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| Table 1. Additional supportive quotations for Theme 1: “Between a rock and a hard place” | |
| Theme 1: “Between a rock and a hard place” | |
| Sub themes |  |
| IAPT & the misnomer of improving access | “But with the degree of rigidity we were confronting, basically patients in their hour of deepest need…were denied a service. And denied many other avenues as well.” (S102, P01)  “I love the misnomer of improving access.” (S03,P01)  “No, they’ve a very low threshold for any kind of risk so we quite often, well, not quite often but there are times when we have a referral from A&E, we ask them to see someone and they say, oh, I’m working with [the IAPT service], been having sessions there, they might have cut their leg or cut their arm and then that will be it, that service that will be stopped because they’re self-harmed they won’t see that person anymore.” (S31,P01) |
| Risk, thresholds, and social crises | “Secondary care mental health services will not take people with self-harm if they’ve not got a significant mental health disorder. It’s really…there’s very little out there for people unless you’re willing to accept that you have a serious mental disorder and a lot of people with self-harm don’t necessarily have any of that...” (S17,P01)  “…the home treatment team …they just want people who are…either got schizophrenia or got bipolar or got really severe and enduring needs. And if we refer them someone and things…if they visit them a couple of times then they don’t need to work with them anymore, it’s almost seen as negatively like, why did you refer them to us, they’re not seen on the same category as severe and enduring. I think there’s a negativity around crisis work, people who are in crisis that just because it resolves after a short while or certainly the acuity part of it and the urgent need is resolved, that’s not genuine, for some reason, a genuine issue.” (S101,P03) |
| Guard the beds | “…it’s a national crisis [lack of inpatient beds]. So, I think I went to a meeting not that long ago, where there wasn’t a single mental health bed in the country, private or public sector. So, then patients are kept here in a non-specialist area, cared for by people who are genuinely trying their best but we are not able to provide 24/7 support for patients that they would have in a mental health unit. They are cared for in an unsafe environment and probably an unsuitable environment with people with as much knowledge as they can have, and we are seeing people daily who are waiting, but there’s people waiting for a week for a bed. And that has a huge impact on the patient, the resources, the flow and then the relationship.” (S27, P0102) |

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| Table 2. Additional supportive for Theme 2” The perennial problem of silo working” | |
| Theme 2: “The perennial problem of silo working” | |
| Bureaucracy, delayed assessments, and strained relationships | "... So, we can’t go into that patient now and at the assessment say: we’d like to offer you some telephone support or some one-to-one support from the Crisis team and we can put that referral in. And then they can come out and they can either then telephone assess you, or you can make an appointment to go and see them, or they can come and see you. What we have to do now is have that assessment ourselves, not offer it to them at that point, then go back and then go and talk to the Crisis team and ask them at that point, this is what we feel. And then they can either accept it or not accept it from that point, obviously from our assessment.” (S28, P01) |
| Professional skill erosion via repeated assessments | “I think it’s extremely frustrating, because I think we’re the professionals who are making that clinical decision as to whether someone is safe to go into CBT – this isn’t like psychotherapy, this is talking about managing distress or managing anxiety – and I think once we’ve made that clinical decision that this is what’s going to help them here and now and then to be faced with no, this tick box says you can’t access it because you’ve done this, rather than looking at a holistic approach with the patient at the heart of it…” (S102,P02)  “... three people that have never met somebody before despite the fact that I’ve spent two hours with them, even on a one-off assessment and send that in and say this is what I think this person needs; then three people sit in a room and discuss it for five minutes and decide that actually the opposite is true 'cause that’s the other thing that happens. You know, as a clinician, you sit down, you do an assessment to the best of your ability, and then you send it in for referral, for a different group of people…. So, someone has been seen by a mental health professional, but it still goes through this strange triage service where they second guess your assessment. Which is mad, because they’ve never met that person. So, yeah, that can be a bit demoralising.” (S27,P03) |

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| Table 3. Theme 3, additional supportive quotations: “Cycle of despair” | |
| Sub themes |  |
| Waiting times | “Being told that IAPT might see you in eight weeks' time or the emotional wellbeing service might pick you up for an assessment in six or eight-weeks' time, doesn't really make you feel anything's any different, does it.” (S07,01)  “I think that’s shocking really because they’ve waited for so long, and then they finally get an appointment and then they’re told, well actually no, you’re engaging in self-harm, it’s not the right time, you have go to the back of the queue. But then I would so disappointed and annoyed that’s only going to escalate the self-harm because then they feel rejected and deflated. So, then they come to A&E and what can I provide, I refer to mental health services, they say, no they need Talking Therapies and then you go round again.” (S13, P01) |
| Inevitability of further harm | “ … we get a lot of patients that say that they’ve waited quite a long time and, you know, they’re on waiting lists. And during that time they’ve gone in to crisis where they’ve become…self-harm has increased, suicidal. And then the risks seem to highlight that they’re too risky for that service now. And they could have been waiting four months and then there’s a possibility that they end up being discharged and referred back in to the access team. But then from there they don't meet the criteria…they’re not under secondary services so they don't meet the criteria for that. So that’s definitely one thing that I’m aware of…And sometimes by the time we’ve got there, you know, they’ve either gone past the motivation to engage or their risks have increased too much where they’re no longer meeting that service.” (S104,P0102) |
| Bearer of bad news | “I think what happens after has a bearing on the quality of the assessment. So, the community provision, as I have said, has really reduced, which means that our staff feel helpless. They might do a very good quality assessment but then they have nothing else to offer to the patient. It doesn’t support them in the community, and that can affect the patient experience as well. That helplessness, you know, can be communicated to the patient, which then leaves the patient feeling helpless.” (S07, P02)  Well, I think it’s thoroughly exasperating really. And some…but this goes with that worry that I have that people are at risk of burnout, that it’s difficult to inspire hope in others when you’re not quite sure whether what you’re offering is going to come to fruition or not. So, there’s…often I can see when I’m reviewing notes and things, that people have gone to great lengths to say there’s this service, it’s great, but there’s quite a long waiting list, what can you do while you’re on it? But yeah, just thinking if only they could get access to this, you know, 12 sessions of CBT within a couple of weeks instead of nine months.” (S04,P01) |

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| Table 4 Theme 3, additional supportive quotations: Improving psychosocial assessments and aftercare plans | |
| Theme 4: Improving psychosocial assessments & aftercare plans | |
| Sub themes |  |
| MTDs, skilled staff, & clinical psychologists | “I think it’s really beneficial because the nurses see one point, your medics will see it from another point, your psychologist. We’ve also got an OT on the team, she brings a completely different…because she’s very…you know, she’s an OT who’s stayed an OT. I think in mental health you find Ots who have become mental health practitioners, but she’s not, she’s very much an OT and very proud of it, which is brill because again, she really helps with that…. And she will work in A&E as well, she does see people who have self-harmed. And again, her approach to… she’s very much an intervention practitioner. So she will very much focus on people’s coping skills, kind of the tools that they’ve got to help them. I think sometimes as nurses, we look at perhaps things around signs of safety and perhaps external factors, whereas our OT will look a bit more, well, what have you got in your reserves or what have you got…yes, you’re saying mum looks out for you but how do you utilise mum’s…I know since I’ve worked with her, I ask her a lot of different questions thinking, oh, I’ve never looked at it.” (S12,P01)  “So we have a psychologist on our team, so sometimes we’ll try and enlist his help to…and he’s only here Monday to Friday but if we can get him to help out with an assessment or something like that, where we think someone…if he thinks a person needs psychology, then we will enlist his help to try and make the referral directly to psychology services or to FRT, but with saying that, yeah, this person has been seen by our psychologist, we feel that he needs to be referred to psychological services within FRT.” (S17,P01) |
| Psychosocial assessment as therapeutic intervention | “And it sort of, to me it’s something that irritates me about services that I think there’s far too much signposting, bouncing, assessing…well perhaps in the other…assessing, signposting, bouncing and not enough actual therapeutic work that goes on in services. And this was a way that we could actually provide some therapeutic work for this group and it’s been dropped in favour of more bloody assessment. So that’s my particular worry about it going.” (S27,P0102)  The thinking then becomes of the biopsychosocial assessment – it’s not an assessment, it’s an intervention, you’re offering treatment. Once we start thinking about it in that space, our staff think about it in a very different way because our frustration previously has been that people think that this is...we’re like a factory, we’re doing assessment and churning things out.” (S15,P02)  “I think being afforded more of an opportunity in A&E to be able to think with people in a therapeutic fashion and do a therapeutic assessment where we weren’t so, kind of, boundaried by time and pressure to get people out, would also be really helpful.” (S27,P03) |

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| Table 5. Theme 5, additional supportive quotations: Navigating, negotiating, and testing boundaries | |
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| Crafting referral letters | “It is complicated sometimes in that when we're trying to refer someone, we might think they deserve a service and need a service, but the service we're referring to sometimes will be…you know, if we don't put the referral in the right words, say, or fit the patient to the service, then they might be declined that service. It feels like that a little bit, that we're trying to do our best to get a person taken on by a particular service… .., you're trying to get your patient a service and the only way to do it is to try and like become a salesperson to try and promote that patient to the other teams.” (S17,P01)  “Another problem I think, particularly around self-harm is that when we are referring them in to say wellbeing or to the ATS, we might actually really be wanting an intervention around their self-harm and around their, you know, that. That might really be what we want for them but that’s not obviously on offer, so they almost, you have to sort of dress it up as they need, well if they’re going to well-being they need an intervention around anxiety and depression generally. (S27, P0102) |
| Probing boundaries | “They may, there’s discretions at work. So, some have discretion with that, and use it, and others automatically say, no this is too high risk. So, my experience of having referred in the past, is that if you can have a conversation about that, and be very clear about those aspects about self-harm, suicidal risk, then they can be more receptive to working with somebody. … So, I think the fear is that it will be too risky to work with somebody, or they won’t be able to work because of their risk in terms of the therapy, so it’s just being very clear about what the, so if I just stick with self-harm for the minute, what the self-harm’s about in relation to something that may be a way of managing difficult emotions or overwhelming emotions, and that that continues to be a way of trying to manage that, but there’s no sort of short-term immediate kind of risk, that the greater gain would be for therapy rather than not having, yeah, so it’s just being really clear about where someone’s thoughts are in relation to their self-harm, the way in which they approached that, what happened afterwards, all those sort of bits, so that’s being clear.” (S101, P02) |
| Pull the consultant card | “We try and negotiate with the person if the Home Treatment Team are refusing or we maybe have a very robust conversation with the Home Treatment Team and maybe reach…sometimes we escalate up to senior doctors and things like that to discuss the risks and potential benefits of Home Treatment Input if that conversation doesn’t seem to come up with a good outcome for the patient. Sometimes we might escalate to secondary managers, if we’re not able to resolve that conversation with the Home Treatment Team to see if there are some other outcomes that we can offer; so, it’s quite difficult sometimes… I think normally we come to a point where we get some outcome.” (S16, P01) |

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| Table 6. Theme 6, additional supportive quotations: Building relationships and integration | |
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| Building relationships | “Absolutely it’s part of the liaison service. The history behind the [specialist psychological service for self-harm] was that we started as a pilot within the liaison team with A&E from the research funding that we received and then managed to convince the commissioner. Because the data was so fabulous they just couldn’t ignore it and our own trust wouldn’t ignore it and I said well if we are, as a trust, going to talk about zero suicide prevention, then let’s lead the way and show that we can actually offer treatment much, much more quickly. And the thing I presented to the trust was to say, well, we always looked at liaison as a service that assesses people and signposts. And I say, we need to shift that, we need to call ourselves an intervention of treatment service.” (S15,P02) |
| Joint working, open and accessible services | “One of the great things I think that we have in [location] is we don’t have the barriers to get into other teams like Home Treatment Team. So, we have delegated authority to accept patients on behalf of Home Treatment Team. So, we don’t have to send them to a separate site and ask Home Treatment Team’s position to take our patient on. If we say that they need home treatment, they need to accept and they’re taken on. And similarly, we don’t need Home Treatment Team’s consent to admit to a ward. We can make our own decision on that. We’re not restricted like... I know that some other trusts, there’s a lot of politics about those sorts of things, but we don’t have those. So, we’re given quite a lot of liberty to do what we think’s appropriate. And we’re... Home Treatment Team, Crisis Resolution, the Health Centre, non-Covid, plus our liaison team have the crisis line. All of those are integrated under a single command structure. So, we’ve got a sort of integrated crisis resolution service that starts at one end with inpatient liaison, passes through ED liaison, passes through therapies then ends up in the Home Treatment Team as well…So, they’re all under a single manager that services in that pathway. So, they’re designed to integrate in a non-clunky way so that patients don’t get stuck between boundaries or services behaving silly and trying to protect themselves whilst exposing patients to risk…I think a lot of trusts, you know HTT will say refer, but we’ll not tell you if we’re taking on. Well, you can’t do that because I can’t take... Let’s say you’re assessing somebody in A&E, and you think that their risk is manageable if they’re on the Home Treatment Team. Well, you can’t discharge them and then wait for Home Treatment Team band six to get back after a consultant’s seen a patient three days earlier and say we don’t think they’re suitable. That makes a nonsense of the risk assessment done in A&E. So, you know, they’re either suitable for discharge with HTT, but if you think that they wouldn’t be suitable for discharge without HTT, you need to have the right to make that decision on behalf of Home Treatment Team….” (S22,P02) |
| Psychological therapies and outpatients | I think in the main the 72-hour pathway helps if they are new presentations, or if it’s somebody who has been through home treatment my referral might be that the staying well plan wasn’t robust enough that you developed, so can we relook at it and develop something else or refresh on some decider skills and then recreate a more robust staying well plan…” (S04,P01)  “Yeah, I always find it reassuring to have that in your back pocket when you’ve got somebody who you’re a bit unsure of. Knowing that you can arrange a follow up and no one’s going to be getting at you, because they haven’t got the capacity to do it, and it’s a routine that we do that. And even so much as being able to offer a follow up and saying, look, I see that you’re in distress, I see that you’re struggling, this is what we can do, that can be really helpful, in that people I think respond well to knowing that they’re going to see you tomorrow if that’s the plan that you’re going to put in place. … And because they’re routine, no one challenges or questions you as to your decision-making on it, because we all do it and we’ve got to do it and it’s built into the service to do it.” (S08, P01) |