Research report

Service user perspectives on psychosocial assessment following self-harm and its impact on further help-seeking: A qualitative study

Cheryl Hunter [a,b,*], Khatidja Chantler [c], Navneet Kapur [d], Jayne Cooper [d]

[a] Manchester Mental Health and Social Care Trust, United Kingdom
[b] School of Community-Based Medicine, University of Manchester, United Kingdom
[c] School of Nursing, Midwifery and Social Work, University of Manchester, United Kingdom
[d] Centre for Suicide Prevention, School of Community-Based Medicine, University of Manchester, United Kingdom

ABSTRACT

Background: Psychosocial assessment is a central aspect of managing self-harm in hospitals, designed to encompass needs and risk, and to lead to further care. However, little is known about service user experiences of assessment, or what aspects of assessment service users value. The aim of this study was to explore service user experiences of assessment, and examine the short-term and longer-term meanings of assessment for service users.
Method: Interpretative phenomenological analysis was applied to 13 interviews with service users following hospital attendance, and seven follow-up interviews conducted 3 months later.
Results: Few participants had a clear understanding of assessment's purpose. Assessment had the potential to promote or challenge hope, dependent on whether it was experienced as accepting or critical. If follow-up care did not materialise, this reinforced hopelessness and promoted disengagement from services.
Limitations: The study sample was small and the participants heterogeneous in terms of self-harm history, method and intent, which may limit the transferability of the findings to other settings. Only self-report data on clinical diagnosis were collected.
Conclusions: This was the first study to utilise an in-depth qualitative approach to investigate service user experiences of assessment and follow-up. The findings suggest that re-conceptualising psychosocial assessment as primarily an opportunity to engage service users therapeutically may consequently affect how health services are perceived. In order to maintain benefits established during the hospital experience, follow-up needs to be timely and integrated with assessment.

© 2012 Elsevier B.V. All rights reserved.

1. Introduction

Self-harm is a public health priority in the UK and internationally (Department of Health, 2002). It is strongly associated with eventual suicide (Cooper et al., 2005) and mental illness such as depression and anxiety (Haw et al., 2001). Self-harm is also a behavior commonly associated with personality disorders, such as BPD, and schizophrenia (Haw et al., 2001, 2005). It is estimated that approximately 150,000 individuals self-harm and attend emergency departments in England annually (Hawton et al., 2007). Service users presenting to emergency departments with self-harm tend to experience multiple difficulties, both

psychological and social in nature (Haw and Hawton, 2008; Hume and Platt, 2007). This complexity makes it challenging for services to respond, and few psychosocial interventions have yet shown a significant impact on rates of self-harm repetition or suicide (Hawton et al., 1998; Crawford et al., 2007; National Institute for Health and Clinical Excellence, 2004). Low-intensity interventions facilitating contact between patients and services following self-harm have so far had mixed success in reducing repetition (Kapur et al., 2010), although patients may perceive them positively (Cooper et al., 2011). In addition, whilst a small number of interventions have reduced self-harm rates, these have tended to be high-intensity interventions focusing on specific sub-sets of people who self-harm, for example, dialectical behavioral therapy for patients with BPD (Kliem et al., 2010). Whilst further research is required to establish mechanisms for effective psychosocial intervention across patient groups, attendance at hospital after self-harm offers an important opportunity for services to intervene and engage patients in determining acceptable avenues for intervention (Crawford and Wessely, 1998).

* Corresponding author at: CHOICE Project, Manchester Mental Health and Social Care Trust, Rawnsley Building, Manchester Royal Infirmary, Manchester M13 9WL, United Kingdom. Tel.: +44 161 276 5326/3313;
fax: +44 161 273 2135.
E-mail addresses: cheryl.hunter@mhsc.nhs.uk, cherylhunter@nhs.net, cheryl.hunter@manchester.ac.uk (C. Hunter).

Psychosocial assessment is a central aspect of self-harm management, designed to assess patient psychological and social needs, assess risk of future self-harm or suicide, and to determine appropriate follow-up care (National Institute for Health and Clinical Excellence, 2004; Royal College of Psychiatrists, 2004). Assessment is "psychosocial" to recognise the importance of, and inter-relationships between, psychological and social domains of patients' lives. Every service user presenting to hospital with self-harm should receive a psychosocial assessment after having received initial triage for medical treatment, and before discharge from the hospital (National Institute for Health and Clinical Excellence, 2004; Royal College of Psychiatrists, 2004). Healthcare professionals are expected to utilise psychosocial assessment both as a management tool to determine how to manage a self-harm presentation and what care to offer, and as a means of engaging service users in further care (National Institute for Health and Clinical Excellence, 2004). Further care can include a range of options, including medical or psychiatric admission into hospital, discharge and referral to general practice, referral to community services, and referral to psychological or social services (Bennewith et al., 2004). Receiving a psychosocial assessment is associated with improved access to aftercare (Barr et al., 2005). Psychosocial assessments are conducted by mental health professionals from a range of disciplines, but within UK emergency departments, patients are predominantly assessed by psychiatrists or psychiatric nurses (Hawton et al., 2007; Royal College of Psychiatrists, 2010). Evidence of psychosocial assessment impacting on future self-harm is equivocal: in one prospective cohort study, psychosocial assessment was associated with a reduced likelihood of repetition following self-poisoning (Kapur et al., 2002), but a multi-centre study found no clear association between psychosocial assessment and repetition (Kapur et al., 2008). Variation in the direction of an association across hospital sites may reflect differences in organisational structures (Kapur et al., 2008). Hospitals in the UK vary widely with regards to the provision of psychosocial assessment, with between 42% and 71% of self-harm presentations receiving psychosocial assessment from a mental health professional (Barr et al., 2005; Kapur et al., 2008). This variability is likely to impact on the effectiveness of psychosocial assessment (Bennewith et al., 2004).

Previous research reports that patients describe both positive and negative experiences of hospital care (Crockwell and Burford, 1995; Hengeveld et al., 1988; Horrocks et al., 2005; Palmer et al., 2007; Taylor et al., 2009; Whitehead, 2002). To date, the impact of psychosocial assessment over time has not been explored: research has either taken place within hospital at the time of psychosocial assessment, or shortly thereafter in the community. No previous studies have utilised interpretative phenomenological analysis (IPA) to interrogate meaning-making around assessment, although IPA has been used effectively to explore experiences of self-harm in service users, carers, and health professionals (Alexander and Clare, 2004; Hadfield et al., 2009; Harris, 2000; Oldershaw et al., 2008). IPA is an idiographic qualitative methodology, which situates meaning-making within the wider sociocultural world of the individual and is well-suited to investigating complex phenomena (Smith et al., 2009). The current study aimed to investigate short and longer term meanings of assessment, and how service users' interpretations of the assessment and hospital experience affect future help-seeking intentions. To achieve this aim, a longitudinal qualitative design was adopted, utilising IPA.

2. Methods

2.1. Ethical issues

Key ethical issues in this study included: ensuring informed consent; approaching service users in an appropriate, non-coercive way; protecting confidentiality; and dealing with emotional distress arising from interviews. These issues were addressed by adopting a consent-as-process approach (Cutcliffe and Ramcharan, 2002), establishing a protocol for handling distress in a sensitive, participant-centred manner (drawing on Faulkner's (2004) guidelines), and involving service users in the design phase of the study. Feedback from service users informed the recruitment strategy and the interview guides.

This study received ethical approval from Tameside and Glossop NHS Research Ethics Committee in July 2008 (Ref: 08/H1013/52).

2.2. Participants

Participants were identified by a specialist self-harm team based at a local urban teaching hospital. As part of routine clinical practice, the team collected information on recent self-harm presentations at the emergency department. Letters of invitation were sent to patients meeting inclusion criteria via this team within a week of attendance.

2.3. Inclusion and exclusion criteria

Eligible participants were adults over 18 years of age who attended the study hospital emergency department following self-harm and who received psychosocial assessment before discharge. For the purposes of this study, self-harm was defined as intentional self-poisoning (including overdosing) or self-injury, irrespective of motivation (Hawton et al., 2003). People fulfilling these criteria are likely to have different needs and preferences regarding support following self-harm (Cooper et al., 2011). During the interviews, participants were asked about their experiences, meanings and reasons for self-harm, in order to contextualise their identified needs and preferences.

Service users were excluded if they could not be reached by letter, or were incapable of giving informed consent. Service users who did not speak English were offered a translator. If there was no evidence of psychosocial assessment recorded on patient notes, service users were not contacted.

2.4. Data collection

Semi-structured interviews were conducted with 13 service users as soon as possible after index episode (average time to interview=5 weeks). Interviews typically lasted 1 h (variation 30 min to 3 h). For a sub-set of participants, follow-up interviews were conducted three months after initial interview. Interviews either took place at participant's place of residence or at a convenient university site, with one exception (P6) being conducted by telephone.

Two topic guides were designed in consultation with service users (see Box 1). The format of both interviews was to start with open questions about the participant's experience at hospital in general to gain a holistic view, and then to probe for specific details around assessment and salient aspects of that experience, in line with IPA guidance on data collection (Smith et al., 2009). The interviewer reflected the participant's terminology to describe self-harm, mental illness or psychosocial assessment where possible, as recommended by the service user consultation group. Initial interviews focused on the index episode of self-harm and experience of psychosocial assessment, and followed a chronological approach starting with an open question about circumstances leading up to self-harm, then asking questions about experiences of hospital and psychosocial assessment, and the time since attendance. Second interviews focused on further experiences of services, self-harm, and outcomes of psychosocial assessment, and was adjusted in light of

Box 1–Summary of interview guides

Initial interview
Introduction—including explaining study, answering questions and taking consent
1. Background information—including socio-demographics and social circumstances
2. How long has it been since your visit to the hospital?
Circumstances leading to hospital visit
3. Could you tell me a bit about what was going on in your life at the time you attended the emergency department?
4. How were you feeling when you self-harmed on the day in question?
What was/were your reason(s) for self-harm?
5. How did you get to the emergency department? How did you feel about seeking medical help/attending emergency department?
6. Did you have a choice about going to the hospital?
Experience of the emergency department & hospital
7. How did you feel when you got to the emergency department? When you realised you were in hospital, how did you feel?
8. Could you tell me what you remember about being at the hospital?
9. How did you feel during this experience?
Experience of psychosocial assessment
10. What (if anything) were you told about the assessment before it happened?
11. How did you feel about having an assessment?
12. Could you tell me in your own words what the assessment was like?
13. How did you feel during the assessment?
Outcome of assessment
14. What were the outcomes of the assessment?
15. What aftercare/follow-up were you offered? Was it discussed with you/explained to you? How did you feel about the course of action chosen?
16. How did you feel at the end of the assessment?
17. How did you get home after the hospital visit?
18. How would you feel about going back to the hospital if you had to?
Improvements/suggestions
19. What would you change about the experience if you could?
20. Can you think of ways to improve hospital services for others?
21. Are there any outcomes you would identify as important/relevant even if not achieved? What are they?
Debrief
Checking how participant feels about the interview, explaining about and seeking consent to invite participant to second interview, leaving feedback form and useful numbers with participant

Second interview
Impact of previous attendance
1. What has your life been like since the hospital visit?
2. What were the reactions of significant others after your hospital visit?
3. What was your reaction? How did you feel afterwards?
4. Do you think the visit was helpful/unhelpful? Yes/no, explore why
5. Since that visit, what contact have you had with services?
6. What has this contact been like for you? Has it been helpful/unhelpful? If so, why/why not?
Self-harm
7. Have you self-harmed since that visit? Yes/no, explore why/why not—what has changed from before? If yes, did you re-attend hospital?
8. How would you/how do you feel about going back to the hospital if you have to?
9. Are there any ways in which you try not to self-harm/to reduce the severity of your self-harm?
Outcomes
10. In what ways do you feel the assessment/hospital visit has affected your life?
11. At the end of the last interview, desired and actual outcomes were identified. Has the experience had an effect on these? Have there been any further effects of the experience that you can think of?
Improvements/suggestions
12. What would you change about the experience if you could?
13. Can you think of ways to improve hospital services for someone like yourself?

emergent themes from initial interviews. Average time between index episode and second interview was 18 weeks.

All interviews were audio-recorded and transcribed verbatim by the first author (C.H.). Participants were offered the opportunity to receive copies of their transcripts in order to offer feedback on transcript anonymisation and content. Four participants requested copies; only two gave feedback on transcripts. In both cases, minor changes were made that did not alter the meaning of the accounts.

2.5. Analysis

QSR NVivo7 was utilised as a data management tool, with all anonymised transcripts being imported into a single NVivo project. Analysis was led by C.H., with regular meetings to discuss and refine analytic concepts with J.C., K.C., and N.K., IPA, the chosen qualitative approach, focuses on the meaning-making of individuals who have experienced a particular phenomenon, and

is widely used in clinical and health psychology research (Smith, 2011). IPA involves an inductive, interpretive approach, recognising the researcher's influence on research process and product (Smith et al., 2009).

Each transcript was first coded thematically, using an in-depth, line-by-line approach. When all 13 initial interviews had been coded, analysis was refined and group-level themes identified, capturing similarities and differences across accounts, following procedures described by Smith and Eatough (2007). A reflexive journal was kept throughout data collection, transcription and analysis to capture and develop ideas stimulated by the data. It was also used to critically appraise and consider the researchers' involvement in the developed interpretation. To analyse follow-up interviews, the initial interview with each participant was re-visited and the individually developed themes used as the starting point for coding follow-up interviews. Follow-up interviews were analysed in-depth, first idiographically, then across case. Where emergent themes from follow-up interviews corroborated or developed the analysis of initial interviews, these themes were incorporated into the relevant group-level theme. Constant comparison of developing themes across individual accounts and with the transcripts was utilised to ensure the interpretation remained grounded in the data.

2.6. Researcher orientations

The lead researcher C.H. conducted the study as a PhD student with experience of people who self-harm within voluntary services and the community, on both a personal and professional basis. These experiences influenced her choice of IPA, her involvement of service users in the design of the research, and her approach to data collection and analysis, which privileged service user-constructed meanings of self-harm and mental illness over traditional biomedical definitions. Hunter (2010) outlines C.H.'s perspectives on reflexivity, emotion and interpretation in the data collection stages of this research. The other investigators included N.K., an academic psychiatrist, J.C., a senior research fellow with a background in psychiatric nursing, with experience of working with those who self-harm, and K.C., a lecturer in social work with a background in counseling psychology and an interest in critical feminist perspectives. The range of perspectives and backgrounds within the research team enabled critical discussion throughout the research process, and informed the conclusions presented in this paper.

3. Results

One hundred ninety-eight service users were sent invitations to take part over a 9 month period (September 2008–May 2009).

Replies indicating interest in taking part were received from 23 participants; of these, seven individuals did not turn up or cancelled interviews, one had no recollection of undergoing psychosocial assessment, another felt unable to spare the time, and we were unable to make subsequent contact with one individual. Of the 13 participants who took part, seven were male, and six female, with ages ranging from early 20s to early 60s. For the index episode, five participants self-cut, five self-poisoned, one participant did both in succession (P6), one scratched (P7), and one reported suicidal ideation only (P9). P9 was included in the study as initial analytic engagement with the data demonstrated considerable overlap of concerns and experiences with other participants who had actively self-harmed at the time of assessment. Attending hospital was P9's means of preventing self-harm at that time (see Table 1.)

All participants were invited to take part in follow-up interviews three months later, and all agreed to be contacted for this purpose. Only seven participants took part in follow-up interview; of the six who did not take part, three were unreachable by telephone or letter, two felt they could not spare the time, and the final participant did not want to revisit the incident in question.

Three primary themes relating to the role of psychosocial assessment are presented below. In addition, a further theme on the impact of hospital experiences, mainly derived from follow-up interviews, is also summarised.

3.1. Function of psychosocial assessment

3.1.1. Function of psychosocial assessment unclear

In general, participants did not have a good understanding of what psychosocial assessment was for, and tended to form their impressions of psychosocial assessment's function based on previous experience or explanations given by staff. Where little information was given, participants filled in the gaps by gauging its purpose from the types of questions staff asked and the outcomes of psychosocial assessment. P3 explained the purpose as referral to other services: *"he just needed to see if I wanted to be referred to [self-harm service] and to give me some leaflets".* This participant had previously attended hospital for self-harm and experienced psychosocial assessment and self-harm services. Some participants interpreted psychosocial assessment as an exercise designed to protect staff, as P4 indicated: *"it's one of those things, isn't it… he's got to ask it, just to cover himself".* This impression came from questions asked by the psychiatrist, covering risk of harm to others as well as suicide risk: *"I suppose, as I say, he has to ask them. I mean, if he didn't ask them and I'd have gone out and just gone on a mass axe-murdering thing, you know, whose blame would it be, because the psychiatrist, well why didn't you ask him these questions, and find out his mental state?".*

Table 1
Participant characteristics.

ID	Gender	Age	Previous self-harm	No. of interviews	Follow-up care arrangements (self-report)
P1	Male	30s	Multiple episodes	2	Referred to existing care team
P2	Male	30s	No	2	Referred to self-harm service
P3	Female	20s	Multiple episodes	1	Referred to GP for re-referral to self-harm service
P4	Male	40s	Multiple episodes	1	Referral to GP for referral to crisis service in community
P5	Female	20s	Multiple episodes	2	Referral to GP with possible referral to counselling
P6	Female	30s	Infrequently	2	Discharged into care of family & current psychiatrist
P7	Female	50s	Multiple episodes	1	No details given
P8	Male	50s	Infrequently	1	Referral to crisis service and alcohol/drugs team in community
P9	Male	20s	No	2	Referral to crisis service in community
P10	Male	60s	No	2	Referral to social services
P11	Female	60s	Infrequently	2	Expected follow-up from psychiatrist
P12	Male	50s	No	1	Referral to GP
P13	Female	20s	Multiple episodes	1	Referral to crisis service in community

3.1.2. Psychosocial assessment as routine aspect of hospital care

Almost half the participants interpreted psychosocial assessment to be mandatory for staff to complete before discharge: "*I think there's like routine questions for this thing*" (P5); "*I just knew I had to be assessed before we can release you from the hospital*" (P12). These participants had never attended hospital for self-harm before. Whilst this impression did not necessitate negative experiences of psychosocial assessment, it meant that participants often did not view psychosocial assessment as an opportunity to engage in discourse about their perceived needs for intervention.

3.2. Positive value of psychosocial assessment

3.2.1. Legitimation of distress

The majority of participants gained something positive from their experience, or identified some way in which psychosocial assessment could be helpful to them. For four participants, having their needs recognised as legitimate, and worthy of psychiatric care, was significant. Participants often felt guilt or shame at having sought help, and having a mental health practitioner recognise their distress allowed them to feel worthy of care. P5 stated that the psychiatric nurse told her "*genuinely you are ill, in the mind, you are ill*", which gave her permission to make changes to help her cope. P13 had previously experienced negative staff attitudes whereby she felt dismissed. She talked about being "*relieved*" that her mental state was taken seriously during psychosocial assessment. Both participants had experienced intense negative emotions towards themselves, prior to self-harming and seeking help, and having their distress legitimated by staff was valued.

3.2.2. Having someone to talk to alleviates distress and loneliness

Having someone to talk to was a major positive theme associated with psychosocial assessment. Several participants expressed relief at being able to share their distress, finding the experience of talking through their difficulties cathartic, for example: "*at least I can speak to someone… instead of just everything built up inside me*" (P3) and "*it gets some of my experiences out*" (P7). P5 described the opportunity to talk as being "*like a massive weight has been lifted*". For participants who were experiencing loneliness, this opportunity to talk was especially valued, as P4 stated: "*When you're living on your own, you can't really talk to anyone*".

3.2.3. Having someone to talk to aids recovery of self-worth

Talking through events leading up to self-harming also helped participants come to terms with their actions, and regain a sense of self-worth through being respected and heard as a human being. Most participants struggled with enduring feelings of low self-worth, referring to themselves as "*unworthy*" (P13), "*stupid*" (P11), or "*less than*" other people (P10). Some of these feelings of low self-worth stemmed from identities which the participants were ashamed of, and were afraid of being judged for. Participants also feared being judged for their actions which led to hospital, and judged themselves for their actions:

> "*I felt terrible [about going to hospital], I felt I was going to be judged*" (P10)
> "*I felt disgraced with myself… why am I putting these people to so much trouble*" (P12)
> "*You're embarrassed you've done it and you've humiliated yourself*" (P5)

Having someone to talk to who seemed caring and non-judgemental was a significant event for participants who both felt judged and judged themselves for their actions. It gave them confidence to seek help in future, and it allowed them to value themselves again, as they felt valued by staff:

> " *I know there's somewhere to turn now, they're not all dark clouds, you know*" (P12).
> "*The main thing was that [psychiatrist] did look as if he actually cared, that's it, and he wanted, he really wanted to help me, and so that was a very positive thing*" (P4)

3.2.4. Inspiring hope for change

The final sub-theme was "hope for change". Both P5 and P13 viewed their experiences of psychosocial assessment as a learning experience, a "*first step*" (P5) towards changing their behaviour and perspective. As P13 stated, her experience with an understanding assessor helped put things into perspective: "*I've got a lot more to learn in life… and what has been now isn't everything*". This shift in perspective gave her hope that things could change in the future. Participants were positive about psychosocial assessment where it led to change, or the possibility of change, in their lives. Hope for change generally related to how participants felt about themselves after psychosocial assessment, as in the case of P5:

> "*[Psychiatric nurse] was dead confident, so that made me feel better in myself, as soon as I left, I was like wow, so nice [yeah] and then she sort of gave me the confidence to get that sick note for work [yeah] and get the ball rolling to get me out of there, and obviously to get myself a counsellor so I could speak to them myself*"

Alternatively, hope was inspired by the aftercare arrangements made by staff:

> "*[I'm] hugely grateful that I've got the help, it's made a whole world of difference [yeah], I'm getting regular phonecalls, people are phoning me, keeping me informed, my care people are coming, I know that within the next couple of weeks, I will have the support I need*" (P10).

Participants then no longer felt that their situations were hopeless, as they perceived staff to care about them through their actions to organise care:

> "*[Psychiatrist] has done quite a bit, and he's… referred, well, he's on to my GP… and he's doing something else, he's going to write to me… and he absolutely does look, seems like he does care*" (P4).

3.3. Negative aspects of psychosocial assessment

3.3.1. Feeling shamed and judged by staff

Negative aspects of psychosocial assessment recounted by participants tended to mirror the positive aspects. For instance, when participants felt judged for their actions instead of validated, this created animosity towards staff and help-seeking, and contributed to participants devaluing themselves. In P11's case, the psychiatrist asking "*do I think about my children, does it bother me that I'm leaving them*" compounded feelings of guilt about her family. For P10, the shame of being perceived as an addict, and the negative attitudes previously experienced, made his experience of hospital care isolating and upsetting. He recounted several incidences when staff blamed or judged him due to his addiction history: "*they judge you if you're an addict, it's on your notes, you get terribly judged*" (P10).

Feeling judged by staff impacted on participants' willingness to open up to staff, and their readiness to seek help in the future:

"Some of [the nurses] were ignorant in their views, they don't realise that people do have mental health problems and they don't know why they've got them, and I wouldn't tell them why I've got them" (P8)

"I still keep harping back to that psychiatrist, and that's why I don't want to see another one" (P11)

3.3.2. Cycle of referral to same/similar services increasing hopelessness

For some participants, the outcome of psychosocial assessment compounded their initial hopelessness, as they were re-referred to previously accessed services, or told only that they should see their GP. Especially in those who had attended services before, there was an attitude of hopelessness, as P2 expresses: *"I was thinking is it worth it?… Is it worth this chat again?"*. P2 had previously attended hospital for overdoses, sometimes accidentally and sometimes with ambivalent intent. Multiple experiences of overdose and attendance had left him feeling that attempts to address his problems were likely to fail.

3.3.3. Struggling to be heard and believed

The experience of fighting to be heard yet feeling ignored during psychosocial assessment, or whilst waiting for psychosocial assessment, had a significant negative impact on participants:

"You're sat there, and you're silent, and you're not talking to anyone, and it just pushes you a bit, it would make you a bit worse than you were" (P5)

For P1, the struggle to be heard related to his experience of voices, which he felt were distressing and required emergency care, yet staff consistently discharged him back to the community. He stated that: *"when I talk about [the voices], nobody listens to me"*. It is likely that this situation was difficult for the staff he saw in hospital to manage; the participant described having a care plan in place which stated he should avoid hospital admission, but the anxiety he experienced due to his voices meant that he felt he needed to seek help at hospital. In the case of P6, the pressure on staff regarding resources such as psychiatric beds was evident. She stated that *"if I couldn't justify to him that things weren't sufficiently serious, they just were going to discharge me"*. She reported feeling she had to fight staff to be seen as a risk to herself, when she attended to try and prevent suicide. This experience increased her distress and hopelessness: *"it was completely giving up hope, not just in my future, but in the fact that anybody else cared"* (P6).

3.4. Outcomes of hospital attendance

Seven participants took part in interviews three months after initial interview.

3.4.1. Unclear arrangements for follow-up care

Most participants were unclear about the timing and procedure for follow-up care, but assumed something would happen. For instance, P12 exhibited confusion when asked about whether his GP was informed: *"they said well we'll contact them, and they will refer you to somebody else, but they never contacted, or else, perhaps I misunderstood, I thought they were going to contact my doctor"*. Whilst participants might have been unclear on what to expect, they tended to expect some form of help due to the nature of their attendance (P11, second interview: *"They say when you try to commit suicide you get these people to help you"*), or expected that the hospital staff would still be aware of them after they were sent home (P4: *"someone's got my name, they've seen me, they'll look at it every so often"*).

3.4.2. Stagnation—little or no change in their circumstances

For several participants, the main outcome of hospital attendance was disappointment with lack of follow-up or change in their circumstances. Participants 1 and 6, who both had multiple experiences of attending hospital, exhibited frustration with staff and the process: *"it were a waste of time"* (P1); *"[It was] very difficult, I didn't really have any support"* (P6). Part of this frustration stemmed from the experience of multiple attendances, where nothing was arranged other than referral back to GP or care team, but it also seemed to reflect lengthy delays in arrangements being put in place. Within 3–4 months of initial contact, most participants had experienced little change in their circumstances, and promised referrals had not come through:

"They were very slow at dragging their heels, I've been made endless promises" (P10)
"Nothing changed for me at all" (P9)

For some participants, this experience of stagnation simply reinforced their expectations that no-one would help:

"I haven't heard from a soul, I never do" (P11, second interview)

Similarly, participant 9, an asylum seeker of indeterminate status, found that his hospital experience reinforced his helplessness. The crisis team's response (*"we can't help you with the house, we can't help you with anything like this… all what we can help just if you feel low we can send you to hospital"*), and the GP's response when he asked to see a psychologist (*"he told me if you like I can give you some medication for a while… medication for what?"*), both mirrored feelings of powerlessness that pervaded his life.

3.4.3. Interactions with staff shape future help-seeking intentions

The patient-staff interaction was essential in shaping future help-seeking intentions. For participants reporting non-judgemental, empathic care, this experience enabled future help-seeking, by encouraging confidence and hope:

"I think I've got more confidence to get in touch with somebody now, before trying to do something like that… I probably didn't have the confidence on that day to say right, I'll walk into the hospital, I'll speak to somebody" (P12)
"It's just nice having that there, you know, that option, where you really really you don't know where to go, you don't know where to turn to" (P5)

In contrast, perceptions of staff as judgemental or dismissive negatively affected participants' readiness to seek help. P6 struggled to be heard by staff and these struggles *"made it quite difficult to… ask people for things"* (second interview). P11's upsetting experience with a psychiatrist left her unwilling to engage with psychiatric help: *"I still keep harping back to that psychiatrist, and that's why I don't want to see another one"*. She refused to continue with psychosocial assessment whilst in hospital and made efforts to avoid further contacts with psychiatry.

3.4.4. Need for contextualised and personalised follow-up care

The perception of the care offered, and how that care fitted in with participants' self-identified needs, was a significant aspect of psychosocial assessment outcomes. For example, in the context of little help with P9's social circumstances or emotional state, being offered medication was interpreted as a form of dismissal:

"They give you medication just to finish with you… this does not sort out your problem, if you sort out all your problems, you will not have depression or thinking about suicide"

Similarly, P10 felt follow-up care failed to meet his needs:

"I've been made endless promises, you know, I'd get aid with shopping… I'd get somebody coming in every day to make sure I was alright, and suddenly, when push comes to shove, I got this computer, which was £349, which I signed for [right] and that was it" (second interview)

P10 was experiencing increasing disability and isolation, and found that the provision of a laptop for online shopping only served to entrench his isolation.

Offers of counseling or referrals to other services were sometimes experienced negatively or rejected when these offers did not account for: previous experiences of the same service (P2: "*I just felt, well what's it worth sitting down with psychiatrist when I've done it before?*"); psychological and physical barriers to accessing services (P10: "*I can't do two major things in a day*"; P2: "*[Help-seeking] gets repetitive to yourself and…it becomes a negative thing*"); and pre-existing expectations of services (P4: "*[the GP]'s not the right person really… it's a mental thing… all he can do is prescribe antidepressants*").

Aspects of aftercare that had previously been valued by participants, or were valued during the follow-up period in the study, tended to reiterate the values attached to assessment. Participants valued services that offered a non-judgemental space for them to talk about their lives whenever needed (P10, second interview: "*[GPs at his practice are] always supportive, they're always willing to go that extra mile to make sure you're ok*"; P3: "*[GP] said to me if anything goes wrong, I can just go in and see her*"), and valued services that encouraged a sense of hope in their ability to change (P2, second interview: "*[at voluntary groups] I think I'm getting more, getting more strength out of it… people [are] talking about their problems…similar problems to myself so you know it can be done*").

4. Discussion

4.1. Main findings

This was the first study to utilise in-depth idiographic methodology to explore service user experiences of psychosocial assessment. In addition, follow-up interviews gave insight into the impact of hospital encounters on further help-seeking intentions. This study found that few participants interviewed knew what psychosocial assessment was for—they attempted to make sense of psychosocial assessment on the basis of their experience and interactions with staff. Psychosocial assessment was valued when participants felt able to talk to someone about what had happened; they had their need for help legitimised in some way; and they felt hopeful for change on the basis of staff attitudes towards them and the aftercare arrangements discussed. Participants disengaged from services when they felt judged for their actions, ignored by staff, or hopeless about the possibility of change. Importantly for participants where their social conditions contributed significantly to their distress, a psychosocial assessment and treatment plan which engaged with the social as well as the psychological was perceived positively (e.g., P5 and P10). In contrast, where the social dimension was dismissed, participants reported this as a dismissal of them as individuals (e.g., P9).

Psychosocial assessment, as a human and social interaction between staff and patients, had the power to reinforce or challenge hopelessness and negative self-evaluations. Psychosocial assessment created or reinforced expectations for future instances of help-seeking and either offered or denied hope for change. Participants' experiences of aftercare were often dominated by a sense of stagnation due to services not following through with promises of aftercare in a timely manner, which affected attitudes towards future help-seeking and towards themselves. Participants interpreted the outcomes of hospital attendance through the framework of what has meaning for them personally. The outcomes of psychosocial assessment (or lack thereof) could reflect and reinforce negative messages about self-harm and by extension, the participant.

These findings support previous research on patient experiences of hospital which demonstrate the importance of assessments as interpersonal encounters between staff and patients (Crockwell and Burford, 1995; Horrocks et al., 2005; Whitehead, 2002). It demonstrates that psychosocial assessment has the ability to impact on attitudes towards further help-seeking (Horrocks et al., 2005; Palmer et al., 2007). Further presentations to hospital to elicit help prior to self-harm might indicate a positive outcome, suggesting continued engagement with services and a belief that attendance could prevent self-harm. Echoing Horrocks and colleagues (2005) and Cutcliffe and Barker (2002), there was a link in several accounts between the perceived nature of the interaction with staff and participants' self-evaluations. This impacted on participants' attitudes towards help-seeking, with negative experiences of staff creating psychological barriers to engagement, and positive encounters inspiring confidence that help is available. This suggests that focusing self-harm interventions on reducing repeat attendances may not capture what is considered beneficial by patients, who value interactions with staff that legitimise their distress, and that develop their confidence in re-attending hospital when needed (Owens, 2010).

4.2. Strengths and limitations

This study is limited by a small sample size, drawn from one hospital, and by a poor response rate (only 6.6% of the invited cohort took part). However, this response rate is in line with previous research in this population (Cooper et al., 2011; Horrocks et al., 2005), which is known to be difficult to engage in research (Hawton and Sinclair, 2003). The small sample limits the study's transferability, and findings should be interpreted cautiously. As the aim was to develop in-depth accounts of experience, a small sample size was considered appropriate, with IPA being suited to smaller data-sets (Oldershaw et al., 2008). Constant comparison was used to ensure interpretations remained grounded in the data (Smith et al., 2009).

The use of follow-up interviews extends the extant literature, as it provides valuable insights into a vulnerable time period following attendance (Kapur et al., 2006). Whilst we were unable to re-interview all participants, those who were re-interviewed shared the experience of stagnation and little positive change following psychosocial assessment. This could indicate a potential bias in the findings, reflecting the opinion or particular characteristics of those willing to take part in follow-up interviews. For those who could be contacted but chose not to take part, two were still experiencing similar difficulties (P4 and P8) and one was in a more positive place and no longer wanted to talk about the index episode (P12). It may be that those who made progress quickly, or for whom aftercare was most successful, were less likely to take part in interviews, especially as participants who did take part seemed to value the opportunity to talk through what happened and make sense of it. A longer follow-up period might yield greater insight into processes of recovery and further help-seeking than was feasible here.

The participants were heterogeneous in terms of previous service use, self-harming behavior, and intent. In addition, information on clinical diagnoses was not collected, although most participants self-reported mental health problems, such as

depression (seven out of 13), and alcohol and/or substance abuse (five out of 13). People who repeatedly self-harm may differ in terms of precipitants, intentions and expectations, compared with people self-harming for the first time (Kapur et al., 2006; O'Connor et al., 2000). Likewise, those with previous experiences of services are likely to have developed expectations as a result of prior attendances, which may influence interactions with staff and readiness to engage with psychosocial assessment. Whilst all participants received psychosocial assessment within the same hospital, previous experiences and self-harm intent are likely to have influenced their interpretations and expectations of hospital. Also, as hospitals vary with regards to whether psychosocial assessment is offered, and how psychosocial assessment is delivered, to service users (Bennewith et al., 2004), the relevance of these findings to other settings should be interpreted cautiously. It is of note that the heterogeneity of sample enabled accounts of under-researched groups to be included, such as men and people over 60. Further research is warranted with service user groups, known to be at risk of suicide, and in the case of older people, to self-harm with greater suicidal intent (Hawton and Harriss, 2006).

4.3. Implications and further research

These findings strongly suggest that psychosocial assessment can be of therapeutic benefit when it encourages a sense of legitimation and hope, and that this benefit is conveyed through interactions with staff. Participants often had little idea of the role of psychosocial assessment, and actively engaged in interpreting its role. Their expectations were formed by their experiences—in particular by the surroundings and staff attitudes. In terms of practice, more attention should be paid to the manner in which assessments are conducted, and a more explicit focus placed on the process of engaging patients. An initial step would be to ensure that service users understand the function and potential outcomes of psychosocial assessment. Several participants commented on feeling unheard or unable to express their needs, and this impacted on their engagement with psychosocial assessment, and services in general. The importance of the relational aspect of psychosocial assessment reinforces findings from previous research on therapeutic relationships within mental health care (Cutcliffe and Barker, 2002; McCabe and Priebe, 2004; Priebe et al., 2005). The stories told (or capable of being told) during psychosocial assessment are dependent on the social circumstances of their production, which in turn impacts on the potential for intervention (Clark and Mishler, 1992).

Careful consideration needs to be given to the purpose and conduct of psychosocial assessment; in particular whether certain aspects of psychosocial assessment enable or restrict the capacity for meaningful discourse and collaborative decision-making. One avenue which often seemed neglected, according to the participants in this study, was the wider social circumstances in which self-harm took place. Where psychosocial assessment replicated or ignored experiences of stigma and helplessness in people's lives, it could damage their engagement with services and hope for the future.

Experiences of stagnation and betrayal after seeking help seemed to act as powerful de-motivators for participants who were re-interviewed. The benefits identified by participants were experienced tentatively and, without reinforcement or follow-up, were liable to disappear. Timely follow-up, consistent with psychosocial assessment, is needed to maintain hope and engagement with services (Cooper et al., 2011). One function of psychosocial assessment is to determine appropriate follow-up care for service users, and psychosocial assessment would be more beneficial for service users if it included clear discussion of the available interventions, the reasons for referral (or re-referral) to specific services, and the time frames for follow-up care. Attention should also be paid to how any proposed intervention would fit with service users' own priorities and goals for recovery, to encourage their engagement with the intervention (Katsakou et al., 2012).

Whilst it can be argued that a caring and empathic response is the foundation of any therapeutic relationship (O'Brien, 2001), this study demonstrates that this is not always reflected in the service users' experiences and the failure to provide these foundational aspects can be detrimental. Further, an understanding and empathic response means engaging and communicating in a manner which does not ignore or dismiss the social worlds that service users inhabit. This may indicate that further training needs to be offered to mental health professionals conducting assessments, focusing more on the relational aspects of psychosocial assessment and the consideration of service users' wider social circumstances. Whilst needs and risk assessment will remain important elements of psychosocial assessment, establishing a therapeutic relationship with patients during psychosocial assessment needs to be given equal weighting.

This study also highlights the importance of attending to service users presenting to hospital in order to *prevent* an episode of self-harm. This refers to incidents where people report having strong urges to self-harm or attempt suicide, but take themselves to hospital, perceived as a place of safety. In relation to research, this means that counting the number of repeat attendances at hospital of people who have previously self-harmed does not take into account service users who attend hospital for prevention purposes. This study therefore highlights the importance of both attending to the number of, and reasons for, attendances.

Finally, further research adopting a longitudinal qualitative approach would create valuable insights into the temporal experience of self-harm, and provide data on the impact of help-seeking experiences over time. Longitudinal research would also help tease apart reasons for re-attendance. This study demonstrates that service user experiences of services can influence attitudes towards future help-seeking, but further research is required to assess how this affects decision-making during repeat self-harm episodes. A deeper understanding of interactions between repetition, help-seeking and service use is required in order for interventions to be evaluated effectively and for services to understand how best to meet service users' needs (Owens, 2010).

References

Alexander, N., Clare, L., 2004. You still feel different: the experience and meaning of women's self-injury in the context of a lesbian or bisexual identity. Journal of Community & Applied Social Psychology 14, 70–84.

Barr, W., Leitner, M., Thomas, J., 2005. Psychosocial assessment of patients who attend an accident and emergency department with self-harm. Journal of Psychiatric and Mental Health Nursing 12, 130–138.

Bennewith, O., Gunnell, D., Peters, T., Hawton, K., House, A., 2004. Variations in the hospital management of self harm in adults in England: observational study. BMJ (Clinical Research Ed) 328, 1108–1109.

Clark, J.A., Mishler, E.G., 1992. Attending to patients' stories: reframing the clinical task. Sociology of Health & Illness 14, 344–372.

Cooper, J., Kapur, N., Webb, R., Lawlor, M., Guthrie, E., Mackway-Jones, K., Appleby, L., 2005. Suicide after deliberate self-harm: a 4-year cohort study. The American Journal of Psychiatry 62, 297–303.

Cooper, J., Hunter, C., Owen-Smith, A., Gunnell, D., Donovan, J., Hawton, K., Kapur, N., 2011. Well, it's like someone at the other end cares about you." A qualitative study exploring the views of users and providers of care of contact-based interventions following self-harm. General Hospital Psychiatry 33, 166–176.

Crawford, M.J., Thomas, O., Khan, N., Kulinskaya, E., 2007. Psychosocial interventions following self-harm: systematic review of their efficacy in preventing suicide. The British Journal of Psychiatry 190, 11–17.

Crawford, M.J., Wessely, S., 1998. Does initial management affect the rate of repetition of deliberate self harm? Cohort study. BMJ (Clinical Research Ed) 317, 985–990.

Crockwell, L., Burford, G., 1995. What makes the difference? Adolescent females' stories about their suicide attempts. Journal of Child and Youth Care 10, 1–14.

Cutcliffe, J.R., Barker, P., 2002. Considering the care of the suicidal client and the case for 'engagement and inspiring hope' or 'observations'. Journal of Psychiatric and Mental Health Nursing 9, 611–621.

Cutcliffe, J.R., Ramcharan, P., 2002. Leveling the playing field? Exploring the merits of the ethics-as-process approach to judging qualitative research proposals. Qualitative Health Research 12, 1000–1010.

Department of Health, 2002. National Suicide Prevention Strategy for England. Department of Health, London, England.

Faulkner, A., 2004. The Ethics of Survivor Research: Guidelines for the Ethical Conduct of Research Carried out by Mental Health Service Users and Survivors. The Policy Press, Bristol, England.

Hadfield, J., Brown, D., Pembroke, L., Hayward, M., 2009. Analysis of accident and emergency doctors' responses to treating people who self-harm. Qualitative Health Research 19, 755–765.

Harris, J., 2000. Self-harm: cutting the bad out of me. Qualitative Health Research 10, 164–173.

Haw, C., Hawton, K., 2008. Life problems and deliberate self-harm: associations with gender, age, suicidal intent and psychiatric and personality disorder. Journal of Affective Disorders 109, 139–148.

Haw, C., Hawton, K., Houston, K., Townsend, E., 2001. Psychiatric and personality disorders in deliberate self-harm patients. The British Journal of Psychiatry 178, 48–54.

Haw, C., Hawton, K., Sutton, L., Sinclair, J., Deeks, J., 2005. Schizophrenia and deliberate self-harm: a systematic review of risk factors. Suicide & Life-Threatening Behavior 35, 50–62.

Hawton, K., Arensman, E., Townsend, E., Bremner, S., Feldman, E., Goldney, R., Gunnell, D., Hazell, P., van Heeringen, K., House, A., Owens, D., Sakinofsky, I., Träskman-Bendz, L., 1998. Deliberate self harm: systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition. BMJ (Clinical Research Ed) 317, 441–447.

Hawton, K., Bergen, H., Casey, D., Simkin, S., Palmer, B., Cooper, J., Kapur, N., Horrocks, J., House, A., Lilley, R., Noble, R., Owens, D., 2007. Self-harm in England: a tale of three cities. Social Psychiatry and Psychiatric Epidemiology 42, 513–521.

Hawton, K., Harriss, L., 2006. Deliberate self-harm in people aged 60 years and over: characteristics and outcome of a 20-year cohort. International Journal of Geriatric Psychiatry 21, 572–581.

Hawton, K., Harriss, L., Hall, S., Simkin, S., Bale, E., Bond, A., 2003. Deliberate self-harm in Oxford, 1990–2000: a time of change in patient characteristics. Psychological Medicine 33, 987–995.

Hawton, K., Sinclair, J., 2003. The challenge of evaluating the effectiveness of treatments for deliberate self-harm. Psychological Medicine 33, 955–958.

Hengeveld, M.W., Kerkhof, A.J.F.M., van der Wal, J., 1988. Evaluation of psychiatric consultations with suicide attempters. Acta Psychiatrica Scandinavica 77, 283–289.

Horrocks, J., Hughes, J., Martin, C., House, A., Owens, D., 2005. Patient experiences of hospital care following self-harm—A qualitative study. University of Leeds, Leeds, England.

Hume, M., Platt, S., 2007. Appropriate interventions for the prevention and management of self-harm: a qualitative exploration of service-users' views. BMC Public Health 7, 9–17.

Hunter, C., 2010. Connecting and disconnecting: reflections on data collection with people who self-harm. Psychology of Women Section Review 12, 28–34.

Kapur, N., House, A., Dodgson, K., May, C., Creed, F., 2002. Effect of general hospital management on repeat episodes of deliberate self poisoning: cohort study. BMJ (Clinical Research Ed) 325, 866–867.

Kapur, N., Murphy, E., Cooper, J., Bergen, H., Hawton, K., Simkin, S., Casey, D., Horrocks, J., Lilley, R., Noble, R., Owens, D., 2008. Psychosocial assessment following self-harm: results from the Multi-Centre Monitoring of Self-Harm Project. Journal of Affective Disorders 106, 285–293.

Kapur, N., Cooper, J., King-Hele, S., Webb, R., Lawlor, M., Rodway, C., Appleby, L., 2006. The repetition of suicidal behavior: a multicenter cohort study. The Journal of Clinical Psychiatry 67, 1599–1609.

Kapur, N., Cooper, J., Bennewith, O., Gunnell, D., Hawton, K., 2010. Postcards, green cards and telephone calls: therapeutic contact with individuals following self-harm. The British Journal of Psychiatry 197, 5–7.

Katsakou, C., Marougka, S., Barnicot, K., Savill, M., White, H., Lockwood, K., Priebe, S., 2012. Recovery in borderline personality disorder (BPD): a qualitative study of service users' perspectives. PLoS One 7 (5), e36517, Available from ⟨http://dx.doi.org/10.1371/journal.pone.0036517⟩.

Kliem, S., Kröger, C., Kosfelder, J., 2010. Dialectical behavior therapy for borderline personality disorder: a meta-analysis using mixed-effects modeling. Journal of Consulting and Clinical Psychology 78, 936–951.

McCabe, R., Priebe, S., 2004. The therapeutic relationship in the treatment of severe mental illness: a review of methods and findings. The International Journal of Social Psychiatry 50, 115–128.

National Institute for Health and Clinical Excellence, 2004. Self-Harm: The Short-Term Physical and Psychological Management and Secondary Prevention of Self-Harm in Primary and Secondary Care. Report No.: CG16. National Institute for Health and Clinical Excellence, London, England.

O'Brien, A.J., 2001. The therapeutic relationship: historical development and contemporary significance. Journal of Psychiatric and Mental Health Nursing 8, 129–137.

O'Connor, R.C., Sheehy, N., O'Connor, D.B., 2000. Fifty cases of general hospital parasuicide. British Journal of Health Psychology 5, 83–95.

Oldershaw, A., Richards, C., Simic, M., Schmidt, U., 2008. Parents' perspectives on adolescent self-harm: qualitative study. The British Journal of Psychiatry 193, 140–144.

Owens, C., 2010. Interventions for self-harm: are we measuring outcomes in the most appropriate way? The British Journal of Psychiatry, Online (serial on the Internet). Available from ⟨http://bjp.rcpsych.org/cgi/eletters/197/1/5⟩.

Palmer, L., Blackwell, H., Strevens, P., 2007. Service Users' Experiences of Emergency Services Following Self-Harm. Royal College of Psychiatrists, London, England.

Priebe, S., Watts, J., Chase, M., Matanov, A., 2005. Processes of disengagement and engagement in assertive outreach patients: qualitative study. The British Journal of Psychiatry 187, 438–443.

Royal College of Psychiatrists, 2004. Assessment Following Self-Harm in Adults. Contract No.: CR122. Royal College of Psychiatrists, London, England.

Royal College of Psychiatrists, 2010. Self-harm, Suicide and Risk: Helping People Who Self-Harm. Final Report of a Working Group. Royal College of Psychiatrists, London, England.

Smith, J.A., 2011. Evaluating the contribution of interpretative phenomenological analysis. Health Psychology Review 5, 9–27.

Smith, J.A., Eatough, V., 2007. Doing interpretative phenomenological analysis. In: Coyle, A., Lyons, E. (Eds.), Analysing Qualitative Data in Psychology. Sage Publications, London, England, pp. 35–50.

Smith, J.A., Flowers, P., Larkin, M., 2009. Interpretative Phenomenological Analysis: Theory, Method and Research. Sage Publications, London, England.

Taylor, T., Hawton, K., Fortune, S., Kapur, N., 2009. Attitudes towards clinical services among people who self-harm: systematic review. The British Journal of Psychiatry 194, 104–110.

Whitehead, L., 2002. Therapeutic Aspects of the Psychosocial Assessment Following Overdose. Oxford Brookes University, Oxford, England.