensional. Young people's roles are largely defined (by adults) as sons/daughters and 'becoming adults', and as noted in Chapter 3, expectations of young people's behaviours are governed by the expectations of adults. It is possible therefore that the participants in this study, while viewing young people and their behaviours as age related, also acknowledged that there are a range of complex factors which influenced their behaviours.

Consequently, age, age in this context being a teenager, is a factor in ameliorating negative attitudes towards self-harm. Indeed some of the accounts of the interviewees and the views expressed within them had a resonance with the framing of young people as vulnerable, rather than the antithetical and more dominant discourse of young people as deviant, their vulnerability frequently resulting from factors out with their own control, the implications of which are further disused below.

9.3.9 Conceptualisations of 'Good and 'Bad' [patients] in the context of Young people who Self-harm

While the interviewees were careful to distinguish between those who were seeking attention (i.e. help) and those who were attention seeking, some negative comments were associated with the latter, particularly in relation to perceptions of manipulative behaviours. Additionally, young people who were drunk and or displayed aggressive behaviour were not viewed as dispassionately as they caused problems for the interviewees at two levels, firstly because of the implications of their behaviour for their immediate care, and secondly due to the difficulties this behaviour caused for onward admission to a children's ward. Distinctions were also made between young people who were reluctant to engage versus those who actively sought out help and proved to be good 'history givers'.

Arguably being drunk and or aggressive, or failing to engage with emergency care staff means that the young person who has self-harmed is failing to legitimise the role of the practitioner (Kelly & May 1982), as without information they are unable to 'process' the young person, and 'move' them effectively and efficiently through the emergency care system, the need for efficiency increasingly a concern given the

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government targets around A&E waiting times (Department of Health 2003a). Moreover as Hopkins (2002) notes, patients who have self-harmed may display violent behaviour due to the toxic or intoxicating effects of the substances that they have ingested. She proposes that as a consequence of this these patients became highly visible, acquiring a high profile; this 'high profile' affected the functioning of the ward as it slowed it down due the necessary diverting of resources needed to manage a violent outburst. This was one of the factors that contributed to nurses in Hopkins's (2002) study demonstrating a high level of ambivalence towards patients who had self-harmed. Arguably the interviewees in this study demonstrated ambivalence about such behaviour, although this was more related to difficulties associated with admission rather than the re-directing of resources, as is discussed further below.

The interviewees did find young people's reluctance to engage challenging and a source of frustration; it did though also cause genuine concern, as the interviewees were worried that by not being able to fully engage with a young person who had self-harmed they might 'miss something'. Missing something potentially had serious implications for the young person who might not have fully disclosed for example, the full-scale of their overdose or the motives behind their self-harming behaviour. 'Missing something' also therefore had implications for the interviewees as professionally accountable practitioners, which also created anxiety.

This fear of 'missing something' is also evident in the research carried out by Wilstrand et al (2007) who examined nurses' experiences of caring for (adult) patients who had self-harmed in an in-patient psychiatric setting. Wilstrand et al (2007) report that the nurses in their study felt that they had to be constantly on their guard as they were aware that self-harm could be fatal. This is couched in terms of the patients being 'manipulative' with the nurses in Wilstrand et al's study (2007) perceiving that patients might attempt to deceive them and as a consequence they (the nurses) would feel cheated. The interviewees in this study did not couch their fears of 'missing something' in a way that inherently 'blamed' the young person. Indeed it was evident from both the survey and interview data that the participants in this study were very attuned to young people's motives for self-harm, and were similarly sympathetic to the fact that young people might not want to engage with them by virtue of the fact

that it was expected of young people irrespective of what they attended for, as they (the interviewees) were both adults and strangers.

As discussed in Chapter 2, A&E staff have been found to variously label patients as 'good', 'bad', 'deviant', 'rubbish' and trivia' (Roth 1972, Jeffery 1979, Dingwall & Murray 1983). 'Good' patients are those who are deemed to be 'deserving' of emergency services, normally the accident victim and patients attending with other trauma related injuries, as well as urgent physical complaints such as chest pain of a cardiac origin. These categorisations have contributed to the literature on 'popular' versus 'unpopular' patients, and notions of an 'ideal service user'. Patients' individual characteristics, behaviours and personal/social traits have been found to influence how popular they are (Stockwell 1972, Kelly & May 1982) as well as diagnoses, with psychiatric patients widely seen as problematic and difficult (May & Kelly 1982).

There are therefore a number of factors that influence how categorisations of 'good' and 'bad' patients are constructed. Firstly the extent to which the patient's illness, conduct and behaviours legitimise the role and function of the clinician (Kelly & May 1982). Secondly responsibility, i.e. the extent to which the patient can be held responsible for their presenting illness (Jeffery 1979); thirdly conformity, the extent to which the patient wants to get better and therefore conforms to clinician's wishes/expectation (Parsons 1951, Jeffery 1979); fourthly professional competence, the extent to which the patient's presentation tests and develops the skills of the practitioners, appropriately drawing on their skills (Jeffery 1979) and finally behaviour that would be morally judged irrespective of whether they are a patient or not (Hill 2010), or which is socially constructed (Johnson & Webb 1995). Table 7.2 provides a tabular representation of how the key traits associated with young people who self-harm as described by the interviewees in this study have been matched to the factors that lead to constructions of 'good 'or 'bad' patients. The first columns are descriptions/statements used by interviewees in this study. These have been matched to the aforementioned factors that influence conceptualisations of 'good' and 'bad' patients. The cells in green indicate 'good' representations of young people who self-harm, red 'bad' representations and amber where it could be seen as ambiguous, with the potential to be either red or green, depending on the presence of other traits.

TABLE 9.2   Construction of 'Good' and 'Bad" in the Context of Young People Who Self-Harm Who Attend For Emergency Care.

Trait/Basis of Judgement	Legitimises Role (Kelly & May 1982)	Degree to which held responsible for illness (Jeffery 1979)	Conformity (Jeffery 1979)	Matches the competencies of the service (Jeffery 1979)	Moral/social judgement (Johnson & Webb 1995, Hill 2010)
Single or infrequent attendance for self-harm.	Legitimise the clinician's role as perceived as being in need of care	Not held responsible for illness as immature and unsure of how to access appropriate services.	Dependent on whether the young person actively engages with staff	Initial urgent intervention required which matches competencies of emergency care staff	Age and immaturity ameliorate moral and social judgements.
Actively seek help, or, is responsive to help when this is offered.	Self-harm legitimate as a means of expressing their feelings and distress; actively seeking help signals to practitioner that young person acknowledges they need help which they can initiate	Although not held responsible, actively seeking help indicates that the young person has accepted responsibility for the actions they've taken	Highly valued as by actively seeking help acknowledges that help is required thus complying with expectations of staff in wanting to get better	Responsiveness enables staff to fully respond as required by the service	Difficulty that young people experience in accessing services means that less judgement about inappropriate use of service as a means of accessing help and support is forthcoming
Actively engage with personnel	Assists interviewees in fulfilling their role and ascertaining the basis of their distress thus legitimises their role	Engagement leads to a fuller understanding of an individual's motives lessening the onus of responsibility for the young person	By actively engaging young people are more likely to be seen to want to get better	Engagement with staff enables thorough assessment central to the work of emergency care, and minimises risk	Recognition that young people can be difficult to engage irrespective of reason for attending, thus engagement very positively evaluated.

TABLE 9.2 Construction of 'Good' and 'Bad" in the Context of Young People Who Self-Harm Who Attend For Emergency Care.

Trait/Basis of Judgement	Legitimises Role (Kelly & May 1982)	Degree to which held responsible for illness (Jeffery 1979)	Conformity (Jeffery 1979)	Matches the competencies of the service (Jeffery 1979)	Moral/social judgement (Johnson & Webb 1995, Hill 2010)
Frequent attendees with minor and inconsequential symptoms – 'manipulative'	Do not always legitimise role as motive for attending is not necessarily congruent with emergency care – the young person can be seen as using emergency services for their own ends/gain	Although not held as responsible for illness, they are judged as more responsible as have 'prior experience' (should know better)	Dependent on whether the young person actively engages with staff, but less likely to be seen as conforming due to previous attendances	Minimal initial intervention required which unlikely to fully match the competencies required.	Age and immaturity ameliorate moral and social judgements, but this is tested in the presence of other negatively ascribed traits
Reluctant to engage and or accept help	Failure to engage results in failure to legitimise/sanction the intervention of clinician's	Engagement seen as necessary for successful management therefore lack of engagement equates to lack of cooperation = more onus of responsibility on young person	Reluctance increases risk and does not therefore confirm to clinician's wishes/expectations	Lack of responsiveness is frustrating as hinders competence of staff in core assessment and facilitates further potential risk to self and increases risk to clinician's own competence	Recognition that young people can be difficult to engage irrespective of reason for attending

TABLE 9.2   Construction of 'Good' and 'Bad" in the Context of Young People Who Self-Harm Who Attend For Emergency Care.

Trait/Basis of Judgement	Legitimises Role (Kelly & May 1982)	Degree to which held responsible for illness (Jeffery 1979)	Conformity (Jeffery 1979)	Matches the competencies of the service (Jeffery 1979)	Moral/social judgement (Johnson & Webb 1995, Hill 2010)
Drunk	Dependent on level of inebriation; if very inebriated unlikely to be able to sanction staff intervention and thus legitimacy	Although not held as responsible (as adults) the element of choice associated with inflicting harm with alcohol increases responsibility for illness	Could be dependent on level of intoxication, but potentially unable to conform	The extent of intoxication will influence whether a young person's needs matches competencies. More intoxicated = higher use of competencies but as intoxication lessens and behaviour changes match with competencies decreases	Although drinking alcohol is not adversely judged, both drinking to excess and combined with harm not condoned
Aggressive	No compatibility with legitimacy – renders staff as 'illegitimate' due to seeming rejection of interventions	Held responsible for aggressive behaviour; compared with others who attend who are not aggressive	Incompatible with conformity	Not matched with competencies, creates difficulties and tensions inclinician's interactions with other members of (mainly paediatric) staff	Aggression socially unacceptable

As discussed in Chapter 2, Dingwall & Murray (1983) propose that, while children should be labelled as 'bad patients' because they 'break the rules' (that 'good' patients conform to), children cannot be treated as agents of their own behaviour and thus are able to break the rules, as they are not held responsible, their responsibility being *'impaired by age, natural deficiency or by injury'* (Dingwall & Murray 1983:136). Their analysis conforms to the framing of young people as vulnerable, rather than the alternative discourse of young people as deviant, with young people's lack of agency central to this framing.

Nevertheless, as discussed in chapter two, Dingwall & Murray (1983) do not explicitly consider whether lack of responsibility applies to 'adolescents', with evidence from their study that 'the young pretender' would be viewed differently from a younger child. White's (2002) study did make an explicit reference to the application of judgements to young people. As with Dingwall & Murray (1983) White (2002) identified that children are exempt from classifications as bad patients, and also noted that:

> "*Whilst children and young people can be described as difficult, sensitive, challenging or damaged, this is attributed to either their embodied condition (e.g. they have autism) to their parents' or carers' mismanagement, or to some other aspect of their biography. This includes those children and young people whose behaviour breaches moral codes, for example those who self-harm, or engage in behaviours dangerous to others and those whose chronological age places them close to adulthood'* (White 2002: 428).

The findings from this study partially support White's (2002) analysis, notably the attribution of age as an aspect of their biography, the conduct of parents (their presence or absence) and self-harm itself being a symptom of distress, a response to the stress and pressure felt by some young people and the associated framing of young people as vulnerable, unhappy and stressed. However, this was not universal. The behaviour of individual young people, and their willingness to seek help and 'comply' with the help and advice given, influenced practitioners' perceptions of young people who self-harm. Thus, contrary to White's (2002) findings, being young/immature did not always in itself abdicate young people from responsibility for their actions and behaviours. As with adults, their conduct as patients potentially influences how they

are perceived and judged, and to this end some young people's behaviour was aligned with the more dominant discourse of young people and their perceived problematical behaviour.

9.4 How does the practice of emergency care work as undertaken by nurses and paramedics influence attitudes towards and perceptions of young people who have self-harmed?

As noted above, generally evaluations made of young people who self-harmed were framed in the context of clinical rather than moral evaluations. However it was evident from the interview data and comments in the questionnaires that staff working in emergency services encounter problems when caring for young people who self-harm, these problems stemming to some extent from the nature and indeed culture, of emergency care work.

9.4.1 Physical Assessment & Care

As noted in Chapter 2 the essence of emergency care work is to make rapid assessments of patients' clinical signs and symptoms in order to determine clinical priorities. Determining clinical priorities is necessary due to the volume of patients who attend for emergency care, thus clinical decisions need to be made that determine which patients are a priority, as order of attendance does not dictate the order in which patients are seen. The accounts of the interviewees conveyed a sense of rapid assessment both during pre-hospital and in hospital (A&E) care. This sense of urgency in undertaking an assessment reflects in part the concerns around risk as well as the need to move patients through the emergency care system, in order to maintain the negotiated order (Strauss et al 1963, 1964) an order that is currently governed by the government's '4-hour' targets (DH 2003a).

In undertaking and making an assessment the initial focus was on physical care/risk, reflecting the priorities and arguably, norms (or 'maxims', Sbaih 1997 a & b) of emergency care work, thus it was evident from the accounts of the interviewees that assessment and therein triage, formed the basis of their work with young people who self-harmed, and that initially the (triage) assessment was concerned with physical assessment. Indeed such was the taken for granted assumption that assessment was an inherent part of their work that many of the interviewees rapidly passed over this

element of how they managed the care of young people who self-harmed, with comments such as, '*obviously airway breathing that kind of thing does attract priority' (P001);* and, '*we'll get a brief handover and we'll do just a very quick assessment general colour and can make sure they're safe* (N012), another notes that, *you pop them in a cubicle and do your observations, clinically you make sure they're stable* (N005).

These comments from the interviewees reflect the widely recognised algorithm associated with physical assessment incorporating the 'A.B.C.D.E'[23] approach in which safety is always paramount, both safety of the patient as well as the 'rescuer'. However as noted above, the interviewees were also conscious of the need to be alert to missing something as there was awareness that self-harm can be fatal. In the context of A & E work practitioners are constantly on the alert for the deteriorating patient, because as Boreham et al (2000) note, the hospital emergency department can be a risky environment. In this context the environment is risky as practitioners can be subject to litigation for negligence, with failures arising from omissions in delays in beginning investigations, obtaining diagnostic information and commencement of appropriate treatment. As a consequence, standardising routine aspects of emergency care work and thereby creating organisational control is seen as a means of militating against such risk (Boreham et al 2000), with standardised approaches to assessment such as triage arguably being one such system that provides organisational control and stability.

While the focus of the interviewees' practice was assessment and the provision of physical care – described as 'patching people up', they identified that a source of their frustration was that young people who self-harm were in need of more than physical care. Providing more than physical care was though perceived as difficult as from the interviewees' perspective, the focus of emergency care is treating the physical. This was encapsulated by the comments of one of the interviewees in respect of physical versus emotional pain, and another who said, '*from what I've seen sometimes A&E care and physical and probably the mental health care don't always coexist* (P008). These sentiments are reflected in Hadfield et al's (2009) study, which analysed A & E

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[23] A = Airway. B = Breathing. C = Circulation. D = Disability. E = Exposure

doctors' responses to treating self-harm. Hadfield and colleagues found that the main priority of the A & E doctors was to 'treat the body', their focus being on 'physiological aspects of treatment at the expense of concerns about the person's emotional distress' (Hadfield et al 2009:759).

In Hadfield et al's (2009) study, treating the mind and treating the body were separate entities. Similar perceptions were evident in this study as reflected in the separation of assessing the mental health needs of young people who self-harmed, as unlike the assessment of their physical needs, mental health or psychosocial assessment was someone else's work, as the following two extracts illustrate:

> *I think there's very much the view is deal with what's in front of you, it's somebody else's job to do the care and the investigation and that type of thing, you know the sort of like the longer term stuff, you know because we don't, you know certainly with a child you know, we don't refer directly to like the mental health unit or something like that, you know there's none of that. You know it is really just a case of deal with the immediate situation, find out whether it's life threatening or not life threatening, do what you can and get them to a place of, you know, like an A&E department or somewhere like that that's more appropriate* (P003).

> *I think nursing wise we've always kind of seen that [assessing their psychosocial status and doing a risk assessment] as a medical perhaps, um, social history yes but psycho, psychological aspects and that, perhaps we see that as medical input, we've done very much the, you know, the initial nursing assessment, the initial kind of physical state and perhaps even a bit of the social history but we've not really gone into the mental health, it's more that we see that as someone else's role, I think we have anyway* (P004).

The fact that the nurses and paramedics interviewed in this study subscribe to the same priorities of physical assessment and 'fixing' patients as held by the A & E doctors in Hadfield et al's (2009) study possibly reflects how they subscribe to and share the 'maxims' of emergency care work (Sbaih 1997 a & b). Anderson et al (2003) similarly found that there was a shared perception by A & E nurses and doctors that making sure that a young person who had self-harmed was out of

(physical) danger was the key priority, the physical element of care having primacy over talking to the individual, as A & E departments and paediatric wards were not conducive to 'therapeutic input'.

Practitioners in Anderson et al's study (2003) were frustrated at the limited amount of time they had to engage therapeutically with young people who self-harm, and indeed frustration is a feature of the accounts of interviewees in this study and found in other studies (McAllister et al 2002 a, Anderson et al 2003, MacKay & Barrowclough 2005, Wilstrand et al 2007, Conlon & O'Tuathail 2012). This frustration is seemingly borne out of a willingness to help, set against constraints and difficulties presented both by the patients themselves, as well as the systems/organisations in which the interviewees worked. This sense of frustration perhaps explains why paramedics readily described themselves as 'case hardened', a term that was used by a respondent in the survey element of the study, who commented as follows:

> *The problem with self-harm is that it is constantly being laid at the door of A&E departments. Every day I see persistent failures from social services ad mental health authorities who use the line, just phone 999, on a daily basis. Crews just become case hardened* (P008).

When discussing this with the paramedic interviewees it was apparent that becoming case hardened was associated with having to go to seriously ill patients and then having to switch to more routine elements of the work, as illustrated in the following comments:

> *I think the reality is that you've just been to a job where someone who's died of a heart attack, it's a really crazy job and maybe adrenalin is flying and then 20 minutes later you go to a patient who says they've taken an overdose who has all these problems and upsets and jumping between these two jobs doesn't always do the patient a service* (P008)

It is possible that the paramedics become 'case hardened' due to their expectation of what emergency work should be, versus the reality. Byrne & Henman (1997) studied A&E nurses' perceptions of their work and found that a number of nurses had been attracted to working in A&E because of the excitement and drama they believed such work would entail, but once they had started they found that this perception was not a

reality; moreover they found caring for 'routine' patients boring. As has been discussed above, the paramedics in particular identified transporting young people who self-harmed as a routine element of their work; it is possible that this routine work, when compared to the more 'adrenalin fuelled' aspects of the work, exacerbated their feelings of frustration, arising from failures in the system which mean that self-harm patients are admitted to an A&E department rather than to a psychiatric assessment unit. Indeed P008 saw this as an area where service enhancement was likely:

> *I find it frustrating as it's completely inappropriate to take someone to A&E for what is essentially a mental health issue or an issue around their wellbeing, when its more appropriate to take to another service. I think in the future that's what paramedics are looking to do, and they'll do that more, but they need these areas to open up more first.*

9.4.2   Moving Young People on – Competing Pressures and Demands

As described in theme 3 of the qualitative data, the accounts of both the paramedics and nurses provided insight into the need for both groups of staff to mobilise patients through their respective organisations. As noted in Chapter 2, nurses are seen as being central to the process of patient categorisation (Hughes 1988, Sbaih 1998a&b, Allen 2004, 2007); with the exception of Hughes (1988) these studies were all undertaken by nurses, but while Hughes (1988) recognises nurses' key role in categorisation he has also noted the influence of ambulance personnel on the patient's journey though the A&E department (Hughes 1980). While the interviewees in this study worked in organisations that both came under the umbrella of emergency services, there was evidence that as practitioners they experienced different pressures with respect to young people who self-harm, and employed different approaches to draw attention to the young person's 'mobilising worth' (Dodier & Camus 1998), although for the nurses this was much more challenging as will be discussed below.

In respect of pre-hospital care it was evident that the paramedics saw their role as making an initial assessment of risk and clinical need, to ensure a safe transfer to the hospital setting, and as Hughes (1980) noted there was a sense that having delivered the patient to the hospital the paramedics viewed their role as complete. Moreover, the speed with which they might make such a decision was also partly determined by

whether or not the young person was inebriated, with a sense that the crews would want to transfer and off-load a drunken teenager as soon as possible. Indeed there was some evidence that young people who were drunk had what Dodier & Camus (1998) would propose is low mobilising worth, with evidence of a quick 'dispatch' – 'a quick five minute job' (P001). There was also evidence of how 'typified pictures of the patient' (Hughes 1980:117) were constructed by the paramedics, and this information then passed on to the nursing staff who appeared to accept its veracity, as the paramedics' accounts while often brief were welcomed by the nursing staff as the following excerpts reveal:

> *You know, you sort of try and get enough information just to kind of highlight and maybe sort of point the nursing staff into a direction as to what might have provoked them or what might have caused it [self-harm]* (P003).

> *I think they're generally good about the actual situation, so where they were and what was around them and what drugs they were carrying, who they were with, you know, and perhaps even some social history about the family* (N004)

Conversely the nursing staff while recounting their role in terms of patient categorisation framed it in such a way that the focus was more on the difficulties they encountered, difficulties that were often expressed as frustration. In the description of theme 3 the response of one nurse was particularly insightful (see page 233). He illustrated the point he made about the problems associated with lack of ownership, acknowledging that as a result young people who self-harm were not his favourite patients, as the following extract illustrates:

> *But yeah, they are not my favourite patients.*
> *Is this because they difficult to process or other reasons?*
> *Both. Yes they're difficult to process so going back to fundamental secondary part of my job is prioritising, time management and patient care one, time management two, so yes they're a pain in the bum in that sense,* (N010)

This admission that young people who self-harm are not this nurse's favourites, due to the difficulties he knows will occur in order to 'move them on' and the associated pressures that this causes given the aforementioned government targets, perhaps

explains why when compared with the other occupational groups, the nurses had lower scores on the AYPSH scale, albeit this was not statistically significant.

9.4.3   Managing the 'Shape'.

Both paramedic and nurse interviewees made reference to having limited time; however the basis of this limited time had differing impacts on the pre-hospital and hospital services. As noted in the previous chapter, one paramedic (P007) lamented that he had limited time, but in this context limited time was half an hour to an hour with a patient. A further paramedic (P008) identified that in his view there was no particular pressure on time once the crews have arrived, their time pressures being related to (crew/vehicle) response times. This contrasted strongly with the time issues faced by nursing staff, which primarily arose due to the competing demands of other patients who are present, and the government '4-hour target'

As has been reported in other studies (Hopkins 2002, Anderson & Standen 2003, O'Donovan & Gijbels 2006, Hadfield et al 2009, Dickinson 2009) part of the frustration that staff experience in caring for patients who self-harm arises from the competing demands they face, which was also evident in this study, 'competing demands' assigned as a code due to the frequency with which the interviewees made reference to competing demands they faced in their daily work. For paramedics this was switching between calls where one minute the 'adrenalin is flying' the next being a more mundane and routine call, for example to a patient who has overdosed. This was, as discussed above, associated with becoming case hardened. For the nurses the competing demands were constantly referred to as having other sick children in the department, as P005 commented, *if they [young people who've attended following self-harm] are actually clinically stable and we have sick children in, we will always be taken away and put with them.*

As discussed above, the nurses interviewed in this study unanimously reported the difficulties they encountered in moving young people on. These difficulties were exacerbated by the fact that young people who self-harmed invariably attended during what would be termed 'out of hours' – i.e. outside of 'Monday – Friday 9 – 5' - as one of the nurses (P005) commented, '*I think our main barrier to helping them a lot of the time is time, invariably these people come in when its busy they just seem to*

have an antenna for that'; another nurse (P010) lamented that *'they always come out of hours'.* Early evenings tend to be the busiest periods in a paediatric A & E, partly as children have returned form school or nursery unwell so parents unable to secure a GP appointment bring them in, or GP's make referrals as early evenings is surgery time. A further factor that contributes to the busyness is parental anxiety; if their child is unwell, parents are keen to 'make sure' their child is 'alright' prior to putting them to bed for the night. As a consequence evenings also herald the arrival of some of the sicker children.

The nurses in this study recognised that they needed to spend time with the young people who self-harmed, but simultaneously recognised that the time they needed was not available; thus given the focus on the physical as outlined above, invariably it was the (often younger) physiologically sick children who took precedence amongst these competing demands. However these 'sick children' also take time, and similarly take the nurses away from the young person who has self-harmed, meaning that at some stage their needs will have to be addressed. Hopkins's (2002) ethnographic study revealed that self-harm patients impeded the functioning of the (acute medical) admissions ward as they *'represent a blockage in the system due to their complex needs'.* Hopkins (2002) makes reference to the ward needing to maintain an unimpeded circulation in order to 'remain healthy'. Hopkins does not conceptualise unimpeded circulation, but it has resonance with the negotiated order and a ward or department's shape (Strauss 1964, 1965 Sbaih 2001, 2002).

As discussed in Chapter 2, Sbaih (2001, 2002) proposes that shape becomes distorted when patients (in the A&E department) become stranded in the cycle of treatment and referral (Sbaih 2002:1346). Nurses employ a number of tactics to rectify poor shape, and in so doing Sbaih found that nurses complained about not being able to finish the job, being too busy and having to manage patients who were deemed inappropriate attendees, however, it was only when shape became distorted that nurses were found to be less tolerant of 'inappropriate attendees'. Parallels can be drawn with the findings of this study. The nurses in this study generally held positive attitudes towards young people who self-harm, but did as outlined above, express frustration if they were unable to attend to the needs of the young person due to the competing demands of the department.

A factor that significantly distorted the shape of the paediatric A & E was the difficulties they encountered in admitting the young people to the children's ward. These difficulties were caused in part by the ambiguity around the Trust's policy on age, the perceptions of young people as disruptive, and the difficulties the nurses encountered in accessing onward referral to CAMH services.

The Trust's policies, based on the NICE guidelines, dictated that all young people who self-harmed should be admitted overnight and fully assessed the following day before further treatment and care is initiated (National Collaborating Centre for Mental Health 2004:29). The ward staff were though reportedly reluctant to take these young people, particularly if they were over the age of sixteen and certainly if they were likely to be disruptive. The NHS Trust where the nurses were employed had a somewhat ambiguous policy on admitting young people. If they were between 16 - 17 years of age but had remained in education they were admitted to the children's ward, if they had left full-time education they were admitted to an adult ward. The nurses in their interviews acknowledged that this resulted in a 'big black hole' for the 16 – 17 year olds (P011).

However the nurses interviewed did not themselves wholly support the admission of those aged 16 – 17 years of age to a paediatric ward, although they also recognised that inpatient (adult) psychiatric units were inappropriate, and locally there were no specialised adolescent units, so this wasn't an option – the nurses were therefore in a double bind when it came to locating a bed for these young people.

It is of note however that the quantitative data revealed that only half the respondents (n=73) were aware of their organisation's guidelines in respect of the management of self-harm in young people; moreover although nurses and doctors were more likely to report awareness of the guidelines, less than a third followed them, a finding contrary to that of McCann et al (2007) who similarly found that 79% of their respondents[24] were aware of the guidelines, but in contrast, 95% followed them. The interviewees in this study acknowledged that guidelines were useful, which was particularly evident

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[24] The respondents in McCann et al's (2007) study were all nurses and the study was undertaken Australia

in the account of a less experienced and recently appointed nurse. However, problems with securing admission perhaps reflect why a significant number of nurses didn't follow the guidelines, particularly given the pressures on the nursing staff to adhere to two sets of guidelines, the need to see, treat and discharge within 4-hours (DH 2004), as well as the need to secure admission for a psychosocial assessment as per the NICE guidelines (National Collaborating Centre for Mental Health 2004). Similar findings are apparent in McCarthy & Gijbels (2010) recent research. They reported that whilst having a 'moderately positive attitude' towards what they termed 'legal and hospital regulation', 68% of the nurses in their study found that the hospital systems impeded their ability to work effectively with self-harm (McCarthy & Gijbels 2010:34).

Green & Armstrong (1993) noted that emergency admissions provide challenges for efficient hospital administration with threats to the negotiated order evident in 'games' that were played between clinicians and bed managers, with some beds being kept outside of bed management. The example cited in their study is elderly care, but in a district general hospital where there is only one children's ward, bed management arguably has the potential to revert to the province of the paediatric consultants and senior nurses. This was evident in this study where the A & E nurses interviewed, although ultimately successful in obtaining admission, did so perhaps in spite of rather than because of the support of their colleagues working in hospital paediatrics and arguably because of the Government's '4-hour target'.

9.4.5   Managing the 'Shape' in the Context of the '4-hour Target'

The nurses interviewed in this study made a number of references to the four-hour target. On the one hand they identified that the target had had an impact as it enabled the nurses to mobilise resources such as CAMH referrals earlier, as it was recognised that getting a referral would take time, and even if the young person ultimately 'breached'[25] a CAMH referral would still be forthcoming. A nurse interviewee observed that previously young people who had self-harmed were, *'left waiting in the department for hours and hours with no one making an effort to actually, you know, do anything'* (N004); he proposed that the four-hour target had improved this element of care. Indeed improvement in patients' waiting times has been widely recognised as

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[25] The term 'breach' is used in A & E departments to denote a patient who is about to or has, exceeded the 4-hour wait.

a benefit of the four-hour targets, even amongst those protagonists arguing against their imposition (Leaman 2003, Mortimer & Cooper 2007, Banarjee et al 2008) with acknowledgement that the target has impacted more on nurses than other occupation groups (Mortimer & Cooper 2007, Weber et al 2011).

Conversely the nurses also identified that (in the context of maintaining shape) A & E could be like a 'conveyor belt', and even though they recognised that these young people had specific and complex needs, they felt under pressure to move them on, which given the aforementioned competing demands on their time, meant they were unable to fully ascertain their needs, which therefore added to the nurses' frustration. This was further exacerbated when they encountered difficulties of securing admission to a ward in a timely way

9.4.6   Transferring Ownership to Maintain Shape

As already noted one of the difficulties that the nurses encountered in terms of 'moving young people on', was admission to the children's ward. The children's ward was required to take these young people as gaining access to inpatient CAMH beds is not possible for all but the most acutely mentally disturbed young person, and waiting lists for CAMH referrals remain very long.   Moreover while accessing CAMH services during 'office hours' (Monday to Friday 9 – 5) took time, accessing out of hours was inordinately difficult, as summarised by the following extract:

> *There is still a huge, huge, gap, for sorting out these patients because they generally, I don't know the stats, but probably 95% are coming in out of hours. The issues have developed over the day and then in the evening when thinking about or when they go to bed and discuss things with their friends or whatever, that's when they tend to come in and that's when you haven't got the accessibility to anyone (N009).*

The nurses indicated that this problem was exacerbated for children and young people as the Trust policy required that, in line with the NICE (2004) guidelines, all young people have an assessment by a member of a CAMH team. The nurses identified that adults who remained in the A & E department would be assessed by the Duty Assessment Nurse (DAN), this nurse being on site due to the co-location of a mental health unit on the acute Trust site. However CAMH services were located some

distance from the hospital, thus ready access to a nurse or other member of the CAMH team was not forthcoming. Access to CAMH expertise and resources for both the young people and the nurses was universally an area where the nurses fell that the management of care could be improved, with almost universal criticism apparent as the following extracts illustrate:

> *We have a CAMHS on call person and in office hours there is somebody on the end of a phone but out-of-hours there isn't and we find that it's just very problematic and of course... the CAMHS person is supposed to provide a psychiatric nurse to look after them so a one-to-one but they're of variable usefulness these guys to be honest* (N002*).*

> *Sometimes it's difficult to actually get these young people recognised and seen by someone and overall CAMHS, the children's mental health service, is less accessible, is less set up for children and young people's mental health compared with what there is for the adult side* (N009)

In response to how things could be improved this nurse proposes that:

> *I mean again the collaboration of departments. For example like paeds and psychiatry because they are so separate; it would be nice to have a paed/psychiatric nurse, but I think you know, having more availability to the CAMHS would be fantastic, but again they're under huge pressure, there's a huge wait for one of them to come and assess* (N005).

The difficulties the nurses faced in gaining access to CAMHS is important as other research has identified that having insufficient support can lead to negative attitudes (O'Donovan & Gijbels 2006, Wilstand et al 2007) while a number of studies have identified the importance of having support from co-workers and management in helping staff manage the demands and inherent frustrations presented by patients who self-harm (Hopkins 2002, Crawford et al 2003, Wilstand et al 2007). Indeed Crawford et al (2003) whose study sites included three London teaching hospitals which had access to a local inpatient psychiatric adolescent unit and CAMHS, propose that the ready availability of psychiatric assessment fostered a generally positive relationship between the casualty departments and CAMHS, which is of note as the attitudes of

staff towards adolescents who self-harmed in their study were overwhelmingly positive (Crawford et al 2003).

9.5   Summary

This chapter has discussed the findings from the survey and interview data and has done so in the context of the research questions posed, thereby it is intended, providing a 'complete picture'   (Creswell & Plano-Clark 2007). The findings have been discussed with reference to previous research and confirm that attitudes towards self-harm are complex, with a number of factors influencing how an individual will perceive a young person per se, and a young person who self-harms.

The findings from the literature review indicated that generally attitudes towards self-harm are becoming less pejorative, although nuances are evident. McCarthy & Gijbels (2010) note that different types of self-harming behaviours elicit different emotions and attitudes, and as noted in the literature review (See P80), the findings from studies that specifically examined attitudes in the context of self-laceration reported negative attitudes (McAllister 2002, Friedman 2006). Earlier studies that used attribution theory identified that factors that precipitate self-harm can influence attitudes, with some situations leading to an individual being perceived as more in control of their choice to self-harm than others the former being more negatively evaluated (Mackay & Barrowclough 2005, Law et al 2009). The findings from this study extend these previous observations; overall the participants in this study demonstrated more positive attitudes. The experiences of the interviewees were largely contextualised by reference to young people who overdose and or misuse alcohol. Where other methods of self-harm were referred to such as laceration or insertion of foreign bodies, these were referred to in a less positive way for example "cutting Hollywood style" (P003) or as a "joke job" (N010).

The medicalisation of self-harm and latterly adolescent self-harm is apparent in the plethora of literature that attempts to explain self-harming behaviours, explanations that take a bio-medical perspective by examining risk factors for self-harm in young people as well as seeking causal relationships between self-harm and completed suicide (Redley 2003). It is acknowledged that the definition I adopted for this study is a 'medical' definition and as such draws on categories of behaviour that are

medically defined as self-harming, whereas the interviewees adopted what might be termed a more culturally bound definition of self-harm, including as they did alcohol intoxication within their own descriptions of self-harm. To this end this study has served to highlight that emergency care practitioners do subscribe to a broader definition of self-harm than is convention from a bio-medical perspective.

As with previous research, a number of variables were examined as part of the survey element of the study, including the influence of occupation, gender, age and length of experience on attitudes towards self-harm. As discussed in this chapter, previous research has failed to reveal consistent trends in relation to these variables and attitudes towards self-harm; likewise, the findings from this study proved inconclusive. Findings from the survey data indicated that gender of respondents might influence attitudes (males generally less positive than females), although analysis of the differences in mean scores revealed no statistically significant difference, and other than male interviewees being more likely to ascribe a female gender to a young person who self-harms, the interview data did not further understanding, or provide any explanations for any gender differences. The findings from this study do though support previous research that has associated experience with more positive attitudes (McLaughlin 1994, Anderson 1997, Freidman et al 2006) and lends some support to a more recently emerging trend (McCarthy & Gijbels 2010), that positive attitudes peak, and then dip when practitioners have more than 16 years experience The interview data did not though provide any specific insight into why this might occur.

The findings of this study lend support to previous research, which has indicated that as an occupation, nurses have less positive attitudes than their peers working in emergency services. Although not statistically significant, the nurses surveyed obtained lower scores on the AYPSH scale than their medical and paramedical colleagues. The data from the interviews illustrated the difficulties and frustration the nurses in this study faced in managing the care of young people who self-harm, which centred on the pressure to 'move young people on', pressures that were exacerbated by the need to do this within 4-hours; these challenges were not faced by their paramedical colleagues.

One of the challenges nurses faced was difficulty in securing admission to a children's ward. This was in part due to the perception that young people who self-harm are more likely to be abusive; if a young person was abusive, the A&E nursing staff interviewed concurred with the reported views of their ward based colleagues, that a children's ward was not an appropriate destination for them. However there was also a sense that it was the diagnostic label of self-harm that affected the (reported) perception about the unsuitability of a children's ward; the accounts of the nurse interviewees suggested that their ward colleagues expected and anticipated that young people who had self-harmed would be challenging in terms of their behaviours, whereas no such expectation existed with for example, a 16 – 17 year old asthmatic being admitted to the ward. To this end the diagnostic label of self-harm had negative connotations.

The two data sets provide a picture of inconsistent and ambivalent attitudes towards young people, with some indication that 'exposure' to young people themselves, may influence attitudes toward them as young people per se as well as influence attitudes towards young people who self-harm. Attribution theory has previously been used as a perspective from which to examine attitudes towards self-harm (MacKay & Barrowclough 2005, Law et al 2008), but neither of these studies specifically addressed the influence of age on attribution and practitioners' willingness to help. Findings from this study indicate that age, i.e. being a young person, does influence attitudes towards self-harm, with young people less adversely judged as their self-harm, having been medicalised, is seen as a symptom of distress, a coping mechanism or response to a stressor out with a young person's control, thus as a consequence, attitudes towards young people who self-harm are benign.

Nevertheless, there were some instances when young people's self-harm became problematic, with a number of traits and factors identified that, based on earlier work on 'good' and 'bad' patients, enabled a construction of 'good' and 'bad' in the context of young people who self-harm (see Table 9.2). As discussed in chapter two, whilst there is a body of literature that has looked at 'good' and 'bad' patients (Roth 1972, Jeffery 1979, Kelly & May 1982, Johnson & Webb 1996, Hill 2010), this body of literature does not address whether the labels 'good' or 'bad' and associated judgements extend to children and young people. Two studies that had considered this

(Dingwall & Murray 1983, White 2002), suggested that young people are exempt from classification as 'bad patients'. The findings from my study confirm this, as age is a factor that, in the context of self-harm, causes practitioners to attribute low controllability and more willingness to help. However when a young person's behaviour breaches moral codes, for example by being aggressive and abusive, then they are adversely judged. In this context whilst the behaviour might be linked to their self-harm, it is their behaviours as young people, not their self-harming behaviour, which is adversely judged. Under these circumstances young people can fulfil the criteria of 'bad patient'. These findings therefore extend previous conceptualisations of 'good' and 'bad' patients, explicitly extending and applying them to young people.

Strauss (1964:308) draws attention to the competing demands between clinical and administrative arrangements in the establishment of a negotiative consensus and the maintenance of shape. He observes that nurses are:

> *'Particularly affected when there is a misalignment between clinical and administrative ends as nurses are torn between the desires for involvement in therapeutic enterprise and for manageable wards and since they have multiple responsibilities to central administration, the physician and the patients, they stand at the very centre of institutional conflict'.*

Nearly fifty years later, the findings from this study have resonance with this observation by Strauss (1964). As discussed in chapter 3 differing professional ideologies influence how emergency care practitioners work together towards a common goal - the 'quick fix' required for patients attending, a 'quick fix' being needed to accommodate the constant stream of patients who access emergency services and secure the shape of the service. If patients are not rapidly moved through the service then the shape and associated negotiated order is not maintained. When patients become stranded (Sbaih 2002) staff in the A&E setting become increasingly stressed, as was evident from the nurses interviewed for this study. Young people who had self-harmed challenged the nurses' ability to maintain shape and were as a consequence, frequently a source of frustration, frustration also arising from the competing demands the nurses faced. These competing demands were further heightened by the 4-hour waiting time target (Department of Health 2000, 2001) and the requirement in accordance with NICE (2004) guidelines, to admit young people

who self-harm to a children's ward for an assessment by CAMHS. These administrative and clinical demands were made more challenging when young people's behaviour challenged the nurses ability to fulfil their clinical and administrative roles. Thus the findings of this study provide further evidence of the presence of and requirements for, a negotiated order, and have further illustrated the role the patient plays in influencing this negotiated order and the potential adverse impact this has on patients themselves (in relation to adverse judgements) should their presence and associated behaviour, disrupt this order.

CHAPTER TEN

CONCLUSION

10.1 Introduction

A nurse respondent (N011) in this study observed that self-harm is "a difficult concept to grasp", while another (P001) viewed the thought of self-harm as "horrendous". Both these comments encapsulate the complexities surrounding self-harm and practitioners' attitudes towards this phenomenon. As outlined in Chapter Four, individuals who self-harm or 'attempt suicide' have been more negatively judged than those who 'complete suicide' as attempted suicide is viewed as a 'non-serious' or a 'failed suicide' attempt (Stengel 1952, 1956, Stengel & Cook 1958).

This final chapter reviews and summarises the findings of the study and considers these in the context of the theoretical perspectives presented earlier in the thesis. The limitations of the study are noted and the implications of the research for policy and practice are discussed with future directions for research outlined. Finally concluding remarks are made, which bring the Chapter and the thesis to a close.

10.2 Summary of the Study and Findings.

The current study employed a mixed methods approach to address the following research questions:

i.   What are the attitudes of emergency care staff toward young people generally and young people who self-harm specifically?

ii.   Is there a relationship between emergency care staff attitudes towards young people generally and young people who self-harm specifically?

iii.   How does the practice of emergency care work as undertaken by nurses and paramedics influence attitudes towards and perceptions of young people who have self-harmed?

iv.   To what extent are the findings from the qualitative data consistent with the findings from the quantitative data?

Analysis of the survey data revealed a correlation between professionals' self-reported attitudes towards young people per se and their attitudes towards young people who

self-harm. Interestingly, the survey respondents' self-reported attitudes towards young people who self-harm were more positive than their attitudes towards young people generally. Findings from the qualitative data provide an explanation for this, as the data clearly suggest that young people's immaturity influenced the practitioners' attitudes towards young people who self-harm, with a prevailing view that young people were too immature to fully understand or appreciate the implications of their (self-harming) actions, actions which also included drinking alcohol to excess. This supports the view that age is a factor that influences attributions of controllability (Weiner 1980, 1986, Corrigan et al 2003) in respect of self-harm in young people.

The interviewees' descriptions of their own and others' reported reactions to young people who self-harm, had resonance with earlier debates and conceptualisations of the 'good' and bad' patient., and provided further insight into how the label of 'attention seeking' can be applied to some young people who self-harm. The 'good' young self-harmer was one who self- presented to emergency services, and engaged with staff and therefore 'presented their story'. In being proactive in seeking help (or attention), the young person's attendance was, paradoxically, more likely to viewed as a means by which a young person could express their need for help, their self-harm more likely to be viewed as a 'cry for help', whereas problematic young self-harmers were those who were difficult to engage, and those who repeatedly attend, usually with 'minor' or 'inconsequential' injuries or overdoses. The latter were more likely to attract derogatory comments, for example they were occasionally referred to as 'frequent flyers' and revolving doors'; they were also more likely to be seen as manipulative and rather than seeking out help, it was these young people who were more likely to be seen as attention seekers. It was recognised by the interviewees that lack of engagement might have manifested because young people per se can be reluctant to talk to adults, particularly adults they don't know, but reluctance to engage also occurred due to alcohol intoxication, which was also associated with aggressive and antisocial behaviour. This latter group of young people were often transported and moved through the service as quickly as possible, even when this contravened published guidelines.

The data also served to provide some explanation as to how the organisation of emergency care services themselves influenced attitudes towards young people who

self-harm. The survey data revealed that nurse respondents self-reported more negative attitudes towards young people who self-harm than their medical and paramedical colleagues. The qualitative data revealed the challenges that nurses faced in securing admission for young people who self-harmed, challenges that were exacerbated both by the tendency of young people to attend 'out of hours', the limited availability of support from CAMHS, and the reported reluctance of ward staff to receive a young person following self-harm due to perceptions about such young peoples' behaviours. These difficulties were compounded by the need to discharge patients from the A&E department within 4-hours of arrival. The paramedics' accounts did not reflect these tensions and difficulties, as organisationally they did not have to address them.

10.3   To what extent are the findings from the qualitative data consistent with the findings from the quantitative data?

As noted in Chapter Three the majority of studies that have set out to determine attitudes towards self-harm have employed quantitative methods, with the Suicide Opinion Questionnaire (SOQ) the most widely used tool for this purpose. In order to capitalise on the strengths of both quantitative and qualitative methods a mixed methods using a triangulation convergent approach was adopted for this study; this enabled me to use different data collection methods thereby allowing me to address the different aspects of the study - the attitudes of practitioners, their basis and how the organisation of emergency care work influences these attitudes.

Findings from analysis of the qualitative data support and extend findings from quantitative analysis of the survey data, particularly in respect of explaining the basis of attitudes. For example as discussed above, the qualitative data revealed the pressures and tensions inherent within A&E nursing practice which may partly explain why nurses had lower scores on the AYPSH scale as these tensions were not apparent in paramedics' work. The qualitative findings proved to be particularly illuminating, highlighting as they did, how the way in which young people respond and interact with the respondents as emergency care practitioners, influences whether the young people might be designated as potentially 'good' or 'bad' patients; the qualitative data therefore, providing some indication as to why some young people who self-harm might be more adversely judged than others.

The qualitative data did not though advance explanations on length of practitioner experience and its interaction with attitudes towards both young people and young people who self-harm. As discussed earlier in this thesis, Anderson et al (2005) found that people who had more daily contact with young people were more likely to have positive attitudes. The interviewees participating in this study all had regular exposure to young people through their respective occupational roles and did not overtly display what would be construed as negative attitudes towards young people, although as discussed in Chapter Nine, the interviewees' 'presentation of self' might be a factor in this. This lends some support to Anderson et al's (2005) suggestion that exposure, and thereby familiarity with young people, have an influence on attitudes both towards young people, and in the context of this study, young people who self-harm.

Some evidence of an interaction between gender and attitudes towards young people who self-harm was found in analysis of the survey data; male nurses were more likely to have self-reported positive attitudes towards young people who self-harm on the AYPSH scale than female nurses, a finding that has been noted in two other attitudinal studies which have surveyed nurses (Anderson et al 2000, Patterson et al 2008). However, although three of the seven nurses interviewed were male, it was not possible to determine whether (these) male nurses held more positive attitudes towards young people who self-harmed than their female counterparts and to that end the qualitative data did not advance further explanation or clarification on this interaction.

During the interviews perceptions of young people emerged which were based on the interviewees day-to-day contact with young people in the context of their professional role. Paramedics' accounts reflected their encounters with young people outside of the hospital setting; these accounts were detailed and descriptive, providing insight into young people's behaviour within the context of excessive alcohol consumption. Indeed overall the interviewees' conceptualised alcohol intoxication as a self-harming behaviour. This was unanticipated, and thus questions relating to perceptions of the link between alcohol and self-harm as well as young people's behaviour in respect of alcohol are not addressed in the survey component of the study.

As discussed in Chapter Four of this thesis, concerns about young people's excessive alcohol consumption have been expressed, although the extent to which these concerns are accurate is contested (Newburn & Shiner 2001). A link between self-harm and alcohol consumption is apparent (Evans et al 2004), however, the most widely adopted definition of self-harm and therefore the one used for this study, does not explicitly include excessive alcohol consumption as a self-harming behaviour. Moreover previous studies that have examined attitudes to self-harm have not included statements relating to alcohol consumption. This is an important consideration for future research given the findings of this study and how perceptions of attribution of controllability (Weiner 1980, 1986, Corrigan et al 2003) influence attitudes.

10.4   Limitations of the Study

The response rate to the survey was comparatively low (24%) when compared to some earlier studies which employed a survey approach (Anderson et al 2000, Crawford et al 2003, Friedman et al 2006, Anderson & Standen 2007, McCann et al 2007, Patterson et al 2007, Sun et al 2007, Conlon & O'Tuathail 2010), although with the exception of two studies (Anderson & Standen 2007, Patterson et al 2007) the number of respondents in the survey component of the research undertaken for this thesis is greater than other studies reported on in the literature review. Nine different NHS sites were selected for the survey element of the study; the low response rate is more notable amongst LAS practitioners, who were distributed across five complexes. Many of the aforementioned studies that had higher response rates had surveyed smaller numbers of practitioners in single locations (e.g in one emergency department).

Participants in the interviews were drawn from the ambulance service and a children's A&E department. The inclusion of medical staff as interviewees would have been useful, particularly in terms of their potential views on the organisational and ideological basis of emergency care work. The views of young people would also have added to the study; however circumstances precluded the planned inclusion of either doctors or young people.

For the purpose of data analysis it would have been useful to examine the survey responses of those interviewed (or administer the questionnaire prior to the interview if they had not previously responded to the survey). This would have provided an opportunity to more closely examine the extent to which attitudes, as self-reported in the survey, were reflected in the interviewees' accounts, thereby more closely integrating the mixed methods data collection and analysis. However this would have removed the anonymity of the survey respondents who volunteered for interviews and given the challenges of recruiting practitioners for the interviews, this might have been off-putting and could have further diminished the number of interviewees willing to take part.

10.5   Implications of the Research Presented in this Thesis.

10.5.1   Implications for Theory Development

This thesis has drawn on Strauss et al's (1964), concept of the hospital as a negotiated order, a perspective that has latterly been applied to the organisation of hospital A&E services (Sbaih1997a&b 1998a&b, 2001, 2002). As the fundamental premise of emergency care work is the rapid assessment of patients' needs, categorisation is an essential element of this work. This thesis therefore also draws on the sociological theories which have examined the categorisation of patients as 'good' or 'bad', as earlier sociological work has clearly demonstrated that practitioners working in emergency services judge patients based on their reasons for accessing the service (Roth 1972, Jeffery 1979, Dingwall & Murray 1983); patients who self-harm are amongst those adversely judged. However the extent to which these categorisations extend to young people was not wholly clear. Findings from earlier research that had considered this were inconclusive and inconsistent (Dingwall & Murray 1983, White 2002).

Drawing on Strauss and Sbaih's work was useful in terms of providing a theoretical context for accident and emergency work. The findings of the study confirm that nurses in particular are concerned with the maintenance of 'shape', playing a fundamental role in directing care. The findings also further illustrated the tensions that exist in the process of maintaining shape, and how factors out with nurses direct control, for example, 4-hour targets, availability of access to and support from

CAMHS and the need to admit to an inpatient bed on a children's ward, distort the shape, and as a consequence influence attitudes of nurses. Thus a negotiated order perspective remains a relevant lens through which to analyse and explore the organisation of hospital services and specifically the work of the A&E department.

Sbaih (1997a&b, 1998 a&b) did not examine the extent to which pre-hospital care influenced shape; by drawing on the perspective of paramedics this study has provided some insight. Overall it would seem that paramedics have little influence on the maintenance of shape, and that shape in the context of ambulance services is potentially more 'flexible', although further empirical work is needed to advance understanding of the interrelationship of both services in the context of shape.

It is evident that young people who self-harm have potential to disrupt the negotiated order of the hospital as an organisation, a factor that Strauss et al (1964) alluded to, as adolescents, when admitted to the (adult) psychiatric wards, distorted shape. Although Strauss et al (1964) did not address the disruption that adolescents caused in any detail, it is evident that it was because they were misplaced – young people on an adult ward. The findings of this study demonstrate that placing young people as inpatients remains challenging, due to their ambiguous status, neither children nor adults.

Previous work that has looked at patients' categorisation as 'popular' and 'unpopular', 'good' and 'bad, has largely ignored children and young people. The exception to this, Dingwall & Murray's (1983) work, suggested that due to 'innate preciousness' children are allowed to break the rules. However it is unclear from Dingwall & Murray's (1983) study as to whether innate preciousness transcends childhood and adolescence as no particular distinction is made, although the case of the 'young pretender' (see page 53) indicates that innate preciousness does not extend to young people. Generally, theorising on popular and unpopular patients has not explicitly considered whether the age of patients influences categorisations and associated judgements. This study, drawing on conceptualisations of how young people's behaviours are framed has added to this body of knowledge. Findings from this study indicate that age is a factor that, in respect of attitudes towards self-harm, ameliorates negative evaluations of these young people as patients. Thus when conceptualising

'good' and 'bad' patients, researchers need to take accounts of age and given the ambiguity of adolescence (see 10.8), further empirical work, which explores perceptions of young people and their behaviours and how these are framed, is warranted.

The findings also confirm that it is not a diagnostic label that influences how patients are categorised and indeed judged, instead it is patients' behaviours, and as found previously (Kelly & May 1982) it is the impact that patients behaviours have on the ability of practitioners to effectively fulfil their role, which is key in determining whether a patient is adversely judged or not.

As discussed in Chapter 3, the proponents of the sociology of childhood do not distinguish between children and adolescents as they view age as a categorical unit as unhelpful in the study of childhood and adolescence. However generally within society such distinctions are made and as Moran-Ellis (2010:186:) notes:

> *In the early stages of childhood studies there was a synchrony between the orientation of the new social studies of childhood in the UK and changes in how children came to be politically positioned, particularly with respect to an emphasis on children's voices, their capacity to be agentic and their status as social actors. Since then the political status of childhood has become more problematic. In the last few years there has been a notable shift towards the demonization of teenagers (adolescents) along with rising levels of anxiety concerning children generally. This represents something of a divergence between the orientations of UK policy and politics and contemporary orientations of the sociology of childhood.*

Although young people are, like children, becoming adults, childhood is distinct from adolescence. Arguably proponents of the sociology of childhood need to more explicitly orientate their research and resultant theory towards children and childhood, adolescents and adolescence, acknowledging the difference, as adolescence brings differing and unique challenges that require further understanding, self-harm within adolescence being a case in point.

Moreover, the perspective of proponents of the sociology of childhood, while helpful in drawing attention to children as beings rather than becoming (adults) who possess agency, is somewhat limited, as despite some recent recognition of heterogeneous childhoods, empirical work within this discipline does not generally consider issues of social class, ethnicity, sexuality, disability and gender in children's lives (Moran-Ellis 2010). These 'issues' have a considerable bearing on children's status as social actors and their capacity to be agentic, affecting choices they make, which in turn may influence whether they self-harm. Moreover having agency suggests that young people who self-harm may choose to self-harm, and while for some this might be a choice, for many young people self-harm is an expression of distress, with young people identifying that they have no alternative way of expressing their 'hurt' (Brophy 2006).

10.5.2   Implications for Children & Young People

Earlier research (Hawton & Rodham 2006, Fortune et al 2008, Hawton et al 2009) has clearly indicated that young people's reluctance to access hospital services following self-harm arises due to their fears of repercussions. The nurses and paramedics interviewed for this study were themselves sensitive to both the motives and risk factors for self-harm in young people as well as young people's fear of the consequences. Although not expressed as such by participants, this fear of the consequences and associated lack of control and choice, may reflect these young people's lack of agency following an episode of self-harm which, whether through choice or not, has by virtue of engagement with emergency services, become 'public' knowledge. Young people's concerns about the repercussions added to the interviewees' perceptions of vulnerability in young people who self-harm and are a factor, along with their associated immaturity which ameliorates negative attitudes.

Hawton et al (2009) recommend that prevention programmes should be school based, and should include screening for adolescents at risk, as well as using the media to educate young people about psychological problems and help-seeking. In light of the findings of the research reported in this thesis such programmes should also reassure adolescents that health professionals working in hospital paediatric services are increasingly understanding of young people's self-harming behaviours. School based prevention programmes could facilitate young people in reflecting on how both their

own behaviours and attitudes towards health care professionals can influence others' perceptions of themselves as young people, including their own adverse behaviours, particularly when drunk. Indeed further research about young people's perceptions of and attitudes towards health care practitioners, and how these influence their health seeking behaviours in respect of self-harm is warranted.

10.5.3   Implications for (Paediatric) Urgent & Emergency Care Practice

Findings from research reported in this thesis suggest that the care of young people who self-harm is an increasingly routine element of paediatric emergency care practice. As outlined in Chapter Two 'routine work' is contrary to the expectations and shared professional ideologies of practitioners who work in emergency care and who value the unpredictable nature of emergency care work and the challenge of managing and responding well in an emergency situation. Consequently, the focus of emergency care work is on responding rapidly and providing physical care, as physical care can be delivered rapidly, providing a 'quick fix', prior to moving the patient on through the service. However the nature of young people who self-harm is that they do not facilitate a quick 'fix', thus (A&E) nursing staff encounter difficulties in 'moving these young people on'.

The reported views of ward staff and the perceptions of A&E nurses themselves that a children's ward was not a suitable location for young people who self-harm impeded the discharge of young people who self-harm from the A&E department. This delay in discharge was both caused and compounded by limited availability of, and access to CAMHS. This failure to 'move young people on', resulted in distortion of 'shape' thereby threatening the negotiated order of the department, a negotiated order that is now also framed by the requirements to see, treat and discharge within 4-hours, the resulting pressures not previously a feature of the organisation of emergency care work discussed in Sbaih's (2001, 2002) earlier studies.

The 4-hour target places pressure on nursing staff when young people who self-harm present, particularly when their presentation is 'out of (CAMHS) hours'; as with the respondents in Sbaih's (2001, 2002) study, the interviewees who participated in the research reported in this study, described strategies that they employed in an attempt to expedite the discharge of young people who self-harm from the department. These

strategies included transporting (to hospital) young people who were likely to be problematic more quickly, attempting to gain rapid admission (often unsuccessfully) to the children's ward and attempting to bypass guidelines which recommend admission when this is either not judged as necessary, or is not viewed as appropriate in terms of admission to an acute inpatient paediatric setting.

Nurses' accounts in the interviews clearly indicated their frustration about lack of access to CAMHS; had nurses been able to access appropriate mental health consultation within the A&E department it is possible that alternative destinations including discharge home, would have been forthcoming (and more timely), which might have assisted the nurses in the maintenance of the negotiated order and associated 'shape' of the department. It is though worth noting that this would be contrary to the NICE guidelines which recommend that assessment by a healthcare professional experienced in assessing adolescent self-harm be undertaken the day following admission (National Collaborating Centre for Mental Health 2004:30).

In order to improve the care the young people receive children's nurses should, in line with the NICE guidelines

> *'be trained in the assessment and early management of mental health problems and, in particular, in the assessment and early management of children and young people who have self-harmed'* (National Collaborating Centre for Mental Health 2004:29).

The effectiveness of this training should be evaluated in relation to A&E waiting times for young people who self-harm, and the appropriateness of onward referrals, drawing on current hospital data for comparisons. Feedback from young people as service users should also be collected as part of this evaluation, and in particular this feedback should determine whether the interaction with children's nurses during the initial assessment and early management of their self-harm has promoted their ongoing participation and engagement with health services in order to better manage their self-harming behaviours.

A key factor in rendering admission to a children's ward difficult to negotiate was the association between aggressive and abusive behaviour of young people who self-

harm, this behaviour often associated with inebriation. Fernandes (2011) reports that between 2002 – 2007 the number of admissions for young people under the age of 18 due to drinking increased by 32%, with underage alcohol related hospital admissions costing £19 million nationally in 2007/08, but despite this, the monitoring of alcohol related attendances and advice with support for young people to modify their harmful drinking is inconsistent (Fernandes 2011:28). As noted above, the findings of this study indicate some ambiguity in terms of practitioners' attitudes towards alcohol use by young people, thus it is recommended that training also considers and reviews practitioners' values and attitudes towards alcohol use in young people. It is also recommended that paediatric services in secondary care settings work collaboratively with colleagues in CAMHS and young people who have accessed services, to determine how best to present advice relating to harmful drinking behaviours. The effectiveness of such advice and the most appropriate point of delivery should be evaluated in future research.

The frustration and isolation experienced by practitioners working in emergency services needs to be addressed as a priority. In order to do this, the skill mix of A&E departments would need to have the resources to include staff with a background in CAMHS. Alternatively, CAMHS could be extended to include provision of out of hours emergency care, and as one paramedic interviewee hoped for, a separate service for those who have mental health emergencies as opposed to 'physical/physiological' crises. The financial climate at the time of writing this thesis means that this kind of service development is unlikely to occur, but as Fernandes (2011) observes,

> *"Silo" thinking has to change if we are to capitalise on the interdependencies between health, social care, self-care and the third sector to provide an urgent and emergency care system that is more joined up and seamless for patients* (Fernandes 2011:6)

It is though imperative that practitioners working in emergency services have more ready access to support from CAMHS. Given the developments in technologies including telemedicine both in emergency medicine and mental health (Currell et al 2000, Norman 2006, Richardson et al 2009) this might be an option to explore, as support could be more readily available, albeit remotely. However as Currell et al (2000) advise, employing such technologies would require practitioners to develop

different clinical skills, particularly in relation to communication and information giving, and the use of telemedicine would alter the dynamics of the professional-patient encounter. Consequently any such adoption would need to be closely monitored and evaluated, including an economic costing evaluation, as well as consultation and evaluation with young people to determine how appropriate this approach to assessment is for their specific needs.

10.5.4   Implications for Policy & Practice

The organisational needs of the A&E department where the nurse interviewees worked were themselves influenced by government policy/targets and frameworks that aim to improve patient care. First and foremost are the targets on A&E waiting times (Department of Health 2001, 2003a) which apply to all patients attending, but also of relevance to this study are the NICE (2004) guidelines pertaining to the short term physical and psychological management of individuals who self-harm (NICE 2004), which form part of the National Suicide Prevention Strategy (Department of Health 2002, Her Majesty's Government 2011). There is a tension between one set of guidelines (Department of Health 2003a) which require staff to assess, see, treat and discharge within 4-hours, and another (the NICE Guidelines) which require young people who have self-harmed to be admitted overnight in order to have a full psycho-social assessment the following day (National Collaborating Centre for Mental Health 2004: 29). As discussed above, analysis of qualitative data revealed the difficulties nurses faced in terms of discharging young people who self-harmed within 4-hours, as well as the perceived lack of support from colleagues on the in-patient paediatric ward and CAMHS. As noted earlier in this thesis (see section 3.6), this tension is exacerbated by the aforementioned lack of clarity about young people aged 16 – 17 years of age as per the NICE guidelines (2004). As a consequence the nurses interviewed reported that occasionally they employed measures to circumvent guidelines. Indeed the quantitative data revealed that doctors and nurses reported relatively low use of the guidelines, despite reporting that their departments had guidelines and that the same nurses and doctors had awareness of their content.

Arguably the blanket adoption of guidelines needs to be challenged, and the need for practitioners to use their professional judgement sanctioned and supported. Practitioners need to be empowered to this end, although decisions made need to be

clearly documented with a sound rationale unambiguously recorded for any decisions out with guidelines. Thus for example, although the 2004 NICE guidelines recommend overnight admission prior to a psychosocial assessment the day following the self-harm event, it is quite possible that admission is not always warranted. Moreover, the cost/benefit of admission of a young person to an inpatient paediatric ward[26] needs to be considered. Further research should evaluate the economic costing of admission to inpatient paediatric beds for young people who self-harm, particularly (according to the nurses interviewed in this study) given that these admissions would seem to frequently occur at weekends, with young people often waiting longer that 24 hours to be assessed, due to the lack of availability of CAMHS.

Where the need for admission is 'clinically' indicated, ideally this would be to a dedicated adolescent inpatient unit/ward, as it is now widely recognised that hospitalised young people have distinct needs that are different to children's, including the needs for privacy, independence and psychosocial support. (Royal College of Paediatrics and Child Health 2003, Royal College of Nursing 2003 Department of Health 2004a, Dodds 2010). However, given that these units are not universally available and certainly not in the area where this study was conducted, it is important that staff working in both emergency care services and acute inpatient paediatric services receive education and training which addresses the specific needs of young people who self-harm; in so doing the education and training should address staff's values and attitudes and where appropriate, the education and training should challenge any entrenched and inappropriate perceptions and attitudes.

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[26] Similarly where admission to inpatient adult psychiatric wards does occur the same applies, although it is generally recognised that admission to these settings is not appropriate.

10.6   Future Directions for Research

In light of findings from the current study future work might also look at the views of doctors, and staff working on inpatient paediatric wards. This latter group are particularly important given the reported reluctance of ward staff to accept young people who self-harm on to the ward and the impact this has on the 'maintenance of shape' in the A&E department. The inclusion of these staff as well as young people in future work would potentially provide further corroboration to findings reported in this thesis and might indicate the extent to which young people's experiences of emergency care following self-harm, influence their future health seeking behaviours, specifically in terms of gaining longer term support for these behaviours. This is particularly important given the emphasis placed on suicide prevention and the role of A&E departments in promoting a positive environment (Department of Health 2002).

As discussed above, interviewees reported that, in their experience, young people could be fearful of the consequences of their self-harm in terms of the possible implications for them and their families. This 'fear' was couched in terms of 'fear of authority'. This was a perception of some of the interviewees, which, if accurate, might suggest why young people who self-harm do not engage with or access health services. Future research involving young people would aim to address how young people view health care practitioners, as indeed young people themselves may hold attitudes, based on (inaccurate) stereotypes of health care practitioners, which may influence their initial and on-going (self-harm) health/help seeking behaviours.

Finally further research which examines attitudes towards self-harm from both a service user and a practitioner perspective, should include alcohol as an element of self-harming behaviour so that further understanding might be gained of how excessive alcohol consumption influences perceptions of self-harm and self-harming behaviours, and whether the presence of inebriation in association with overdose or self-injury affects perceptions of controllability and thus attribution of responsibility and control (Weiner 1980, 1986, Corrigan et al 2003).

10.7 The Ambiguity of Adolescence

Given that self-harm as a behaviour has historically been judged pejoratively, it might be expected that the respondents to the survey would have self-reported more negative attitudes towards young people who self-harm than they would towards young people in a general sense, however this proved not be the case with, as noted above, more positive attitudes towards young people who self-harm evident.

As briefly discussed earlier in this thesis (see page 50), ambiguity in relation to attitudes towards young people was noted in Anderson et al's (2005) study, and is similarly reflected in the findings of the research reported here, with contradictions evident within and between both data sets. For example, the survey data indicated that participants perceived, on the one hand, that young people's behaviour is worse today than it was in the past, but conversely, young people were also largely seen as helpful and friendly. Similarly in the interviews young people were seen to be both potentially problematic due to their reported aggressive and disruptive behaviour and propensity to be drunk, whilst vulnerable due to their immaturity.

It is proposed that the ambiguity evident in the perceptions of young people and young people who self-harm by those participating in this research reflect the ambiguity of adolescence itself - neither adult nor child. This is reflected in the interviewees' accounts, which identify that while self-harm in young people might be 'a difficult concept to grasp', young people's age and associated or perceived immaturity provided to the interviewees in this study a reason for not holding young people responsible for their self-harming behaviours. As a consequence they are less adversely judged than an adult might be. This is also exemplified in the interviewees' attitudes towards young people's use of alcohol. While young people's inebriation may cause problems for both paramedics and nurses, there is similarly a viewpoint that young people don't appreciate the implications of drinking to excess, just as young people don't appreciate the potential harm and consequences of their self-harming behaviour.

The ambiguity of adolescence as a life-stage is also reflected in policy which guides both the delivery of emergency care of children and young people (Royal College of

Paediatrics and Child Health 2007, 2011) and the short-term physical and psychological management of young people who self-harm (National Institute of Health and Clinical Effectiveness 2004), and which, as outlined in Chapter Three, is inconsistent in defining when eligibility for paediatric services ends, and in the case of self-harm, where 16 – 17 year olds fit. Arguably these inconsistencies in health policy and guidelines further exemplify the ambiguity surrounding adolescence as a life-stage.

The attendance policy in the department where the nurses who participated in the interviews worked, allowed for attendance of young people up to the age of 17, thus the 16 – 17-year olds who attended following self-harm were treated and managed as 'paediatric patients'; the nurses interviewed in this study reported that it was these patients that presented particular difficulties in terms of admission (see page 220). This was further compounded by the fact that while, or indeed because, these 'paediatric patients' were managed in accordance with the NICE (2004) guidelines, the specific challenges they posed meant that it was frequently difficult for the nurses to secure admission within the 4-hours as per the government target; failure to meet this target and the pressure it added was apparent in the nurse interview accounts, and also partly explain why these young people were perceived as "heart sink patients" with a sense of *"being stuffed before you start"* (P010) articulated by one respondent.

Thus it is the ambiguity of adolescence, which, it is proposed, has a significant influence on the care that young people who self-harm receive from emergency services. This ambiguity both shapes practitioners' attitudes and directs young people's pathways through services, pathways that might not always be appropriate to a young person, given their unique developmental stage. These at times inappropriate pathways, i.e. attending a minor injury or emergency department which is geared up for managing and treating physical illness and injury, when presenting with a psychological problem, in turn influence practitioners' attitudes towards young people who self-harm, and thus arguably it is the nature of the service, the policy and guidelines which direct these, which have a key bearing on attitudes, and as with the (historical) debates about inappropriate attendances in A&E, it is the service that is inappropriate, not the [self-harm] patient (Murphy 1998b).

10.8   Concluding Comments

The main aims of this thesis were to explore the attitudes of emergency care staff towards young people (aged 12– 18 years) who self-harm and to gain an understanding of the basis of attitudes that might exist. These aims have been achieved.

The findings from the research presented in this thesis have extended existing knowledge of practitioners' attitudes towards young people who self-harm, providing as they do an insight into how young peoples' immaturity, perceived lack of choice and thus agency, contribute to the framing of young people as vulnerable, thus their self-harming behaviour is less adversely judged.

The ambiguity of adolescence as a life-stage is reflected in the attitudes and perceptions of the practitioners who participated in this study, and is also reflected in the inconsistency in how the emergency care needs of young people between the ages of 16 – 18 years generally, and young people who self-harm specifically, are addressed in health policy and guidelines. This inconsistency places additional burdens on emergency care practitioners when caring for young people who self-harm, as they attempt to maintain the negotiated order and retain shape. These inconsistencies need to be addressed so that, inline with the QIPP urgent care work stream (Department of Health 2011), emergency services can *"maximise the number of instances when the right care is given by the right person at the right place at the right time for patients"* (Fernandes 2011: 17).

Lastly it is evident that, in the context of caring for young people who self-harm, practitioners working in the emergency care settings studied, maintain humanity against difficult circumstances. Young people who self-harm may present challenges (to the system), but, in relation to their self-harm, they are not held responsible. Self-harm is seen as an emotional response, a cry for help and a response to the challenges that are associated with the wider demands placed on young people, as they emerge into adulthood.

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APPENDIX 1

Summary of Previous Studies and Measures /Variables Explored which Influenced the Design of Survey Instrument used for this Study.

Author / Date	Study Aims	Study Design	Sample	Data Collection Tool	Key findings/variables explored	Comments
Anderson (1997)	Explore and compare attitudes of CMHN & A&E nurses	Survey	40 CMHN & 40 A&E Nurses. 66 Nurses responded 33 from each group.	SOQ	Both groups held generally positive attitudes. A&E nurses with more experience had more positive attitudes. Older CMHN's had less positive attitudes. Suicidal behaviour acceptable in response to an incurable illness. Tended to disagree that SH patients were mentally ill. Pt s need specialised care and services. Suicidal behaviour seen as a form of communication	Discussion speculative as has not explored the background to attitudes, thus for example supposes that length of experience might influence attitudes because nurses have had experience of caring for more patients who self-harm. Sample limited to one A&E dept and one CMHN team. Not specific to YP
Anderson, et al (2000)	Identify the attitudes of nurses and doctors. towards suicidal behaviour in young people	Survey followed by Qualitative interviews	Drs & Nurses from one DGH - 33 participated 10 MHN 7 ADN 5 lecturers 4 psychiatrists, 6 physicians 1 HCA	SOQ followed by 8 interviews using SOQ headings as a guide.	No significant difference between groups in terms of profession and age. More experienced more likely to see SH as normal behaviour. Females less likely to see SH as a cry for help. Not necessarily a MI dependent on symptoms. Nurses more likely to see SH as attention seeking but also cry for help - a distinction is made. . SH seen as more as impulsive act esp. female overdoses.	Doesn't state who participated in interviews (by occupation) Focus on sexual abuse emerged in discussion - not clear why. Some discussion of SH in the context of young people - but minimal. *Specific to young people.*

Author / Date	Study Aims	Study Design	Sample	Data Collection Tool	Key findings/variables explored	Comments
Anderson, &. Standen (2007)	Investigate attitudes towards suicide among nurses and doctors who work with young people who SH	Survey	230 questionnaires distributed, 179 responded. One A&E, 2 Paed medical units and 2 adolescent inpatient units.	SOQ	Suicide perceived as reflecting mental illness - behaviour often represents a cry for help; less likely to see it as a morally bad action. for the main effect of professional group only the scores for Mental Illness were statistically different between nurses and doctors, with doctors scoring higher than nurses. Both nurses and doctors expressed disagreement with the argument that suicide may be more acceptable in older people. They also indicated that they would regard suicide as a normal behaviour and do not see it as a puzzling phenomenon in young people.	Focuses on self-harm but doesn't fully explore within context of young people. Doesn't examine differences within occupational groups only between despite good sample size. *Specific to young people.*
Anderson, et al (2003)	Exploration of perceptions of SH in YP (amongst nurses and doctors working in A&E)	Grounded theory	45 nurses, doctors working in A&E, paed medicine, and CAMH. (29 of participants were in A &E)	Semi-structured interviews based on SOQ clinical scales.	Based on perceptions of their relationships with young people. Main area was frustration, lack of time and resources, Barriers in relationships identified. Identified need for E&T as YP who SH need specialist skills. Difficult to judge young people's competency thus their choice in taking life questioned more than adults.	Age group not explicitly specified but possibly 11-16 yrs. This part of a wider study and data set also reported on by Anderson et al spanning 2003-2007. *Specific to young people*

Author / Date	Study Aims	Study Design	Sample	Data Collection Tool	Key findings/variables explored	Comments
Crawford et al (2003)	Investigate: knowledge and attitudes concerning SH in adolescents; and training needs of staff	Survey	126 psychiatric and non-psychiatric nurses (n= 68) and doctors (n=39) from teaching hospitals in South London.	Own tool specifically devised.	Knowledge tested with mean score of 60%, lacked awareness of LGBT and Sexual abuse as a risk factor, or increased risk of suicide. Staff who felt effective felt less negative with 42% identifying need for further training. Doctors more knowledgeable than nurses (Stat sig), psychiatric higher than non-psychiatric nurses but not different amongst doctors. Generally low level of negativity towards YP who SH. Need for training identified.	A&E departments had good close links with CAMH - which was proposed might influence lower levels of negativity and higher knowledge scores but qualitative data not available to support this - not clear what the findings from the qualitative were as not reported on not where the qualitative data was - presumably comments on questionnaire. *Specific to young people*
Conlon & O'Tuathail (2012)	To measure nurses' attitudes to- wards deliberate self-harm	Survey	87 Nurses across 4 A&E depts in Ireland	Self-Harm Antipathy Scale (Patterson et al.)	Nurses showed slightly negative antipathy indicating positive attitudes. Attitudes were significantly different in accordance with a nurse's age. Education and social judgment also contributed to the way nurses view interact and make moral decisions regarding self-harm patients. .	Makes recommendations for improvement in the training, supervision and support of nurses caring for patients who self-harm, and that practical strategies should be implemented to manage the alienation process and inform practice

Author / Date	Study Aims	Study Design	Sample	Data Collection Tool	Key findings/variables explored	Comments
Dickinson et al (2009)	Not stated - implied by title: The attitudes of nursing staff in secure environments to young people who self-harm.	Mixed methods	60 RN's & Nursing aides	Survey using Patterson's SHAS. Interviews	No significant differences in scores between Nursing aides and RN's. Correlation with SH education and positive attitudes. Females more positive than males.	8 themes emerged from qualitative analysis but limited/no detail on the participants or how the data was analysed and thus the themes emerged.
Friedman et al (2007)	To investigate the attitudes of accident and emergency (A&E) staff towards patients who self-harm through laceration	Survey	117 questionnaires distributed to A&E staff in Leicester RI– RR 54% (n=70).	Questionnaire developed following focus group methodology	The staff believed that self-laceration was an important problem but felt unskilled in managing patients. They were unsure of the relationship between self-laceration and both mental illness and risk of suicide. They had previously received little training in managing SH In those staff without previous training, a longer period working in A&E was correlated with higher levels of anger towards patients and an inclination not to view patients as mentally ill. A&E staff were keen for further training and wanted a higher proportion of patients to be seen by specialist mental health services.	Only focuses on self-laceration. Limited analysis and information on study population characteristics in terms of age and length of experience, despite the conclusions drawn. i.e. – 'Despite considerable experience in the field, we found evidence for unhelpful attitudes amongst some staff. This is particularly true for more senior staff without previous SH training, who, as a group, were less sympathetic to this group of patients'.

Author / Date	Study Aims	Study Design	Sample	Data Collection Tool	Key findings/variables explored	Comments
Ghodse (1978)	Explore the attitudes of casualty staff and ambulance personnel towards drug-overdosed patients	Survey	1350 questionnaires distributed, 92% RR (n= 1248). 669 nurses, 212 ambulance staff, 189 Drs and 153 other casualty staff i.e. porters.	Hypothetical overdose patient, accidentally, addiction or suicide. Analysed using correlation matrices	Pts who take an overdose accidentally are regarded more favourably than those who do so deliberately in a suicide attempt, who in turn are viewed more favourably than those who overdose in the course of drug addiction.	Although not conceptualised as attribution theory findings have resonance with theory of attribution and controllability. Only study located that included ambulance personnel.
Hadfield et al (2009)	How A&E doctors respond to treating people who self-harm.	Interpretive Phenomenology	5 A&E doctors	Open - semi structured interviews	Three main themes were extracted: treating the body, silencing the self, and mirroring cultural and societal responses to self-harm. Within these themes, both facilitative and unhelpful aspects of the relationships between people who self-harm and A&E doctors were identified	Not specific to an age group. supports aspects of lacking in expertise.

Author / Date	Study Aims	Study Design	Sample	Data Collection Tool	Key findings/variables explored	Comments
Law et al (2009)	To explore the way healthcare and non-healthcare students think and feel about adolescent self-harm behaviour	Survey	184 final year students from 2 HEI's in England studying medicine, nursing, psychology and physics.	Two hypothetical Vignettes, drawing on Corrigan et al's Attributional model of public discrimination.	Consistent with the public discrimination model, students who believed that a young person was responsible for their self-harm reported higher feelings of anger towards them. Anger, was associated with a belief in the manipulatory nature of the self-harm and with less willingness to help. Perceived risk was found to be associated with higher levels of anxiety and increased support for the use of coercive and segregatory strategies to manage self-harming behaviour. Gender and student type were important influences on public stigma, with both men and medical students reporting more negative attitudes towards self- harm.	Medical student displayed significantly more negative attitudes and therefore propose that they would be more likely to endorse discriminatory behaviour, but difficult to confirm this from such a study. The context of young people not explored and the relationship between the sample group and their age and the age of the YP in the vignettes not discussed.

Author / Date	Study Aims	Study Design	Sample	Data Collection Tool	Key findings/variables explored	Comments
Mackay & Barrowclough (2005)	Hypothesis - staff who attribute precipitants of the act of SH as controllable, internal, and stable patient factors, display greater negative affect, less optimism, and less willingness to help the patient.	Four hypothetical scenarios in a two-factor between-subjects design, contextual factors describing a self-harm patient were manipulated.	89 A&E medical and nursing staff across 4 A&E departments.180 questionnaires originally distributed 49% response rate.	Questionnaire using Weiner's attributional model of helping	The greater attributions of controllability, the greater the negative affect of staff towards the person, and the less the propensity to help. The higher the ratings of stability of outcome, the less staff optimism for the success of their input. Male staff and medical staff had more negative attitudes, and medical staff saw less need for further training.	Excluded agency staff - not sure why. No differences according to profession. Notes that the age of the patient might be a factor in attributing controllability but does not explore this within the discussion or as part of the research.

Author / Date	Study Aims	Study Design	Sample	Data Collection Tool	Key findings/variables explored	Comments
McAllister et all (2002a)	To develop and test a scale to identify relevant dimensions of ED nurses' attitudes to clients who present with self-injury.	Survey	Following an initial pilot, a survey of nurses working within 23 major public and 14 major private EDs in Queensland, Australia (n = 1008). 352 questionnaires were returned (35% response rate).	ADSHQ	Analysis revealed four factors that reflected nurses' attitudes toward these clients. The factors related to nurses' perceived confidence in their assessment and referral skills; ability to deal effectively with clients, empathic approach; and ability to cope effectively with legal and hospital regulations that guide practice. There was a generally negative attitude towards clients who self-harm. Correlations were found between years of ED experience and total score on the ADSHQ, and years of ED experience and an empathic approach towards clients who deliberately self-harm.	Relatively low RR and authors acknowledge that there was missing data in the data included. Only focuses on self-injury.

Author / Date	Study Aims	Study Design	Sample	Data Collection Tool	Key findings/variables explored	Comments
McCann et al (2006)	Do A&E nurses have positive or negative attitudes and to assess influence of age, length of experience and E&T	Survey	Convenience sample of 43 A& E nurses	Modified SOQ based on McLaughlin's adaptation.	Attitudes varied between undecided and somewhat supportive. Strongest level of agreement with therapy. Unaware of link with repeat SH. Older and more experienced nurses had more positive attitudes. Nurses who had attended education had more positive attitudes.	Same data set as study below. Similar findings reported.
McCann et al (2007)	Investigate nurses' attitudes towards patients who SH and their attitudes towards, and triage and care decisions with, these patients	Survey	43 nurses from 1 large hospital in Australia	A modified version of the SOQ	Most nurses had received no educational preparation - over 20% claimed that the department either had no practice guidelines or they did not know of their existence. One-third who knew of them had not read them. Overall, nurses had sympathetic attitudes including both professional and lay conceptualisations of SH They did not discriminate in their triage and care decisions.	Not specific to YP. Uses the scenario. Nurses in sample were relatively inexperienced.

Author / Date	Study Aims	Study Design	Sample	Data Collection Tool	Key findings/variables explored	Comments
McCarthy & Gijbels (2010)	To examine ED nurses' attitudes towards individuals presenting with DSH, including the relationship between attitudes and age, academic achievements, length of experience, and self-harm education.	Survey	71 nurses working in 1 trauma centre in Ireland	Amended version of McAllister's et al's Attitude Towards Deliberate Self-Harm Questionnaire (ADSHQ).	The nurses held positive attitudes towards individuals presenting with DSH. No correlation was found between total scores and gender, ED experience, or a history of self-harm education, although older nurses and hospital trained nurses had less positive attitudes. Age and length of clinical experience produced a trend in which attitudes increased, reached a peak and then declined.	Rationale for not surveying all staff in the trauma centre not given.
McKinley et al (2001)	To examine relationship between nurses' attitudes and social pressures to determine caring types of behaviour.	Survey	74 RGNs working acute medical admissions and A&E	Reasoned action theory using two vignettes one positive and one negative	Nurses' own attitudes, and what they believe about the attitudes of others, predict their behavioural intentions towards self-poisoning patients. The study also shows that nurses with a more positive orientation towards self-poisoning patients differ in behavioural and normative beliefs from nurses who have a less positive orientation. More positive more prone to value emotional involvement and valued working with these patients.	No discussion of whether any differences between the two groups of nurses. No information about sample and how selected provided. Discussion focuses on theoretical aspects of reasoned action etc. Limited to self-poisoning patients.

Author / Date	Study Aims	Study Design	Sample	Data Collection Tool	Key findings/variables explored	Comments
McLaughlin (1994)	To investigate if casualty nurses have positive or negative attitudes and to ascertain if age or length of experience influence attitudes.	Survey	95 (out of 142) casualty nurses across Northern Ireland (4 health boards)	Modified SOQ and 4 hypothetical patients where nurses were asked to assess priority	Generally positive attitudes. Older nurses and those with more experience have more positive attitudes. Nurses more likely to prioritise chest pain than overdoses	Questions whether experience and age means that these nurses have cared for more suicidal patients.

No detail is given on the hypothetical cases, and no emphasis is placed on this other than passing reference in conclusion. |
| Patterson etal (2007) | To develop an instrument for assessing nurse attitudes towards self-harm (Self-harm antipathy scale (SHAS) | Survey | 153 health professionals attending post-registration courses of which 45% (n=69) were attending an approaches to self-harm course. | SHAS instrument as developed for the study. | Complex attitudes - general nurses higher antipathy than RMN's; previous study associated with lower antipathy, as was being female, - but not statistically significant. Little difference according to age but there was with experience those with more than 10yrs greater levels of antipathy – different dimensions of attitude than can vary in different ways indifferent individuals. | Detailed discussion of factor analysis. Despite study aims its not clear if all participants are nurses. |

Author / Date	Study Aims	Study Design	Sample	Data Collection Tool	Key findings/variables explored	Comments
Sun, et al (2007)	To investigate casualty nurses' attitudes towards patients who SH and to identify factors contributing to their attitudes towards attempted suicide	Survey	155 casualty nurses from 7 large hospitals in Taiwan	Modified SOQ	Nurses held positive attitudes with 3 statistically significant differences - The higher the level of nursing education the more positive the nurses' attitudes - The casualty nurses who did not have a religion held more positive attitudes than those who followed a religion. - Casualty nurses who had suicide care experience with 1–10 patients had more positive attitudes than nurses who had nursed above 10 patients who had attempted suicide.	Only 2 male nurses. Generally inexperienced staff. Religion primarily Buddhists or Taoists. Only 8 nurses had had staff development specific to SH but attitudes generally positive. Unusual in that explores nurses suicide experiences

Author / Date	Study Aims	Study Design	Sample	Data Collection Tool	Key findings/variables explored	Comments
Suokas et al (2008)	To examine the association between staff members' psychological distress and attitudes towards suicide attempters. Also compared attitudes towards suicide attempters among emergency personnel between a general and a psychiatric hospital.	Survey	All staff in the emergency rooms of a general hospital and a psychiatric hospital (n=151) in Norway. 66 responded	The Understanding Suicidal Patients (USP) Questionnaire and the 12-item version of General Health Questionnaire	A&E staff in general hospital had more negative attitudes towards suicide attempters than those in MH hospital - stat sig diff in understanding and willingness to care for attempted suicide patients between the A&E staff in the general and psychiatric hospital. The high-scoring groupolder, had longer work experience and were more often in contact with suicide attempters (not stat sig). No differences found between the two groups in relation to sex and profession. There was no evidence of association between feelings of psychological distress and negative attitudes towards suicide attempters	Only study that focuses on psychological distress of staff and how this might impact on attitudes towards SH

Appendix 2 Covering Letter Accompanying Questionnaire Inviting Practitioners to Participate in Interviews; Questionnaire Attached.

Dear colleague,

I am currently studying for my doctorate (PhD) at the University of Greenwich. The subject area for my research is the emergency care of young people who self-harm. As part of the research I am conducting a survey of nurses, doctors, paramedics, ambulance and clerical/administrative personnel working across four emergency departments in South-East London. To assist me in my research I would be very grateful if you could complete the following questionnaire.

The questionnaire asks you firstly a bit about yourself and your experience of emergency care work. It then goes onto provide you with some statements which you need to consider and then identify your level of agreement with, by placing a tick in the box, (adjacent to the statement) which most closely corresponds with your level of agreement.

For the purpose of the study young people are those aged between 11 – 18 years of age, and deliberate self harm is defined as the intentional poisoning or injury of one's self, irrespective of the underlying purpose of the act.

You are not obliged to complete this questionnaire but it will be much appreciated if you do, as it will assist in developing an understanding of the issues faced by emergency department staff when providing care for this client group. You do not need to give your name and all answers will be treated with strictest confidence. The questionnaire is anonymised which means that I am unable to know who completed which questionnaire. The only means of identification are by the hand written letter and number (i.e. L1) on the first page; this merely tells me which hospital and the questionnaire number, so that I can track how many questionnaires are distributed and how many are then returned from each of the departments.

By completing the questionnaire you are indicating your consent to participate in the study, for which I am very grateful. As part of the study I am also intending to conduct interviews with medical and nursing staff within your department. I will be leaving notices in the department asking for volunteers to participate in the interviews; if you are interested in participating in the interviews, please feel free to email or contact me as per above. Should you wish to receive further information about the study or have any queries or concerns please do not hesitate to contact me, as per the details above.

Many thanks for your co-operation

Karen Cleaver

YOUNG PEOPLE & SELF-HARM:
EMERGENCY DEPARTMENT OPINION QUESTIONNAIRE

The following questions are about your personal background

1. **Sex**
Male   **[ ]** 1   Female**[ ]** 2

2. **Age group**

16 – 2O	**[ ]** 1
21 – 25	**[ ]** 2
26 – 30	**[ ]** 3
31 – 35	**[ ]** 4
36 – 40	**[ ]** 5
41 – 45	**[ ]** 6
46 – 50	**[ ]** 7
51 – 55	**[ ]** 8
56 – 60	**[ ]** 9
61 – 65	**[ ]** 10
66 and above	**[ ]** 11

3. **What best describes your role in the emergency department?**

Registered Nurse (with children's nursing qualification)	**[ ]**
Registered Nurse (with emergency nursing qualification)	**[ ]**
Registered Nurse (with both qualifications identified above)	**[ ]**
Registered Nurse (other)	**[ ]**
Paramedic	**[ ]**
Ambulance personnel	**[ ]**
Senior Doctor (registrar or consultant)	**[ ]**
Junior Doctor	**[ ]**
Administrator/clerical	**[ ]**

4. **Length of experience in emergency department/s.**

Under 1 year	**[ ]** 1
1 – 2 years	**[ ]** 2
3 – 5 years	**[ ]** 3
6 – 10 years	**[ ]** 4
11 – 15 years	**[ ]** 5
16 – 20 years	**[ ]** 6
21 years or more	**[ ]** 7

5. **Have you ever attended any specific education sessions on the care of patients with deliberate self-harm?**

        Yes   [   ] 1 (Please continue with questions 6 & 7)

        No   [   ] 2 (Please go to question 8)

6. **Please indicate the length of the specific education session/s that you have attended on the care of patients with deliberate self-harm? (please tick all appropriate boxes)**

        Workshop/study day, lasting one-two hours   [   ] 1

        Lasting one-half day   [   ] 2

        Lasting one full day   [   ] 3

        Specific course (1- 3 weeks duration)   [   ] 4

        Specific course (3- 6 weeks duration)   [   ] 5

        Specific course (6-12 weeks duration)   [   ] 6

        Specific course (more than 12 weeks duration)   [   ] 7

        Other please specify ……………………………………..

7. **Did any of these education sessions specifically look at the needs of young people?**

        Yes   [   ] 1

        No   [   ] 2

8. **Does your emergency department have practice guidelines for caring for patients who present with deliberate self-harm?**

        Yes   [   ] 1 (Please continue with question 9)

        No   [   ] 2 (Please go to question 11)

9. **Do you know what these practice guidelines specify in relation to caring for patients who present with deliberate self-harm?**

        Yes   [   ] 1 (Please continue with question 10)

        No   [   ] 2 (Please go to question 11)

10. **How often do you follow these practice guidelines for caring for patients who present with deliberate self-harm?**

        always   [   ] 1

        nearly always [   ] 2

        occasionally [   ] 3

        rarely/never [   ] 4

Please feel free to comment:

This part of the questionnaire requires you to tick the box that most closely resembles your level of agreement with each of the following statements.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
The behaviour of young people today is no worse than it was in the past:					
The views of young people aren't listened to enough					
Girls are more badly behaved than boys nowadays					
Most young people are responsible and well-behaved					
Young people today have no respect for adults					
Most young people are helpful and friendly☐					
Young people today are not disciplined by their parents					
Adults have no respect for young people					
Young people today don't get enough care and attention from their parents					
Young people today have more stress in their lives than they did before					
Most young people who deliberately harm themselves don't want to die					
Young people who deliberately harm themselves are trying to get sympathy from others					
Young people who deliberately self-harm are in desperate need of help					
Most young people who attend having deliberately harmed themselves are likely to repeat this behaviour					
Young people who deliberately self-harm are attention seekers					
Young people who deliberately self-harm should be required to undergo therapy					
Young people who deliberately self-harm are more at risk of successfully completing a suicide attempt					

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Young people who deliberately self-harm are mentally ill					
Young people who deliberately self-harm are more likely to have difficult relationships with their families					
Deliberate self-harm is a normal part of youth culture					
Young people who self-harm do it because they want to show how desperate they are feeling					
Young people who self harm do it because they wanted to frighten someone					
Young people who self-harm do it because they want to find out if someone really loves them					
Young people who self-harm do it because they want to get their own back on someone					

AND FINALLY....

Maxine aged 16 has just been admitted to the emergency department for the tenth time with deliberate self-harm. Have you ever heard other colleagues say something along the lines of: 'Why didn't she do it right this time and save us a lot of trouble'?

Yes   [   ] 1 (please continue with question 14)
No   [   ] 2 (there are no further questions)

When you hear colleagues say something along the lines of: 'Why didn't she do it right this time and save us a lot of trouble,' how does it affect the care you provide to young people who have self-harmed? (Choose ONE response).

I provide more care than I would normally give to patients   [   ] 1

I provide the same level of care that I would normally give to patients [   ] 2

I provide less care than I would normally give to patients   [   ] 3

I only look after them if nobody else is willing to provide care   [   ] 4

None of the above   [   ] 5

This is the end of the questionnaire. Thank

Appendix 4 [Interviewee] Participant Information Sheet.

Emergency Care of Young People who Self-Harm - A Research Study
Participant Information Sheet

My name is Karen Cleaver and I am a lecturer in children's nursing at the University of Greenwich. I would like to invite you as a registered nurse or doctor working in the emergency department at QMST, to take part in this study. To help you decide if you would be interested and willing to participate I have provided information about the study in a question and answer format.

For your information, the study has been approved by the Bromley (NHS) Local Research Ethics Committee and your Trust's R & D department.

What is the study about?
I am currently registered for a PhD with the University of Greenwich and in order to fulfill the requirements for my doctorate I am undertaking a study entitled

> "An exploration of attitudes towards young people who-self harm and an investigation into the care they receive in hospital emergency departments".

Why have I been invited to take part?
You have been invited to take part, as you are either a doctor or a nurse who is working on a substantive basis at QMST. I have already surveyed emergency care staff across four hospitals in South East London and now wish to get further information on how, as either a nurse or a doctor, you manage the care of young people who self-harm and gain an insight into your experiences of looking after these young people. I am hoping to interview around 10 - 12 members of staff.

Do I have to take part?
You do not have to take part; whether or not you take part will have no influence on your current role and responsibilities at the Trust. If you do decide to take part, you may change your mind at any time and withdraw from the study.

If I take part what will I have to do?
If you consent to participate in the study then you will be interviewed. The interview will be semi-structured; I will have a topic guide to provide a basic format to the interviews. The interview will last around half an hour and will be tape-recorded.

Where will the interview take place?
In a quiet location within or adjacent to the emergency department.

When will the interview take place if I agree?
Interviews will be arranged to suit your own needs and that of the department's.

Will I be identifiable?
All data will remain confidential. In the write up of the thesis direct quotes from interviews may be cited to illustrate a point. These will not though make reference to any individual they will merely be coded by participant number. A participant number will be allocated randomly, not in the sequence in which interviews occur.

What if I disclose information that indicates that aspects of care have been inadequate and or of concern?

If during the interview you disclose that you have witnessed or participated in what might be considered to be sub-optimal care in relation to young people and self-harm, I may possibly discuss this issue anonymously with the relevant senior member of staff within the department; if this were to be the case then I would inform you of this.

How do I know this research is being conducted ethically and has been approved?

Permission to undertake this research has been granted by both the Hospitals R& D committee, and the senior nurse and clinical director for the department. The research has also been approved through Bromley LREC. The University of Greenwich is the sponsor for this research, and my main supervisor based at the University is Professor Liz Meerabeau; any complaints about the conduct of the research can be raised with Professor Meerabeau as per contact details below.

What should I do if, having read this information sheet, I am happy to participate in the study?

If you are happy to participate in the study please return the attached letter to me, inserting your preferred method of contact and your name, in the enclosed stamped addressed envelope. I will then make contact with you to arrange for a date for the interview.

If you have any queries that haven't been addressed by this information sheet that need to be addressed before you give consent please do not hesitate to contact me either via e-mail at: k.p.cleaver@gre.ac.uk or by phone on: 020 8331 8075

Contact details for Professor Liz Meerabeau:
e-mail: e.meerabeau@gre.ac.uk
Phone: 020 8331 9151

Appendix 5: Consent Forms.

CONSENT FORM   - NHS Personnel

Title of Project: Emergency Care of Young People who Self-harm.

Name of Researcher: Karen Cleaver

(Please tick the boxes at the end of each statement) to indicate your understanding and agreement)

1. I confirm that I have read and understand the information leaflet for the
above study. I have had the opportunity to consider the information,
ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to
withdraw at any time without giving any reason

☐

3. I understand that I will be interviewed once and that this interview will,
if I agree, be tape-recorded.

☐

4. I understand that transcripts from the interview may be shared with
Karen's supervisors, but these will be anonymised. Karen may use verbatim
quotes when writing up her study but these will also be anonymised.

☐

5. I agree to take part in the above study.

☐

_____   _____   _____

Name   Date   Signature

Karen Cleaver

_____   _____   _____

 Name of Person   Date   Signature
taking consent

Appendix 6   Email Correspondence re SOQ

From: CLEAVER KAREN P <ck04@greenwich.ac.uk>
To: terence.mccann@vu.edu.au
Subject: suicide opinion questionnaire

Dear Professor McCann
I read with interest your paper published earlier this year in Accident & Emergency Nursing.
To fulfil requirements for my Phd I am currently planning my data collection for a study
examining young peoples' perspectives of emergency care following an episode of DSH. As
part of the study I am hoping to try and determine the attitudes of staff (working in emergency
Departments) towards young people who self-harm. I was therefore wondering if it would be
possible to have a look at your adaptation   of the Suicide Opinion questionnaire.

I would also value any feedback or advice you can offer on its use   in terms of the validity
and reliability of the questionnaire through   the experience gained in the study undertaken by
yourself and   your colleagues.

I look forward to hearing from you
 Karen Cleaver

Date sent: Thu, 27 Apr 2006 15:31:13 +1000
From: Terence McCann <terence.mccann@vu.edu.au>
Organization: Victoria University
To: CLEAVER KAREN P <K.P.Cleaver@greenwich.ac.uk>
Subject: Re: suicide opinion questionnaire

Dear Karen,

See attached for a copy of the questionnaire. Another article from the study is due to be
published this year in J. Clinical Nursing. You may find that the JCN nursing gives a bit more
comment about methodology. We had some problem in interpreting what were negative items
as this was not clearly stated in earlier publications. However, the main problem we
experienced was in getting sufficient participants (post educational intervention) for the follow-
up data collection. Most had moved on to other jobs.

Best wishes.

Terence.

From: CLEAVER KAREN P <ck04@greenwich.ac.uk>
To: Terence McCann <terence.mccann@vu.edu.au>
Subject: Re: suicide opinion questionnaire
Date sent: Thu, 27 Apr 2006 09:15:16 GMT

Dear Terence
many thanks for the copy of the questionnaire and your prompt response. I look forward to
reading your paper in the Journal of Clinical Nursing
Karen

Appendix 7.   Mapping Demonstrating Relationship of Statements Within AYPSH Scale to Previous Studies.

Statements comprising the AYPSH scale used for this study.	*Most young people who deliberately harm themselves don't want to die*	*Young people who deliberately harm themselves are trying to get sympathy from others*	*Young people who deliberately self-harm are in desperate need of help*	*Young people who attend having deliberately self-harmed themselves are likely to repeat this behaviour*	*Young people who deliberately self-harm are attention seekers*	*Young people who deliberately self-harm should be required to undergo therapy*	*Young people who deliberately self-harm are more at risk of successfully completing a suicide attempt*
Studies where identical or similar statements are drawn from	McLaughlin (1994) McCann et al (2006, 2007),	McLaughlin (1994) Anderson (1997) Sun et al (2007) Patterson et al [1] (2007)	Anderson (1997) Anderson et al (2000) McAllister et al (2003) Anderson & Standen (2007)	McCann et al (2006, 2007)	McLaughlin (1994) McAllister et al (2003) McCann et al (2006, 2007), Sun et al (2007) Patterson et al (2007)	McLaughlin (1994) Crawford et al (2003) McCann et al (2006, 2007)	McLaughlin (1994) Crawford et al (2003) McCann et al (2006, 2007), Anderson & Standen (2007)

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[1] Patterson et al (2007), Crawford et al (2003) and McAllister et al (2003) did not employ the SOQ but scales used by these authors contained items from the SOQ

Appendix 7. Mapping Demonstrating Relationship of Statements Within AYPSH Scale to Previous Studies.

Statements comprising the AYPSH scale used for this study.	*Young people who deliberately self-harm are mentally ill*	*Young people who deliberately self-harm are more likely to have difficult relationships with their families*	*Deliberate self harm is a normal part of youth culture*	*Young people who self harm do it to show how desperate they are feeling*	*Young people who self harm do it because they wanted to frighten someone*	*Young people who self-harm do it because they want to find out if someone really loved them*	*Young people who self-harm do it because they want to get their own back on someone*
Studies where identical or similar statements are drawn from	Anderson et al (2000) Crawford et al (2003) Anderson & Standen (2007)	McLaughlin (1994) McCann et al (2006, 2007)	Anderson et al (200) Crawford et al (2003) Anderson & Standen (2007)	McLaughlin (1994) McCann et al (2006, 2007)		McCann et al (2006, 2007),	Anderson (1997) McCann et al (2006, 2007), Sun et al (2007), Patterson et al (2007)

Appendix 8: Topic Guides for Semi-Structured Interviews with NHS Personnel

- Begin by asking them if they completed a questionnaire – if so did this raise any particular issues for them? Remind them (if they have) that the questionnaire was looking at attitudes towards young people, what have they encountered in their practice? If not ask them about the kinds of attitudes they have encountered

- Explore the term 'attention seeking' – is this something they've heard said of young people who self-harm – what do they think about this?

- How do they find looking after young people who self-harm – prompt is it something they have commonly encountered, or is it relatively uncommon – depending on answer how does this make them feel when they do?

- In their experience why have the young people they have cared for self-harmed, and how? How does this make them feel and does it influence the approach they might take when caring for these young people, and why?

- Are there particular challenges in caring for this client/population group?

- Explore with them the use of protocols – what level of awareness do they have? Is it their experience that they are followed?

- How do they feel the care for these young people could be enhanced – and why?

- Any other issues not addressed during the interview relating to the attendance of young people who have self-harmed that hasn't been addressed?

Appendix 9: Matrix Demonstrating Précis of transcript for each participant with key messages assigned to AYP, AYPSH and Emergency Care Work. [2]

ID	Role	M/F	Age	Exp	AYP	AYPSH	Emergency Care Work
001	AT	M	40+	16+	• Clearly distinguishes vulnerability with age, adults know better • Alcohol is normal, but contradictory, also poison • YP not engaged (due to SH though) • Difficult to engage • YP fear authority, uses this if they don't engage	• CfH related to vulnerability • Difficult to engage if open up it's a blessing • Element of SH as normal if just once, but contradictory • Scale – can OD by 1 • Tries to be tender, and make light of situation • Risk adverse - no parent leaves him vulnerable, risk to YP - safety	• Doesn't have time to delve • ==Looks for cues, makes mental notes to self, judges what he will make public[3]== • Problem needs to be visible otherwise greater concern • Focus on the immediate and physical, time critical and speed of essence • Dismissive of social services as 'namby pamby' • Case hardened – going to a dead baby rock bottom, nothing else compares.
002	N	M	<40	16+	• Children's wards not right place for YPSH as disrupt others (more vulnerable) – questions why elderly aren't seen as vulnerable	• Change evident • SH as inconsequential – depends on size • If drunk & m/c with parents send home even though supposed to admit • YPSH disruptive • Mostly female upset and tearful (mostly drink related) • Staff should be less judgemental as paeds trained. • Is diagnosis or actual behaviour that's the problem?	• Notes clear pathways for physical but not the mental • Out of hrs = delays in accessing CAMH = breach • Difficult to admit due to being disruptive • Considers that Pm's get holistic view but contradicts (Pm's views) as thinks they don't consider 'forensics' • Views 16-18's as falling into a hole.
003	P	M	40+	16+	• Noted an increase in alcohol consumption; element of alcohol as normal, tends to be women • YP can be aggressive & abusive • YP don't recognise implications and worry about getting into trouble • Refers to YP who have died from glue sniffing/substance abuse whose parents	• Refers to normal domestic resulting in OD – carer not dismissive versus supportive. • Discusses repeats as frequent flyers • Cutting wrists – Hollywood style (superficial) • 'Bargained with pregnant women who'd taken an OD – look after unborn baby.	• Immediate care, safety • Do a bit more probing likens to child protection • Engage in conversation to eke info out, but • Priority is to remove to hospital, deal with what's in front of you. • Recounts suicides

[2] Colours signify allocated to theme:

Red = Theme 1 (Positioning self-harm in young people)

Blue = Theme 2 (Defining 'good' and 'bad' young self-harmers)

Green = Theme 3 (Emergency care and self-harm work).

[2] Yellow highlight = not allocated to a theme

| | | | | | were not around | | |

ID	Role	M/F	Age	Exp	AYP	AYPSH	Emergency Care Work
004	N	M	40+	16+	• YP under more pressure at school etc	• SH increased but changed from punishment to tx • Questions whether some behaviours might be labelled not SH i.e. anger management • Only participant to question whether own experiences might influence care (others make reference to their own personal experiences) • "Ordinary paediatric nurses" (i.e. ward nurses) don't see it as their role to care for YPSH, and generally not nurses role to assess psychological state.	• 4-hour targets have improved care as patients moved on quicker • YPSH might be poorly viewed due to difficulties in admission and locating beds. • Staff worry about missing something – relates to CP policies raised awareness • Crews focus on circumstances but not detail
005	N	F	<40	<16	• Younger age groups are more vulnerable engender more sympathy (in context of SH)	• Alcohol and spat with BF = inconsequential, not good, quiet and trying to hide i.e. coping = good but worry • Sympathetic to teenage girls – associated with violence • Abusive receive less sympathy • Treated like the pariahs of A&E • SH can be AS but need to look at motives • Repeats exhaust sympathy	• Nowhere for YPSH to go - paeds see them as dangerous – doesn't blame the ward for not wanting to take them • 4 hour targets have improved things
06	P	F	<40	<16	• People more accepting of children as have life ahead • Doesn't see 16-18's as children but needs to take them to paeds.	• Recounts a girl who hung herself – traumatic • Measures self-harm against this – CfH not serious	• Will try to find out what's going on, but limited attempt to do so • Makes distinction between medical being physical and mental not.
007	P	M	40+	16+	• Get a sense of the community • YP changed less discipline • Recounts a number of experiences in relation to drunk teenagers • Risk of violence in relation to alcohol	• Paed A&E have slightly better attitudes, otherwise depends on time of day and how busy, but contradictory • Questions why a YP person would do that (SH) • PM's become hardened because they see so much of it, and the same ones.	• Dispose of drunk teenagers quickly • Spends half an hour at scene but thinks it's not long enough

ID	Role	M/F	Age	Exp	AYP	AYPSH	Emergency Care Work
008	P	M	<40	<16	• In area where he works YP are a problem – relates to gangs and gang violence, level of deprivation – again sense of his community • Can feel intimidated by YP – situations can be 'explosive' – uniform helps • Alcohol inevitable – links alcohol with violence and deprivation • Difficult to engage often (95%)don't want help	• OD's and alcohol common, hasn't seen the extreme – suicide • Might agree with A/S but there is a reason behind it	• Gets a feel for what's happening at the scene, chatting helps to get YP to open up • No time pressures at scene • Going from death to SH difficult • A&E not the right place to take these YP to – or other MH problems. • Ref to uniform giving authority and protection
009	N	F	<40	16+	• Links SH and alcohol to stress	• Attitudes have changed – got better • Dismissive of A/S as need to seek attention to get help • Mixed response from parents • SH can be hidden – recognises it as a taboo area unlike alcohol which is more normal	• Finds it frustrating as they need time and competing demands • Likens SH to social issues – which take you away from A&E work • A&E work is physical care • 4 hour targets – get seen quickly – need to be as a risk • Paramedics don't do a lot unless medically unwell – don't get huge detail from crews • need better access to CAMH
010	N	M	<40	<16	• Fear going into care • YP difficult to engage – hackles rise (context of SH).	• Discusses 8 yr old with ID and challenging behaviour as SH • Makes reference to some being funny and explains some attitudes as gallows humour. • Surprised at how many he sees and doesn't feel equipped to care • Distinguishes between CfH & AS • Discusses scale – and revolving doors • SH a recent phenomenon	• 'Nightmare' of lack of ownership • Difficult to process due to time management issues • Identifies good things about A&E work SH isn't within this • Ref to uniform and authority • Protocols and guidelines don't work, human behaviour difficult to standardise, and come out of hours so can't implement guidance. • Crews get info needed, can be emotionally upsetting for them

	Role	M/F	Age	Exp	AYP	AYPSH	Emergency Care Work
011	N	F	<40	<16	• Hopes teenagers are treated better than adults – more understanding and gentle • d/c pressures on teenagers esp peer pressure • Aggressive – can understand why a children's ward won't take them	• Witnessed poor attitudes (elsewhere) • People fail to grasp why a YP would SH • OD's more likely to be serious suicide attempt • SH/MH = social • Age magnifies concerns • Parents reactions vary – some hide it	• Paeds don't deal with trauma A&E want to fix – A&E = physical illness and trauma • Policies (and authority) help to reinforce to YP requirements to stay and be admitted • Difficulty in moving through in 4 hours – some get pushed out to soon • Lack of access to CAMH
12	N	F	<40	<16	• Fear consequences • Should do extra for YP	• Scale 2-3 tablets compared with 50 – have to judge if telling the truth • Staff are scared of SH as it's unknown – lack of E&T • AS = CfH – needing to get noticed, not premeditated	• Initial quick assessment to assure safety • Can be conflict of interest with family so not always involved • Guidelines help her as she's inexperienced, grateful for them being there.

Appendix 10 Analysis of Codes by Occupation, Gender, Length of Experience and Age

Analysis by Occupation (Paramedics shaded).

Code	Theme	Explanation	P001	P002	P003	P004	P005	P006	P007	P008	P009	P010	P011	P012	Analysis
ATTITUDE	Positioning SH in YP	Expressed or observed example of an attitude	1	5	6	1	7	1	3	0	1	5	7	2	All bar P008 describe an attitude observed or expressed own views
INTENTION – (SCALE)	Positioning SH in YP	How practitioners perceive the YP's intentions when harming	3	1	2	0	0	1	2	0	0	0	1	0	Paramedics tend to draw more on suicide when discussing YP's intentions
ALCOHOL	Positioning SH in YP	Discussion of alcohol in context of YP's lives (normal) and SH	4	3	2	1	0	1	8	3	2	0	0	0	Paramedics tend to make a link between SH and Alcohol
PARENTAL REACTIONS	Positioning SH in YP	Observed reactions (by practitioners) of parents	1	1	0	3	0	0	1	0	1	1	2	1	More nurses observed and noted parental reactions
DESCRIPTIONS	Positioning SH in YP	Descriptions of young people who have self-harmed or responses to self harm/ Examples provided by practitioners of injuries etc which constitute self-harm	6	3	9	1	2	1	10	3	1	6	4	1	Paramedics tend to give more descriptions/ draw on their past cases.
GOOD or BAD GD/BAD ADJ	Defining 'Good' and 'Bad'....	YP as vulnerable or YP as problematic Good/bad patient /Adjectives describing approach to YP who SH (gentle etc all denote vulnerable)	5	6	5	2	4	2	3	8	1	2	5	10	All make reference to young people as both problematic and vulnerable or positive
CONSEQUENCES.	Defining 'Good' and 'Bad'....	For YP – fear of parents, care etc	5	2	1	0	0	1	5	1	0	2	2	0	Paramedics more likely to discuss how young people view consequences – based on initial response on arrival

Code	Theme	Explanation	P001	P002	P003	P004	P005	P006	P007	P008	P009	P010	P011	P012	Analysis
CfH/AS	Defining 'Good' and 'Bad'....	Defining a cry for help distinguishing from attention seeking	3	1	1	1	4	2	2	4	3	3	1	2	All have coding in this category with similar responses across the groups
RISK	Defining 'Good' and 'Bad'....	At risk from harm – YP or practitioner – risk adverse as at risk	3	0	1	0	4	0	1	3	1	0	1	0	Paramedics tended to consider risk – both to self and young person.
UNDERSTANDING	Defining 'Good' and 'Bad'....	Level of understanding practitioners demonstrate in relation to SH motives	2	1	2	4	4	3	1	1	6	4	1	3	All have coding in this category with similar responses across the groups
DELVING	Defining 'Good' and 'Bad'....	Needing to get more information;	2	1	4	2	3	0	1	1	2	1	2	5	Nurses tend to talk more about needing to get more information – to the bottom of the problem or delving.
ENGAGMENT	Defining 'Good' and 'Bad'....	Level of engagement with YP – clamming up	6	0	5	3	1	2	2	8	1	5	4	4	Paramedics tend to make more reference to engaging with YP - NB links to time.
AUTHORITY/ UNIFORM	Defining 'Good' and 'Bad'....	Invoking authority – the role of uniform	3	0	0	1	0	0	1	6	0	5	2	1	Paramedics more likely to make reference to authority and uniform

Code	Theme	Explanation	P001	P002	P003	P004	P005	P006	P007	P008	P009	P010	P011	P012	Analysis
FOCUS FIX	SH Work in A&E – working with contradictions	Focus on the physical or focus on the emotional needs of YP Emphasis on fixing/mending/cure	4	3	4	10	1	3	6	3	5	5	10	5	Clear focus on physical are across the two groups
MOVING ON PT Mnt	SH Work in A&E – working with contradictions	Having to move patients through the service(s) to final destination Processing patients through A&E	3	4	2	5	2	0	4	1	3	4	6	1	Clear focus across both groups of moving patients through the system
ACCESS TO EXPERTISE	SH Work in A&E – working with contradictions	Access to a HCP/service who has expertise required for either the patient or practitioner	0	7	0	3	1	0	0	0	3	4	2	0	Only nurses make reference to access to expertise
TIME/TIMING	SH Work in A&E – working with contradictions	Not enough time, or speed needed, time spent	6	3	0	1	2	0	1	2	2	3	4	0	No obvious trends
UNWANTED	SH Work in A&E – working with contradictions	YP not wanted in a service – could have been nowhere to go.	0	8	0	2	4	0	0	0	3	7	3	0	Only nurses make reference to YP having nowhere to go
COMP DEM	SH Work in A&E – working with contradictions	Competing demands placed on practitioners how balanced and effect;	3	0	1	0	1	0	4	1	4	2	1	2	Similar responses across the groups
IMPOTENT	SH Work in A&E – working with contradictions	Unable to do anything for YPSH due to barriers, treat to the best of ability	0	0	0	0	2	0	0	5	2	4	0	0	Similar responses across the groups
PAEDS	SH Work in A&E – working with contradictions	Benefits of paediatrics (training, staff = better care, or not)	0	3	0	9	0	2	3	2	5	0	3	0	Similar responses across the groups
CONFIDENCE	SH Work in A&E – working with contradictions	Reference to having (or not) confidence/experience	4	0	0	3	1	0	1	0	0	3	4	2	Similar responses across the groups
DOC	SH Work in A&E – working with contradictions	Documentation (inc guidelines, policy, action plans)	0	1	2	4	0	1	0	1	1	8	2	6	Nurses make more reference to using guidelines and policy

Analysis by Gender (Males shaded)

Code	Theme	Explanation	P001	P002	P003	P004	P005	P006	P007	P008	P009	P010	P011	P012	Analysis
ATTITUDE	Positioning SH in YP	Expressed or observed example of an attitude	1	5	6	1	7	1	3	0	1	5	7	2	All bar P008 described an attitude observed or expressed own views
INTENTION – (SCALE)	Positioning SH in YP	How practitioners perceive the YP's intentions when harming	3	1	2	0	0	1	2	0	0	0	1	0	Similar responses across the groups
ALCOHOL	Positioning SH in YP	Discussion of alcohol in context of YP's lives (normal) and SH	4	3	2	1	0	1	8	3	2	0	0	0	Males more likely to link alcohol with self-harm (NB all bar one of paramedics were male but two male nurses also make the link)
PARENTAL REACTIONS	Positioning SH in YP	Observed reactions (by practitioners) of parents	1	1	0	3	0	0	1	0	1	1	2	1	Similar responses across the groups
DESCRIPTIONS	Positioning SH in YP	Descriptions of young people who have self-harmed or responses to self harm/ Examples provided by practitioners of injuries etc which constitute self-harm	6	3	9	1	2	1	10	3	1	6	4	1	Males tend to give more descriptions/ draw on their past cases (NB all bar one of paramedics were male but two male nurses also make a number of comments).
GOOD or BAD GD/BAD ADJ	Defining 'Good' and 'Bad'....	YP as vulnerable or YP as problematic Good/bad patient /Adjectives describing approach to YP who SH (gentle etc all denote vulnerable)	5	6	5	2	4	2	3	8	1	2	5	10	Similar responses across the groups
CONSEQUENCES.	Defining 'Good' and 'Bad'....	For YP – fear of parents, care etc	5	2	1	0	0	1	5	1	0	2	2	0	Similar responses across the groups

Code	Theme	Explanation	P001	P002	P003	P004	P005	P006	P007	P008	P009	P010	P011	P012	Analysis
CfH/AS	Defining 'Good' and 'Bad'....	Defining a cry for help distinguishing from attention seeking	3	1	1	1	4	2	2	4	3	3	1	2	Similar responses across the groups
RISK	Defining 'Good' and 'Bad'....	At risk from harm – YP or practitioner – risk adverse as at risk	3	0	1	0	4	0	1	3	1	0	1	0	Similar responses across the groups
UNDERSTANDING	Defining 'Good' and 'Bad'....	Level of understanding practitioners demonstrate in relation to SH motives	2	1	2	4	4	3	1	1	6	4	1	3	Similar responses across the groups
DELVING	Defining 'Good' and 'Bad'....	Needing to get more information;	2	1	4	2	3	0	1	1	2	1	2	5	Similar responses across the groups
ENGAGMENT	Defining 'Good' and 'Bad'....	Level of engagement with YP – clamming up	6	0	5	3	1	2	2	8	1	5	4	4	Similar responses across the groups
AUTHORITY/ UNIFORM	Defining 'Good' and 'Bad'....	Invoking authority – the role of uniform	3	0	0	1	0	0	1	6	0	5	2	1	Males more likely to make reference to authority and uniform

Code	Theme	Explanation	P001	P002	P003	P004	P005	P006	P007	P008	P009	P010	P011	P012	Analysis
FOCUS FIX	SH Work in A&E – working with contradictions	Focus on the physical or focus on the emotional needs of YP Emphasis on fixing/mending/cure	4	3	4	10	1	3	6	3	5	5	10	5	Similar responses across the groups
MOVING ON PT Mnt	SH Work in A&E – working with contradictions	Having to move patients through the service(s) to final destination Processing patients through A&E	3	4	2	5	2	0	4	1	3	4	6	1	Similar responses across the groups
ACCESS TO EXPERTISE	SH Work in A&E – working with contradictions	Access to a HCP/service who has expertise required for either the patient or practitioner	0	7	0	3	1	0	0	0	3	4	2	0	Male nurses make more reference than their female nursing colleagues to accessing expertise (CAMH)
TIME/TIMING	SH Work in A&E – working with contradictions	Not enough time, or speed needed, time spent	6	3	0	1	2	0	1	2	2	3	4	0	Similar responses across the groups
UNWANTED	SH Work in A&E – working with contradictions	YP not wanted in a service – could have been nowhere to go.	0	8	0	2	4	0	0	0	3	7	3	0	Similar responses across the groups
COMP DEM	SH Work in A&E – working with contradictions	Competing demands placed on practitioners how balanced and effect;	3	0	1	0	1	0	4	1	4	2	1	2	Similar responses across the groups
IMPOTENT	SH Work in A&E – working with contradictions	Unable to do anything for YPSH due to barriers, treat to the best of ability	0	0	0	0	2	0	0	5	2	4	0	0	Similar responses across the groups
PAEDS	SH Work in A&E – working with contradictions	Benefits of paediatrics (training, staff = better care, or not)	0	3	0	9	0	2	3	2	5	0	3	0	Similar responses across the groups
CONFIDENCE	SH Work in A&E – working with contradictions	Reference to having (or not) confidence/experience	4	0	0	3	1	0	1	0	0	3	4	2	Similar responses across the groups
DOC	SH Work in A&E – working with contradictions	Documentation (inc guidelines, policy, action plans)	0	1	2	4	0	1	0	1	1	8	2	6	Similar responses across the groups

Analysis by Length of Experience (Those with more that 16 years shaded)

Code	Theme	Explanation	P001	P002	P003	P004	P005	P006	P007	P008	P009	P010	P011	P012	Analysis
ATTITUDE	Positioning SH in YP	Expressed or observed example of an attitude	1	5	6	1	7	1	3	0	1	5	7	2	Similar responses across the groups
INTENTION – (SCALE)	Positioning SH in YP	How practitioners perceive the YP's intentions when harming	3	1	2	0	0	1	2	0	0	0	1	0	More experienced practitioners tend to make reference to their personal histories seeing self-harm in terms of scale
ALCOHOL	Positioning SH in YP	Discussion of alcohol in context of YP's lives (normal) and SH	4	3	2	1	0	1	8	3	2	0	0	0	More experienced practitioners tend to link SH to alcohol
PARENTAL REACTIONS	Positioning SH in YP	Observed reactions (by practitioners) of parents	1	1	0	3	0	0	1	0	1	1	2	1	Similar responses across the groups
DESCRIPTIONS	Positioning SH in YP	Descriptions of young people who have self-harmed or responses to self harm/ Examples provided by practitioners of injuries etc which constitute self-harm	6	3	9	1	2	1	10	3	1	6	4	1	Similar responses across the groups
GOOD or BAD GD/BAD ADJ	Defining 'Good' and 'Bad'....	YP as vulnerable or YP as problematic Good/bad patient /Adjectives describing approach to YP who SH (gentle etc all denote vulnerable)	5	6	5	2	4	2	3	8	1	2	5	10	Similar responses across the groups
CONSEQUENCES.	Defining 'Good' and 'Bad'....	For YP – fear of parents, care etc	5	2	1	0	0	1	5	1	0	2	2	0	Similar responses across the groups

Code	Theme	Explanation	P001	P002	P003	P004	P005	P006	P007	P008	P009	P010	P011	P012	Analysis
CfH/AS	Defining 'Good' and 'Bad'....	Defining a cry for help distinguishing from attention seeking	3	1	1	1	4	2	2	4	3	3	1	2	Similar responses across the groups
RISK	Defining 'Good' and 'Bad'....	At risk from harm – YP or practitioner – risk adverse as at risk	3	0	1	0	4	0	1	3	1	0	1	0	Similar responses across the groups
UNDERSTANDING	Defining 'Good' and 'Bad'....	Level of understanding practitioners demonstrate in relation to SH motives	2	1	2	4	4	3	1	1	6	4	1	3	Similar responses across the groups
DELVING	Defining 'Good' and 'Bad'....	Needing to get more information;	2	1	4	2	3	0	1	1	2	1	2	5	Similar responses across the groups
ENGAGMENT	Defining 'Good' and 'Bad'....	Level of engagement with YP – clamming up	6	0	5	3	1	2	2	8	1	5	4	4	Similar responses across the groups
AUTHORITY/ UNIFORM	Defining 'Good' and 'Bad'....	Invoking authority – the role of uniform	3	0	0	1	0	0	1	6	0	5	2	1	Similar responses across the groups
FOCUS FIX	SH Work in A&E – working with contradictions	Focus on the physical or focus on the emotional needs of YP Emphasis on fixing/mending/cure	4	3	4	10	1	3	6	3	5	5	10	5	Similar responses across the groups
MOVING ON PT Mnt	SH Work in A&E – working with contradictions	Having to move patients through the service(s) to final destination Processing patients through A&E	3	4	2	5	2	0	4	1	3	4	6	1	Similar responses across the groups
ACCESS TO EXPERTISE	SH Work in A&E – working with contradictions	Access to a HCP/service who has expertise required for either the patient or practitioner	0	7	0	3	1	0	0	0	3	4	2	0	More experienced nurses identify the need for access to external expertise, not apparent in paramedics.

Code	Theme	Explanation	P001	P002	P003	P004	P005	P006	P007	P008	P009	P010	P011	P012	Analysis
TIME/ TIMING	SH Work in A&E – working with contradictions	Not enough time, or speed needed, time spent	6	3	0	1	2	0	1	2	2	3	4	0	Similar responses across the groups
UNWANTED	SH Work in A&E – working with contradictions	YP not wanted in a service – could have been nowhere to go.	0	8	0	2	4	0	0	0	3	7	3	0	Similar responses across the groups
COMP DEM	SH Work in A&E – working with contradictions	Competing demands placed on practitioners how balanced and effect.	3	0	1	0	1	0	4	1	4	2	1	2	Similar responses across the groups
IMPOTENT	SH Work in A&E – working with contradictions	Unable to do anything for YPSH due to barriers, treat to the best of ability	0	0	0	0	2	0	0	5	2	4	0	0	More experienced practitioners tend not to experience or report that they feel unable to treat/manage
PAEDS	SH Work in A&E – working with contradictions	Benefits of paediatrics (training, staff = better care, or not)	0	3	0	9	0	2	3	2	5	0	3	0	More experienced nurses saw that children's nurses and paediatrics were more likely to met the needs of YPSH
CONFIDENCE	SH Work in A&E – working with contradictions	Reference to having (or not) confidence/experience	4	0	0	3	1	0	1	0	0	3	4	2	Similar responses across the groups
DOC	SH Work in A&E – working with contradictions	Documentation (inc guidelines, policy, action plans)	0	1	2	4	0	1	0	1	1	8	2	6	Similar responses across the groups

Analysis by Age (Those aged under 40 yrs of age shaded)

Code	Theme	Explanation	P001	P002	P003	P004	P005	P006	P007	P008	P009	P010	P011	P012	Analysis
ATTITUDE	Positioning SH in YP	Expressed or observed example of an attitude	1	5	6	1	7	1	3	0	1	5	7	2	Similar responses across the groups
INTENTION – (SCALE)	Positioning SH in YP	How practitioners perceive the YP's intentions when harming	3	1	2	0	0	1	2	0	0	0	1	0	Similar responses across the groups
ALCOHOL	Positioning SH in YP	Discussion of alcohol in context of YP's lives (normal) and SH	4	3	2	1	0	1	8	3	2	0	0	0	Similar responses across the groups
PARENTAL REACTIONS	Positioning SH in YP	Observed reactions (by practitioners) of parents	1	1	0	3	0	0	1	0	1	1	2	1	Similar responses across the groups
DESCRIPTIONS	Positioning SH in YP	Descriptions of young people who have self-harmed or responses to self harm/ Examples provided by practitioners of injuries etc which constitute self-harm	6	3	9	1	2	1	10	3	1	6	4	1	Similar responses across the groups
GOOD or BAD GD/BAD ADJ	Defining 'Good' and 'Bad'….	YP as vulnerable or YP as problematic Good/bad patient /Adjectives describing approach to YP who SH (gentle etc all denote vulnerable)	5	6	5	2	4	2	3	8	1	2	5	10	Similar responses across the groups
CONSEQUENCES.	Defining 'Good' and 'Bad'….	For YP – fear of parents, care etc	5	2	1	0	0	1	5	1	0	2	2	0	Similar responses across the groups

Code	Theme	Explanation	P001	P002	P003	P004	P005	P006	P007	P008	P009	P010	P011	P012	Analysis
CfH/AS	Defining 'Good' and 'Bad'....	Defining a cry for help distinguishing from attention seeking	3	1	1	1	4	2	2	4	3	3	1	2	Similar responses across the groups
RISK	Defining 'Good' and 'Bad'....	At risk from harm – YP or practitioner – risk adverse as at risk	3	0	1	0	4	0	1	3	1	0	1	0	Similar responses across the groups
UNDERSTANDING	Defining 'Good' and 'Bad'....	Level of understanding practitioners demonstrate in relation to SH motives	2	1	2	4	4	3	1	1	6	4	1	3	Similar responses across the groups
DELVING	Defining 'Good' and 'Bad'....	Needing to get more information;	2	1	4	2	3	0	1	1	2	1	2	5	Similar responses across the groups
ENGAGMENT	Defining 'Good' and 'Bad'....	Level of engagement with YP – clamming up	6	0	5	3	1	2	2	8	1	5	4	4	Similar responses across the groups
AUTHORITY/ UNIFORM	Defining 'Good' and 'Bad'....	Invoking authority – the role of uniform	3	0	0	1	0	0	1	6	0	5	2	1	Similar responses across the groups
FOCUS FIX	SH Work in A&E – working with contradictions	Focus on the physical or focus on the emotional needs of YP Emphasis on fixing/mending/cure	4	3	4	10	1	3	6	3	5	5	10	5	Similar responses across the groups
MOVING ON PT Mnt	SH Work in A&E – working with contradictions	Having to move patients through the service(s) to final destination Processing patients through A&E	3	4	2	5	2	0	4	1	3	4	6	1	Similar responses across the groups
ACCESS TO EXPERTISE	SH Work in A&E – working with contradictions	Access to a HCP/service who has expertise required for either the patient or practitioner	0	7	0	3	1	0	0	0	3	4	2	0	Similar responses across the groups

Code	Theme	Explanation	P001	P002	P003	P004	P005	P006	P007	P008	P009	P010	P011	P012	Analysis
TIME/ TIMING	SH Work in A&E – working with contradictions	Not enough time, or speed needed, time spent	6	3	0	1	2	0	1	2	2	3	4	0	Similar responses across the groups
UNWA NTED	SH Work in A&E – working with contradictions	YP not wanted in a service – could have been nowhere to go.	0	8	0	2	4	0	0	0	3	7	3	0	Similar responses across the groups
COMP DEM	SH Work in A&E – working with contradictions	Competing demands placed on practitioners how balanced and effect.	3	0	1	0	1	0	4	1	4	2	1	2	Similar responses across the groups
IMPOT ENT	SH Work in A&E – working with contradictions	Unable to do anything for YPSH due to barriers, treat to the best of ability	0	0	0	0	2	0	0	5	2	4	0	0	Similar responses across the groups
PAEDS	SH Work in A&E – working with contradictions	Benefits of paediatrics (training, staff = better care, or not)	0	3	0	9	0	2	3	2	5	0	3	0	Similar responses across the groups
CONFID ENCE	SH Work in A&E – working with contradictions	Reference to having (or not) confidence/experience	4	0	0	3	1	0	1	0	0	3	4	2	Similar responses across the groups
DOC	SH Work in A&E – working with contradictions	Documentation (inc guidelines, policy, action plans)	0	1	2	4	0	1	0	1	1	8	2	6	Similar responses across the groups

Appendix 11: Matrix Comparing Components of AYP Scale and Text from Transcribed Interviews
(Shaded boxes indicate paramedic response)

The behaviour of young people today is no worse than it was in the past:	Mean Scores 2.45 N 2.064 PAT (18% agreed)	The views of young people aren't listened to enough	Mean Scores 3.23 N 3.31PAT (50% agreed)	Girls are more badly behaved than boys nowadays	Mean Scores 3.21 N 3.12 PAT (18% agreed)	Most young people are responsible and well-behaved	Mean Scores 3.20 N 3.33PAT (67% agreed)	Young people today have no respect for adults	Mean Scores 2.81 N 2.62 PAT (61% agreed)
Teenagers that come in maybe have been drinking, out with friends, had an argument with boyfriend 05		But young people, need a little bit more time (to talk) 01		And it does tend to be ladies that fall over 02		Drunk or high on drugs.. invariably they are abusive and you are open to verbal and physical attacks 05		this daughter was screaming was because she didn't want her dad to see the state she'd got in 07	
the drink you can get over the counters, and they go wha hey, and you wake up with a headache, that's nothing, that's life 01		'well hold on, you told me that you'd bring me here and this would all be okay and such and such'. 07		you know there may be something else, another drug been added to their alcohol or something and by lads they don't know 02		they've usually fallen over in one way or another so if it's alcohol they've had too much and collapsed 02		I mean some, you know sometimes they're, you know just abusive 03	
everyone gets drunk, it's a normal part of growing up 01		"Right, well okay, well I'll talk to your mum about it" "no, no, 'because that's patient confidentiality, you can't tell my mum" 07		she'd had drunk over a litre of vodka, her friends had used her lipstick to write over her forehead 07		can't even sit on the bench, they're actually on the floor, there is vomit everywhere, the person is like a young teenager, 13 or 14 years of age 07		They're scared of uniforms and service provision 10	
It's the norm to go out for a few drinks, it gets a bit silly after exams 08		You know and then you've got to try and work out whether what they're telling you is close to the truth or not 03		And we're seeing lots of them who are coming in who are out drinking at the age of 13, 14, and they think they come in and think they may have slept with some boy 11		Our weekends now, you're going to the children ... they're under 16 years of age, in public places, 'x' amount of cans, you'll get called to a park area anywhere, 07		Definitely I would say yes I've been intimidated before 08	
But children a lot of them are too inexperienced too immature, they haven't experienced life 01		And then maybe once you've gained their trust maybe engage them in a conversation 03		They're usually female, the vast majority I'd say are female in my experience, and they're usually upset, tearful. 02		absolutely blotto binge drink, absolutely totally out of it 07			

The behaviour of young people today is no worse than it was in the past:	Mean Scores 2.45 N 2.06 P 2.03 AT (18% agreed)	The views of young people aren't listened to enough	Mean Scores 3.23 N 3.44 P 3.18 AT (50% agreed)			Most young people are responsible and well-behaved	Mean Scores 3.20 N 3.47 P 3.00 AT (67% agreed)		
Teenagers I think are very vulnerable people, they're like little sponges half the time, and they absorb their environment 05		If they don't want to chat then and then I'll tend to get them outside they tend to open up more after that 08				I think they're abusive because they're defensive, you know, because they perceive that they're in trouble 04			
when I say the modern-day youngster ... they're not like the youngsters like when we were young, you were not allowed to do this, you were not allowed to that 07		The biggest challenge is to get them to open up and talk to you and from where we work to, for us to show we understand and to build the trust very quickly 08				YP are seen as, it's probably not fair to generalise but they have a bad reputation, they have a reputation that if they're not in school they are troublemakers 08			
where I work a lot of them are expected or seen to be in gangs and that's the expectation they have the police 08		I say we've got to get a parent or a responsible adult, otherwise we'll have to get the police, because there's got to be somebody reliable 01				Definitely I would say yes I've been intimidated before 08			
Unfortunately a lot of it is gang related violence 08		Teenagers do have a very big tendency to blow things out of proportion 05				Invariably they are abusive and you are open to verbal and physical attacks with these people 05			
						She'd had drunk over a litre of vodka, her friends had used her lipstick to write over her forehead 07			

Most young people are helpful and friendly	N 4.00 P AT 4.26 (46% agreed)	Young people today are not disciplined by their parents	N 2.49 PAT 2.04 (72% agreed)	Adults have no respect for young people	N 2.51 PAT 2.75 (18% agree)	Young people today don't get enough care and attention from their parents	N 2.68 PAT 2.57 (46% agree)	Young people today have more stress in their lives than they did before	N 3.28 PAT 3.40 (60% agree)
If they're sober, they clam up, 03		they're too frightened to say, too frightened, because they think to themselves I'm going to be separated 01		a lot of them are too inexperienced too immature, they haven't experienced life 01		Normally they don't have anyone with them 05		they have everything in the sense of technology, they have the clothing, they go out 07	
those the other ones just do a bit moody and "well I didn't want you here anyway" 06		A lot of them are frightened they've done something and they don't know how if it's the first time, their mum and dad's going to react, 01		people were quite dismissive about young people 02		it's usually a third party who has called the ambulance 02		I had a group from a school ...and they were all from the same school...when they looked into it was the peer group 09	
And I guess if you're a stroppy 15, 16, 17 year old with issues 02		they worry about, you know, they're going to get into trouble and they're going get punished in some way for it. 02		people who just roll their eyes 05		youngsters have been involved in drink, either in homes, having parties while the parents are not there 07		Well, of course, like you see the youngster nowadays, they have everything in the sense of technology, they have the clothing, they go out 07	
I also see a lot of people who are young carers the family are very unwell I see a lot of people who grow up incredibly young for other reasons 08		they're absolutely, you know, drunk and incapable and flat out on a trolley and then the parents turn up and they're mortified 02		as soon as they go under the 17 16 yr old back people think they can't help it 05		the fact that the parents had actually found their daughter 07		its, very difficult for them and it's getting worse than rather better for teenagers, 11	

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Most young people are helpful and friendly	N 4.00 P 4.35 AT 4.18 (46% agreed)	Young people today are not disciplined by their parents	N 2.49 P 2.06 AT 2.03 (72% agreed)	Adults have no respect for young people	N 2.51 P 2.82 AT 2.68 (18% agree)	Young people today don't get enough care and attention from their parents	N 2.68 P 2.44 AT 2.71 (46% agree)	Young people today have more stress in their lives than they did before	N 3.28 P 3.44 AT 3.36 (60% agree)
often the young person is unwell, not cooperative, won't communicate 04		there is a big fear a big fear about being separated, some want that, but they're still afraid 10		hope we treat the teenagers a lot better than that and a bit more understanding and try and be more gentle 11		I should think, you know, deeply upsetting, probably some parents feel 04		it's just awful the whole way society is hitting and putting a lot of pressure on girls especially. 11	
A couple of times they've just not wanted to communicate because they don't want to be part of it... just do a bit moody and "well I didn't want you here anyway"06				Most teenagers now, as you probably know are taller than me and I wouldn't take them on, 01		Or it's a parent who either returns or finds… the child comes home and they're in a state 07		I don't want my parents to know' .... They really do have, in some instances, a very good relationship with one parent and don't want that parent to know 07	
Sometimes they won't communicate with you so you need to get a rapport with them 09				you know you kind of tread, tread carefully and just keep them compliant 02		I think parents feel this overwhelming responsibility – I would, you know that 09		a lot peer pressure in adolescents 09	
They can, sometimes they're completely closed down they won't tell you anything at all, won't answer any questions 11				I think it's always that people can be more accepting of children, you know or young people 06		Some of them just do sit back and don't say much and are quite argumentative with the teenagers 11		There is bullying at school or feeling stressed at exams or there are other facts that are linking into them feeling out of control 11	

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Most young people are helpful and friendly	N 4.00 P 4.35 AT 4.18 (46% agreed)	Young people today are not disciplined by their parents	N 2.49 P 2.06 AT 2.03 (72% agreed)	Adults have no respect for young people	N 2.51 P 2.82 AT 2.68 (18% agree)	Young people today don't get enough care and attention from their parents	N 2.68 P 2.44 AT 2.71 (46% agree)	Young people today have more stress in their lives than they did before	N 3.28 P 3.44 AT 3.36 (60% agree)
				Now, in my day, you were told to something, you did it, if you didn't, you got belted" well you can't do that now 07		I think sometimes it's the first time that they've maybe seen that the people round them do actually care what happens to them, 06			
				I think a lot of people where I work don't respect them at all 08		I think they lack people they can go to ask for help 08			
				Because I'm white middle class and I walk in and they think you don't have a clue you don't have a clue about where I live and what I'm doing I can understand that I will respect that 08					

Appendix 12: Matrix comparing components of AYPSH scale and text from transcribed interviews (Shaded boxes indicate paramedic response)

Most young people who deliberately harm themselves don't want to die	Mean Scores N3.83 PAT 4.29 85% agree	Young people who deliberately harm themselves are trying to get sympathy from others	Mean Scores N2.74 PAT 2.63 49% agree	Young people who deliberately self-harm are in desperate need of help	Mean Scores N 4.00 PAT 4.26 88% agree	Most young people who attend having deliberately harmed themselves are likely to repeat this behaviour	Mean Scores N 4.08 PAT 4.29 94% agree	Young people who deliberately self-harm are attention seekers	Mean Scores N 3.13 PAT 3.19 28% agree
Some people take the paracetamol, usually it's paracetamol, genuinely thinking they're going to die OK from our point of view it's not serious, it's only ten or whatever, and let's say six paracetamol, it's not a big deal 002		She'd taken an overdose and it was the resident carer that called us and he was, you know obviously very concerned, he wasn't dismissive of it at all 003 I feel a bit sorry for them that they think that's the only solution 003		OK, obviously they don't usually take it do they, they've taken this they've done that and its and they've got to go and they've got to get help 001		she regularly chops herself up and I've seen her a few times and she just, she does it 002		What about the cutting? Ooh that's definitely a cry for help 001 Yeah and I'd agree (AS) with it to some extent with some patients but you can't pigeon hole every one like that, 010	
It's just skin wounds rather than anything significant 003		Even if we think that it's not a big deal because they only took six or whatever it is 002		you think to yourself ok is that a cry for help? 001		then followed by bigger guilt that they've actually fallen into it again.003		And you know, and a lot of the frequent ones are, it's they see it as, you know, like an attention seeking or it's a way of getting emotional support 003	

Most young people who deliberately harm themselves don't want to die	Mean Scores N3.83 PAT 4.29 85% agree	Young people who deliberately harm themselves are trying to get sympathy from others	Mean Scores N2.74 PAT 2.63 49% agree	Young people who deliberately self-harm are in desperate need of help	Mean Scores N 4.00 PAT 4.26 88% agree	Most young people who attend having deliberately harmed themselves are likely to repeat this behaviour	Mean Scores N 4.08 PAT 4.29 94% agree	Young people who deliberately self-harm are attention seekers	Mean Scores N 3.13 PAT 3.19 28% agree
More of a "I'm very upset for whatever reason, I'm going to swallow a handful of pills and that will be that". 006		I think majority of people do still feel sympathy for them, I think you do get a few with a very warped, A & E people who just roll their eyes 005		If you get some of the young people particularly teenagers that come in maybe have been drinking, out with friends, had an argument with boyfriend then take either OD or cut themselves or take OD of tabs or things like that, I think the sympathy is not necessarily there as much 005		You know, everything's a little bit better for a while and then they go back to it. 003		I think rarely people do that to themselves, because, I mean some teenagers obviously do it because they want attention 010	
								That's not attention seeking as they haven't sought any attention it's someone else bringing them into hospital or mum's found them or they've told one friend because they're a bit scared 005	
		They're deemed to have used the system then, and I do think their sympathy wanes the more times they come in, I'm sure it does, because they know what to do 005						I have been in not to, not wanting to sound cold or anything, but more what as I would describe as cries for help than serious suicide attempts 006	
								some people, and that may be colleagues who I've worked with, 'they're just attention-seeking, that's why they've done that' 007 I'd say are more cries for help than the actual event itself although they've still taken drugs which they don't realise is harmful 007	

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Most young people who deliberately harm themselves don't want to die	Mean Scores N3.83 PAT 4.29 85% agree	Young people who deliberately harm themselves are trying to get sympathy from others	Mean Scores N2.74 PAT 2.63 49% agree	Young people who deliberately self-harm are in desperate need of help	Mean Scores N 4.00 PAT 4.26 88% agree	Most young people who attend having deliberately harmed themselves are likely to repeat this behaviour	Mean Scores N 4.08 PAT 4.29 94% agree	Young people who deliberately self-harm are attention seekers	Mean Scores N 3.13 PAT 3.19 28% agree
It's not been anything significant that is sort of like the real pre-planning and that goes into it, it's more, it seems to be more of a knee jerk reaction to a situation rather than a thoughtful, planned process 006		I have to say I think its easier to feel sympathy for someone who isn't being abusive and it's easier to feel sympathy for someone who is very quiet and seems very frightened 005		If it's a young person who comes in alone may be taken pills has tried to hide it for a few hours and then got worried because they're not feeling well then umm, those people are given, it seems to be a lot more sympathy and lot more compassion 005		It's an addictive behaviour like smoking and drinking, that's why it becomes a problem 009		people think they're time wasters and just attention seeking, and those sorts of things you hear 011	
I've heard of people who, I've never actually witnessed it thankfully, who've said um for cutters and things like that they need suturing no need to give lignocaine because they enjoy the pain anyway, 009		"Doesn't really mean it, what's she done this time". 003		I would say most of them are a cry for help and unfortunately the ones who aren't are the ones who've done something serious 009				I see it as the same thing, cry for help, attention seeking, as why are you seeking attention- you want help whether you actually want the help or you want a reaction 010	
								Whereas AS it intimates that they don't necessarily need help but they want attention? 010	

Most young people who deliberately harm themselves don't want to die	Mean Scores N3.83 PAT 4.29 85% agree	Young people who deliberately harm themselves are trying to get sympathy from others	Mean Scores N2.74 PAT 2.63 49% agree	Young people who deliberately self-harm are in desperate need of help	Mean Scores N 4.00 PAT 4.26 88% agree	Most young people who attend having deliberately harmed themselves are likely to repeat this behaviour	Mean Scores N 4.08 PAT 4.29 94% agree	Young people who deliberately self-harm are attention seekers	Mean Scores N 3.13 PAT 3.19 28% agree
You do get the comments that are made how many tabs did they take and its only 8- 10 paracetamol and its like that's not nowhere going to touch the sides tell them to take a decent dose next time, 011		When I first started in A&E it was put the tube down and, you know, kind of you know it was almost seen as a punishment routine and not seen as a help thing 004		sometimes, it's very apparent, other times it's crowded and shrouded in them not talking to you and manipulative behaviour. 010				I would personally say and the way I see it is that someone has called an ambulance for a reason and sometimes it help patients to talk and I would say most of them are a cry for help 008	
... The time I wanted to kill myself and now I don't and I'm sorry I did it - the majority of them have not taken massive OD's that are going to cause them long term harm 011		If you get some of the young people particularly teenagers that come in maybe have been drinking, out with friends, had an argument with boyfriend then take either OD or cut themselves or take OD of tabs or things like that, I think the sympathy is not necessarily there as much 005		Some of them do actually ask for help themselves don't they, some of them they've gone to someone and say this what I've done, then I think that's the first step in the fact that they're recognising that they need some help themselves 009				A couple of times they've just not wanted to communicate because they don't want to be part of it... just do a bit moody and "well I didn't want you here anyway"006	
				OK, obviously they don't usually take it do they, they've taken this they've done that and its and they've got to go and they've got to get help, 001 and you think to yourself ok is that a cry for help? 001				And you know, and a lot of the frequent ones are, it's they see it as, you know, like an attention seeking or it's a way of getting emotional support 003	

Young people who deliberately self-harm are more at risk of successfully completing a suicide attempt	Mean Scores N 3.42 PAT 3.51 56%	Young people who deliberately self-harm are mentally ill	Mean Scores N 2.85 PAT 3.04 30% agree	Young people who deliberately self-harm are more likely to have difficult relationships with their families	Mean Scores N3.61 PAT 3.72 69% agree	Deliberate self-harm is a normal part of youth culture	Mean Scores N1.96 PAT1.73 16% agree	Young people who self-harm do it because they want to show how desperate they are feeling	Mean Scores N 3.52 PAT 3.67 66% agree
No. But that's, that's, I mean those are only two, yeah those were only two that self-harmed to the point of killing themselves.003		But it doesn't mean that at the time they took the overdose there weren't actually very serious things going on in their head at the time 002		I think she'd had argument with somebody, you know, and it was just a, you know so, patient way of coping or something 003		Social services and the rest of it, a classic they can't do anything, they're so naive they think it's normal 001		it was more emotional turmoil 003	
				Boyfriend, girlfriend, well boyfriend because it's been mostly females, or parents or something, you know arguments with parents and that kind of stuff 003		Unless of course you're a masochist, would you really want to do that 001		she's got drunk doesn't know where to go what to do and in those cases I've felt very sad that they're in that situation so young 005	
Sometimes people SH the adolescents for example they're not intending to commit suicide 00 9		I mean I think it's a case by case history, I think it's the reasons, it's not the act of being drunk is self-harm it's the reason behind why they've got drunk so I think you need to have that discussion 004		And that's one of the reasons they've taken, done self-harm, because of some situation, some family dynamics and they don't want them there but they're very complicated family dynamics 004		But no healthy teenager with a healthy lifestyle and healthy friends and family and everything, normally come into A&E having taken an OD 005		More to the point of they don't know what else to do, not to be... it's not to be taken seriously or anything like that, not sort of like to crave the attention 006	
One very traumatic case, which was a 10 year old who hung themselves 06		A lot more surrounding things like depression that's how I understand it., from what I've seen 008		Because it doesn't have to be anything major it doesn't always have to be abuse or it could just be that they are feeling very out of their depth or think who are their crowd or are their crowds are moving onto this and that and they 05 15, 16 yr olds who've been living with boyfriends and got into a fight or the boyfriend has beaten her up 005		I didn't really have many people who self-harmed but now, it's part and parcel of our daily workload 007		if they can't overcome the problem with who they've got available... whereas for them, they're in a position whereby they've got a problem and no matter who they go to, no-one can help them with resolving their problem. 007	
						Now I don't, I would never do that to myself, why would you do it? Would you do it to yourself? 007			

Young people who deliberately self-harm are more at risk of successfully completing a suicide attempt	Mean Scores N 3.42 PAT 3.51 56%	Young people who deliberately self-harm are mentally ill	Mean Scores N 2.85 PAT 3.04 30% agree	Young people who deliberately self-harm are more likely to have difficult relationships with their families	Mean Scores N3.61 PAT 3.72 69% agree	Deliberate self-harm is a normal part of youth culture	Mean Scores N1.96 PAT1.73 16% agree	Young people who self-harm do it because they want to show how desperate they are feeling	Mean Scores N 3.52 PAT 3.67 66% agree
He actually killed himself 07		I'd say depression, it sounds very stupid but really depression 010		I think sometimes it's the first time that they've maybe seen that the people round them do actually care what happens to them, especially if it can be difficult parent/child situations where they can then see the impact of what they've done on other people and it does hit home sometimes. 006		I think if you're talking recreational drugs and alcohol l see that every day, if we're talking about people who take OD's and SH OD's are I'd say are relatively common 008		but when I do this to myself, it makes me feel better. And that's the only way I ever feel better, nobody's doing anything for me' 007	
But um I've not seen the extreme (suicides) 008		It doesn't necessarily mean they are going on to have MH problems in the future, I think if it continues and continues then overall that would be different problems. 009		'I don't want my parents to know'.... They really do have, in some instances, a very good relationship with one parent and don't want that parent to know 007		I had a group from a school I was seeing quite a few, ...and they were all from the same school it was peer pressure 09			
				Because there were problems and the daughter was screaming, etc, and what this daughter was screaming was because she didn't want her dad to see the state she'd got in 007		I wonder what provokes somebody else into doing it 003			

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It's not always with the intention of suicide, sometimes it's a release of their bad feelings 009				Sometimes the parents can be quite upset especially if it's related to SH incidence which has occurred as a result of an argument with a parent and sometimes it does, it can be an argument with a peer you know but I think parents have this guilt trip that they've caused it 009		It's a difficult concept to grasp why someone would cut and harm themselves and what release they get from that 011			
At least one girl here came in with recurrent OD's and ended up succeeding in committing suicide and that's not what were aiming for at the end of the day, it's sad isn't it. 009				They don't want to move that way (home) 005 – She didn't want to go home for whatever reason that I can't fix 010 Family break up, not liking new partners so family break-up is the original thing but not liking the new partners they're living with, not being able to see the other partner it's another separate thing 010,					
I've seen [YP] potential attempted hangings and stuff who've ended up intubated and poorly from that, hypoxic injuries, so it is in every dep't you know 012				It was one of those stand out things that you always remember, all to do with bullying and ridiculous things like that, 006					

Young people who self-harm do it because they want to show how desperate they are feeling	Mean Scores N 3.52 PAT 3.67 66% agree	Young people who self-harm do it because they want to get their own back on someone	Mean scores N3.63 PA T 3.47					
It was more emotional turmoil 003 If they can't overcome the problem with who they've got available… whereas for them, they're in a position whereby they've got a problem and no matter who they go to, no-one can help them with resolving their problem. 007		I know they're distressed because they wanted this and couldn't have it blah de blah, so you know because they're stress levels are raised their way of coping with that is invariably to hurt themselves 005						
She's got drunk doesn't know where to go what to do and in those cases I've felt very sad that they're in that situation so young 005								
... but when I do this to myself, it makes me feel better. And that's the only way I ever feel better, nobody's doing anything for me' 007								
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