**Appendix 2. Additional methodological details**

**Analytic approach**

Thematic analysis, within a qualitative paradigm (as opposed to a post-positivist paradigm) was used to explore patterns, shared meaning, similarities, and differences across the study dataset.1-5 Thematic analysis was used over other methods (e.g., content analysis6) because we wanted to explore subjective experiences of accessing psychological therapies following an episode of self-harm. We addressed our research questions from a qualitative critical realist theoretical position, which considers meaning and experience as subjective realities for participants and our active role in conducting the analyses.1 Coding and themes were generated through our reflexive and active engagement with the data. People with lived experience, clinicians, mental health epidemiologists, and researchers with health services and qualitative expertise were intentionally involved throughout the study to bring their perspective, views and experiences to the analyses.

Consistent with the approach developed by Braun and Clarke,1-4 after immersion and familiarisation with the data, we coded the data systematically and iteratively at a predominantly semantic level. Two authors (LG and LQ) independently coded the full dataset. Six members of our patient and public involvement with lived experience in this area panel coded sections of the data (dataset split across members to reduce burden). Throughout the process, codes and themes were iteratively generated, revised, reviewed, and named via discussion within the team (LQ, LG, SM EM, SA, RW, NK). This team facilitated discussion and reflection around the process of accessing psychological therapies following self-harm, which enriched the robustness and interpretation of the data. The final themes, thematic structure, and write-up (report) were agreed through discussion amongst the team. Themes addressed important aspects of the data in relation to our research question. We did not quantify qualitative data (e.g., use of counts or percentages). This approach is inconsistent with our methodological approach and undermines the importance of some subjective experiences over others. 2,5

**Analysis: research team backgrounds**

Data were analysed and interpreted by a multidisciplinary team that included expertise in clinical and academic psychiatry, mental health services research, mental health epidemiology, psychology, and qualitative methodologies. The public contributors involved in the analyses included people with lived experience of self-harm and attending mental health services after harming themselves, as well as carers of these individuals. We developed themes through reflexive engagement with the data, and intentionally involved people with diverse experiences to enrich our analyses and interpretation, via their lived experience.

**Recruitment**

This study was conducted as part of a larger programme of applied research investigating psychosocial assessments and psychological therapies following self-harm in the NIHR Greater Manchester Patient Safety Translational Research Centre. The survey was accessed through a University of Manchester website that contained a summary of the research process, a link to the participants’ information sheet, consent form, and post-assessment debrief statement. We expected to recruit approximately 100 respondents, an estimate that was based on our previous studies that were conducted using online surveys.8-9

**Online survey procedure**

The study website, online survey tool, question format (e.g., yes/no, free-text; how the questions were asked), were developed with our patient/carer advisory panel via a series of workshops.10 Questions were co-produced with our patient/care/ clinician advisory panels on the basis of lived experience, and informed by previous research indicating poor and variable access to services. We included open and closed text questions (e.g., demographics, selecting choices for services; binary response experiences) to elicit participant’s views and experiences of assessments and follow-up care (see Appendix A). We also asked for self-reported diagnosis, age, gender, and educational attainment. Survey questions for patients and carers were similar. Carers were invited to provide proxy information for diagnosis, living arrangements, and employment; and share their views of assessments for the person presenting with self-harm. Participants could tick boxes, skip questions, and/or complete free text responses without word limits. All participants provided informed consent for their participation. Due to the sensitive nature of the topic, links were provided to several online support sites after the assessment. Informed consent was obtained from all participants which was indicated by clicking continue on the survey.

However, some participants may have been excluded by the use of an online survey, including non-English speaking participants, and people with limited digital access or literacy. Carers in our study acted as proxy respondents for patients who have self-harmed and provided their perspectives on care quality. Further standalone research is necessary to investigate carer specific experiences when supporting significant others in accessing psychological therapies.

This is a large study qualitative study examining patient and carer experiences and preferences about accessing psychological therapies following self-harm. Over 150 participants shared their experiences of accessing psychological therapies and provided recommendations for improving practice. Our study was strengthened by patient and carer involvement throughout all stages of the research process. Research questions and methodological choices were determined by patient need and lived experiences.

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Recruitment:

* NHS Trusts: *n*=80, 35.6%
* Twitter: *n*= 50, 22.2%
* Facebook: *n*=19, 8.4%
* University networks (newsletters): n=13, 5.8%
* Internet search: *n*= 13, 5.8%
* Friends/ Family: *n*=5, 2.2%
* Charities: *n*=6, 2.7%

**Completed survey:** N= 225

**Excluded:**  *n*=39

* *n* = 19 (e.g., near complete missing data)
* *n*= 20 (partial missing data, not enough data for analyses)

**Included:** *n* = 186

**Mental health assessments study:**  *n* = 128

**Psychological therapies study:** *n* = 157

**Qualitative text responses:**  *n* = 151

**Qualitative text responses:**  *n* = 102

Figure 1

Flow chart of participants in the assessments and psychological therapies following self-harm. There were no relationships between missing data on age, sex, or ethnicity.

Table 1 Additional participant demographics

|  |  |  |
| --- | --- | --- |
| Participant demographic characteristics | | N=151 |
|  |  | N (%) |
| Patient/carer | Patients | 128/151 (84.8) |
| Patients Age | Median age | 32 (IQR = 26 to 45) |
| Carers age | Median age | 50 (38 to 59) |
| Patient gender | Female | 106/128 (82.8) |
|  | Male | 18 (14.1) |
|  | Other | 4 (3.1) |
| Carer gender | Female | 20 (87.0) |
|  | Male | 3 (13.0) |
| Patient ethnicity | White ethnicity | 121/127 (95.3) |
| Carer ethnicity | White ethnicity | 21/23 (95.5) |
|  |  |  |
| Nation | England | 147/150 (98.0) |
| Patient employment status | Work or voluntary work | 58/127 (45.7) |
|  | Disability benefits | 39/127 (30.7) |
|  | Not working | 13/127 (10.2) |
|  | Student | 17/127 (13.4) |
|  |  |  |
| Patient self-reported psychiatric diagnosis\* |  |  |
|  | Depression | 78 (60.9) |
|  | Anxiety/ GAD\*\* | 49 (38.3) |
|  | Emotionally unstable personality disorder/ PD\*\*\* | 45 (35.2) |
|  | Complex PTSD/ PTSD\*\*\*\* | 29 (22.7) |
|  | Obsessive compulsive disorder | 7 (5.5) |
|  | Attention deficit hyperactivity disorder | 1 (0.8) |
|  | Autism spectrum | 3 (2.3) |
|  | Bipolar disorder | 9 (7.0) |
|  | Eating disorders | 15 (11.7) |
|  | Psychotic disorders | 10 (7.8) |
|  | Dysmorphic disorders | 1 (0.8) |
|  | Dissociative disorders | 5 (3.9) |
|  | Alcohol dependency | 1 (0.8) |
|  | No diagnosis | 16 (12.5) |
| \*not mutually excusive; \*\*GAD= Generalised anxiety disorder; \*\*\*personality disorder; \*\*\*\*post-traumatic stress disorder | | |

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