Service user experiences of attending Accident and Emergency departments for mental health reasons

A thesis submitted to the University of Manchester for the degree of Doctor of Clinical Psychology in the Faculty of Biology, Medicine and Health

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Word Count

(Excluding title pages, references and appendices, but including tables and figures)

Paper One: 10,225
Paper Two: 9,455
Paper Three: 6,163

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Thesis Abstract

The aim of this thesis was to explore service user experiences of attending Accident and Emergency (A&E) departments for mental health reasons. The thesis comprises of three separate papers, the contents of which are described below.

The first paper presents a systematic review examining service user experiences of attending A&E departments for mental health care. Studies containing quantitative evidence were critically appraised and synthesised. Twenty studies were included and results indicated that service users are often dissatisfied with the care received; although may value accessing mental health liaison services operating within A&E. Service users, predominantly, were not involved within study designs seeking to elicit their feedback. Further research is required which actively involves service users to develop a greater understanding.

The second paper presents an empirical study which explored service user experiences of attending A&E for risk to self, from the perspectives of people who experience psychosis. Face-to-face semi-structured interviews were conducted with eleven participants to gather detailed descriptions. Following thematic analysis three themes were identified: ‘feeling unsafe and distressed’, ‘staff interactions’ and ‘future help-seeking’; all of which comprised seven subthemes. Results demonstrate A&E attendances were perceived as inadequate in meeting participants’ needs and compounded their existing distress. Participants experienced a ‘disparity of esteem’ with care provided, found the acute environment intolerable and described staff interactions as pivotal. Experiences of attending A&E influenced attitudes towards further help-seeking. Recommendations for future research and clinical implications are discussed.

The final paper presents a critical appraisal of the design, methodology, analysis and conduct of the review and empirical studies. Personal reflections, further discussions of strengths and limitations and implications for future research and clinical practice are provided.

Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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Paper 1: A systematic review of service user experiences of accessing Accident and Emergency departments for mental health care

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This paper has been formatted according to the publication guidelines of Journal of Mental Health (Appendix A).

A systematic review of service user experiences of accessing Accident and Emergency departments for mental health care

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Abstract

Background: A significant proportion of individuals who frequently attend Accident and Emergency (A&E) departments are those who also experience mental health difficulties. However, there remains limited understanding of service users' experiences of attending A&E for mental health care. Examining service user perspectives is crucial for ensuring high-quality, person-centred and improved future care.

Aim: The aim of this review was to evaluate studies, which examined service user experiences of accessing care at A&E departments for mental health difficulties.

Method: A systematic search was conducted using PsycINFO, MEDLINE, EMBASE, CINAHL and Web of Science databases, alongside grey literature. Quantitative findings were synthesised using a narrative synthesis approach.

Results: After applying the eligibility criteria, 20 studies were included. This comprised of 18 peer reviewed studies, a non-peer reviewed study, and a healthcare report. Studies that were included evaluated various aspects of care and demonstrated experiences of attending A&E can be impacted by a number of factors, particularly staff interactions. Findings also indicated service users were often dissatisfied with care received within A&E departments; however, valued accessing mental health liaison services.

Conclusion: It is imperative to involve service users in the design of studies evaluating their experiences to ensure perspectives are accurately captured and research is meaningful. Further research of service users' experiences within A&E departments is required to develop an in-depth understanding.

Keywords: accident and emergency; user experiences; mental health; healthcare; systematic review

Introduction

Individuals who experience mental health difficulties are frequent users of Accident and Emergency (A&E) departments (Hunt, Weber, Showstack, Colby & Callagham, 2006), presenting up to five times more often and involving a longer stay than those not attending for mental health reasons (Brennan, Chan, Hsia, Wilson & Castillo, 2014; Little, Clasen, Hendricks & Walker, 2011; Nolan, Fee, Cooper, Rankin, & Blegen, 2015). Individuals may attend A&E for help and support for a variety of mental health issues, including suicidal ideation, self-harm and psychotic experiences (Aagaard, Aagaard & Buus, 2014; Arfken et al., 2004; Vandyk, Harrison, VanDenKerKhof, Graham & Ross-White, 2013).

Research demonstrates that supporting individuals experiencing mental health difficulties within an acute A&E environment may not be conducive to providing optimal care (Marynowski-Traczyk & Broadbent, 2011), as their needs may be different to those attending for physical health reasons (Sinclair, Hunter, Hagan, Nelson & Hunt, 2006). Accident and Emergency departments are experiencing additional pressures, with staff shortages, growing demand and wider capacity problems within the health and social care system (Care Quality Commission [CQC], 2015; 2018). Increasing numbers of people are attending A&E for reasons related to mental health issues (Dove, Mistry, Werbeloff, Osborn & Turjanski, 2018), which may be partly due to fragmented systems of care and barriers accessing alternative community services (Clarke, Dusome & Hughes, 2007; Poremski et al., 2016; Vandyk, Young, MacPhee & Gillis, 2018). Attendances at A&E for mental health reasons are often highest outside of routine working hours, as they provide 24-hour care when alternative community services are not available (CQC, 2015; Vandyk et al., 2018; Wise-Harris et al., 2017). Service user experiences of A&E are influenced by various factors including the lack of privacy, long waiting times, and interactions with staff, which can be perceived as judgemental and stigmatising (Clarke et al., 2007; Harris, Beurmann, Fagien & Shattell, 2016; Vandyk et al., 2018). Research has found that staff working in A&E can find it challenging to support individuals experiencing mental health difficulties, particularly if they have limited training and knowledge relating to mental health (Clarke et al., 2007; Crowley, 2000; Marynowski-Traczyk & Broadbent, 2011).

Examining perspectives of care within A&E departments is imperative, as A&E is often the place where individuals first seek help for mental health difficulties (Cerel, Currier & Conwell, 2006; Shand et al., 2018). Additionally, service users' experiences of attending A&E can affect attitudes towards further help-seeking (Clarke et al., 2007; Hunter, Chantler, Kapur & Cooper, 2013). Feedback from service users is important in determining quality of care and for ensuring the voices of those with lived experience are heard (Donley, 2015; Mind, 2012). However, there remains limited research exploring service users' views and experiences of A&E departments. A previous qualitative review (Carstensen et al., 2017) identified only nine studies across four countries and no previous reviews have examined the existing quantitative evidence. Developing a greater understanding from the perspectives of service users informs service planning and delivery, with potential to improve quality and ensure meaningful person-centred future care within A&E (Carstensen et al., 2017; Department of Health, 2017). Therefore, the current review aimed to synthesise the existing quantitative evidence exploring individuals' experiences of care at A&E departments, from the perspectives of those who have experienced mental health difficulties. Specifically, the objectives of the review were to examine: 1) which aspects of care have been evaluated; 2) which methods have been used to examine service user experiences; 3) what conclusions can be drawn from the evidence; and 4) what the quality of the available evidence is.

Method

A systematic review method was employed utilising reproducible and transparent methods to ensure an objective and rigorous assessment of the evidence (Campbell, Katikireddi, Sowden, McKenzie & Thomson, 2018; Mallett Hagen-Zanker, Slater & Duvendack, 2012). In accordance with the Centre for Reviews and Dissemination (CRD, 2009) and Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA, Moher, Liberati, Tetzlaff & Altman, 2009) guidance, a protocol was developed and the review was registered with Prospero (CRD42019146758, 10/12/2019) to ensure methodological transparency (Gough & Elbourne, 2002; Moher et al., 2015). A systematic search was conducted across relevant electronic databases and the results were quality appraised and synthesised. Data extraction was performed by the first author (LO) and the study results were synthesised using a narrative approach, as meta-analysis was not appropriate given the heterogeneity of retrieved studies in terms of aims, design and outcomes (Campbell et al., 2018). Narrative synthesis can involve manipulation of statistical data; however, it predominantly adopts a textual approach to synthesise and present findings from included studies (Popay et al., 2006). Following data extraction, the first author organised and grouped the included studies by the areas examined and study outcomes. These findings were then synthesised using textual description and summary tables to provide a coherent narrative in line with the review objectives.

Search strategy

The electronic databases PsycINFO, MEDLINE, EMBASE, CINAHL and Web of Science were systematically searched to identify appropriate studies for inclusion. Studies relevant to the topic area identified through initial scoping were reviewed (e.g. Carstensen et al., 2017; Vandyk et al., 2013) alongside MESH headings to help develop appropriate search terms. Search terms were structured using PICO as recommended in the CRD (2009) and PRISMA guidelines (Moher et al., 2009). The following terms were applied across each of the five databases to ensure consistency: mental health OR mental illness OR psychiatric patient OR mental disorder AND emergenc* OR acute OR emergency service hospital OR emergency service psychiatric AND experienc* OR satisfaction OR perspective* OR perception* OR evaluation*. The search which was conducted in December 2019 was limited to English, adult populations, and from the year 1990 to 2019. The year 1990 was selected to coincide with the introduction of NHS guidance which placed an emphasis on making mental health services available within A&E departments (e.g. Department of Health, 1999) and research interest initiating within this area. To ensure sufficient literature saturation, the first author (LO) conducted additional searching via hand searches of reference lists of included studies, relevant reviews and studies which cited the included studies. All studies included in the current review were discussed by the research team to agree they met eligibility criteria.

Eligibility criteria

Inclusion and exclusion criteria were designed to select appropriate studies relevant for the review.

Inclusion:

- Published in English language
- Peer reviewed publications
- Grey literature (i.e. editorials, internet resources, dissertations/theses)
- Adult populations (≥16 years)
- Quantitative studies (those employing formal statistical analysis or descriptive statistics)
- Mixed method studies (those which have conducted formal statistical analysis or descriptive statistics for the quantitative component)
- Studies focusing on individuals with mental health difficulties (i.e. any formal diagnostic criteria (i.e. ICD-10) or self-reported mental health difficulties)
- Studies focusing on Accident and Emergency or Emergency Department settings within an acute general hospital
- Studies focusing on service user viewpoints
- Publication date from 1990-2019

Exclusion:

Studies were not eligible for inclusion if they: focused on organic causes of mental health problems; moderate to severe learning disabilities; or where it was not possible to separate service users' viewpoints of A&E departments from others' perspectives (e.g. staff or carers).

Definition and operationalisation of terms

For the current review, the term 'Accident and Emergency' (A&E) will be used throughout. Variations in terms were considered during the design of search terms and eligibility criteria to elicit comparable studies as, for countries outside of the UK, A&E may be referred to as the 'Emergency Room' or 'Emergency Department'.

Additionally, across the studies included in the review, there are varying terms to describe individuals who experience mental health difficulties. Individuals accessing A&E for mental health care often report stigmatising experiences (Cerel et al., 2006; Wise-Harris et al., 2017); therefore, the use of language has been carefully considered throughout this review. The terms ‘service user’ and ‘mental health difficulties’ will be used to reduce the possibility of further stigma (Vandyk et al., 2013).

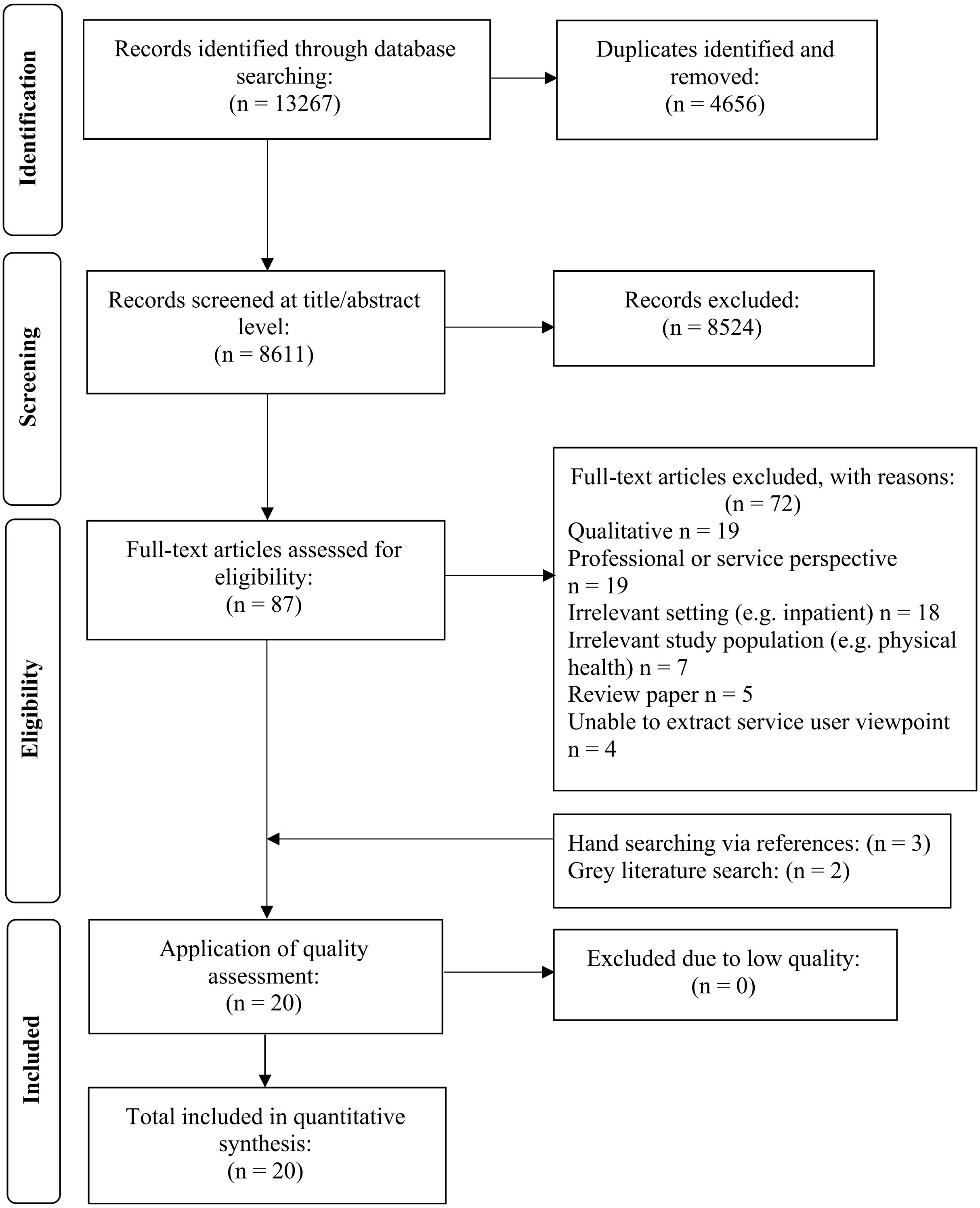
Quality assessment

A quality assessment tool was used to appraise the methodological quality of the included studies by identifying strengths, limitations, potential bias and impact of study quality upon results (Protogerou & Hagger, 2019). The 16-item Quality Assessment Tool (QATSDD, Sirriyeh, Lawton, Gardner & Armitage, 2012) was considered appropriate as it is applicable to both quantitative and mixed method studies using diverse methods and is particularly suitable for studies focussed on healthcare. The QATSDD has good re-test and inter-rater reliability (k = 71.5%; Sirriyeh et al., 2012). Scoring ranges on a four-point scale (0 = not at all, 1 = very slightly, 2 = moderately, 3 = complete) across 14 items for quantitative studies and 16 items for mixed method studies. The minimum score on the tool is 0, with a maximum score achievable on quantitative items of 42 points and 48 for mixed method items. Each item was scored for every included study and the total score was converted to a percentage to provide an overall quality rating. The tool examines a variety of areas including, theoretical framework, study aims, sampling, data collection and analysis and discussions of strengths and limitations.

Selection process

Figure 1: PRISMA flow diagram

Figure 1 illustrates the selection process of the studies included and excluded at each stage. The following electronic databases were searched: PsycINFO, Medline, Embase, CINAHL and Web of Science.



Results

Overview of included papers

Searching across the databases using the predefined terms identified 13,267 results. 4,656 studies were identified as duplicates and were excluded. 8,611 studies were screened using titles and abstracts, and following exclusions, 87 studies were screened at full paper level, with 72 excluded for reasons specified in Figure 1. Three studies identified through hand searching and two studies identified through grey literature searching were also included, resulting in 20 papers in total. All papers were evaluated using the QATSDD with none excluded on the basis of low quality.

To ensure inter-rater reliability and rigour of study screening, an independent researcher screened a proportion of studies at title and abstract level (N=861, 10.0% of the total 8,611 results) and full paper level (N=19, 21.8% of the total 87 results). Agreement of 97.21% (kappa = 0.685), was achieved at title and abstract level and an agreement of 94.74% (kappa = 0.872) was achieved at full paper level, indicating substantial agreement. Any discrepancies were discussed to reach consensus and determine eligibility for inclusion.

In summary, eighteen of the included studies were peer-reviewed journal articles, one was a non-peer reviewed published journal article and one was a healthcare report. Eleven studies were mixed methods and nine were solely quantitative methodology. Two studies were repeated measures and the remaining were cross sectional in design. Sixteen studies examined A&E departments specifically and four studies examined healthcare services more generally, but included information relating to A&E. Studies comprised a total of 2,793 participants, across seven countries; the majority from Australia. Fifteen studies reported on mixed gender samples and five papers did not provide this information. Two studies included participants with specific mental health diagnoses (e.g. borderline personality disorder); five papers focused upon self-harm/suicidality; seven papers reported on a range of diagnoses; and the remaining six did not provide this information. In the current review, all studies have been reported and critiqued and only relevant results are summarised to explore the pre-defined research questions and enable comparison of results.

Table 1: Study characteristics

Area examined	Author & year	Aim	Country/ setting	Study design	Quantitative measures/ data collection tools[1]	Sample size (N)/ characteristics	Main findings[2]	Quality assessment main limitations & rating (%)
A&E services broadly	Fleury, Grenier & Farand (2019)	To evaluate use of and satisfaction with emergency departments and other mental health services	Canada – four emergency departments	Mixed methods, cross sectional	Bespoke questionnaire providing descriptive data	N = 328 service users	Participants were highly satisfied with staff attitudes, 95% agreed 'somewhat' or 'totally' that staff were respectful, 91% agreed 'somewhat' or 'totally' that adequate treatment for their problems was provided.	Statistical assessment of measurement tools, justification for analytical method, user involvement; 75.00
	Harrison, Mordell, Roesch & Watt (2015)	To understand how patients with mental health emergencies who are later admitted to psychiatric units perceived their experience in the emergency department; specifically, whether they felt their experience was helpful or harmful	Canada – emergency department	Quantitative, cross sectional	Bespoke survey	N = 49 service users	Perceptions of having control over attending were predictive of participants' perceptions of being helped and psychologically hurt. 33% reported they found the staff to be helpful and kind, 22% reported the service was efficient, 22% reported their experience was chaotic and intense and 20% reported long waiting times.	User involvement; 80.95

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[1] Other data collection methods may have been used, only measures ascertaining service user experiences have been presented

[2] Only results derived from service users relevant to the review have been presented

	Cerel, Currier & Conwell (2006)	To understand the separate experiences of patients and family members in the emergency department following a suicide attempt	United States of America – online study	Mixed methods, cross sectional	Online survey	N = 465 service users & 254 family members	Fewer than 40% of participants perceived staff listened to them, described the nature of treatments to them, or took their injury seriously. More than half of the participants felt directly punished or stigmatised by staff.	Sample size considered in analysis, statistical assessment of measurement tools; 62.50
	Ruggeri et al. (2006)	To examine users' satisfaction with crisis intervention, comparing a community-based mental health service in Italy and a hospital-based emergency service in the United Kingdom	United Kingdom & Italy – emergency department & community service	Quantitative, cross sectional, between groups	Verona Satisfaction Scale (VSSS)	N = 44 service users in emergency department & 40 service users in community services	Participants reported higher levels of satisfaction for community services compared to the emergency department (88.5% vs 50%).	Sample size considered in analysis; 80.95
Mental health liaison & psychiatric services within A&E	Wand, D'Abrew, Barnett, Acret & White (2015)	To evaluate a nurse practitioner led, extended hours, mental health liaison service based in an emergency department	Australia – emergency department	Quantitative, cross sectional	Telephone interviews using a bespoke questionnaire	N = 14 service users & 23 staff	Participants endorsed the liaison service. Positive ratings for feeling their concerns were listened to and understood (61.5%) and for being satisfied with the care received (69.2%).	Sample size considered in analysis, representative sample, statistical assessment of measurement tools, justification for analytical method, user involvement, discussion of strengths/ limitations; 57.14

	Wand, White, Patching, Dixon & Green (2012)	To evaluate a mental health nurse practitioner outpatient service based within an emergency department	Australia – emergency department	Quantitative, repeated measures	Client Satisfaction Tool, bespoke interview questionnaire & postal survey	N = 51 service user surveys, 23 service users took part in telephone interviews & 20 staff	74.5% rated ‘strongly agree’ to receiving support regarding mental health concerns and 68.6% were satisfied with the care they had received. 87% of participants in the telephone interviews rated ‘to a considerable extent’ for feeling that their experience was listened to and understood.	User involvement; 80.95
	O’Regan & Ryan (2009)	To measure the rate of satisfaction of the sample population with an emergency department psychiatric service	Ireland – emergency department	Mixed methods, cross sectional, postal survey	Postal questionnaire using the Client Satisfaction Questionnaire	N = 15 service users	35% scored low, 29% scored medium and 36% scored high levels of satisfaction.	Representative sample, justification for analytical method, user involvement; 62.50
	Tadros et al. (2014)	To examine and evaluate both patient and staff satisfaction of the Rapid Assessment, Interface and Discharge (RAID) service. To compare working age patients to older patients on their experience of satisfaction of care	United Kingdom – A&E	Mixed methods, cross sectional	Bespoke structured telephone survey	N = 122 service users & 50 staff	Positive ratings for the service being helpful in their care, meeting their mental health needs and being treated with respect. Difference in satisfaction levels between working age and older adults was statistically significant (p=0.02).	Rationale for data collection tool, statistical assessment of measurement tools, user involvement, discussion of strengths/ limitations; 60.42

	Wand & Schaecken (2006)	To evaluate the role of a mental health liaison nurse within an emergency department	Australia – emergency department	Mixed methods, cross sectional	Telephone interview using a bespoke questionnaire	N = 59 service users	Participants perceived they were treated with respect (98%) and follow up plans were discussed with them (85%). 46% reported waiting <10 mins before seeing a triage nurse and 38% waited >20 mins from triage until meeting a mental health nurse. 63% rated the service provided by the mental health nurse as ‘excellent’.	Aims/objectives, representative sample, statistical assessment of measurement tools, justification for analytical method, user involvement; 54.76
	Clarke, Hughes, Brown & Motluk (2005)	To evaluate client satisfaction with care provided by psychiatric emergency nurses	Canada – emergency departments	Mixed methods, cross sectional	Survey using the Client Satisfaction Questionnaire (CSQ-8)	N = 50 service users; 130 staff & 15 family members	Overall, participants were highly satisfied. Average score of 27.4 (out of possible 32).	Theoretical framework, aims/ objectives, sample size considered in analysis, representative sample, statistical assessment of measurement tools, justification for analytical method, user involvement; 37.50
	Summers & Happell (2003)	To determine patient satisfaction with the treatment received in the emergency department	Australia – emergency department	Mixed methods, cross sectional	Telephone interview using a bespoke questionnaire	N = 136 service users	Results indicated a high level of satisfaction. Participants reported they received information (94%), staff were professional (97%) and listened to their problems (93%).	Rationale for data collection tool, statistical assessment of measurement tools, user involvement, discussion of strengths/ limitations; 64.58

	Callaghan, Eales, Coats, Bowers & Bunker (2002)	1. To describe referrals to the service during a one-year period. 2. To investigate service users' views on the service. 3. To investigate users' satisfaction with the service	United Kingdom – A&E	Mixed methods, cross sectional	Postal survey	N = 71 service user questionnaires, 17 service users interviewed	Participant responses indicated high levels of satisfaction. 24 rated staff attitudes as positive and 3 as negative. 18 people were unsatisfied with waiting times and 4 were satisfied.	Sample size considered in analysis, detailed recruitment data, statistical assessment of measurement tools, justification for analytical method, user involvement; 52.08
Assessment within A&E	Donley, McClaren, Jones, Katz & Goh (2017)	To examine the satisfaction levels and experiences of emergency department patients, emergency department patient-end clinical staff and mental health staff in utilising telepsychiatry during a psychiatric emergency	Australia – emergency department	Quantitative, cross sectional	Bespoke survey	N = 10 service users & 34 staff	80% of participants were satisfied with having a video consultation in lieu of a face-to-face consultation, with 20% giving neutral responses.	Sample size considered in analysis, representative sample, detailed recruitment data, statistical assessment of measurement tools, justification for analytical method, user involvement; 54.76
	Donley (2015)	To examine mental health consumer experiences of suicide risk assessment and management in the emergency department by psychiatric	Australia – three emergency departments	Mixed methods, cross sectional	Bespoke online questionnaire	N = 20 service users	Participants reported waiting from 0-2 hours (30%), 2-4 hours (35%), to 4-8 hours (25%). Participants reported 70% of the time that their perspective was understood. Interactions with the	Sample size considered in analysis, representative sample, statistical analysis of measurement tool, user involvement; 54.17

		triage. To what extent are mental health consumers satisfied with psychiatric triage assessment and management in the emergency department?					mental health clinician were rated positively. Participants receiving initial assessments reported greatest improvements in mood. 61.1% reported having time to talk and being listened to, 29.4% perceived feeling negatively labelled and 29.5% reported the noise and lack of privacy as unhelpful.	
	Suominen, Isometsä, Henriksson, Ostamo & Lönnqvist (2009)	To examine patients' views of their psychiatric consultations after a suicide attempt	Finland – emergency department	Quantitative, cross sectional	Bespoke interview schedule	N = 53 service users	47% rated psychiatric consultation as 'somewhat' or 'very useful'. 42% evaluated timing of consultation as appropriate. Perceived usefulness of the consultation was found to correlate significantly with the appropriateness of its timing ($r=-0.30$, $P<0.05$) and perceived influence on aftercare ($r=-0.34$, $P<0.01$).	Theoretical framework, sample size considered in terms of analysis, statistical assessment of measurement tool, user involvement; 59.52
Interventions within A&E	Adams-Leask et al. (2018)	A pilot study exploring the benefits of offering sensory modulation within a mental health emergency setting for consumers	Australia – emergency department	Mixed methods, repeated measures	Bespoke evaluation form	N = 74 service users	Statistically significant reduction ($t(73) = 15.83$, $p<0.001$) in self-reported distress post sensory modulation use.	Sample size considered in analysis, statistical assessment of measurement tool, user involvement; 58.33

		experiencing distress during a psychiatric presentation						
Healthcare services broadly with A&E included	Shand et al. (2018)	Examined: 1. what type of and how much care people received after a suicide attempt, 2. how satisfied people were with their health service experience and 3. predictors of future help-seeking for suicidality	Australia – online study	Quantitative, online survey	Bespoke online survey	N = 112 service users	Low service satisfaction was associated with lower help-seeking intentions. First point of contact was most commonly emergency departments, which were rated as lowest for satisfaction compared to other services. Low ratings for quality of services, staff attitudes and staff knowledge.	Rationale for data collection tools, statistical assessment of measurement tool, user involvement, discussion of strengths/ limitations; 59.52
	Simon, Specht & Doederlein (2016)	To describe use of services and self-care strategies by people experiencing suicidal thoughts	United States of America – online study	Quantitative, cross sectional, survey	Bespoke online survey	N = 611 service users	Unfavourable ratings for emergency rooms. 59% rated going to the emergency room as ‘somewhat’ or ‘very helpful’.	Theoretical framework, sample size considered in analysis, description of procedure for data collection, statistical assessment of measurement tools, justification for analytical method; 52.38
	Care Quality Commission (CQC; 2015)	To explore whether: 1) responses to people experiencing a mental health	United Kingdom - A&E	Mixed methods, cross sectional	Bespoke survey	N = 316 service users	Responses indicated negative perceptions of A&E services. 36% felt respected, 35% felt they were able to access help in a timely	Theoretical framework, sample size considered in analysis, detailed recruitment data,

		crisis varied across the country; 2) quality of care people received was a matter of concern; 3) a lack of joined-up working between different agencies was putting people at risk					way, 37% felt listened to, 34% felt treated with warmth and compassion, 33% did not feel judged and 29% felt advice and support given was right for them.	statistical assessment of measurement tool, justification for analytical method; 60.42
	Lawn & McMahon (2015)	To explore perceptions of barriers to care and the quality of services they receive from the perspectives of individuals with borderline personality disorder	Australia – survey across healthcare services	Quantitative, cross sectional	Online survey	N = 153 service users	26.5% reported being seen within 1-4 hours, 23.5% waited longer than 8 hours and 23.5% did know how long it took.	Sample size considered in analysis, statistical assessment of measurement tools; 69.05

Quality assessment results

Methodological limitations of each study, including items scored as 0 (not at all) or 1 (very slightly) on the QATSDD, are summarised in Table 1. To ensure inter-rater reliability, an independent researcher also assessed a proportion of the studies (N=5, 25% of included studies), with 73.68% agreement (kappa = 0.705) in total scores, indicating substantial agreement. All studies scored within the region of 18-36 points and highest scores were for clear description of aims and research setting, rationale for choice of data collection tool and evidence of user involvement.

Of the studies identified, only five studies had involved service users in the research design; four of these scored 3, ‘completely’ (Cerel et al., 2006; CQC, 2015; Lawn & Mahon, 2015; Simon et al., 2016), as service user consultation was explicit during planning of the study. One study scored 2, ‘moderately’ (Ruggeri et al., 2006), as pilot interviews were conducted with service users to gather feedback pertaining to the study design. The remaining studies scored ‘0, not at all’ as they did not provide any description of service user involvement. Therefore, it is not possible to establish whether the aims, design and data collection tools for most studies were appropriate for examining service user perspectives of A&E. Only four studies described any assessment of reliability and validity of their measurement tools (Harrison et al., 2015, O’Regan & Ryan, 2009, Ruggeri et al., 2006; Wand et al., 2012) and the majority (N=14) scored ‘0 not at all’, due to using bespoke data collection tools which had not been assessed for validity and reliability. Additionally, six studies did not have a representative sample size, comprised of different age ranges and mental health diagnoses, and several studies had small sample sizes (N=4, e.g. Donley et al., 2017; O’Regan & Ryan, 2009). Thirteen studies did not sufficiently justify the sample size considered in terms of analysis. It is possible that sample size was considered, but this was not acknowledged within these studies. Nine studies provided no justification of the choice of analytical method; four did not provide detailed recruitment data and seven studies did not sufficiently discuss the strengths and limitations.

As the majority of studies did not use valid data collection tools or conduct appropriate statistical assessment, it is not possible to ascertain whether they accurately measured constructs in line with the intended research aims (Drost, 2011). The quality assessment results suggest limitations on the degree to which findings are generalisable.

Conclusions drawn from the results and subsequent limitations have been considered during interpretation and synthesis of results.

What types of experiences have been examined?

A diverse range of aspects of care within A&E departments were explored and included studies have been grouped in accordance with the areas examined in Table 1. Half the studies examined experiences of mental health liaison services operating within A&E (N=10; e.g. Clarke et al., 2005; O'Regan & Ryan, 2009; Wand et al., 2015), six of which specifically evaluated satisfaction. Three studies evaluated assessments and consultations within A&E, two specifically reported on assessment following self-harm and suicidality (Donley, 2015; Suominen et al., 2004) and one study (Donley et al., 2017) explored experiences of individuals utilising telepsychiatry for assessment. Only one study examined interventions offered within A&E, specifically the use of sensory modulation (Adams-Leask et al., 2018). Four studies examined individuals' experiences within A&E departments from a broader general perspective (Cerel et al., 2006; Fleury et al., 2019; Harrison et al., 2015; Ruggeri et al., 2006), examining areas such as satisfaction and comparing perceptions of A&E departments with other mental health services. Four studies evaluated experiences, perceptions and satisfaction with healthcare services more widely, such as General practitioners (GP's) and inpatient settings alongside A&E departments (CQC, 2015, Lawn & McMahon, 2015; Shand et al., 2018; Simon et al., 2016).

Which methods have been used to evaluate peoples' experiences?

All studies provided data collected through self-report methods. Studies used an array of data collection tools to examine experiences of care, which have been summarised and compared in Table 2. An overarching theme was the use of bespoke data collection tools comprising of surveys, interview schedules and questionnaires (N=16); the majority created by the authors. Only four studies developed data collection tools in collaboration with service users (Cerel et al., 2006; CQC, 2015; Lawn & McMahon, 2015; Simon et al., 2016). Studies varied in information provided about the bespoke measures used; some provided minimal detail, such as the number of questions, (e.g. Donley, 2015) and others included a copy of the tool used (e.g. Suominen et al., 2004). Studies where information was available about the specific items on the data collection tool demonstrated heterogeneity within areas examined.

Many studies focused on measuring service user satisfaction (N=12); yet a variety of measurement tools were employed across studies to elicit participants' ratings of satisfaction. Only four studies used validated measurement tools; one study (Wand et al., 2012) used the Client Satisfaction Tool (Bear & Bowers, 1998) and two studies (Clarke et al., 2005; O'Regan & Ryan, 2009) used the Client Satisfaction Questionnaire (CSQ, Larsen, Attkisson, Hargreaves & Nguyen, 1979). Additionally, one study (Ruggeri et al., 2006) stated that they had used the Verona Satisfaction Scale (VSSS, Ruggeri & Dall'Agnola, 1993) and another study (Callaghan et al., 2002) described the data collection tool which appeared to possibly be the VSSS; however, this was not explicitly stated.

Data collection methods across studies had a number of limitations, particularly due to the number of bespoke measurement tools used with no established validity or reliability. Several studies which used postal surveys or questionnaires reported poor response rates, ranging from 15-55% (Callaghan et al 2002; Clarke et al., 2005; O'Regan & Ryan, 2009 & Wand et al., 2012). Some studies reported that individuals declined to take part or have their data used within the results; for example, Adams-Leask et al. (2018) reported that only 74 of 187 participants agreed for their data to be used. Additionally, timings of data collection varied across studies, with online surveys providing an unspecified amount of time (e.g. Cerel et al., 2006), to data collection within three weeks of A&E attendance (e.g. Summers & Happell, 2003).

Furthermore, five studies utilised online surveys, which may be inaccessible to individuals without access to the internet, and only one study stated that it had distributed the survey both electronically and on paper (Lawn & McMahon, 2015). Cerel et al. (2006) acknowledged the location of the survey on an advocacy website may have been accessed by individuals with a desire to improve care. These limitations may present sampling biases and thereby influence the conclusions to be drawn from the results.

Table 2: Comparison of data collection methods used to gather service user experiences within included studies

Data collection method	*Study authors*
Bespoke questionnaire or survey (completed by post, telephone or in person)	Adams-Leask et al. (2018); CQC (2015)*; Donley et al. (2017); Harrison et al. (2015); Fleury et al. (2019); Summers & Happell (2003); Suominen et al. (2004); Tadros et al. (2014); Wand et al. (2015); Wand & Schaecken (2006)
Validated questionnaire	Callaghan et al. (2002, unclear); Clarke et al. (2005); O'Regan & Ryan (2009); Ruggeri et al. (2006); Wand et al. (2012)
Online questionnaire or survey	Cerel et al (2006)*; Donley (2015); Lawn & McMahon (2015)*; Shand et al (2018); Simon et al. (2006)*

(*) whereby the data collection tool was developed in consultation with service users

What conclusions can be drawn from the current evidence?

Studies included in the current review explored a diversity of service user experiences and findings have been grouped in accordance with areas examined. Table 3 provides a summary of service user experiences at A&E by country of origin, as there are likely to be differences within healthcare service accessibility, availability and provision across countries which may influence results.

Table 3: Summary of service user experiences at A&E by country

Country	*Study authors & Area examined within A&E departments*	*Summary of service user experiences within A&E departments*
Australia	Adams-Leask et al. (2018) Intervention	Participants reported reduced distress following sensory modulation intervention within A&E.
	Shand et al. (2018) Healthcare services broadly	First point of contact was most commonly A&E departments, which were rated as lowest for satisfaction compared to other services examined.
	Donley et al. (2017) Assessment	The majority of participants were satisfied with a video consultation rather than face-to-face.
	Lawn & McMahon (2015) Healthcare services broadly	Participants generally reported long waiting times whilst in A&E.
	Donley (2015) Assessment	Participants considered the risk assessment to be a positive experience. Interactions with the mental health clinician were rated positively. Participants reported long waiting times and environmental factors to be unhelpful.
	Wand et al. (2015) Liaison services	Participants valued a mental health liaison nurse service and reported high levels of satisfaction with the care received.
	Wand et al. (2012) Liaison services	Participants reported ‘high to very high’ satisfaction with the liaison service. Participants provided positive perceptions of staff and reported that they felt listened to and understood.
	Wand & Schaecken (2006) Liaison services	Participants reported high levels of satisfaction with a liaison service comprising of nurse practitioners who provided assessment and support at A&E. Participants reported positive perceptions of staff and reported that they felt respected whilst in A&E.
	Summers & Happell (2003) Liaison services	Results indicate a high level of satisfaction. Participants provided positive perceptions of staff and reported that they felt listened to and considered staff to be professional.
Canada	Fleury et al. (2019) A&E services broadly	Participant satisfaction with A&E services was high. Participants perceived staff to be respectful and felt they were treated fairly. Participants reported negative experiences to comprise of environmental factors.

	Harrison et al. (2015) A&E services broadly	Participants perceptions varied with some being satisfied and others dissatisfied, with only 39% endorsing ratings of feeling helped by their A&E attendance. Participants perceived A&E to be chaotic and intense.
	Clarke et al. (2005) Liaison services	Participants were highly satisfied with a liaison service offering assessment, assistance with discharge planning and support.
United Kingdom	CQC (2015) Healthcare services broadly	A&E received the lowest scores compared to the other services examined for providing help and support during a mental health crisis. Participants generally did not feel listened to or that they were treated with warmth and compassion.
	Tadros et al. (2014) Liaison services	Both working age and older adults rated a mental health liaison service favourably, indicating participants were generally very satisfied with the care provided. Participants reported positive perceptions of staff.
	Callaghan et al. (2002) Liaison services	Participants reported high levels of satisfaction with the liaison service and reported positive perceptions of staff. Participants were generally dissatisfied with waiting times.
United States of America	Simon et al. (2016) Healthcare services broadly	Participants provided unfavourable ratings for A&E. Only 59% of participants reported encounters at A&E as ‘somewhat helpful’.
	Cerel et al. (2006) A&E services broadly	Participants attending A&E following a suicide attempt did not feel their needs were met. Participants generally did not feel listened to or that their suicide attempt was taken seriously.
Italy & United Kingdom	Ruggeri et al. (2006) A&E services broadly	Participants were more likely to report high satisfaction with emergency consultation in community services in Italy than they were within a UK A&E setting.
Ireland	O’Regan & Ryan (2009) Liaison services	Participants reported medium or high levels of satisfaction with a mental health liaison service.
Finland	Suominen et al. (2009) Assessment	Participants reported a positive or indifferent attitude towards their consultations following a suicide attempt.

Perceptions of A&E

A number of studies found service users were not satisfied with their experiences within A&E, particularly when compared to other healthcare services. Shand et al. (2018) compared satisfaction across different services and found that A&E was typically the initial health service contact for people who had attempted suicide. However, A&E was rated lowest for service user satisfaction compared to other services, in terms of quality of services, staff attitudes and knowledge, scoring an average of 3 to 3.2 (where 5 denotes the lowest score). This was considerably lower than the highest rated service (GP's) which scored an average of 1.5 to 1.8. An important finding was that satisfaction with A&E had a significant association with revealing future suicidality to a healthcare professional (x2=8.1, p=0.005). Similarly, Cerel et al. (2006) identified a significant proportion of those attending A&E following a suicide attempt did not feel their needs were met.

The UK Care Quality Commission, (CQC, 2015) found that A&E received the lowest score of any service examined for providing help and support to individuals during a mental health crisis. Only 40% of participants provided positive responses to survey items, indicating participants did not feel they could access help in a timely way or that advice and support was right for them. Ruggeri et al. (2006) reported that participants were more likely to report high satisfaction with emergency consultation provided by community services in Italy than they were within a UK A&E setting (88.5% vs 50%). Simon et al. (2016) found only 59% of participants reported encounters at A&E as 'somewhat helpful' and Harrison et al. (2015) found that participants' perceptions varied with some being satisfied and others dissatisfied, with only 39% endorsing ratings of feeling helped by their A&E attendance. Harrison et al. (2015) also examined factors which could account for satisfaction and reported that the level of perceived coercion significantly predicted service user perceptions of being psychologically hurt by A&E experiences, ($F(3,45) = 3.75$, p =.02). In contrast, Fleury et al. (2019) found that service users' satisfaction with A&E services was high, with 78% of participants reporting A&E provided adequate treatment for their problems and 77% considered they had received sufficient information on treatment options.

Perceptions of assessment and interventions

Two studies reported that participants had generally positive perceptions of assessment within A&E departments following experiences of self-harm or suicidality. Suominen et al. (2004) found that all participants reported a positive or indifferent attitude towards their consultations with a psychiatrist following a suicide attempt and none were negative. However, only 42% of participants found the timing of their psychiatric consultation to be appropriate to their needs and 54% reported that the consultation took place too soon following their suicide attempt. Timing of consultation was particularly pertinent for participants who had attempted suicide by self-poisoning, who may have been experiencing adverse toxicity effects at the time of consultation. An important finding was that the perceived usefulness of the consultation was significantly associated with the appropriateness of its timing ($r=-0.30$, $P<0.05$) and perceived influence on aftercare ($r=0.47$, $P<0.01$).

Donley (2015) found that, overall, service users reported the risk assessment to be a positive experience that positively affected their mood. This was often attributed to the interaction with staff members, as 50% reported they perceived the mental health clinician as helpful and 70% reported their risk of harm had been understood. In particular, participants undergoing an initial assessment at A&E reported the greatest improvements in mood and were more likely to perceive the clinician as caring, compared to participants who had experienced more than ten prior assessments at A&E. The latter reported feeling negatively labelled and considered the mental health clinician to have less empathy.

One study specifically explored service users' experiences of consultations using telepsychiatry (Donley et al., 2017) and reported that the majority of participants (80%) were satisfied with a video consultation rather than a face-to-face consultation, with the remaining participants (20%) providing neutral responses. However, the Donley et al. (2017) study was based on a very small sample size (N=10) and thus caution is required in drawing conclusions.

Only one study examined an intervention offered within A&E (Adams-Leask et al., 2018), and reported that Sensory Modulation (SM), comprising of visual, smell, movement, proprioception or touch-based interventions, was beneficial in reducing distress within an A&E setting. Participants (N=74) were found to have lower (N=70) or the same distress (N=4) subsequent to SM use, with individuals self-reporting that their distress significantly decreased from pre SM use (M=6.6) to post SM use (M=3.6, t(73)=15.83, p<0.001, r=.88).

Perceptions of mental health liaison services

A general finding across studies was that participants valued and had positive perceptions of mental health liaison services situated within A&E. Clarke et al. (2005) reported that participants were highly satisfied with a liaison service offering assessment, assistance with discharge planning and support for service users and their families. Participants provided an average score of 27.4 (out of a possible of 32) on the CSQ. O'Regan and Ryan (2009) reported that 64.2% of participants scored medium or high levels of satisfaction with a mental health liaison service. Wand and Schaecken (2006) found high levels of satisfaction with a liaison service comprising of nurse practitioners who provided assessment and support for service users attending A&E for mental health concerns. All participants rated the service provided as 'very good' or 'excellent'. Similarly, Wand et al. (2012) found participant satisfaction with a liaison service was 'high to very high', with 80.4% reporting their concerns were addressed. Wand et al. (2015) reported participants valued a mental health liaison nurse service, with 76.9% reporting they were satisfied with the care received. Furthermore, Tadros et al. (2014) found both working age and older adults rated a liaison service favourably with average scores of 4.1 and 4.6 retrospectively (with 5 denoting the highest score), indicating participants were generally very satisfied with the care provided, felt the team were helpful in their care (84.4% & 85.7%) and that their mental health needs were met (69.7% & 85.7%).

Perceptions of staff

An overarching theme in the results of included studies related to interactions directly with staff, which were significant in influencing service user experiences of A&E. Studies included examination of general staff working within A&E, as well as staff working within liaison services. Some studies identified positive perceptions of staff interactions, as Donley (2015) found that 75% of participants reported A&E staff were 'good or very good', with none reporting staff to be poor; and Fleury et al. (2019) reported that participants perceived staff to be respectful (95%) and treated them fairly (91%). In contrast, a proportion of the included studies reported negative experiences with staff, which comprised of experiencing dismissive care lacking compassion, validation, respect and understanding. The Care Quality Commission (2015) found only 37% of participants felt listened to and as though their concerns were taken seriously; 34% perceived they were treated with warmth and compassion and only 33% did not feel they were judged. Importantly, the number of participants reporting feeling judged during their attendance at A&E (52%) was substantially higher than any of the other services examined. Additionally, Cerel et al. (2006) found that negative experiences at A&E were impacted upon by staff behaviours and participants reported feeling that their suicide attempt was not taken seriously, with only 55.2% reporting they were treated with respect and 54.5% felt directly punished or stigmatised by staff.

Where studies report mixed findings in relation to service user experiences of staff within the wider A&E context, interactions within mental health liaison services were rated more positively, denoting that participants found the expertise and attributes of staff working within liaison services helpful. Participants valued feeling listened to, cared for and being involved in shared decision making. Both the studies conducted by Callaghan et al. (2002) and Tadros et al. (2014) reported positive perceptions of staff. Additionally, in Summers and Happell's (2003) study, participants reported staff were easy to talk to (100%), professional (97%) and listened to their problems (93%). Participants in the study conducted by Donley (2015) reported the clinician cared a lot (85%) and they were included in decision making (75%). Similarly, Wand and Schaecken (2006) found that the majority of participants felt respected whilst in A&E (98%) and Wand et al. (2012) reported participants felt listened to and understood (88.2%) and considered staff members to have a positive approach towards their mental health needs (86%).

Perceptions of the A&E environment and waiting times

Six studies evaluated service users' experiences of waiting times and the physical environment within A&E. Studies reported that individuals perceived A&E to be chaotic and intense (Harrison et al., 2015), and found the noise and lack of privacy to be unhelpful (Donley, 2015). Additionally, Fleury et al. (2019) reported that for 40% of participants, negative experiences comprised of environmental factors. Studies reported examples of service users waiting for significant periods within A&E; Callaghan et al. (2002) reported the majority of participants (18 out of 22) to be dissatisfied with waiting times. Lawn and McMahon (2015) reported that almost a quarter (23.5%) were waiting more than eight hours for their self-harm to be addressed, with only 26.5% being seen within four hours. Similarly, Donley (2015) reported that 25% of individuals who attended for self-harm or suicidality were waiting between 4-8 hours, with only 30% being seen within two hours. Wand and Schaecken (2006) reported that 41% of participants were waiting less than 20 minutes to see the mental health liaison nurse; however, 38% were waiting longer than 20 minutes and 21% were unsure how long they were waiting.

Discussion

This is the first review to examine service user experiences of attending A&E for mental health care from a quantitative perspective, consolidating findings within an under-researched area. Results highlight significant methodological limitations across studies, and thus, conclusions are to be drawn with caution as further research is required to develop an in-depth understanding.

Available evidence from quantitative studies report conflicting results regarding perceptions of care at A&E, whereby a proportion of studies identified that service users were dissatisfied and reported unhelpful aspects of care. In contrast, some studies reported positive perceptions and high levels of satisfaction, particularly those reporting evaluation of mental health liaison services. The main factor influencing service users' perceptions of care was their direct experiences of staff. This reaffirms previous research demonstrating staff experiences are integral to healthcare experiences (e.g. Gilburt, Rose & Slade, 2008) and particularly service user experiences within A&E for both physical (e.g. Sonis, Aaronson, Lee, Philpotts & White, 2018) and mental health needs (e.g. Carstensen et al., 2017). Half of the included papers (N=10) had examined service users' experiences of mental health liaison services. These studies suggest that people are generally satisfied with the care received and find liaison services to be a valuable resource within A&E departments. This may be due to staff being specifically trained and equipped to support individuals with mental health needs.

The impact of staff interactions on individuals' experiences underscores the necessity for staff to develop therapeutic relationships with service users attending A&E for mental health care. Through demonstrating compassion, understanding and person-centred care, this can enable transformative healthcare experiences (Kornhaber, Walsh, Duff & Walker, 2016; Shattell, Starr & Thomas, 2007). Development of safe, trusting, transparent therapeutic relationships can also support provision of trauma-informed care (Sweeney, Filson, Kennedy, Collinson & Gillard, 2018), which may be particularly crucial for service users attending A&E during distress and whom may have a history of trauma and adverse relationship experiences (e.g. Kessler et al., 2010). Additionally, individuals experiencing mental health difficulties can have insecure attachment styles (Mortazavizadeh & Forstmeier, 2018) and during experiences of accessing care may seek proximity, comfort and interpersonal contact with staff to help regulate their emotional needs (Adams, Wrath & Ming, 2018; Maunder et al., 2006; Maunder & Hunter, 2016). Therefore, A&E departments and staff working there may have an attachment function and can potentially offer a secure base and provision of emotional and physical security, which may serve a crucial role in alleviating distress (Maunders & Hunter, 2016; Mikulincer & Shaver, 2012).

The challenges of providing timely and optimal mental health care within an acute A&E environment have been acknowledged from both provider and staff perspectives (Innes, Morphet, O'Brien & Munro, 2014 & Marynowski-Traczyk & Broadbent, 2011). Results of the present review demonstrate service users' experiences can be negatively impacted upon by the physical A&E environment and long waiting times, in keeping with previous qualitative research examining service users' experiences of attending A&E (e.g. Clarke et al., 2007; Harris et al., 2016). Included studies identified service users can experience long waiting times, which may be interpreted as discriminatory (Wise-Harris et al., 2017) and result in individuals choosing to leave A&E without being seen (Blake, Dissanayake, Hay & Brown, 2014). Service users who leave A&E before receiving appropriate care are likely to have unmet needs, which may lead to a requirement for future reattendance at A&E (Vandyk et al., 2013).

Furthermore, findings support a qualitative review by Carstensen et al. (2017), which found interactions with staff, busy A&E environments and long waiting times were significant in influencing service users' experiences. Results of the current review underscore Carstensen et al. (2017) findings in demonstrating how A&E can be perceived as inadequate by individuals experiencing mental health difficulties. This is important as A&E is often the first point of contact for mental health care (Shand et al., 2018), yet findings illustrate service users can be dissatisfied with care received, with A&E often receiving the lowest satisfaction ratings when compared to alternative services (e.g. CQC, 2015). It is essential that service users receive care within A&E which meets their needs, as experiences of attending A&E can be crucial in impacting upon attitudes towards future help-seeking (Broadhurst & Gill, 2007; Clarke et al, 2007).

Challenges to evaluating peoples' experiences

There are methodological challenges to measuring and evaluating service users' experiences from a quantitative perspective. Idiosyncratic experiences are complex and the individual nature of these is difficult to reflect through routine clinical outcomes (LaVela & Gallan, 2014). A significant proportion of the studies aimed to measure satisfaction, which is often used to indicate quality of care (Blenkiron & Hammill, 2003); however, lack of consensus remains alongside difficulties in defining and measuring satisfaction within healthcare (Al-Abri & Al-Balushi, 2014; LaVela & Gallan, 2014; Lehman & Zatowny, 1984). In particular, the positive or negative framing of questions pertaining to satisfaction, which was evident in bespoke satisfaction tools (e.g. Wand et al., 2015), can result in acquiescence and skewing of results (Dunsch, Evans, Macis & Wang, 2018).

Methodologically, studies included in this review employed a diverse range of data collection tools, many of which were bespoke; therefore, indicating evaluations of service user experiences have not been collected in a standardised way. This may affect the quality of the results and raises a number of limitations. Surveys and telephone interviews, which were a predominant method of data collection, can introduce social desirability bias, reduce generalisability of findings and may have created over-reporting of positive findings (Bowling, 2005). Additionally, methodological differences within studies such as order of response choices, methods of administration and length of time to recall may have led to inaccuracies in reporting and influenced results (Bowling, 2005; Manary, Hagan-Zanker, Slater & Duvendack, 2013). Many of the included studies were conducted within a single A&E department, where individuals may have encountered only one clinician (e.g. Wand & Schaecken, 2006) further limiting generalisability.

Furthermore, as this was a quantitative review, it is important to recognise that it may be more likely that dissatisfaction is expressed in a qualitative context (Perrault, Leichner, Sabourin & Gendreau, 1993) and this discrepancy was found in some of the mixed method studies (e.g. O'Regan & Ryan, 2009). Differences in perceptions of care may be due to heterogeneous samples, as study samples within the included studies comprised of a variety of presenting difficulties and mental health diagnoses. This can influence findings as particular types of mental health difficulties (e.g. self-harm, psychotic experiences) are associated with greater utilisation of A&E departments than others (Aagaard et al., 2014; Vandyk et al., 2013). Furthermore, previous research including heterogenous samples found that service user descriptions of their experiences of care at A&E can differ dependent on their mental health diagnosis (Vandyk et al., 2018).

Variations in A&E services across countries

Although A&E departments are used as a primary service for accessing care across many countries (Huibers, Giesen, Wensing & Grol, 2009), there is likely to be variation in terms of A&E service provision, accessibility and availability within the included studies. The majority of included papers (N=9) were studies conducted in Australia, followed by Canada, the UK, the United States of America (USA), Italy, Ireland and Finland. It has been recognised that there is variation across countries in terms of the availability of A&E services in comparison to the size of the population (Baier et al., 2019). Additionally, some countries provide publicly funded health care systems which are free to access (e.g. Canada, Finland & the UK), whereas others provide healthcare which is largely privatised and relies upon both private insurance and publicly funded insurance programmes (i.e. the USA) and others involve a mixed system of public and privatised healthcare services (i.e. Australia; Pines et al., 2011). There are also differences in healthcare provision within the countries themselves (i.e. states within Australia; Baier et al., 2019).

Therefore, there may be potential challenges in accessing care and differences in how people use A&E services (Currie & Duque, 2019) dependent on whether they are privately insured, uninsured, able to access A&E services for free, or accessing A&E via publicly funded insurance programmes (i.e. Medicaid, a public insurance programme for individuals with low- income in the USA; Currie & Duque, 2019; Zhou, Baicker, Taubman & Finkelstein, 2017). For example, individuals accessing A&E via Medicaid have reported being treated differently and have described insurance insecurity as presenting a barrier to accessing care (Capp et al., 2016). Additionally, individuals accessing A&E via Medicaid have been found to be nearly twice as likely to return to A&E for mental health emergencies than those self-funding or those with private insurance (Misek, DeBarba & Brill, 2014). There are also likely to be cultural differences regarding stigmatisation and understanding of mental health difficulties across countries, which may also impact upon service user reports of their experiences at A&E (Carstensen et al., 2017).

Despite the differences within A&E service provisions, there have been globally recognised challenges (e.g. overcrowding, long waiting times and increasing numbers of A&E visits) in accessing care at A&E departments, even within countries where A&E services are publicly funded and free to access. This may indicate A&E departments provide an important role in service provision even amongst other health care systems (Baier et al., 2019; Pines et al., 2011). Emergency care systems are complex (Baier et al., 2019) and these existent differences across countries provide additional factors which may have impacted upon service user experiences and therefore influenced results within the included studies.

Involving individuals with lived experience in research

The importance of conducting research in partnership with service users is well recognised and the best way of ensuring that the focus of research is both meaningful and important to those individuals (Department of Health, 2017; National Institute for Health Research, 2019). The current review aimed to explore experiences of A&E from the perspective of individuals with mental health difficulties, and so it is a limitation that only five papers included service users within the design of their study. Therefore, it is not possible to conclude whether all studies included have examined what people experiencing mental health difficulties regard as the most salient aspects of A&E care.

Strengths and limitations

This review explored experiences of attending A&E for mental health care from the perspective of service users, providing an opportunity to highlight and address aspects of care requiring improvement (LaVela & Gallan, 2014). Systematic searching and methodology were employed in accordance with guidance (CRD, 2009; Moher et al., 2015) and inter-rater reliability was conducted during study selection and quality assessment to ensure rigour and reliability. A wide scope of databases of varying disciplines and search terms were included to identify a breadth of evidence, which extended those used within a previous review of qualitative literature (Carstensen et al., 2017). Inclusion of grey literature minimised publication bias and importantly ensured service user experiences were incorporated in sources which may not have been published within peer-reviewed literature (Mallett et al., 2012).

The findings of the current review were largely reliant on data collected through bespoke measures, which may limit the findings and generalisability. The inclusion of studies in languages other than English, may have provided additional insights. Carer, service and professional perspectives were excluded from this review in favour of focusing on service user viewpoints, although inclusion of such studies may have provided further information relating to the quality of care within A&E. Studies were somewhat heterogeneous in terms of aims, design and outcomes, which influenced comparability of outcomes during synthesis; this has been acknowledged as a difficulty in recent reviews within this topic area (e.g. Evans et al., 2019). Furthermore, search terms were reviewed on several occasions and additional hand-searching was conducted to ensure searching was completed comprehensively; however, due to the broad scope of the review and heterogeneity within the topic area, it is possible some papers may not have been identified.

Excluded studies

Some studies were excluded from the current review as relevant data could not be extracted. For example, Morphet et al. (2012) examined service user and carer perspectives of A&E; yet it was not possible to extract data on the service user's perspective. Similarly, in another study (Allen, Carpenter, Sheets, Miccio & Ross, 2003) it was not possible to extract A&E data from other emergency services and therefore these papers were excluded.

Clinical implications

There is currently relatively little evidence relating to service user experiences of A&E, limiting the extent to which clinical implications can be drawn. However, findings underscore the importance of the quality of staff interactions, particularly the necessity for developing therapeutic alliances and providing compassionate, person-centred care. Results highlight how the attitudes and limited knowledge of staff working within A&E outside of liaison services can negatively impact upon service user experiences.

Therefore, it would be beneficial to ensure staff receive appropriate training and clinical supervision pertaining to supporting individuals with mental health needs to increase knowledge, confidence and skills. Provision of adequate training is crucial, as staff working within A&E report feeling under-equipped and unprepared to support service users presenting with mental health difficulties (Innes et al., 2014; Marynowski-Traczyk & Broadbent, 2011). Findings demonstrate service users valued the expertise and knowledge of staff working within mental health liaison services; this supports the NHS Long Term Plan (2019) recommending increased availability and provision of A&E liaison services.

The majority of studies utilised bespoke measures and therefore it will be important to develop standardised outcome measures in collaboration with service users, which can be distributed routinely within A&E departments. Despite the lack of consensus on the most appropriate methods to measure service user experiences, development of standardised outcome measures is essential in ensuring perspectives are captured and are used to inform future care, in line with NHS guidance (Department of Health, 2017; NHS England, 2016). Furthermore, results within this review provide findings relating to service user experiences as being influential upon attitudes towards future attendance. This reaffirms the necessity for positive help-seeking experiences and has ramifications for risk and wellbeing if service users are reluctant to access A&E services in the future (Broadhurst & Gill, 2007).

Future research

The methodological limitations evident within the included studies highlight a requirement for further high-quality research evaluating service user experiences of attending A&E for mental health reasons. The current limited evidence provides a disservice to service users attending A&E for mental health care and neglects a crucial viewpoint in considering the effectiveness of A&E services (Evans et al., 2019). The results of further research can be used to inform clinical guidelines and recommendations for service delivery within A&E departments. The heterogeneity of presenting difficulties within the current review indicates it may be useful to develop an understanding pertaining to homogeneous populations and specific mental health diagnoses to enable care to be individualised and tailored accordingly (Vandyk et al., 2018). Furthermore, future research should ensure meaningful collaboration with service users within the design and implementation of studies, particularly within the development of data collection tools (Department of Health, 2017).

Conclusion

There is currently limited quantitative research evaluating service user experiences of attending A&E departments for mental health care. Findings affirm the importance of staff interactions in influencing experiences of A&E departments. Continuing to develop a greater understanding of service users' experiences is crucial to ensure high-quality and improved future care. Future research should actively collaborate with service users to ensure study aims, designs and outcomes are both valuable and meaningful.

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Paper 2: First-hand perspectives from people experiencing psychosis who attend Accident and Emergency departments for risk to self

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This paper has been formatted according to the publication guidelines of Qualitative Health Research (Appendix B).

First-hand perspectives from people experiencing psychosis who attend Accident and Emergency departments for risk to self

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Abstract

Individuals who experience mental health difficulties are frequent attenders of Accident and Emergency (A&E) departments. Yet, there is limited research exploring peoples' first-hand qualitative experiences of A&E. The current study examined service users' experiences of attending A&E at times of risk to self, from the perspectives of those who experience psychosis. Eleven participants were recruited from NHS secondary care mental health services. Face-to-face semi-structured interviews were conducted to gather rich narratives from participants. Interview data was audio-recorded, transcribed verbatim and analysed using thematic analysis. Three themes were identified, comprising of further subthemes pertinent to participant experiences. Themes of 'feeling unsafe and distressed' and 'staff interactions' were inter-related and impacted upon an additional theme of 'future help-seeking'. Subthemes 'intolerable waiting' and 'unwelcoming environment' highlighted factors within A&E departments which compounded participants' existing distress. Participants perceived a 'disparity of esteem' between physical and mental health care and considered A&E to be inadequate in meeting their needs. Study findings encompass a number of clinical implications.

Keywords: mental health; accident and emergency; qualitative research; user experiences; healthcare

Introduction

Psychosis is an umbrella term relating to experiences whereby an individual hears, sees, tastes, smells or feels things that others do not, or holds beliefs that are inconsistent with their own social and cultural norms. These experiences are usually associated with mental health diagnoses such as schizophrenia (Mind, 2020; Rethink Mental Illness, 2020). Psychotic experiences are often linked to increased risk of self-harm (Haw, Hutton, Sutton, Sinclair & Deeks, 2005) and significantly reduced life expectancy compared to the general population (Chesney, Goodwin & Fazel, 2014); partly due to a higher incidence of suicide (Hor & Taylor, 2010; Nielssen & Large, 2009). Difficulties relating to psychosis and risk to self can result in individuals having increased attendances at Accident and Emergency (A&E) departments for accessing support (Aagaard, Aagarrd & Buus, 2014; Brennan, Chan, Hsia, Wilson & Castillo, 2014; Vandyk, Harrison, VanDenKerKhof, Graham & Ross-White, 2013).

Within the United Kingdom (UK), numerous policy documents have aimed to improve urgent and emergency mental health care (e.g. Care Quality Commission [CQC], 2015; NHS England, 2016a), resulting from service users' negative experiences of attending A&E departments (CQC, 2015). Additionally, research has demonstrated an increase in presentations from individuals experiencing mental health difficulties and attendances are greatest outside of routine working hours (Dove, Mistry, Werbeloff, Osborn & Turjanski, 2018; CQC, 2015). Individuals attending A&E for mental health reasons have described their A&E visits as 'unavoidable' with many attending due to difficulties accessing alternative community services (Clarke, Dusome & Hughes, 2007; Wise-Harris et al., 2017; Vandyk, Young, MacPhree & Gillis, 2018).

Accident and Emergency departments have an important role in addressing needs and reducing distress of individuals experiencing mental health issues (CQC, 2015), and they are often a first point of contact for individuals who experience psychosis (Bhui, Ullrich & Coid, 2014) and for those who self-harm (Mackay & Barrowclough, 2005). Additionally, research has identified a relationship between presentations to A&E departments for self-harm and subsequent suicide (Ryan, Rushdy, Perez-Avila & Allison, 1996; Da Cruz et al., 2011). Therefore, A&E departments can have a crucial role in suicide prevention (Ryan et al., 1996), which is important as suicide remains a leading cause of preventable mortality and a prevalent concern both within the UK and worldwide (Donley, 2015; Naghavi, 2019).

There is relatively little research exploring service users' experiences of attending A&E for mental health reasons. A recent systematic review (Carstensen et al., 2017) identified only nine qualitative studies across four countries, with the majority being conducted outside of the UK. Previous research suggests that A&E departments are not conducive environments for providing optimal mental health care, particularly because of the limited resources and time available to clinicians (Marynowski-Traczyk & Broadbent, 2011). Service users' perceptions of A&E have been shown to be influenced by a number of factors including waiting times, busy environments and a lack of privacy (Horrocks, Hughes, Martin, House & Owens, 2005; Hunter, Chantler, Kapur & Cooper, 2013; Wise-Harris et al., 2017), all of which can exacerbate the distress of those experiencing mental health difficulties (Harris, Beurmann, Fagien & Shattell, 2016). Additionally, the quality of interpersonal relationships between service users and staff has been found to have a significant impact upon experiences within A&E (Clarke et al., 2007; Wise-Harris et al., 2017; Vandyk et al., 2018). Research has indicated staff may hold judgemental and discriminatory attitudes towards individuals attending for mental health reasons (Clarke, Usick, Sanderson, Giles-Smith & Baker, 2014; Carstensen et al., 2017), especially where self-harm is involved (Cerel, Currier & Conwell, 2006; Saunders, Hawton, Fortune & Farrell, 2012).

The limited research to date has focused on A&E experiences from the perspectives of service users as a heterogeneous group, encompassing various presenting difficulties and mental health diagnoses. There have been no prior studies specifically aimed at examining the perspectives of individuals who experience psychosis and attend A&E for reasons relating to risk to self. Understanding service users' experiences of attending A&E has important clinical implications, as the experiences of those who seek support from A&E for mental health reasons is known to influence their perceptions and future help-seeking attitudes (Clarke et al., 2007; Hunter et al., 2013). Furthermore, service user experiences and perceptions can provide information relating to quality of care and assist in ensuring A&E services can be improved and tailored appropriately (Aimola et al., 2019; Vandyk et al., 2018). Therefore, the aim of the current study was to develop an understanding, first hand, from people experiencing psychosis, of what it is like for them to attend A&E departments for risk to self. For the purpose of this study, the term ‘risk to self’ will relate to self-harm and suicidality, including ideation and behaviours, irrespective of motivation (National Institute of Clinical Excellence [NICE], 2013).

Method

Design

A qualitative design was selected to gather detailed data directly from participants (Braun & Clarke, 2013), as this is the first study to explore experiences of attending A&E for risk to self specifically from the perspective of those who experience psychosis. Thematic analysis was chosen, due to its flexibility and utility in deriving detailed findings through examination and comparison of individual accounts (Braun & Clarke, 2006; 2013). Face-to-face, semi-structured interviews, enabled an in-depth exploration of individuals’ experiences, perceptions, thoughts and feelings (Moser & Korstjens, 2018). Following a review of the literature (e.g. Vandyk et al., 2018; Wise-Harris et al., 2017) and consultation with individuals with lived experience, a topic guide (Appendix C) was developed comprising of open-ended questions and prompts to explore areas pertinent to the research aim.

Epistemology and ontology

This qualitative study was influenced by contextualism, which considers knowledge as emerging from contexts and therefore being both situated and provisional (Braun & Clarke, 2013; Madill, Jordan & Shirley, 2000). A critical realist approach was taken, which understands reality as stratified and mediated through individuals’ experiences and interpretations (Fletcher, 2017). This was in keeping with the aim of understanding participants’ experiences as comprising of different valid perspectives, which may be open to subjectivity and social influence (Braun & Clarke, 2013; Maxwell, 2012; Madill et al., 2000). These epistemological and ontological underpinnings are conducive with thematic analysis approaches (Braun & Clarke, 2013).

Eligibility

Inclusion criteria

The following participant inclusion criteria was applied:

- Over 18 years of age at time of A&E attendance

- Capacity to provide written informed consent
- Met: 1) the threshold for Early Intervention services denoting first episode psychosis (e.g. score of 4 or higher on The Positive and Negative Syndrome Scale [PANSS] positive items of hallucinations or delusions) OR 2) the DSM-V/ICD-10 criteria for schizophrenia, schizoaffective disorder, schizophreniform disorder or delusional disorder, as obtained from the referring clinician OR 3) self-reported experience of psychosis
- Currently receiving care from a primary or secondary NHS mental health service
- Attended A&E within the last 12 months for reasons relating to risk to self
- Proficiency in spoken English

Exclusion criteria

Individuals unable to understand interview questions (e.g. due to organic brain syndrome) were not eligible to take part.

Procedure

The study was advertised through posters (Appendix D) within NHS community and inpatient mental health services and A&E departments. The first author (LO) attended team meetings to inform clinicians (i.e. care coordinators) about the study. Clinicians were asked to provide study information to service users they were working with who may be interested in taking part. Potential participants could either contact the researcher directly or provide verbal consent to their clinician for the researcher to contact them directly. Potential participants could also self-refer to the study, as long as they were currently in receipt of care from an NHS mental health service. The researcher telephoned participants to confirm eligibility and provide further information about the study. All participants received a participant information sheet (Appendix E) and were given a minimum of 24 hours to consider whether they wished to take part. Recruitment to the study took place between April 2019 and November 2019.

Data collection

All participants (N=11) were recruited via clinician referral from NHS secondary care community based mental health services across the North West of England. Participants were required to provide written consent before the interview commenced (Appendix

F), which was followed by the completion of a paper-based self-report demographics form (Refer to Tables 3 & 4; Appendix G). Interviews were conducted using a semi-structured format, informed by the topic guide and lasted up to an hour. All interviews were audio-recorded, anonymised and transcribed verbatim for analysis. Individual adaptations were made to the interviews as appropriate to support participation and participants were reimbursed for their time. Interviews took place at participants' preferred venue; either their home (N=6) or an NHS building (N=5).

Ethical considerations

The research team considered any possible risk and ethical concerns during the design of the study. Relevant protocols and procedures were followed to minimise any potential harm or distress and ensure participant safety. Participants were advised of the limits of confidentiality before the interview commenced and that they could stop the interview or take a comfort break at any time. All participants were provided with contact information for support services and the researcher conducted a debrief with each participant through checking how they had experienced the interview. The study was approved by an NHS Research Ethics Committee (REC: 19/NW/0118; Appendix H).

Consultation

The importance of involving individuals with lived experience in the design and conduct of research studies is well established (Department of Health, 2017; National Institute for Health Research [NIHR], 2019). A service user representative group was consulted during the study planning to inform the research aims, study procedure and topic guide. Feedback from service users suggested the use of a pilot interview to enable topic guide refinement and the importance of the researcher providing reassurance that participation would have no impact upon future care received within the NHS. Feedback and recommendations were implemented into the study design.

Analysis

Thematic analysis was carried out in accordance with Braun and Clarke's (2006) six-stage systematic procedure, identifying themes reflecting similarities, differences and patterns within the data (Braun & Clarke, 2006; 2013). All interviews were transcribed at a semantic level, including verbal and non-verbal utterances. The first author (LO) conducted analyses, first becoming immersed with the data by listening to the audio-recordings and reading the transcriptions multiple times. NVivo software for data management (NVivo QSR, 2018) was used to code and organise the research data (Appendix I). Paper-based approaches were used in preliminary coding stages to develop initial themes (Appendix J). An inductive analysis of the interview transcripts was conducted to develop 'bottom up' data driven themes (Braun & Clarke, 2006). Each interview transcript was initially coded line by line to produce an extensive range of codes comprising of concepts of importance within the data (Nowell, Morris, White & Moules, 2017). Initial codes were collapsed into broader codes which were subsequently organised into themes and sub-themes to develop a coherent accurate depiction of the data (Braun & Clarke, 2006). The researcher continually reviewed initial coding and the transcripts to ensure all data had been accurately captured.

Quality, rigour and reflexivity

Guidance related to ensuring trustworthiness, quality and rigour was followed for the thematic analysis (e.g. Nowell et al., 2017) and the study methodology was developed against Lincoln and Guba's (1985) criteria; credibility, dependability, confirmability and transferability. A study protocol was developed to ensure methodological consistency and development of codes and themes were discussed with the research team, (which consisted of the second and third authors, YA and ST) to minimise interpretative bias (Forero et al., 2018). Throughout study conduction and data collection the researcher kept a reflective journal and field notes to minimise bias and ensure findings accurately represented participants' experiences (Forero et al., 2018). In terms of reflexivity, the primary researcher (LO) is a Trainee Clinical Psychologist with no previous experience of working within A&E. However, the researcher was aware of the potential impact of prior clinical experience of working therapeutically with individuals experiencing psychosis upon data analysis and interpretation (McNair, Taft, Hegarty, 2008). Reflexivity and objectivity were enhanced through the researcher undertaking an observation of a clinician working within an A&E mental health liaison service.

Results

Participants

Demographical information was collected from participants using a self-report form and this data is provided in Tables 4 and 5. All identifiable information was anonymised and demographical information was grouped to protect individuals' confidentiality. Fourteen people were referred to the study by clinicians; two were not contactable despite multiple attempts from the researcher and one was not eligible to take part, the remaining eleven were recruited to the study. Additionally, one person self-referred to the study; however, had a diagnosis of a personality disorder and therefore was not eligible to take part.

Demographics

Table 4: Demographic information

Demographical information	**(Total)**
Gender	M (9) F (2)
Age	Range: 18-61 years; Mean: 29.82
Ethnicity	White British (11)
Higher education	Secondary School (5) College (3) University (3)
Employment Status	Unable to work (5) Employed (4) Unemployed (2)
Living Status	Living with family (5) Cohabiting (4) Living alone (2)
Anti-psychotic medication	Currently taking: (9) Not taking: (2)
Diagnosis	Psychosis not otherwise specified (10) Schizoaffective disorder (1)

Time since A&E attendance	Range: 0 months-11 months; mean: 5 months
Reason for attendance	Suicidal ideation (7) Self-harm (3) Suicide attempt (1)
Outcome of A&E attendance (N.B participants may have had multiple outcomes)	Seen by mental health liaison team (10) Follow up by secondary care service (8) Admitted to hospital (2) Follow up by GP (1)
Number of A&E attendances in previous 12 months	Range: 1-5 times; Mean: 1.72
A&E department attended	Site A (4) Site B (3) Site C (2) Site D (2)
Times attended	Evening [after 5pm] (8) Daytime (3)
Methods of attending A&E	Independently attended (4) Recommended by GP (3) Taken by family members (2) Taken by ambulance (2)

Table 5: Demographic information by participant pseudonym

Pseudonym, Gender & Age	**Ethnicity**	**Higher Education**	**Employment status**	**Living status**	**Currently taking Anti-psychotic medication**	**Time since A&E attendance (in months) & Reason for attendance**	**Outcomes of A&E attendance**	**Number of A&E attendances in previous 12 months**	**A&E department attended**	**Time attended[3] & Method of attending A&E**
Joe (M,24)	White British	Secondary school	Unemployed	Living with family	No	6; Suicidal ideation	Seen by mental health liaison team	1	Site A	Evening; Independently attended
Susan (F,61)	White British	Secondary school	Unable to work	Living alone	Yes	6; Suicidal ideation	Seen by mental health liaison team; Follow up by GP	2	Site B	Evening; Taken by ambulance
Adam (M,27)	White British	University	Unable to work	Cohabiting	Yes	5; Suicidal ideation	Seen by mental health liaison team; Follow up by secondary care services	5	Site B	Evening; Recommended by GP
Lucas (M,32)	White British	Secondary school	Unable to work	Cohabiting	Yes	3; Suicidal ideation	Seen by mental health liaison team; Follow up by secondary care services	1	Site C	Daytime; Taken by family member

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[3] Evening denotes attendance outside of usual working hours (i.e. after 5pm)

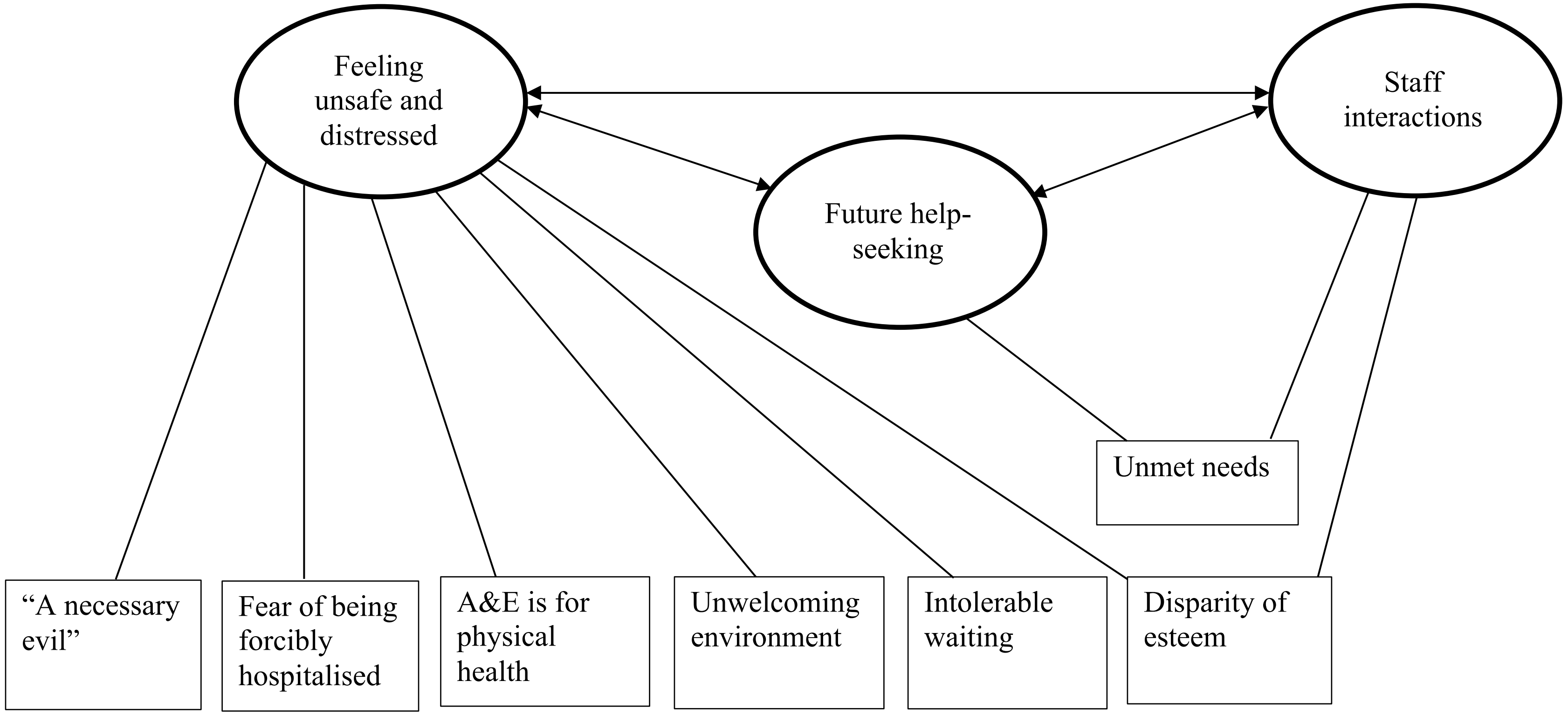
Oliver (M,33)	White British	Secondary school	Unable to work	Cohabiting	Yes	0; Self-harm	Seen by mental health liaison team; Follow up by secondary care services	1	Site B	Evening; Independently attended
Tom (M,43)	White British	College	Employed	Cohabiting	Yes	5; Suicidal ideation	Seen by mental health liaison team; Follow up by secondary care services	1	Site C	Daytime; Recommended by GP
Lucy (F,26)	White British	University	Unable to work	Living alone	Yes	3; Self-harm	Admitted to hospital; Follow up by secondary care services	4	Site A	Evening; Independently attended
Edward (M,21)	White British	College	Employed	Living with family	Yes	0; Suicidal ideation	Seen by mental health liaison team; Follow up by secondary care services	1	Site C	Evening; Independently attended
Jason (M,23)	White British	University	Employed	Living with family	Yes	11; Suicide attempt	Seen by mental health liaison team; Admitted to hospital	1	Site C	Evening; Taken by family member
Matthew (M,18)	White British	Secondary school	Employed	Living with family	No	5; Self-harm	Seen by mental health liaison team; Follow up	1	Site D	Evening; Taken by ambulance

							by secondary care services			
Scott (M,20)	White British	College	Unemployed	Living with family	Yes	11; Suicidal ideation	Seen by mental health liaison team; Follow up by secondary care services	1	Site D	Daytime; Recommended by GP

Identified themes

Participants described their individual experiences of attending A&E, including their reasons for attending, experiences of care and treatment and subsequent discharge. Following analysis, three themes were identified: ‘feeling unsafe and distressed’, ‘staff interactions’ and ‘future help-seeking’. These themes comprised of a further seven subthemes, which represented the pertinent factors within participants’ experiences of attending A&E (Refer to Figure 2). All verbatim participant quotes have been described using pseudonyms to protect individuals’ anonymity.

Figure 2: Diagrammatic map of themes



N.B. Themes are depicted using an oval shape and encompassed subthemes are depicted using a rectangle. Relationships between themes and subthemes are demonstrated through connecting lines. Bidirectional arrows depict reciprocal relationships between the themes.

Feeling unsafe and distressed

Feeling unsafe and experiencing distress was a central theme for all participants as attending A&E for reasons of risk to self consequentially resulted in high levels of distress. Participants anticipated A&E would provide a place of safety, enabling them to access support and reduce their distress, yet most reported that this was unfulfilled.

Oliver: "That's what I wanted... to talk, talk about my feelings and how I'm feeling and how I can feel safe."

Jason: "I went to A&E was because I was, I was really distressed at the time and I felt like I couldn't cope."

Six subthemes related to pertinent factors, which were perceived as threatening and subsequently amplified existing distress and perceptions of being unsafe.

"A necessary evil"

Participants described their reasons for and motivations towards attending A&E as a means for accessing help and support. Oliver, Jason and Edward described that they had no alternative other than to attend A&E out of hours because limited alternative support provision meant this was the only service available. Participants had varying expectations of A&E, which was influenced by previous contact with healthcare services.

Jason: "Generally I think it's a necessary evil. You have, it has to, you have to go there, 'cos [because] you have to be safe, and you need to go there at weird times, and that's A&E, they're open at all hours."

Edward: "I was just walking round and then realised that I'm gonna [going to] have to go, so I walked there, 'cos [because] it was out of hours, so, I couldn't ring anyone."

Participants (Oliver, Scott, Tom, Edward & Jason) considered their attendance at A&E to be necessary and imperative for accessing urgent support to enable them to feel safe, reduce their distress, and to speak to someone who understood what they were experiencing.

Scott: "I just wanted somemat [something], it just felt like the right thing to do was to go, 'cos [because] if I didn't I would have just been lost basically."

A&E is for physical health

Participants (Jason, Susan, Adam & Matthew) perceived A&E as inappropriate and inadequate for the help they required. This was reflected in their descriptions of feeling "*out of place*" and believing that A&E is focused on meeting physical health needs as opposed to mental health needs. Jason described having been allocated a bed within A&E as inappropriate for his needs and expressed how this increased his sense of feeling unworthy of accessing care, as he perceived this should have been provided to someone attending for physical health reasons.

Jason: "Well, it's not that I don't think they shouldn't, be in the hospital, in the A&E, it's that everyone around you has got like something, medical, you know, like physically medical, and, so when you're sat there with, like, psychosis, it's kind of like, I don't, I shouldn't be here."

Matthew described being required to recall distressing events and re-tell his experiences to different staff members during the A&E process as unhelpful and compounded his existing distress.

Matthew: "You can still feel where you've hurt yourself you can still feel the emotions that are just taking over, your body feels numb, like you're reliving that ten times without already replaying it in your head as many times as possible, so it's like, I don't need to tell that many people that many people, like fair enough tell one person they go consult with the rest, you shouldn't have to."

Additionally, Adam described A&E as being like a "*videogame*" where the assessments with different health professionals were expressed as "*completing different levels*" echoing his frustrations and perception of barriers. Three participants (Jason, Susan & Matthew) described a desire for a separate bespoke service as an alternative to attending A&E.

Matthew: "I feel like it's wrong to go to A&E, I feel like there should be sommat [something] separate for that."

Fear of being forcibly hospitalised

Five participants (Scott, Lucas, Lucy, Tom & Joe) reported concerns due to uncertainty about potential adverse outcomes following A&E attendance; specifically fears relating to whether disclosing their risk to self may lead to them be sectioned under the mental health act or admitted to an inpatient psychiatric hospital. A fear of forced hospitalisation led some participants to feel reluctant to disclose they were experiencing risk to themselves.

Scott: "It was scary…I didn't know whether I should or not at the time, I was really worried I thought that I'd end up getting like sectioned or like having to stay at hospital that was like my biggest fear at that point."

Lucas reflected on how the presence of police officers in A&E had exasperated his fears of potentially being forcibly hospitalised and increased his sense of being unsafe. In contrast, Oliver described how upon disclosure of experiencing risk to self staff had provided reassurance and therefore he believed staff should be forthcoming regarding possible outcomes to alleviate anxiety.

Lucas: "To be honest, I thought that the police were gonna [going to] be waiting here for me…when I seen the police cars arriving then I nearly legged it [ran off], I thought there was a few police cars, these have phoned the police to get me sectioned."

Unwelcoming environment

All participants described how the A&E environment, which they perceived as busy and chaotic with limited privacy, had an impact on their overall experiences. Edward described how his fear of being overheard by others had reduced his sense of safety when disclosing that he was experiencing risk to self, and as a result, he did not disclose this to staff members. Additionally, Tom reported noticing a security camera in the room, which increased his experience of paranoia. Three participants (Tom, Oliver & Matthew) described that they had valued the use of a smaller separate waiting room, which provided both privacy and a sense of safety.

Oliver: "'cos [because] it was open… you feel a bit, when you talk, when I was talking to the doctor, I felt like everyone could hear you, everyone could hear you, hear what's being said."

Jason, Tom and Matthew each described busy waiting rooms as unhelpful and contributing to their distress; specifically, increased experiences of paranoia and difficulties distinguishing reality.

Jason: "Yeah, just, 'cos [because] the A&E's are so busy, you have to sit with loads of people, so, when you're psychotic, you don't wanna [want to] sit with other people around you, because it makes it worse."

A number of participants described the impact of lack of privacy within A&E departments, which left them feeling exposed and vulnerable as they felt their distress was highly visible to others. Matthew described this as being put "*in black and white compared to the colour*" which reflected his sense of feeling "*singled out*" compared to individuals surrounding him with physical health needs. Matthew further described a juxtaposition of his behavioural distress being somewhat observable to others and providing a potential to be stigmatised; however, his urgent internal emotional needs remained invisible to others.

Matthew: "People are looking at me, especially 'cos [because] my face is out here, like I've got scratches on my forehead and I'm shaking and going back and forward, my legs going, it's like it feels like I'm bringing attention to myself, and that attention isn't good attention, that attentions making me go more mad, its making me get more anxious and more, I feel vulnerable in that situation and obviously these people are in with like, could be a nasty cut it could be stomach ache like, to them it's like they can't see what's inside my head, so being in a waiting room with all this in my head and these coming from the outside, it's like, it's like you do feel vulnerable…you do feel more mental in a sense, you feel like you are that one person in there going crazy sort of thing."

Intolerable waiting

All participants described how waiting times had an impact on their experiences within A&E. With the exception of Tom and Lucas, participants described long waiting times that felt intolerable. The uncertainty of potential waiting times and numerous consultations with different healthcare professionals elevated their anxiety and sense of vulnerability. Lucy described not feeling prioritised, stigmatised and being "*put to the back of the list*", which she attributed to the fact that she presented with self-harm. Matthew said that A&E attendance for risk related reasons was something he thought should be prioritised and long waiting times increased the potential to engage in self-harm behaviour.

Matthew: "It's like I don't think you have got time to waste 'cos [because] you don't know what's gonna [going to] happen and it is, especially it makes you feel vulnerable as well, so prolonging the way you're feeling is just gonna [going to] make that situation worse off."

Jason: "I think, having such a long waiting time at A&E for something like that is, it's hard… 'cos [because] you sort of have to sit there and I'm completely out of reality, it's distressing."

Staff interactions

A central theme that was pivotal in influencing all participants' perceptions of A&E was their interactions with staff. The quality of interactions with staff was crucial in determining participants' perceptions of the helpfulness of A&E. Participants' accounts related to experiences both with medical staff working within the A&E department and mental health trained staff working within liaison teams. 'Staff interactions' was interrelated with the theme of 'feeling unsafe and distress' and also affected participants' attitudes towards 'future help-seeking'.

Seven participants perceived the attitudes and behaviours of staff, in the wider A&E department and also within liaison services, as dismissive and judgemental. Participants described being made to feel like an "*inconvenience*", "*time-waster*", "*a burden*" and "*just another number*" and expressed how this increased their distress and led to them feeling uncared for. Participants further described "*not being taken seriously*" and believed that staff were disinterested in their experiences. Lucy gave an account of a discriminatory experience in which she was refused anaesthetic for suturing following self-harm, which subsequently reinforced her derogatory voice-hearing experiences. Participants said they thought general staff working within A&E departments required greater understanding of mental health difficulties.

Joe: "It's worse because they see you as an inconvenience to staff there, see you as an inconvenience."

Lucy: "It makes the voices worse as well, because they kind of jump on the band wagon in that, they kind of reinforce that nobody gives a damn, and this is your own fault, and you don't deserve treatment, and that feeds into, that kind of like goes with how I feel about how the nurses and the doctors are treating me."

In contrast, some participants gave accounts of staff interactions which were caring, compassionate and understanding, enabling them to feel heard and understood. Participants placed great importance on these interactions and how it made them feel they were "*being treated like a person*". Participants described staff being "*patient*" and "*reassuring*" as important in helping them to feel cared for. Typically, positive interactions were described with staff working within mental health liaison teams, as opposed to staff working within the wider A&E service. Lucas described the importance of validation and feeling believed in relation to his psychosis experiences and how this was a pivotal moment in his experience at A&E. Participants described how crucial these interactions where in instilling hope and reducing distress.

Lucas: "Just the, just the, er, like, like the affection they had for me…you could see the way they referred to you… she was just trying to calm me down and she was just dead nice, she was really nice to me."

Jason: "Having someone there who like looks you, looks at you, and takes you seriously is, it makes you feel like they know what you're going through, you know."

Scott: "They gave me like time to answer they weren't like rushing or me or kind of like pressuring me to move on or just give them an answer erm… they were just like patient with me."

Disparity of esteem

A subtheme within staff interactions related to participants experiencing a disparity of esteem between physical and mental health care. Participants perceived their attendances at A&E for mental health reasons as differential, inadequate and discriminatory, which was often described within the context of prevalent stigma and fear of judgement from others. Lucy, Oliver and Adam specifically compared their experiences of going to A&E for risk to self reasons to previous attendances at A&E for physical health reasons (i.e. pneumonia), which they considered to have been a more positive experience due to receiving timely and compassionate care. Lucy expressed a desire for equitable care regardless of the attendance being related to physical or mental health.

Lucy: "I was in once because I had pneumonia, erm, and I went to an A&E, and they were, had a lot more positive towards me, and their interactions were a lot more positive. They seemed to care that I was getting the right antibiotics and, was I feeling alright, did I need any pain relief. Erm, when I went up, last time, erm, they didn't even ask me if I wanted any pain relief, when I was seeing the triage, didn't even say, do you need something for the pain, nothing."

Oliver: "Care's different, you're looked after more when you go in for your physical health, you're checked up on, more by nurses, and you're, like your blood pressure and stuff like that and, you, you just, you, you've got, you've got that person checking are you ok, and stuff like that, whereas with mental, you've not really got that."

Future help-seeking

For all participants their experiences of attending A&E, particularly interactions with staff and whether they perceived their needs had been met, influenced subsequent attitudes to future help-seeking. 'Future help-seeking' comprised a subtheme of 'unmet needs'.

Those who reported a globally negative experience at A&E described a reluctance to reattend in the future; for example, Joe reported he would "*never*" return to A&E for future support and expressed *"there's no hope for me"*. Oliver described how feeling dismissed by staff *"put me off a little bit"* from attending A&E again.

Lucy: "Not to get anything out of it, and particularly not to go into hospital, or anything like that, never going back there again."

Joe: "They talk to you like you're rubbish, they make you feel, they encourage you to feel bad, they encourage you to never bother asking for help again."

Adam: "Going to the same one probably wouldn't help me, 'cos [because]I wouldn't go back, 'cos [because] they didn't have the right staff in place, maybe if I went to a different A&E it would have been different."

In contrast, participants who perceived their experience to have been helpful in meeting their needs, expressed they would be willing to reattend in the future. Lucas and Tom described that they felt A&E was an appropriate service to access support for mental health reasons and therefore would recommend attending A&E to others. These attitudes were based upon their own positive experiences, as they had received support within A&E which had met their needs.

Lucas: "I'd advise people to just, to be coming to the hospital and go through A&E, and 'cos [because]I had a good experience with them, erm, I can't, I can't say a bad thing, I can't say a bad word about anyone."

Tom: "Erm, I think it's the, it's the right thing to do, erm, if you don't go to A&E and, for the support that you need, you're not going to get better on your own."

Unmet needs

All participants described the importance of having their emotional and physical needs met at A&E, and for the outcome of their attendance to be synonymous with their expectations. This, specifically, influenced attitudes towards future help-seeking. Staff interactions were fundamental for ensuring that participants considered their needs to have been addressed through receiving timely, compassionate and person-centred care. All participants, except for Lucas, Tom and Susan, perceived attendances at A&E had resulted in unmet needs and subsequently reflected it was "*pointless*" and a "*waste of time*". Adam described the consequences of unmet needs as "*I was kept unwell for a longer period than I should have been*" and felt if A&E had addressed his needs this would have enabled him to access appropriate treatment sooner.

Oliver: "I just kept thinking, it was pointless being there…I feel like I've just wasted me time…on nothing, no help."

Participants who perceived their experience of going to A&E as meeting their needs (Lucas, Tom, Susan), described being provided with comfort and refreshments, as well as being referred to appropriate mental health services both within A&E (i.e. liaison teams) and upon discharge (i.e. specialist community services).

Tom: "I was wanting the help, I knew I needed it and when I just, more than anything I just looking, hoping to get the support that I needed and…that's what did happen."

Discussion

This is the first study to explore service user experiences of attending A&E for risk to self, from the perspectives of those who experience psychosis. Existing qualitative research within this area has been limited, through the inclusion of heterogeneous samples experiencing a variety of mental health issues, as opposed to examining specific populations. Therefore, the findings of the present study provide novel first-hand perspectives in an under researched area. Participants within this study described the value of sharing their experiences, which has the potential to inform future service delivery and organisation. The key findings, which are important for considerations in future practice, are described below with reference to existing theoretical knowledge and relevant research.

Immediate support and basic needs

Accident and Emergency departments are a common pathway to care for individuals who experience psychosis (Bhui et al., 2014); yet, participants predominantly considered A&E as inappropriate for their needs and better equipped to meet the needs of those attending for physical health reasons. Within the UK, A&E services have set objectives to reduce frequent A&E attendances by individuals experiencing mental health difficulties (Royal College of Emergency Medicine, 2017); however, participants within the current study considered their attendances as essential for ensuring their safety and described barriers in accessing alternative urgent mental health care. This finding is consistent with international research which has identified service users experiencing mental health difficulties consider their A&E visits as 'necessary and unavoidable' (Vandyk et al., 2018). Individuals who experience psychosis have usually experienced a number of adverse life events (Kelleher et al., 2013; Kessler et al., 2010), which combined with risk to self, may contribute to needs and desires for immediate support (Vandyk et al., 2018).

In keeping with Maslow's hierarchy of needs, which suggests individuals are motivated to achieve certain needs for optimal wellbeing (Maslow, 1943), participants who perceived a positive experience described their basic needs being met through the provision of emotional and physical comfort (e.g. through support and refreshments). Similarly, all participants described their motivations for attending A&E as being to meet their primary needs of reducing distress and feeling safe. The latter may be particularly important to this population due to established links between a history of trauma and psychotic experiences (e.g. Kelleher et al., 2013).

Disparity of esteem

Results of the present study indicated that A&E may not meet service users' needs, which may increase future need resulting in reattendance (Vandyk et al., 2013) and raises concerns regarding parity of esteem (CQC, 2015). It has been recognised that society does not always place the same value on mental health as it does upon physical health and consequentially individuals experiencing mental health difficulties can receive inferior care (Mitchell, Hardy & Shiers, 2017). Participants described a prevailing 'disparity of esteem' due to feeling dismissed and unprioritised and ultimately considered care to be differential to that received for physical health. This reaffirms service users' can perceive their mental health concerns to not be taken as seriously as physical health concerns (Clarke et al., 2007) and is in contrast with UK healthcare guidance (e.g. NHS England, 2016b; Department of Health, 2017) and the Equality Act (2010), which places a responsibility on health services to ensure equitable care (Mitchell et al., 2017).

The majority of participants reported long waiting times, despite attending A&E in a mental health emergency. Long waiting times can be perceived as discriminatory (Wise-Harris et al., 2017) and have been recognised as a reason for individuals choosing to leave A&E without being seen (Blake, Dissanayake, Hay & Brown, 2014). There is existing Government policy for individuals who experience psychosis stating the requirements for provision of timely specialist mental health services (e.g. NHS England, 2016c); however, no such standards currently exist for service users experiencing psychosis and accessing care through A&E departments.

Additionally, participants described varying availability of liaison services, dependent upon the A&E department they had attended, which highlights inequalities in service provision. This supports recommendations within The NHS Long Term Plan (2019) for increased availability of mental health liaison teams to ensure equitable and round the clock care.

Experiences of psychosis and attending A&E

Participants experiences of psychosis were described to be exacerbated by their A&E attendance. This was encompassed across several themes; however, it was particularly pertinent within the 'unwelcoming environment', 'A&E is for physical health', 'staff interactions' and 'intolerable waiting' themes.

Participants' experiences were particularly influenced by the busy physical A&E environment, similar to previous studies exploring service user experiences of A&E departments outside of the UK (e.g. Vandyk et al, 2018; Wise-Harris et al, 2017). It has been well recognised that the A&E environment is not conducive to privacy or optimal care for individuals experiencing mental health difficulties (Donley, 2015; Marynowski-Traczyk & Broadbent, 2011) and can lead to service users feeling exposed and vulnerable (e.g. Harris et al., 2016; Horrocks et al., 2005). This was echoed within participants' descriptions of the lack of privacy and the intolerability of busy waiting areas, which compounded their distress.

Participants described feeling different and 'singled out' during their A&E attendances. The A&E environment, which is predominantly focused towards physical health needs, combined with being within a waiting room with individuals attending for physical health reasons may have elicited feelings of difference, due to the potential of being identified as an individual experiencing mental health difficulties (Liddicoat, 2020). Research has shown individuals experiencing psychosis can experience stigma, report concerns around feeling negatively labelled or judged and be aware of unhelpful narratives surrounding psychosis type difficulties (Burke, Wood, Zabel, Clark & Morrison, 2016; Sweeney, Gillard, Wykes & Rose, 2015; Gronholm, Thornicroft, Laurens & Evans-Lacko, 2017). Participants described anxiety surrounding potential stigma within A&E through their descriptions of feeling 'out of place', relaying concerns around the lack of privacy and expressing fears of being overheard by others.

Research has recognised the importance of waiting areas within health services and the potential impact upon service user emotional and psychological wellbeing (Liddicoat, 2020). Participants described noticing security cameras and spoke of physical environmental factors (i.e. Staff being behind a panel at A&E reception) as increasing their anxieties and distress. Security measures and physical segregation within waiting areas have been found to reinforce stigma and power imbalances for those experiencing mental health difficulties (Liddicoat, 2020).

Additionally, historically abusive or victimising experiences, which are especially pertinent for people experiencing psychosis (e.g. Bonoldi et al., 2013), can have a substantial impact upon an individual's interpretation of the world (Hardy, 2017). Those who experience psychosis may negatively interpret ambiguous social situations, have a perceived hostility bias and selectively attend to potentially threatening information (An et al., 2010; Hardy, 2017; Moritz & Laudan, 2007; Savulich, Shergill & Yiend, 2012). These difficulties may be particularly relevant to A&E environments, as participants within this study experienced attending A&E as threatening and described how busy waiting areas in particular exacerbated difficulties of voice-hearing, paranoia and difficulties distinguishing reality.

In contrast to findings of a previous UK based review (Taylor, Hawton, Fortune & Kapur, 2007), which identified that individuals attending A&E for self-harm had mixed feelings towards separate waiting areas, the participants within the current study described valuing a smaller private waiting area, stating it reduced their feelings of vulnerability. Provision of privacy may be particularly important, given participants' expressed needs for safety, fears of stigma, potential difficulties relating to paranoia (e.g. Veling, Pot-Kolder, Counette, van Os & van der Gaag, 2016) and reluctance to disclose risk to self, due to fears of being overheard by others. The results therefore reaffirm research indicating health service environments and waiting rooms can have potentially detrimental effects through increasing distress and anxiety for service users (Liddicoat, 2020).

Interpersonal influences

Similar to existing qualitative research within this area (e.g. Wise-Harris et al., 2017; Vandyk et al., 2018) the quality of interpersonal interactions with staff was a pivotal factor in influencing service user perceptions of their experiences at A&E. Those who perceived that staff demonstrated warmth, empathy and compassion reported a globally positive perception of attending A&E. Generally, positive staff interactions were experienced with mental health liaison services, where staff are trained and equipped to support service users experiencing mental health difficulties.

In contrast, a number of participants perceived general staff working within A&E to be judgemental, stigmatising, dismissive, and lacking care, which increased their distress, and for one participant, reinforced their derogatory voice-hearing experiences. Such experiences illustrate a discrepancy with NHS guidance which affirms the importance of service users who self-harm being cared for with compassion, respect and dignity (NICE, 2016). Within the UK A&E departments and staff working within are currently under pressure; however, reducing distress is a crucial function of providing appropriate care (CQC, 2015). Results support previous studies, which have identified that service users often report negative staff experiences at A&E comprising of stigmatisation, discrimination and dismissive care (Clarke et al., 2007; Wise-Harris et al., 2017, Vandyk et al., 2018). This potentially raises risk implications as feeling dismissed and unprioritised may result in increased low mood and sense of hopelessness, the latter being a risk factor for suicide attempts for those who experience psychosis (Klonsky, Kotov, Bakst, Rabinowitz & Bromet, 2012).

Interactions with staff may be pivotal for service user experiences as research has shown staff can hold prevailing negative attitudes towards service users who attend A&E for mental health reasons (e.g. Clarke et al., 2014) and particularly towards service users who self-harm (e.g. Horrocks et al., 2005; Saunders et al., 2012). Additionally, staff working within A&E have reported finding caring for individuals experiencing mental health difficulties as challenging (Clarke et al., 2014) and describe lacking sufficient knowledge, resources and skills to feel adequately equipped to provide appropriate care (Crowley, 2000; Doyle, Keogh & Morrissey, 2007; Marynowski-Traczyk & Broadbent, 2011).

Individuals experiencing psychosis may have encountered trauma which may involve an interpersonal component (e.g. Bonoldi et al., 2013; Kelleher et al. 2013), and include potentially difficult relationships with voices (e.g. Gilbert et al., 2001). Therefore, staff responses may be potentially unhelpful (Sweeney et al., 2018) if reminiscent of voice-hearing content or prior experiences of neglect or invalidation. Additionally, psychotic experiences are associated with insecure attachments (Gumley, Taylor, Schwannauer & MacBeth, 2013); thus, attachment theory (Bowlby, 1969) can be important within the context of seeking and receiving care (Adams, Wrath & Ming, 2018; Maunder et al., 2006). In times of distress service users may seek proximity and interpersonal contact to help regulate their emotional needs (Adams et al, 2018; Maunder et al., 2006; Maunder & Hunter, 2016). Therefore, healthcare services and staff working within have the potential to serve as an attachment function through provision of a secure base (Maunder & Hunter, 2016). This is important as negative A&E experiences may inadvertently strengthen negative models of self and others, and perpetuate difficulties relating to trust and inability to alleviate distress (Adams et al., 2018; Mikulincer & Shaver, 2012).

Findings demonstrate the necessity of providing compassion, safety, trust and transparency within relationships between staff and service users to provide trauma-informed care (Sweeney et al., 2018). The development of effective therapeutic relationships is imperative to enable transformative healthcare experiences, which appropriately respond to service users' emotional needs (Dizopa & Ahern, 2009; Kornhaber, Walsh, Duff & Walker, 2016).

Implications for future help-seeking

Participants who considered A&E to be a negative experience, comprised of unmet needs and uncaring staff interactions, expressed they would be reluctant to return. This supports existing evidence which has found A&E experiences can shape future help-seeking attitudes (e.g. Clarke et al., 2007; Hunter et al., 2013). For participants who described dismissive and stigmatising experiences at A&E, this may be particularly significant given experiences of stigma have been pertinent within service user help-seeking narratives and may hinder access to future mental health care (Liddicoat, 2020; Sweeney et al., 2015). Furthermore, this has important clinical implications as A&E may be indirectly associated with suicide (Broadhurst & Gill, 2007), if service users leave A&E and continue to experience thoughts or behaviours relating to risk to self and choose to not seek future support.

Strengths and limitations

The present study did not limit inclusion criteria to frequent A&E attenders, which previous studies in this area have done (e.g. Vandyk et al., 2018), and findings pertain specifically to people experiencing psychosis; thus, providing new perspectives. The majority of previous research has been conducted outside of the UK; therefore, the findings of this study, although comprised of a small sample size, may be useful for informing future service planning within NHS A&E departments. Study results are clinically relevant, particularly as all participants had attended A&E within the last twelve months. Individuals with lived experience were consulted during the study design to ensure the topic area was meaningful and important to those who access services for mental health care. Consultation with service users enabled feedback to be gathered relating to aims and methodology, in accordance with NHS guidance and recommendations (e.g. Department of Health, 2017; NIHR, 2019). During data analysis themes were continually refined and reviewed by the research team to ensure rigour. Participants had accessed four A&E departments within the North West of England, which provided an array of experiences across A&E services. Face-to-face interviews were beneficial in establishing rapport and engagement and provided an opportunity for service users' voices to be heard. Additionally, face-to-face interviews enabled data to be obtained directly from individuals, enabling the researcher to gather observational data providing ecological validity. Efforts were made to reduce social desirability bias, with participants being reassured regarding confidentiality, anonymity and the researcher's independent position outside of A&E departments.

The present study has several limitations. Recruitment involved a small sample of participants and although there was some diversity in terms of age range, the majority of participants were male and all participants were White-British; therefore, providing a limited breadth of experiences. A predominantly male sample is representative of psychosis research, which has been conducted disproportionately with men (Longenecker et al., 2010), and may reflect the increased prevalence of schizophrenia diagnoses in male populations (McGrath, Saha, Chant & Welham, 2008). However, the current study sample may be considered unrepresentative in comparison to previous research examining risk to self, which has found females to be overrepresented in clinical study samples and more likely to report experiencing self-harm (Bresin & Schoenleber, 2015; Victor et al., 2018). All participants were recruited from four community mental health services in the North West of England and individuals recruited from additional services, such as inpatient or primary care settings, may have provided different perspectives of A&E experiences. Additional recruitment from alternative services may have led to the development of new themes. Only individuals who were proficient in English language were eligible to take part, which is a significant limitation given the cultural and ethnic diversity within the North West of England. During interviews two participants reported difficulties relating to concentration, which highlighted the importance of the researcher employing a flexible and person-centred approach. This may be, in part, due to fact that the majority of participants were taking neuroleptic medications that have potential sedative effects (e.g. Muench & Hamer, 2010), or due to the experience of psychoses which can negatively influence cognitive functioning (e.g. Gopal & Varient, 2005; Hill, Schuepbach, Herbener, Keshavan & Sweeney, 2004). Furthermore, individuals who have experienced emotionally significant experiences may have been more willing to be interviewed, which may have resulted in over-reporting of negative experiences (Clarke et al., 2014).

Clinical implications

The study comprised of a small sample, which limits the wider generalisation of results. However, findings demonstrate the perceived inadequacy of A&E in addressing participants' needs and therefore highlights clinical implications for how risk to self can be supported more effectively within A&E departments.

Results are important, given staff working within NHS mental health services will sign post individuals to A&E at times of distress, particularly when community services are inaccessible outside routine working hours. Staff experiences were pivotal in influencing perceptions of care, with participants describing dismissive and judgemental interactions. This finding reaffirms the necessity of staff working within A&E developing therapeutic relationships comprising of compassionate, non-judgemental and person-centred care. This is particularly important when considering individuals who experience psychosis may have had a history of trauma (Kelleher et al., 2013) and therefore development of trusting therapeutic relationships is essential to the provision of trauma-informed care (Sweeney et al., 2018). Additionally, participants described reluctance to disclose risk to self, due to fears of forced hospitalisation and therefore staff should be transparent in providing information relating to potential outcomes to help reduce anxieties. Staff may benefit from receiving education and training pertaining to psychosis and risk to self to help combat stigmatising attitudes (Horsfall, Clearly, & Hunt, 2010).

Furthermore, findings demonstrate the importance of timely compassionate care to enable positive help-seeking experiences which meet service user needs, as this can influence attitudes towards future help-seeking (Broadhurst & Gill, 2007; Hunter et al., 2013). This is imperative, given the increased risk of self-harm and suicide in psychosis (Harvey et al., 2006; Nielssen & Large, 2009) and the association between presenting to A&E for self-harm reasons and risk for future suicide (Caroll, Metcalfe & Gunnell, 2014; Hawton, Zahl & Weatherall, 2003; Ryan et al., 1996). Therefore, if A&E departments are able to adequately address service users' emotional and physical needs, they may have a crucial role in suicide prevention (Ryan et al., 1996). Clinical recommendations are summarised below and clinical implications have been summarised in Table 6.

Summary of clinical recommendations

- A&E clinicians require education to improve knowledge, skills and understanding relating to supporting individuals who experience psychosis and risk to self. This may help to develop clinicians' confidence and reduce stigmatising care.
- Clinicians need to develop safe, trusting and therapeutic relationships with individuals attending A&E for risk to self by displaying warmth, compassion and non-judgmental attitudes.
- Individuals experiencing psychosis and risk to self should be referred to specialist mental health liaison teams 24/7.
- Care needs to be person-centred to meet individual needs and ensure a positive help-seeking experience.
- Clinicians need to provide information during the A&E process regarding possible outcomes following A&E attendance (e.g. discharge to a community service or admission to inpatient setting) to ensure transparency and to

support shared decision making. Information regarding potential next steps should be provided to help alleviate possible anxiety and distress.

- For timely care to be provided where possible and where long waiting times exist ensure individuals are adequately informed regarding how long they may potentially be waiting.
- Ensure individuals' basic needs are met through offering refreshments and medications (i.e. pain killers) if required.
- Offer individuals a separate waiting area to help provide safety, privacy and to reduce possible anxiety.

Horrocks et al. (2005) provided a framework for understanding individuals' experiences of attending A&E departments for self-harm reasons. This described individuals' wants and needs, identified barriers and consequences of these barriers within A&E. Table 6 presents an adaptation of this framework to illustrate clinical implications based upon the results of the current study. It presents participants described needs and expectations for attending, perceived difficulties encountered and the subsequent consequences and resulting unmet needs.

Table 6: Clinical implications based upon Horrocks et al. (2005)

Described needs & expectations for attending A&E	• To feel safe • Reduction of distress • Understanding and acceptance • Reassurance and to feel cared for • Person centred and individualised care • Privacy • Timely care
Difficulties encountered during A&E attendance	• Dismissive and judgmental staff attitudes & behaviours • Long waiting times • Uncertain process and outcomes • Lack of privacy • Chaotic and busy A&E environments

	• Lack of expertise within staff
Subsequent consequences of difficulties & unmet needs	• Feeling dismissed, judged, uncared for and not prioritised • Reluctance to re-attend A&E in the future • Unmet emotional and psychological needs • Increased distress, hopelessness and experiences of psychosis • Increased anxiety and perceived lack of safety

Future research

There remains a paucity of research examining A&E experiences from the perspectives of individuals who experience mental health difficulties, particularly within the UK; therefore, further research is required to enable a greater understanding. Participants within this study were fearful of being forcibly hospitalised following disclosure of risk to self. This finding is significant as it has not been prominent within previous studies examining service users' experiences of attending A&E from heterogeneous perspectives (e.g. Vandyk et al., 2018; Wise-Harris et al., 2017). This potentially indicates idiosyncrasies and nuances regarding particular mental health issues or reasons for attending and what might be significant within their experiences. Therefore, this supports previous recommendations by Vandyk et al. (2018) to conduct future research examining experiences of A&E from the perspectives of specific mental health diagnoses to enable care to be tailored appropriately.

During study recruitment clinicians expressed a desire to refer service users with a diagnosis of borderline personality disorder. Individuals with personality related difficulties have been associated with increased frequency and recurrent attendances at A&E (Penfold et al., 2016); however, there is currently limited qualitative research (e.g. Vandyk, Bentz, Bissonette & Cater, 2019). Therefore, examining the first-hand perspectives of those who experience personality related difficulties within an NHS setting may produce valuable insights. Additionally, some participants within this study reported that their family members who had accompanied them to

A&E wished to participate and examining caring perspectives would provide further important information regarding A&E experiences and quality of care.

Conclusion

This study explored individuals' experiences of attending A&E for risk to self, from the perspectives of those who experience psychosis. Exploring service user experiences of A&E departments is imperative to enable the quality of care to be improved. Participants within this study reported they required urgent care and support; however, experienced a disparity of esteem and perceived A&E as inadequate in meeting their needs. Participants' A&E experiences also influenced their attitudes towards future help-seeking; thus, providing important clinical implications. Study findings demonstrate care provided within A&E departments requires significant improvement to ensure the provision of timely, compassionate and person-centred care, which will assist in striving for parity of esteem.

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Paper 3: Critical appraisal

Word count: 8,135 (complete text), 5,935 (main text, excluding tables and references)

This paper contains personal reflections and is not intended for publication.

Critical appraisal

Overview

The aim of this paper is to provide a critical appraisal of the systematic review and empirical studies undertaken and described within this thesis. This paper includes critical reflection on the planning, design and conduct of the studies, alongside the researcher's personal reflections. The initial section will focus on the systematic review and the latter section will focus on the empirical study.

Systematic review (paper one)

The aim of the systematic review was to evaluate studies, which examined service users' experiences of accessing care at Accident and Emergency (A&E) departments for mental health difficulties.

Rationale for topic choice

Within the United Kingdom (UK) A&E departments are facing growing demands with staff shortages and increasing numbers of attendances each year (Care Quality Commission [CQC], 2018), which is subsequently impacting upon delivery of care (Blunt, 2014; CQC, 2018). Examining service user experiences of healthcare services is recommended within NHS guidance (e.g. NHS Institution for Innovation and Improvement, 2013), and can assist in ensuring high-quality service provision and improved person-centred future care (Aimola et al., 2019; Department of Health, 2017). Therefore, examining service user perspectives of A&E was considered an important topic area.

Initially, the researcher considered the feasibility of including all service user experiences of attending A&E, encompassing individuals attending for both physical and mental health reasons; however, this proved too broad as a topic area. It was considered important to focus specifically on individuals who have attended A&E for mental health reasons, as their needs may be different than the needs of those attending for physical health reasons (Sinclair, Hunter, Hagen, Nelson & Hunt, 2006). Additionally, there are a number of existing systematic reviews which focus upon experiences of attending A&E from a physical health perspective (e.g. Gordon, Sheppard & Anaf, 2010; Sonis, Aaronson, Lee, Philpotts & White, 2018).

Scoping searches identified that there remains limited understanding regarding service user experiences of attending A&E for mental health care; therefore, this provided a novel topic area. The topic area was also considered clinically important, as A&E is often an initial contact point for individuals accessing mental health care, particularly when in acute distress (Shand et al., 2018), and previous A&E experiences have been found to influence future help-seeking attitudes (Hunter, Chantler, Kapur & Cooper, 2013).

The researcher considered whether the review could include exclusively studies which have focused upon evaluating experiences of attending A&E for reasons involving risk to self (i.e. self-harm/suicidality). However, there is currently limited research within this area and many of the existing studies do not detail demographical information and include participants as a heterogeneous group (e.g. Vandyk, Young, MacPhee & Gillis, 2018). Therefore, focusing upon risk to self was deemed too narrow a scope as there would be insufficient evidence to develop conclusions with confidence. Instead the topic area was broadened to encompass the experiences of all service users who attended A&E for any mental health reason.

The researcher was aware of research focused upon A&E experiences from provider (e.g. Webster & Harrison, 2004) and carer perspectives (e.g. Collom, Patterson, Lawrence-Smith & Tracey, 2019) and considered whether the review could encompass these viewpoints. However, it was considered that these viewpoints would provide limited understanding pertaining to service users' experiences. The researcher felt it would be valuable and meaningful to focus exclusively upon service user experiences, as these perspectives appear neglected within the literature. Additionally, a review examining service users' experiences of A&E would be in keeping with the topic area of the empirical study. The researcher acknowledged that this topic choice provided a limitation, as it would not allow examination or comparison of alternative important viewpoints regarding A&E experiences.

Rationale for conducting a systematic review

A systematic review was considered the most appropriate method for ensuring a rigorous and transparent review of the available evidence, which would provide an empirically derived answer to the research question (Mallett, Hagen-Zanker, Slater & Duvendack, 2012). Systematic reviews use objective, replicable and pre-defined methods, which was considered advantageous in minimising bias (Gough & Elbourne, 2002) and ensuring prioritisation of empirical evidence over pre-conceived knowledge (Mallet et al., 2012). Systematic reviews are considered particularly important within healthcare research, as they are often crucial for the development of clinical guidelines (Gopalakrishnan & Ganeshkumar, 2013). In contrast, a narrative review was considered less appropriate due to the limited research in this area, thus increasing the potential for bias and subjectivity, as they do not typically provide explicit methods regarding searching or selection of studies (Collins & Fauser, 2005).

Despite the advantages of conducting a systematic review, there are also a number of limitations. The search is limited to the timing of when the search is conducted and new studies are continually published; therefore, they inherently become out of date upon publication. Reviewing at title and abstract level can result in exclusion of relevant studies if the relevance has not been stated explicitly within the abstracts. In order to mitigate against this, the researcher conducted additional searching comprising of checking reference lists and relevant reviews and also conducted inter-rater reliability with an independent researcher. However, the risk of potential exclusion of relevant studies remains a possibility. Systematic reviews are resource intensive given the high number of studies that are assessed at the first stage of screening (Mallett et al., 2012); this was an acknowledged challenge within the present review, where search terms were required to be broad to capture appropriate evidence, which resulted in a high proportion of results being retrieved. The researcher considered the topic area and was aware service user views and relevant evidence may exist outside of formal peer-reviewed studies and therefore chose to include grey literature. However, it was recognised that additional searching can undermine the objectivity of the search and introduce bias into the review. The researcher considered these potential limitations and sought to balance rigour with flexibility of methods (Mallett et al., 2012).

Originally the plan was to include both quantitative and qualitative papers, but a recent review of the qualitative literature had been published (Carstensen et al., 2017). Scoping identified limited qualitative research published since so it was considered more appropriate to focus solely upon the quantitative evidence, as no prior reviews had examined this. Conducting a systematic review comprising of the quantitative evidence would enable identification of any clinically and statistically significant information, as well as findings to be compared and contrasted with the existing qualitative review.

Potential analytical and synthesis methods were considered. Research studies within this area are largely heterogeneous and significantly differ in terms of aims, design and outcomes; therefore, it was considered inappropriate to conduct a meta-analysis, as they require homogeneous data to produce meaningful results (Campbell, Katikireddi, Sowden, McKenzie & Thomson, 2018; Mallett et al., 2012). Additionally, studies have typically used descriptive analytical methods, as opposed to formal statistical analysis, and bespoke data collection tools. Therefore, narrative synthesis was considered advantageous for this review, which would comprise of diverse evidence. The researcher was aware of the limited consensus and guidance relating to narrative synthesis methods and therefore it would be important to recognise a potential for bias (Campbell, Katikireddi, Sowden & Thomson, 2019).

Inclusion and exclusion criteria

Eligibility criteria was clearly defined prior to conducting the search. Considerations were made to exclude studies which had not distinguished between service user and other perspectives (e.g. Morphet et al., 2012) or between the results of mental health and physical health participants (e.g. Sinclair et al., 2006). Other studies were excluded which provided observational data and provider viewpoints (e.g. Webster & Harrison, 2004), which would not be representative of service user perspectives. Furthermore, alternative services (e.g. emergency psychiatric units, Svindseth, Nøttestad & Dahl, 2010) which were similar to inpatient psychiatric settings were excluded. Inclusion of alternative settings would have provided heterogeneity, which may have presenting difficulties for synthesising and comparing results. The researcher sought to be as inclusive of studies as possible, due to the limited research in this area, in order to produce a coherent and robust synthesis of the current evidence.

The search was limited to start at the year 1990 to coincide with the establishment of The NHS and Community Care Act (1990) advocating the provision of care and treatment in the community and also research interest subsequently growing in this area. A number of NHS policies were initiated in the late 1990’s and early 2000’s, (e.g. Department of Health, 1999; NHS, 2000), which stated the importance of mental health services being introduced within A&E departments. The researcher identified that the previous review (Carstensen et al., 2017) had not limited the search criteria by date range; however, did not include any studies prior to the year 2000. For these reasons, a date range commencing at 1990 was considered appropriate. The review was limited to studies published in English, which may provide a language bias (Centre for Reviews & Dissemination [CRD], 2009; Wright, Brand, Dunn & Spindler, 2007); however, it was not possible to translate articles due to time and resource constraints.

Quality rating

A quality assessment tool was considered important as this was the first review to examine the quantitative evidence in this area. One of the review aims was to examine the methods used to evaluate service user experiences; therefore, a quality assessment would enable consideration of the validity and reliability of studies and any subsequent impact upon findings (CRD, 2009; Protogerou & Hagger, 2019). In order to appraise the quality of all of the presented evidence the two non-peer reviewed studies were incorporated within the quality assessment and no studies were excluded on the basis of quality.

The researcher considered a variety of quality assessment tools to determine the most appropriate for the review. Many quantitative quality assessment tools are designed to examine single methodological approaches, for example, the Consolidated Standards of Reporting Trials (CONSORT, Schulz, Altman & Moher, 2010), which assesses only randomised controlled clinical trials. However, single methodological approaches present difficulties when examining heterogeneous evidence utilising different methodologies (Sirriyeh, Lawton, Gardener & Armitage, 2012). The Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, Thomas, Ciliska, Dobbins & Micucci, 2004) was considered inappropriate due to its focus upon clinical trials with areas examining confounders and blinding. As mixed method studies, which comprised of quantitative components, were also being included within the review, the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018) was considered; however, was deemed to be more appropriate for clinical trials and interventional studies.

The Quality Assessment Tool (QATSDD; Sirriyeh et al., 2012) is designed to assess both qualitative and quantitative studies which have used diverse methodology. It has been found to be useful for healthcare studies, has good re-test and inter-rater reliability (k=71.5%) and utilises scaled scoring (Sirriyeh et al., 2012). Therefore, the QATSDD was considered the most appropriate quality assessment tool, as it would provide a standardised approach and allow quality comparisons to be drawn (Sirriyeh et al., 2012).

In order to mitigate against any potential bias (Wright et al., 2007), the researcher rated all of the papers on two separate occasions and a proportion (N=25%) were further rated by an independent researcher. Upon reflection there were limitations to the QATSDD in that some of the descriptions for scoring were subjective (e.g. “limited detail” vs “fairly detailed”) with limited guidance on how to decipher between scores. It has been recognised that scaled scoring can present challenges for inter-rater reliability over dichotomous scoring (Sirriyeh et al., 2012). Despite these limitations, the researcher considered the QATSDD a useful quality assessment tool within the present review.

Empirical study (paper two)

The aim of the empirical study was to explore service user experiences of attending A&E departments at times of risk to self, from the perspectives of those who experience psychosis.

Rationale for topic choice

A previous review which examined qualitative service user experiences of attending A&E for mental health reasons found only nine studies across four countries and only one included study was from the UK (Carstensen et al., 2017). The majority of previous research within this area has focused upon service user experiences as a heterogeneous group, where participants have encompassed a variety of different mental health diagnoses. These studies have identified differences within participants’ narratives and therefore have recommended future research to focus upon specific mental health diagnoses to ensure care can be tailored appropriately (Vandyk et al., 2018). There has been one study to date, which has examined a particular diagnostic group (Vandyk, Bentz, Bissonette & Cater, 2019); this focussed upon A&E experiences from the perspectives of individuals with a diagnosis of borderline personality disorder.

There have been some studies conducted within the UK which have explored service users' experiences of A&E within the context of risk to self, specifically self-harm (e.g. Horrocks, Hughes, Martin, House & Owens, 2005; Hunter et al., 2013). However, there have been no previous studies which have explored attending A&E for risk to self, from the perspectives of individuals who experience psychosis. Research has found that people who experience psychosis are more likely to attend A&E (Brennan, Chan, Hsia, Wilson & Castillo, 2014) and also have higher prevalence levels of suicidality and self-harm (Carlborg, Winnerbäck, Jönsson, Jokinen, & Nordström, 2010; Hor & Taylor, 2010). It is essential that service users access appropriate care at A&E, as research has found a relationship between presenting to A&E for risk to self and subsequent suicide (Da Cruz et al., 2011; Ryan, Rushdy, Perez-Avila & Allison, 1996) and experiences at A&E have been shown to influence attitudes towards future help-seeking (e.g. Hunter et al., 2013). Therefore, reviewing the literature identified a clinically important yet novel area, where findings could support recommendations to improve future care within NHS A&E departments.

Consultation

Service user involvement within research is incredibly valuable in ensuring the utilisation of experiential knowledge and in providing alternative views to staff or research team members (Lindenmeyer, Hearnshaw, Sturt, Ormerod & Aitchison, 2007; National Institute for Health Research [NIHR], 2019; NHS Health Research Authority, 2020). Collaborating with service users is underpinned by the NHS constitution (Department of Health, 2015) and is recommended within the design of research studies (NIHR, 2019) to ensure research is meaningful to those with lived experience (Department of Health, 2017).

During the design of the empirical study, the researcher consulted a service user group (Clinical Liaison Group [CLG], the University of Manchester) to obtain views relating to methodology and procedures. A pilot interview was conducted to enable topic guide refinement and establish any required adjustments during participation. Service users advised it would be important to provide comfort breaks and to be considerate to possible medication side effects, which may impact someone's ability to maintain prolonged periods of concentration. It was recommended that participants should be thanked and reimbursed for their time to ensure their participation was recognised as valuable. Additionally, it was advised that the researcher should remind participants that they only needed to share what they felt comfortable doing so and to explicitly state that taking part would be confidential and with no impact upon their future care. Consultation highlighted that attending A&E may have been during a distressing time and therefore it would be important to debrief participants through checking how they had experienced the interview and signposting to additional support if required. Service users felt the research area was important and individuals would be interested in taking part, which was important in considering study feasibility. All recommendations were considered and implemented into the study design.

The research study was also discussed with academics and clinicians that worked within this area during study design and establishment of feasibility. The study was reviewed by an independent panel at the University of Manchester, consisting of Clinical Psychologists, researchers and service users, which provided additional valuable feedback.

Inclusion criteria

The inclusion of people with other mental health diagnoses, which may also involve psychosis related experiences (i.e. bipolar disorder, Burton et al., 2018) was considered. However, given there is symptomatic crossover in a number of mental health diagnoses (Gaudiano & Zimmerman, 2013), it was felt that to enable homogeneous population it would be important to limit inclusion criteria to psychosis related to diagnoses described as a schizophrenia spectrum. This would ensure an exploration of a particular range of experiences.

Initially a time period of six months since attendance at A&E was specified; however, due to difficulties recruiting and as part of the predetermined contingency plan an amendment was submitted and approved by the NHS Research Ethics Committee to increase the time period following A&E attendance to 12 months. A time period of 12 months was considered reasonable, as this time period has been stipulated within studies within this area (e.g. Vandyk et al., 2018) and would balance participants’ ability to remember the experience in sufficient detail, whilst ensuring the information provided was clinically relevant. The researcher was aware that attending A&E during a mental health crisis could be an emotional experience, which may impact upon recollection of the event (Kensinger, 2009). During recruitment the researcher observed participants who attended A&E longer ago could still recount vivid descriptions, which may signify the pertinence of the experience.

A proportion of research exploring A&E experiences has sought to examine an understanding in relation to frequent attenders and as a result has applied inclusion criteria relating to number of times attended at A&E (e.g. Vandyk et al., 2018). It was considered inappropriate to limit the inclusion criteria in this way as the study was not examining frequency of attendance and it would potentially not give voice to individuals who had attended for the first time. Furthermore, it was considered appropriate to include all forms of risk to self which encompassed both ideations or behaviours associated with self-harm or suicidality, irrespective of motivation in line with NHS guidance (National Institute for Health and Care Excellence, 2013).

Including only individuals proficient in English was a potential limitation, particularly as the geographical area in which the research was conducted was culturally and ethnically diverse. However, limited resources and time constraints meant it was not possible to use interpretation services.

Recruitment

The process of gaining NHS approvals, which was lengthy and time-consuming, was a learning experience for the researcher. Delays gaining governance and ethical approvals impacted upon recruitment and are recognised as presenting barriers within research more generally (Department of Health, 2017; Thompson & France, 2010).

In accordance with ethical approval and the study protocol, participants were provided with study information via their clinician (i.e. care coordinators). However, there are recognised recruitment difficulties existing at both clinician and provider levels when conducting mental health research (Bucci et al., 2015; Department of Health, 2017). These barriers may exist for a number of reasons, such as clinicians not having protected time to consider research and having multiple studies to consider, which may be burdensome (Adams, Caffrey, & McKevitt, 2015). Clinicians have been found to idiosyncratically apply eligibility criteria and demonstrate paternalism when considering potential referrals to research studies (Howard, de Salis, Tomlin, Thornicroft & Donovan, 2009; Patterson, Kramo, Soteriou & Crawford, 2010), which is in contrast to guidelines which state the importance of service users being informed of research studies (e.g. Department of Health, 2015; 2017; NIHR, 2019).

A number of factors may influence individuals to be reluctant to participate, such as practical barriers (i.e. travel) and concerns relating to confidentiality, stigma and distrust of research (Woodall, Morgan, Sloan & Howard, 2010). The researcher sought to overcome these potential barriers through conducting interviews at places convenient to participants, providing reimbursement for participant time and providing reassurance regarding confidentiality.

The researcher found the time-intensive recruitment process challenging alongside completing other demands of the clinical psychology doctorate and considered a longer recruitment period would likely have increased the number of referrals. The study was advertised within four mental health NHS trusts; however, participants were only referred from two trusts. The researcher approached 63 teams across the trusts to advertise the study, 31 teams provided permission for the researcher to present within team meetings and five teams referred potential participants. The researcher attended team meetings within a variety of secondary care mental health services including early intervention services, community mental health teams, A&E liaison services, home based treatment teams, inpatient units and psychology specific services. The researcher sought to spend time within services to establish relationships with clinicians, as the importance of continued engagement with clinical teams has been recognised (Bucci et al., 2015) in ensuring staff are motivated to assist with the process of identifying potential participants (Skea, Treweek & Gillies, 2017).

The researcher was required to make multiple attempts to contact potential participants and sought to establish a balance of attempts to contact, whilst ensuring individuals did not perceive any influence to participate, as this has been recognised as potentially creating ethical issues and power imbalances (Donley, 2015). The researcher recognised it may have been useful to have advertised and recruited within third sector agencies to enable study information to be directly disseminated to service users. However, as the inclusion criteria specified attendance at A&E for risk to self, it was felt that recruiting from NHS services would ensure service user safety as participants would have a clinician currently working with them.

Risk and ethical issues

Risk and ethical issues were considered during the study design and appropriate protocols (Appendix K) were implemented and approved by the NHS Research Ethics Committee to ensure the study maintained the highest ethical standards (Braun & Clarke, 2013). Appropriate guidance (e.g. British Psychological Society, 2018; NHS Health Research Authority, 2020) was followed and supervision was utilised to maintain awareness of the researcher's limits of competence to ensure protection of participants (Braun & Clarke, 2013). The study inclusion criteria specified that participants were in receipt of care from an NHS clinical service, which ensured risk could be monitored prior to and following taking part in the study. In line with the Mental Capacity Act (2019) capacity to consent was assumed, unless indications to the contrary, and no capacity concerns were encountered during recruitment. The researcher explicitly asked clinicians regarding any potential capacity issues and advised them not to refer anyone who may potentially lack capacity. A lone working protocol was followed to ensure safety of the researcher and interviews were conducted within NHS premises if required for risk reasons. Participants were advised of the limits of confidentiality before the interview commenced and that in the event of the disclosure of risk issues, information would need to be shared with the appropriate agencies. Additionally, participants were informed their participation was voluntary with no impact on their future care and that they only needed to share information they felt comfortable doing so. As interviews may have touched on topics that were distressing, all participants were provided with contact information for support services and the researcher conducted a debrief with each participant following the interview.

Interviews

The researcher was aware that difficulties such as psychosis have been associated with high drop-out rates within health services (Dixon, Holoshitz & Nosell, 2016) and it can take time to develop trusting relationships, which means engagement and recruitment within this population can be challenging. The researcher reflected upon her previous experience of working therapeutically with individuals experiencing psychosis and sought to balance establishing a therapeutic alliance, whilst maintaining appropriate research boundaries. The researcher felt engagement had been established through the use of an initial telephone call, which provided an opportunity to build rapport whilst establishing study eligibility. The researcher aimed to ascertain true and honest perceptions of A&E and was mindful of potential power imbalances, given she was both a researcher and clinician, and provided reassurance of confidentiality and anonymity.

The researcher found the interviews a powerful, emotive and inspiring experience. Upon reflection, she considered her inherent dual role as both a researcher and clinician and the complexities this posed with continuous shifting between roles during conduction of the study (Yanos & Ziedonis, 2006). This conflict was experienced during interviews where she experienced a strong desire to offer therapeutic input, particularly upon hearing individuals distressing experiences, and valued supervision as an opportunity to discuss any emotional impact arising from the interviews. Research interviews which consisted of one meeting, were in contrast to her initial meetings as a clinician where she would be seeking to engage an individual to return for further therapeutic sessions. The researcher felt her clinical role had been beneficial in assisting the development of rapport with clinicians who acted as facilitators to recruitment (Yanos & Ziedonis, 2006).

The researcher had intended to transcribe all of the interviews; however, this was not possible due to difficulties encountered during recruitment. Therefore, 45% (N=5) were transcribed by an independent professional transcriber. This agreement was specified within the participant information sheet and a confidentiality agreement was signed by the transcriber. All transcriptions were checked for complete accuracy by the researcher.

Rationale for methodology

Thematic analysis provides a method of identifying, analysing and reporting patterns within the data in rich detail and can examine differences and similarities within complex individual accounts (Braun & Clarke, 2006). Thematic analysis as described by Braun and Clarke (2006) has been recognised as a useful methodology particularly when the topic area is novel (Vaismoradi, Turunen & Bondas, 2013), which was applicable to the current study where there has been limited prior research and the aim was to develop an initial understanding.

Interpretative Phenomelogical Analysis (IPA) and grounded theory were considered as potential alternatives as they utilise inductive approaches and are data driven (Braun & Clarke, 2013). However, grounded theory places an emphasis on social processes and influencing factors, as opposed to examining individual experiences and is primarily concerned with developing a theory of a phenomenon (Braun & Clarke, 2006; 2013; McLeod, 2001). Interpretative Phenomelogical Analysis focuses upon personal meanings (Pietkiewicz & Smith, 2014), whereas thematic analysis gathers detailed descriptive accounts (Braun & Clarke, 2013), which was considered more in keeping with the research question. Both IPA and grounded theory are theoretically and epistemologically bound (Braun & Clarke, 2006, 2013; Pietkiewicz & Smith, 2014), whereas thematic analysis is a flexible and theoretically independent methodology and can be used within a number of epistemological positions (Braun & Clarke, 2006; 2013). Thematic analysis can also be advantageous in providing flexibility within data collection, for example sampling is not required to be purposive as recommended within the theoretical underpinnings of IPA (Pietkiewicz & Smith, 2014).

Additionally, IPA generally requires a smaller and more homogeneous sample (Pietkiewicz & Smith, 2014), whereas thematic analysis can be useful for more heterogeneous samples, which was applicable to the present study where there was heterogeneity in terms of diagnosis and reasons for attending A&E. Furthermore, thematic analysis has been used successfully in prior research within this area (e.g. Vandyk et al., 2018), acknowledges the researchers' active role within analysis and enables interpretation to draw upon a number of theoretical approaches (Braun &

Clarke, 2006; 2013); therefore, it was considered advantageous over alternative methods.

Member checking

The researcher places great value on service user involvement within research; however, recognised that due to time constraints this resulted in limited capacity to involve service users during study implementation. The possibility of completing member checking of results was considered, which can be important in ensuring the accuracy of representing peoples' experiences and that the results are credible and dependable (Braun & Clarke, 2013). However, the researcher decided it would be inappropriate to conduct member checking due to a number of reasons. Member checking can create power imbalances, which may lead participants to feel reluctant to express criticism, and existent time-constraints within the clinical psychology doctorate would likely impact upon the ability to conduct member checking meaningfully (Braun & Clarke, 2013; McLeod, 2001). Additionally, research has found no evidence to support that member checking necessarily enhances the credibility or trustworthiness of qualitative research (Thomas, 2017).

Theoretical sufficiency

The concept of sample size is complex (Sandelowski, 1995) with the notion of saturation often used to guide how much data is required (Braun & Clarke, 2013; Guest, Bunce & Johnson, 2006). Within thematic analysis, Braun and Clarke (2013) have advocated the region of 6-10 participants within studies which use interviews and a sample size of 12 has been acknowledged as point where data saturation often occurs (Guest et al., 2006). It has been argued that saturation as a quality marker is inappropriate due to its various meanings and limited transparency across qualitative approaches (O'Reilly & Parker, 2013). Instead sample adequacy and data quality are considered more important components as opposed to the number of participants (Malterud, Siersma & Guassora, 2016). The researcher had faced recruitment challenges and had a pre-defined recruitment time period; therefore, as this was an initial study providing new insights, it may be more realistic to consider recruitment as having reached theoretical sufficiency (Malterud et al., 2016).

Reflexivity, quality and rigour

The researcher kept a reflective journal throughout the duration of the study to collate reflections, field notes and observations during participant interviews to ensure critical thinking, self-awareness and integrity throughout conduction of the study (Nowell, Norris, White & Moules, 2017; Probst, 2015). The researcher was aware of the importance of considering reflexivity as she understood her own personal experiences, biases, perceptions and prior experiences of working therapeutically with individuals experiencing psychosis could impact upon data analysis and study results (Probst, 2015). In order to broaden reflexivity, the researcher arranged an opportunity to shadow a nurse within a mental health liaison team situated in an A&E department. Study methodology was developed and reviewed against Lincoln and Gubas' (1985) criteria to ensure rigour (Refer to Table 7).

Table 7: Rigour methods used within the empirical study adapted from Lincoln and Guba (1985) and Forero et al. (2018)

Rigour criteria:	**Purpose:**	**Strategies used:**
Credibility	To establish confidence in an authentic representation of experiences which are true, credible and believable.	• Researcher observed a night shift within A&E. • Topic guide tested using pilot interview. • Regular supervision during data collection. • Researcher attended qualitative tutorials to ensure adequate knowledge and skills. • Verbatim quotations provided within findings.
Dependability	To ensure findings are repeatable within the same cohort of	• Detailed pre-defined study protocol used throughout

	participants, coders and context. Minimisation of idiosyncrasies in interpretation and use of identifiable sources.	recruitment, data collection and analysis. • Study procedure detailed within the paper. • Data collection and analysis conducted and stored in line with agreed data management plan to enable detailed records for audit purposes.
Confirmability	Extent to which biases and perspectives of researcher influence results and to ensure confidence results would be confirmed by other researchers.	• Researcher kept reflexive journal and field notes throughout study conduction. • Attendance at qualitative tutorials. • Coding discussed and reviewed with other research team members.
Transferability	The degree to which the results fit with contexts outside of the study situation or transferred to other settings.	• Included sample relevant to target study population • Theoretical saturation achieved. • Sample inclusive of range of ages and experiences. • Findings linked with existing theoretical and empirical evidence.

Clinical implications

There is currently limited research within this area, particularly within a UK setting; therefore, it is too preliminary to recommend significant changes to clinical practice. However, results of the current study support findings from previous research within this area, highlighting the importance of staff interactions in establishing trusting and therapeutic relationships with service users. Findings demonstrate the perceived inadequacy of A&E in supporting individuals experiencing risk to self and highlight a variety of factors which can exasperate distress; therefore, suggesting A&E services require improvements. The researcher considered the study had provided a valuable opportunity for service users to be heard and have their experiences potentially shape future service provision; this was echoed in participant feedback and their expressed motivations to participate.

Suggestions for further research

The majority of research evaluating A&E services has been conducted from staff and provider perspectives, neglecting service user voices (Carstensen et al., 2017; Vandyk et al., 2018). During recruitment the researcher encountered clinicians expressing a desire to refer individuals with a diagnosis of borderline personality disorder and also had a self-referral from an individual with this diagnosis. There has been a study conducted in Canada (Vandyk et al., 2019) which has explored experiences of attending A&E from the perspectives of individuals with borderline personality disorder; however, it may be useful to conduct research within NHS settings to ensure the experiences of those with personality related difficulties are captured. In line with the recommendations raised by Vandyk et al. (2018), it would be valuable to continue to examine A&E experiences from the perspectives of service users with specific mental health diagnoses to develop further understanding. Additionally, participants expressed to the researcher that their family and carers who accompanied them to A&E would be interested in participating in research. Carer perspectives provide an additional valuable viewpoint relating to healthcare experiences (Collom et al., 2019) and therefore this warrants further exploration.

Dissemination

The systematic review will be submitted to the Journal of Mental Health (author guidelines in Appendix A) and the empirical study will be submitted to the Qualitative Health Research journal for review (author guidelines in Appendix B). The results of the empirical study will be sent to each participant who took part and consented to hearing about the findings. Authors will also seek to disseminate study results at conferences and within service user forums.

Additional personal reflections

Recruiting within the NHS

The researcher found the numerous processes involved in initiating a clinical research study, which involved recruiting from NHS mental health services to be challenging, particularly amongst competing clinical psychology doctorate demands. The researcher valued opportunities to present in team meetings and to maintain contact with clinicians to enable development of relationships; however, recognised the challenges of doing this within the time constraints.

A number of NHS mental health services advised that they were unable to support the study, primarily due to existing commitments supporting clinical trials. Additionally, some of the teams approached advised that they were unable to help facilitate research due to staff absence, which may reflect the current contextual difficulties of recruiting within the NHS. Upon reflection, the researcher recognised that commitment to multiple research studies would have likely placed increased demands on clinicians working within services already under additional pressures. Consideration was also given to whether clinicians might be feeling over-researched or over-burdened by clinical responsibilities, which may have understandably caused challenges in prioritising research. The researcher felt that the recruitment difficulties encountered conflicted with national guidance (e.g. Department of Health, 2017), advocating the importance of service users hearing about research opportunities, and her personal beliefs that conducting research is important to ensure high-quality mental health care.

A&E observation

During recruitment to the empirical study the researcher observed a nurse working within an A&E mental health liaison service during a night shift, which provided an opportunity to broaden her reflexivity, as she had no prior experience of working within an A&E department. The researcher observed elements of the A&E service user journey including triage, mental health act assessments and discharge and was able to discuss with clinicians their experiences of supporting individuals with mental health difficulties. Clinicians reported administrative duties and contextual factors as impacting upon their ability to deliver timely care and felt A&E was facing increasing demands, which was resulting in high levels of staff burnout.

The researcher had a number of personal reflections. She considered staff to be doing their upmost to deliver excellent care whilst constrained by service and system related factors. Being within A&E allowed her to envision from a service user perspective, how feeling unsafe and experiences of paranoia could be exacerbated by the environment. The researcher noted that there were security cameras fitted only within the mental health assessment rooms and wondered how being filmed during a time of distress could impact upon someone's difficulties and potentially reinforce prevailing stigma. The researcher noted an internal emotional shift following the A&E observation, given her interviews so far and clinical experiences had left her feeling somewhat disheartened around attending A&E for support; she noticed an increase in understanding towards A&E services and subsequently increased objectivity. As the researcher was also a Trainee Clinical Psychologist, she could identify with the desires to deliver high-quality care; however, feel constrained by the current context within the NHS. This opportunity was an incredible learning experience and the researcher was appreciative of how willing, honest and forthcoming clinicians had been to share their frustrations of working within complex systems.

Overall reflections

The researcher found the process of completing both the systematic review and empirical study demanding, yet also considered the process to be invaluable in developing her capabilities as both a researcher and clinician. The systematic review at times felt challenging, particularly given the large number of search results. Yet, it emphasised the importance of the researcher being proactive in seeking advice to guide her learning. The conduction of a clinical project, that involved recruiting from NHS mental health services, felt ambitious given the constrained time frames within the clinical psychology doctorate. However, despite these challenges, the researcher felt incredibly passionate in having completed a clinically relevant and meaningful thesis which places service user voices at the forefront.

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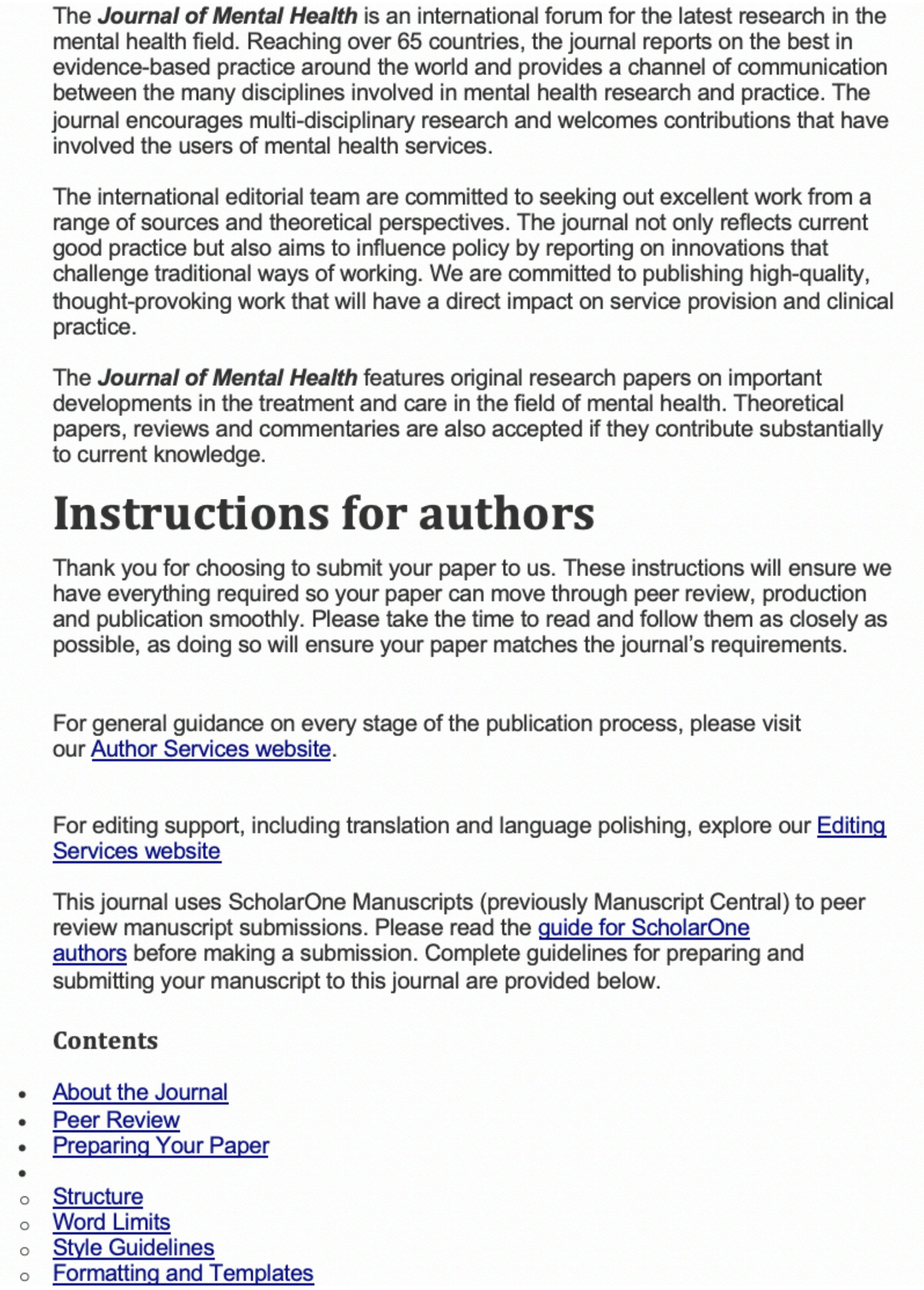
Appendix A: Author guidelines for Journal of Mental Health



The ***Journal of Mental Health*** is an international forum for the latest research in the mental health field. Reaching over 65 countries, the journal reports on the best in evidence-based practice around the world and provides a channel of communication between the many disciplines involved in mental health research and practice. The journal encourages multi-disciplinary research and welcomes contributions that have involved the users of mental health services.

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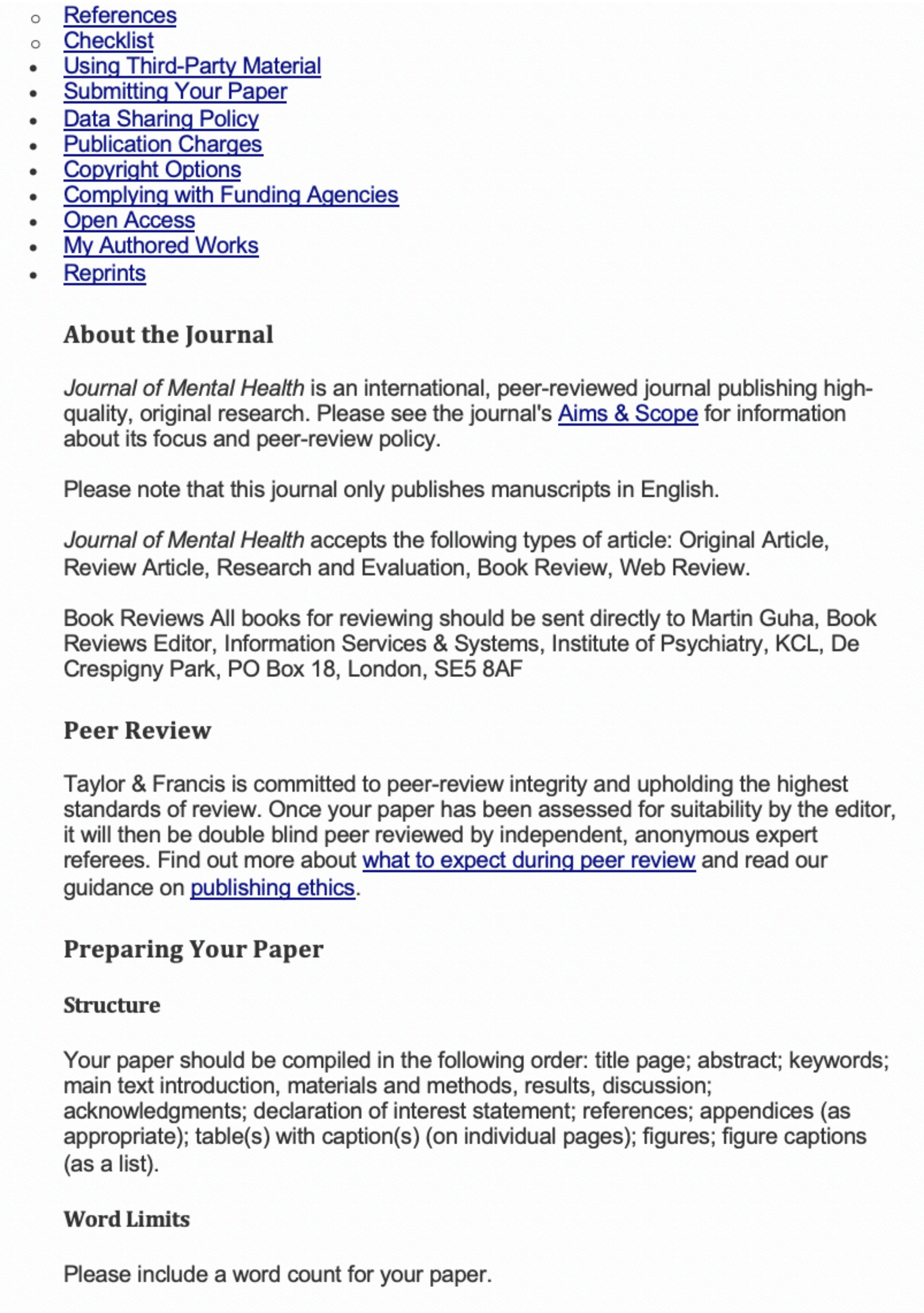
Contents

- About the Journal
- Peer Review
- Preparing Your Paper
-
    - Structure
    - Word Limits
    - Style Guidelines
    - Formatting and Templates



  - References
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- Submitting Your Paper
- Data Sharing Policy
- Publication Charges
- Copyright Options
- Complying with Funding Agencies
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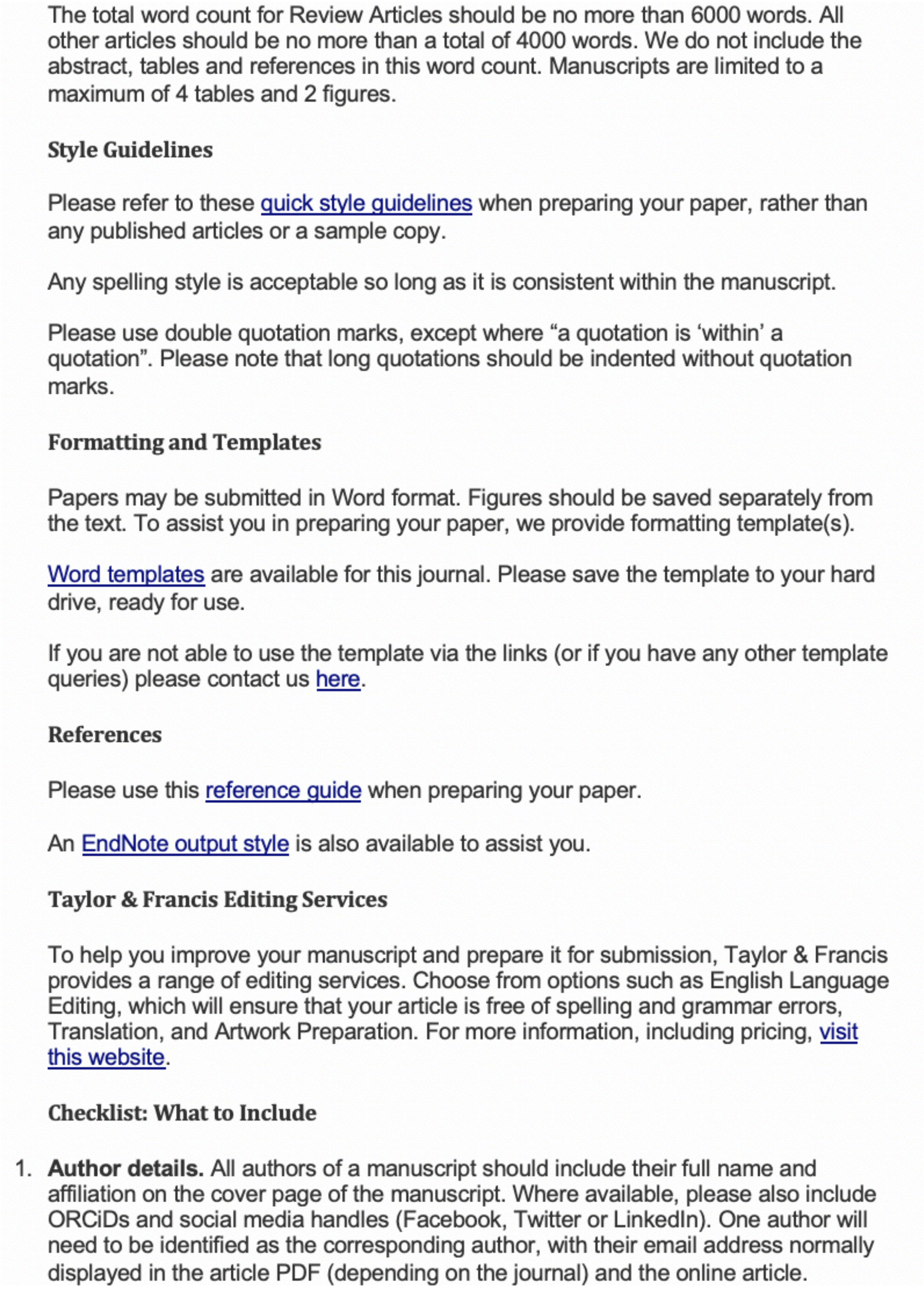

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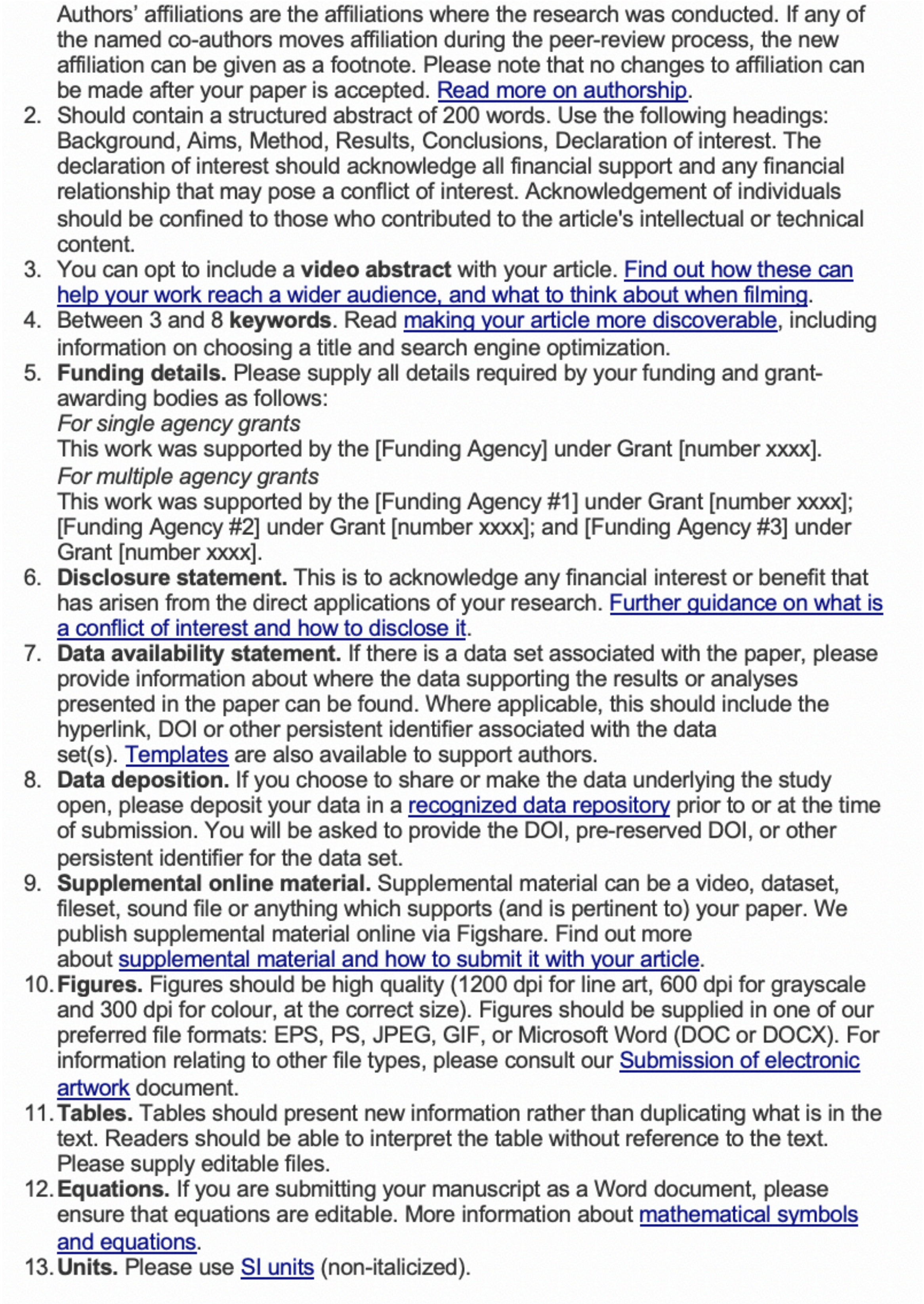

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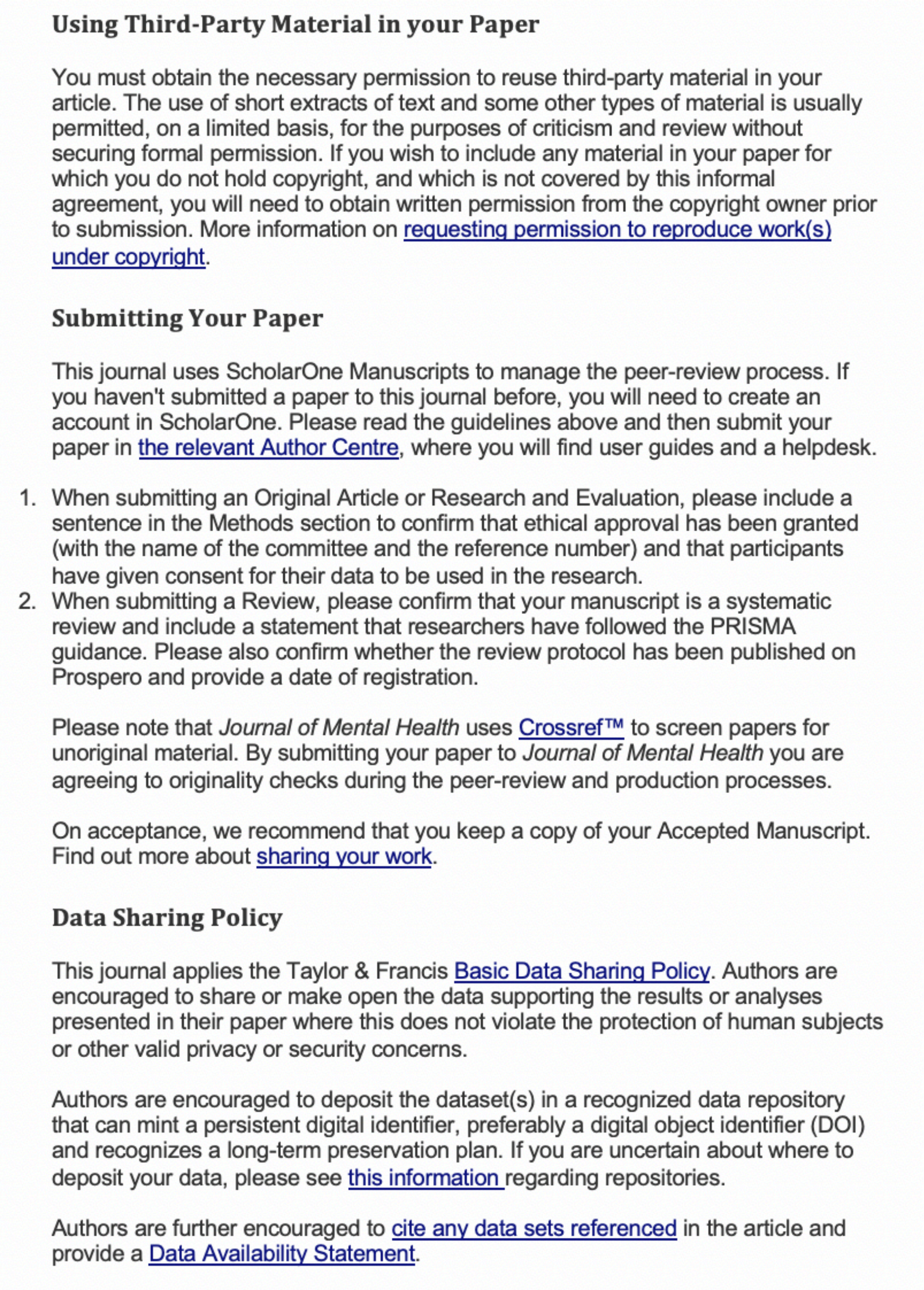

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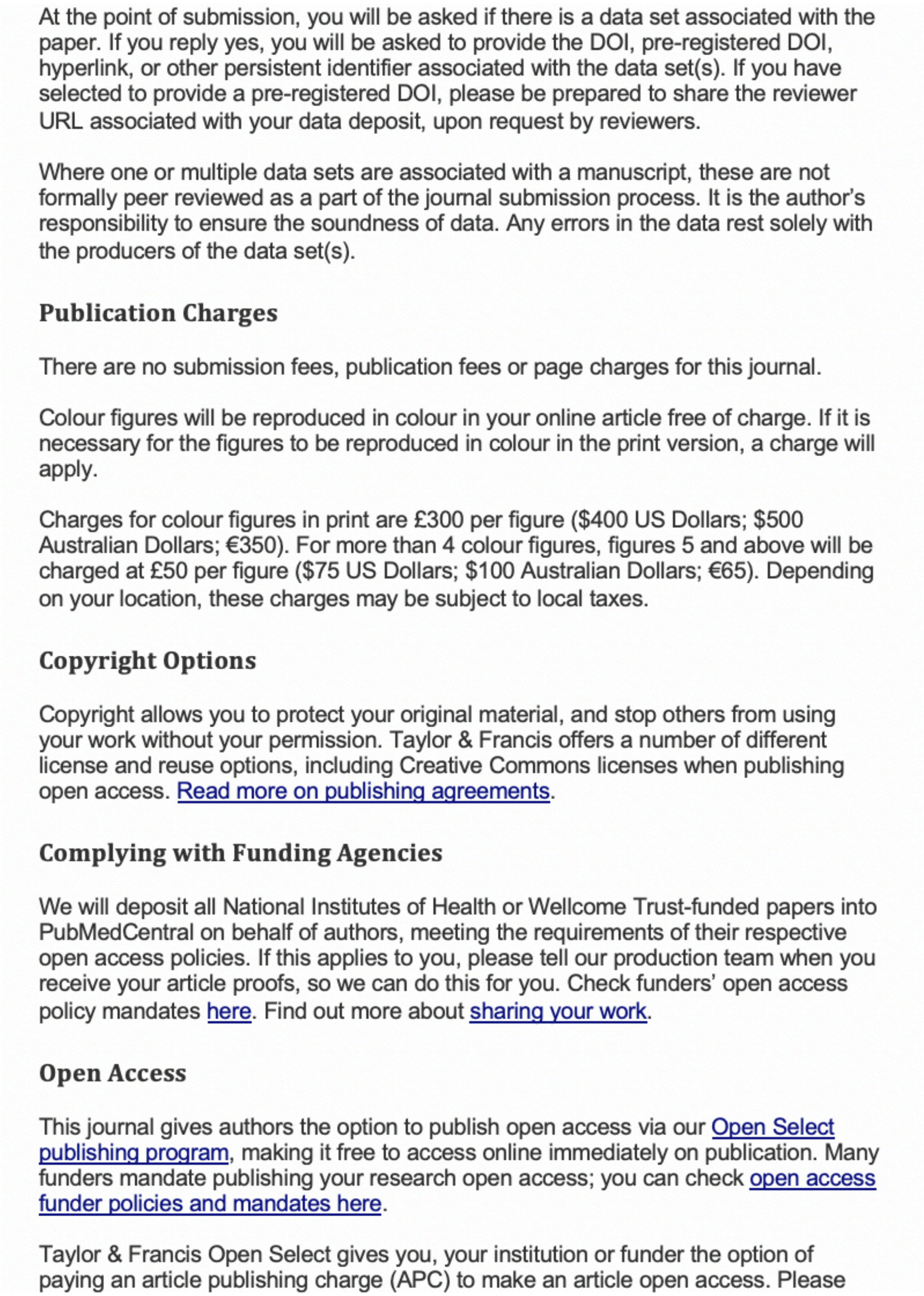

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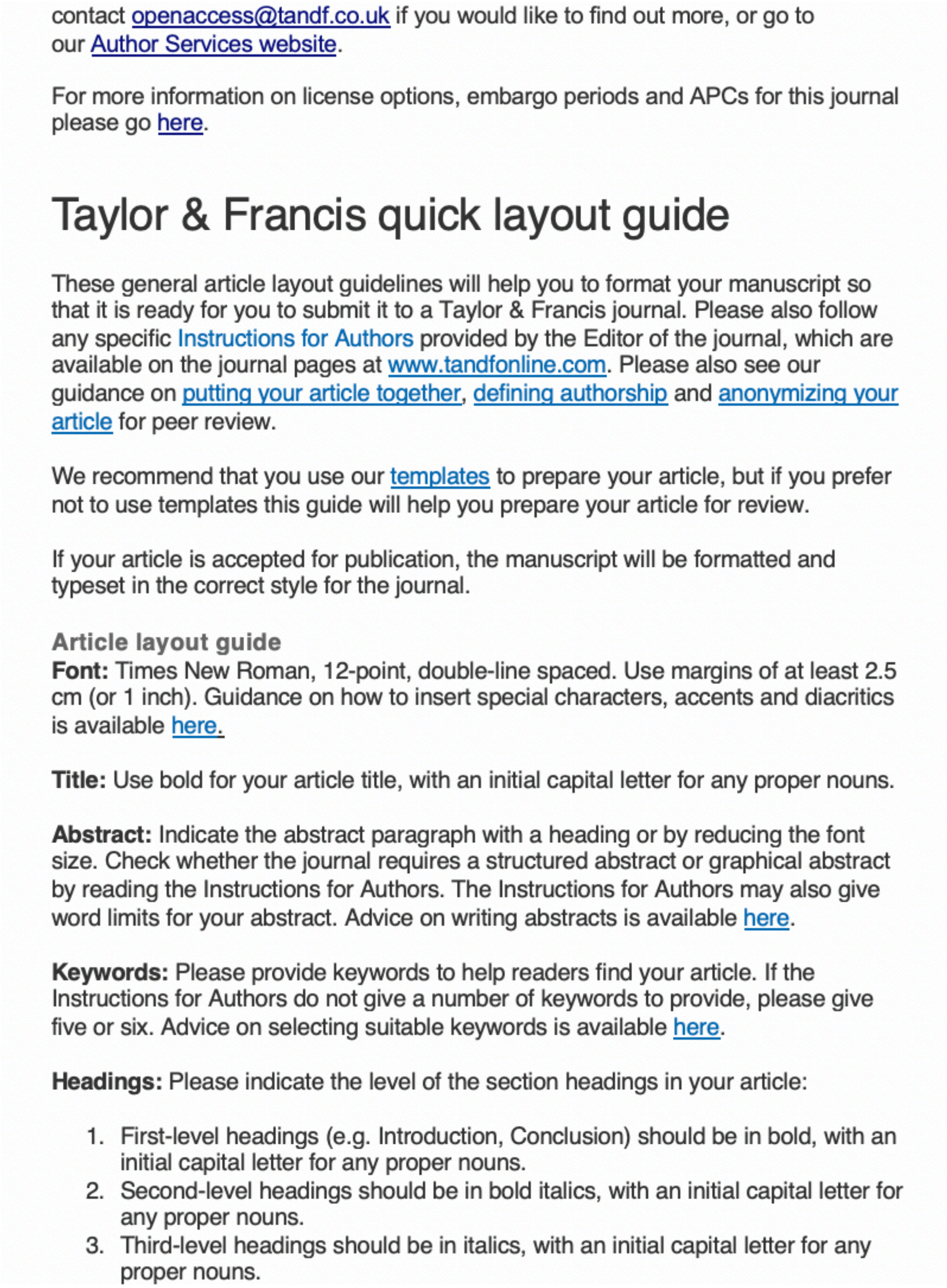

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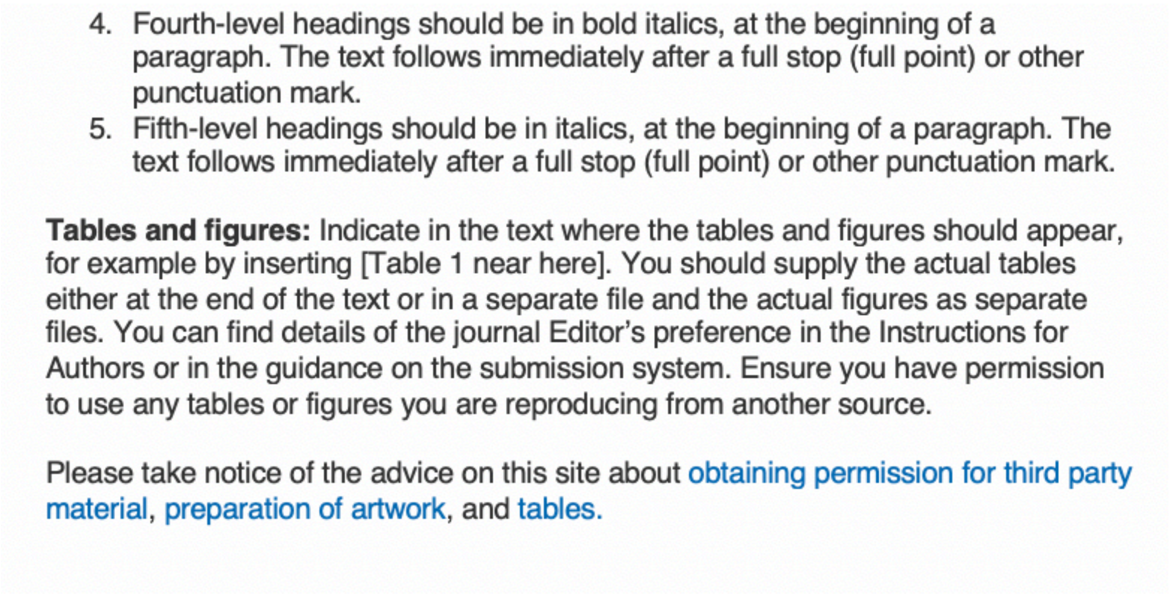

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Only manuscripts of sufficient quality that meet the aims and scope of *Qualitative Health Research* will be reviewed.

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1. What do we publish?
1.1 Aims & Scope
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1.3 Writing your paper

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1. What do we publish?

1.1 Aims & Scope

Before submitting your manuscript to *Qualitative Health Research*, please ensure you have read the Aims & Scope.

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Each issue of *Qualitative Health Research* provides readers with a wealth of information —, commentaries on conceptual, theoretical, methodological and ethical issues pertaining to qualitative inquiry as well as articles covering research, theory and methods.

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(ii) Drafted the article or revised it critically for important intellectual content,
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Please ensure that a 'Declaration of Conflicting Interests' statement is included at the end of your manuscript, after any acknowledgements and prior to the references. If no conflict exists, please state that 'The Author(s) declare(s) that there is no conflict of interest'. For guidance on conflict of interest statements, please see the ICMJE recommendations here

2.6 Research ethics and patient consent

Medical research involving human subjects must be conducted according to the World Medical Association Declaration of Helsinki

Submitted manuscripts should conform to the ICMJE Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals:

- All papers reporting animal and/or human studies **must state in the methods section that the relevant Ethics Committee or Institutional Review Board provided (or waived) approval.** Please ensure that you blinded the name and institution of the review committee until such time as your article has been accepted. The Editor will request authors to replace the name and add the approval number once the article review has been completed

- **For research articles, authors are also required to state in the methods section whether participants provided informed consent and whether the consent was written or verbal.**

Information on informed consent to report individual cases or case series should be included in the manuscript text. A statement is required regarding whether written informed consent for patient information and images to be published was provided by the patient(s) or a legally authorized representative. Please do not submit the patient's actual written informed consent with your article, as this in itself breaches the patient's confidentiality. The Journal requests that you confirm to us, in writing, that you have obtained written informed consent but the written consent itself should be held by the authors/investigators themselves, for example in a patient's hospital record.

Please also refer to the ICMJE Recommendations for the Protection of Research Participants

2.7 Clinical trials

Qualitative Health Research conforms to the ICMJE requirement that clinical trials are registered in a WHO-approved public trials registry at or before the time of first patient enrolment as a condition of consideration for publication. The trial registry name and URL, and registration number must be included at the end of the abstract.

2.8 Reporting guidelines

The relevant EQUATOR Network reporting guidelines should be followed depending on the type of study. For example, all randomized controlled trials submitted for publication should include a completed CONSORT flow chart as a cited figure and the completed CONSORT checklist should be uploaded with your submission as a supplementary file. Systematic reviews and meta-analyses should include the completed PRISMA flow chart as a cited figure and the completed PRISMA checklist should be uploaded with your submission as a supplementary file. The EQUATOR wizard can help you identify the appropriate guideline.

Other resources can be found at NLM's Research Reporting Guidelines and Initiatives

2.9. Research Data

At SAGE we are committed to facilitating openness, transparency and reproducibility of research. Where relevant, The Journal **encourages** authors to share their research data in a suitable public repository subject to ethical considerations and where data is included, to add a data accessibility statement in their manuscript file. Authors should also follow data citation principles. For more information please visit the SAGE Author

Gateway, which includes information about SAGE's partnership with the data repository Figshare.

3. Publishing Policies

3.1 Publication ethics

SAGE is committed to upholding the integrity of the academic record. We encourage authors to refer to the Committee on Publication Ethics' International Standards for Authors and view the Publication Ethics page on the SAGE Author Gateway

3.1.1 Plagiarism

Qualitative Health Research and SAGE take issues of copyright infringement, plagiarism or other breaches of best practice in publication very seriously. We seek to protect the rights of our authors and we always investigate claims of plagiarism or misuse of published articles. Equally, we seek to protect the reputation of the journal against malpractice. Submitted articles may be checked with duplication-checking software. Where an article, for example, is found to have plagiarized other work or included third-party copyright material without permission or with insufficient acknowledgement, or where the authorship of the article is contested, we reserve the right to take action including, but not limited to: publishing an erratum or corrigendum (correction); retracting the article; taking up the matter with the head of department or dean of the author's institution and/or relevant academic bodies or societies; or taking appropriate legal action.

3.1.2 Prior publication

If material has been previously published it is not generally acceptable for publication in a SAGE journal. However, there are certain circumstances where previously published material can be considered for publication. Please refer to the guidance on the SAGE Author Gateway or if in doubt, contact the Editor at the address given below.

3.2 Contributor's publishing agreement

Before publication, SAGE requires the author as the rights holder to sign a Journal Contributor's Publishing Agreement. SAGE's Journal Contributor's Publishing Agreement is an exclusive licence agreement which means that the author retains copyright in the work but grants SAGE the sole and exclusive right and licence to publish for the full legal term of copyright. Exceptions may exist where an assignment of copyright is required or preferred by a proprietor other than SAGE. In this case copyright in the work will be assigned from the author to the society. For more information please visit the SAGE Author Gateway

3.4 Open access and author archiving

Qualitative Health Research offers optional open access publishing via the SAGE Choice programme. For more information please visit the SAGE Choice website. For information on funding body compliance, and depositing your article in repositories, please visit SAGE Publishing Policies on our Journal Author Gateway.

4. Preparing your manuscript

4.1 Article Format (see previously published articles in QHR for style):

- Title page: Title should be succinct; list all authors and their affiliation; keywords. Please upload the title page separately from the main document.
- Blinding: Do not include any author identifying information in your manuscript, including author's own citations. Do not include acknowledgements until your article is accepted and unblinded.
- Abstract: Unstructured, 150 words. This should be the first page of the main manuscript, and it should be on its own page.
- Length: QHR does not have a word or page count limit. Manuscripts should be as tight as possible, preferably less than 30 pages including references. Longer manuscripts, if exceptional, will be considered.
- Methods: QHR readership is sophisticated; excessive details not required.

- Ethics: Include a statement of IRB approval and participant consent. Present demographics as a group, not listed as individuals. Do not link quotations to particular individuals unless essential (as in case studies) as this threatens anonymity.
- Results: Rich and descriptive; theoretical; linked to practice if possible.
- Discussion: Link your findings with research and theory in literature, including othergeographical areas and quantitative research.
- References: APA format. Use pertinent references only. References should be on a separate page.

Additional Editor's Preferences:

- Please do not refer to your manuscript as a "paper;" you are submitting an "article."
- The word "data" is plural.

4.2 Word processing formats

Preferred formats for the text and tables of your manuscript are Word DOC or PDF. The text should be double-spaced throughout with standard 1 inch margins (APA formatting). Text should be standard font (i.e., Times New Roman) 12 point.

4.3 Artwork, figures and other graphics

- Figures: Should clarify text.
- Include figures, charts, and tables created in MS Word in the main text rather than at the end of the document.
- Figures, tables, and other files created outside of Word should be submitted separately. Indicate where table should be inserted within manuscript (i.e. INSERT TABLE 1 HERE).
- Photographs: Should have permission to reprint and faces should be concealed using mosaic patches – unless permission has been given by the individual to use their identity. This permission must be forwarded to QHR's Managing Editor.
    - TIFF, JPED, or common picture formats accepted. The preferred format for graphs and line art is EPS.
    - Resolution: Rasterized based files (i.e. with .tiff or .jpeg extension) require a resolution of at least 300 dpi (dots per inch). Line art should be supplied with a minimum resolution of 800 dpi.
    - Dimension: Check that the artworks supplied match or exceed the dimensions of the journal. Images cannot be scaled up after origination.
- Figures supplied in color will appear in color online regardless of whether or not these illustrations are reproduced in color in the printed version. For specifically requested color reproduction in print, you will receive information regarding the costs from SAGE after receipt of your accepted article.

5. Submitting your manuscript

Qualitative Health Research is hosted on SAGE Track, a web based online submission and peer review system powered by ScholarOne™ Manuscripts. Visit https://mc.manuscriptcentral.com/qhr to login and submit your article online.

IMPORTANT: Please check whether you already have an account in the system before trying to create a new one. If you have reviewed or authored for the journal in the past year it is likely that you will have had an account created. For further guidance on submitting your manuscript online please visit ScholarOne Online Help.

5.1 ORCID

As part of our commitment to ensuring an ethical, transparent and fair peer review process SAGE is a supporting member of ORCID, the Open Researcher and Contributor ID. ORCID provides a unique and persistent digital identifier that distinguishes researchers from every other researcher, even those who share the same name, and, through integration in key research workflows such as manuscript and grant submission, supports automated linkages between researchers and their professional activities, ensuring that their work is recognized.

The collection of ORCID IDs from corresponding authors is now part of the submission process of this journal. If you already have an ORCID ID you will be asked to associate that to your submission during the online submission process. We also strongly encourage all co-authors to link their ORCID ID to their accounts in our online peer review platforms. It takes seconds to do: click the link when prompted, sign into your ORCID account and our systems are automatically updated. Your ORCID ID will become part of your accepted publication's metadata, making your work attributable to you and only you. Your ORCID ID is published with your article so that fellow researchers reading your work can link to your ORCID profile and from there link to your other publications.

If you do not already have an ORCID ID please follow this link to create one or visit our ORCID homepage to learn more.

5.2 Information required for completing your submission

You will be asked to provide contact details and academic affiliations for all co-authors via the submission system and identify who is to be the corresponding author. These details must match what appears on your manuscript. The affiliation listed in the manuscript should be the institution where the research was conducted. If an author has moved to a new institution since completing the research, the new affiliation can be included in a manuscript note at the end of the paper. At this stage please ensure you have included all the required statements and declarations and uploaded any additional supplementary files (including reporting guidelines where relevant).

5.3 Permissions

Please also ensure that you have obtained any necessary permission from copyright holders for reproducing any illustrations, tables, figures or lengthy quotations previously published elsewhere. For further information including guidance on fair dealing for criticism and review, please see the Copyright and Permissions page on the SAGE Author Gateway

6. On acceptance and publication

6.1 SAGE Production

Your SAGE Production Editor will keep you informed as to your article's progress throughout the production process. Proofs will be made available to the corresponding author via our editing portal SAGE Edit or by email, and corrections should be made directly or notified to us promptly. Authors are reminded to check their proofs carefully to confirm that all author information, including names, affiliations, sequence and contact details are correct, and that Funding and Conflict of Interest statements, if any, are accurate. Please note that if there are any changes to the author list at this stage all authors will be required to complete and sign a form authorizing the change.

6.2 Online First publication

Online First allows final articles (completed and approved articles awaiting assignment to a future issue) to be published online prior to their inclusion in a journal issue, which significantly reduces the lead time between submission and publication. Visit the SAGE Journals help page for more details, including how to cite Online First articles.

6.3 Access to your published article

SAGE provides authors with online access to their final article.

6.4 Promoting your article

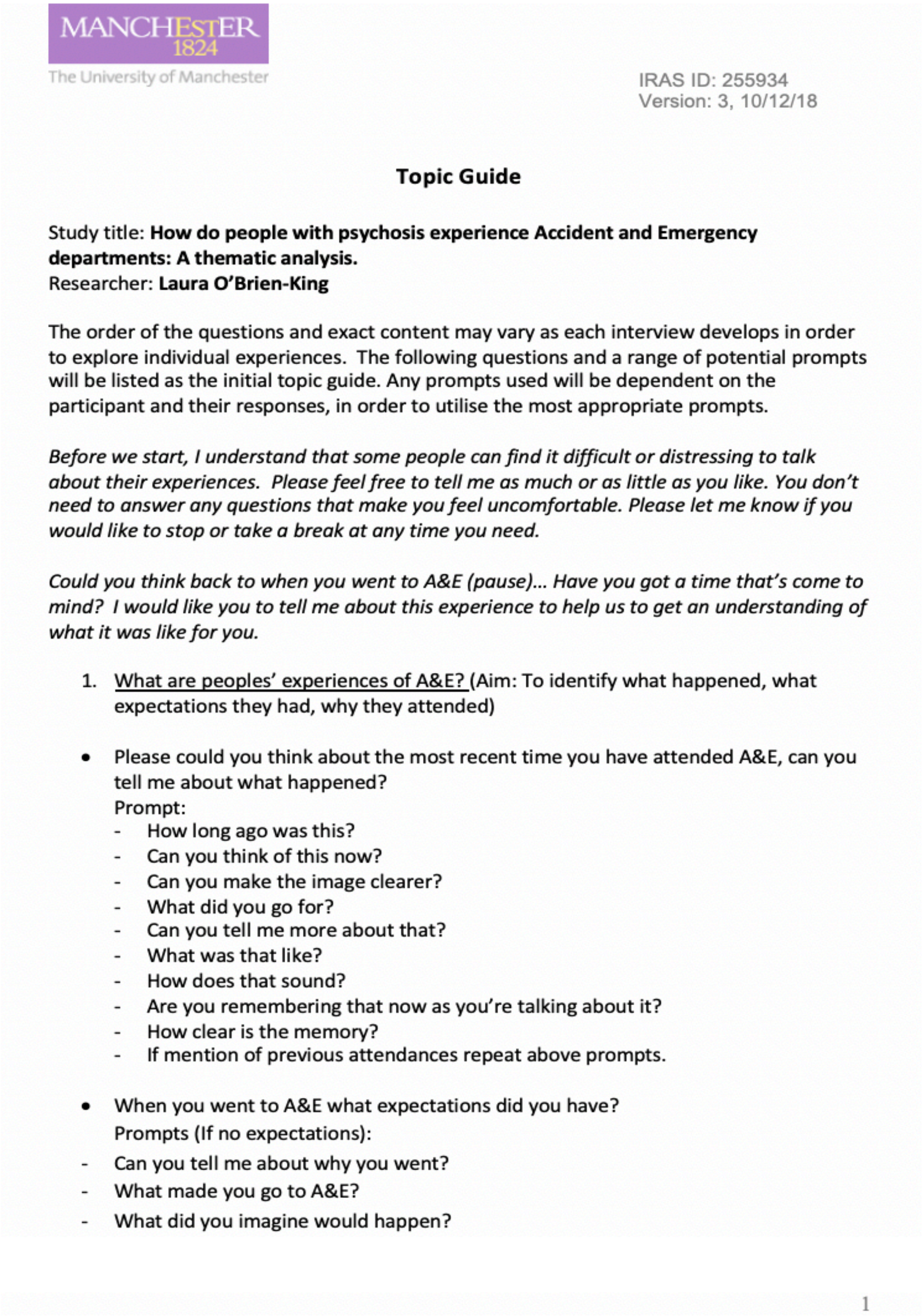
Publication is not the end of the process! You can help disseminate your paper and ensure it is as widely read and cited as possible. The SAGE Author Gateway has numerous resources to help you promote your work. Visit the Promote Your Article page on the Gateway for tips and advice.

7. Further information

Any correspondence, queries or additional requests for information on the manuscript submission process should be sent to the *Qualitative Health Research* editorial office as follows:

Vanessa Shannon, Managing Editor
Email: vshannonqhr@gmail.com

Appendix C: Topic guide



MANCHESTER 1824
The University of Manchester

IRAS ID: 255934
Version: 3, 10/12/18

Topic Guide

Study title: **How do people with psychosis experience Accident and Emergency departments: A thematic analysis.**
Researcher: **Laura O'Brien-King**

The order of the questions and exact content may vary as each interview develops in order to explore individual experiences. The following questions and a range of potential prompts will be listed as the initial topic guide. Any prompts used will be dependent on the participant and their responses, in order to utilise the most appropriate prompts.

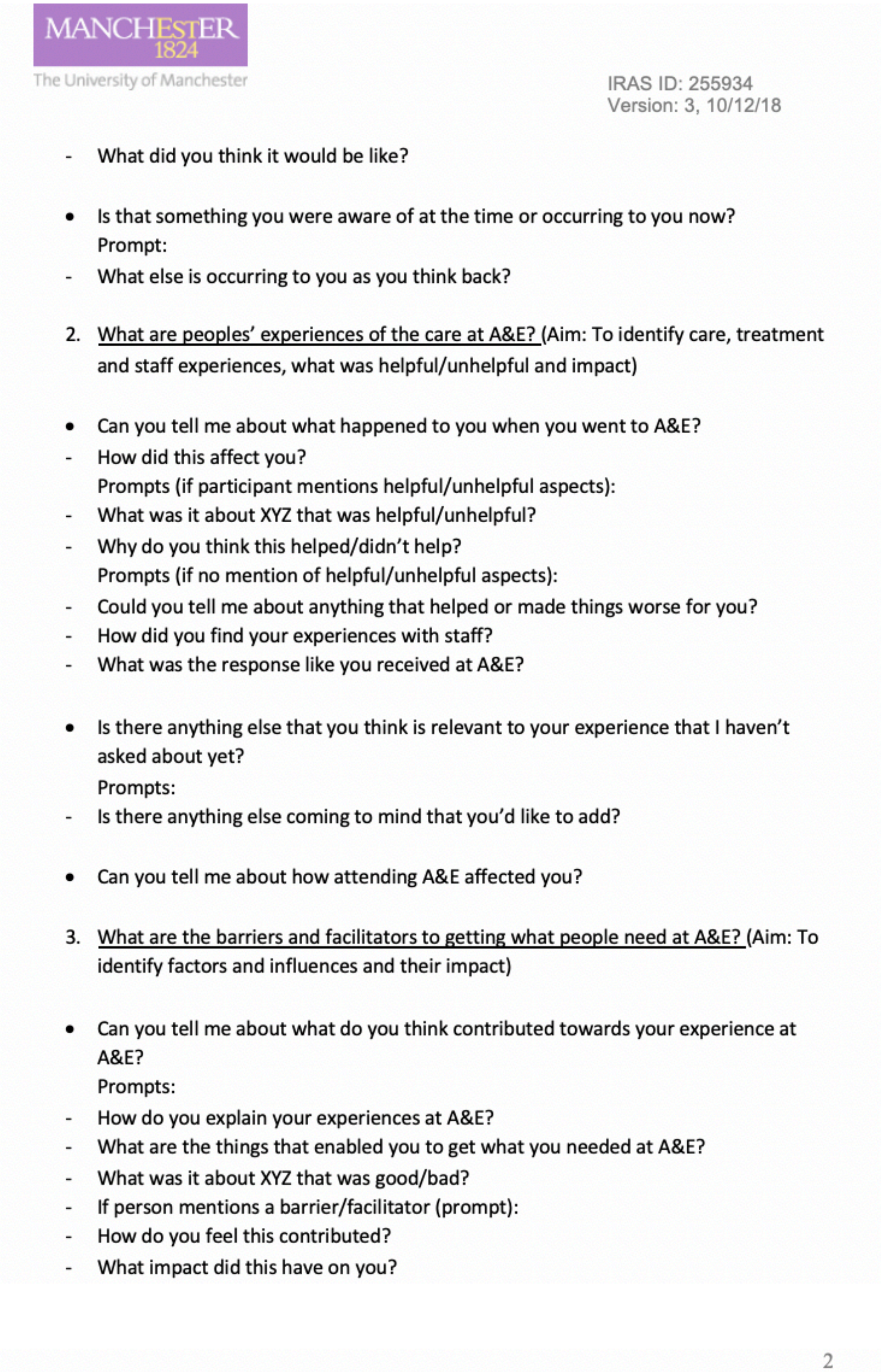
Before we start, I understand that some people can find it difficult or distressing to talk about their experiences. Please feel free to tell me as much or as little as you like. You don't need to answer any questions that make you feel uncomfortable. Please let me know if you would like to stop or take a break at any time you need.

Could you think back to when you went to A&E (pause)… Have you got a time that's come to mind? I would like you to tell me about this experience to help us to get an understanding of what it was like for you.

1. What are peoples' experiences of A&E? (Aim: To identify what happened, what expectations they had, why they attended)

- Please could you think about the most recent time you have attended A&E, can you tell me about what happened?
  Prompt:
  - How long ago was this?
  - Can you think of this now?
  - Can you make the image clearer?
  - What did you go for?
  - Can you tell me more about that?
  - What was that like?
  - How does that sound?
  - Are you remembering that now as you're talking about it?
  - How clear is the memory?
  - If mention of previous attendances repeat above prompts.

- When you went to A&E what expectations did you have?
  Prompts (If no expectations):
- Can you tell me about why you went?
- What made you go to A&E?
- What did you imagine would happen?



The University of Manchester

IRAS ID: 255934
Version: 3, 10/12/18

- What did you think it would be like?

- Is that something you were aware of at the time or occurring to you now?
  Prompt:
- What else is occurring to you as you think back?

2. What are peoples' experiences of the care at A&E? (Aim: To identify care, treatment and staff experiences, what was helpful/unhelpful and impact)

- Can you tell me about what happened to you when you went to A&E?
- How did this affect you?
  Prompts (if participant mentions helpful/unhelpful aspects):
- What was it about XYZ that was helpful/unhelpful?
- Why do you think this helped/didn't help?
  Prompts (if no mention of helpful/unhelpful aspects):
- Could you tell me about anything that helped or made things worse for you?
- How did you find your experiences with staff?
- What was the response like you received at A&E?

- Is there anything else that you think is relevant to your experience that I haven't asked about yet?
  Prompts:
- Is there anything else coming to mind that you'd like to add?

- Can you tell me about how attending A&E affected you?

3. What are the barriers and facilitators to getting what people need at A&E? (Aim: To identify factors and influences and their impact)

- Can you tell me about what do you think contributed towards your experience at A&E?
  Prompts:
- How do you explain your experiences at A&E?
- What are the things that enabled you to get what you needed at A&E?
- What was it about XYZ that was good/bad?
- If person mentions a barrier/facilitator (prompt):
- How do you feel this contributed?
- What impact did this have on you?

2

- Can you tell me about anything else that might have contributed towards your experience? Or affected your experience?

4. <u>What constitutes ideal care at A&E? (Aim: To identify what would need to be different)</u>

- If you were to sum up accessing mental health care at A&E on the basis of your experience what would you say to somebody else?
  Prompts:
- Would you describe that as a positive/negative/neutral thing?
- How was that for you?

- On the basis of your particular experience, can you tell me about what you think about accessing A&E for mental health care?
  Prompts:
- (If mentions positive/negative aspects): What is it about XYZ that is positive/negative?

- Looking back at it now, what would you have wanted to be different, if anything?
  Prompts:
- How would you have liked it to be different?
- If XYZ was the case what difference do you think this would make?
- What would have been helpful for you?
- What would you have liked to happen?

5. <u>Summary</u>

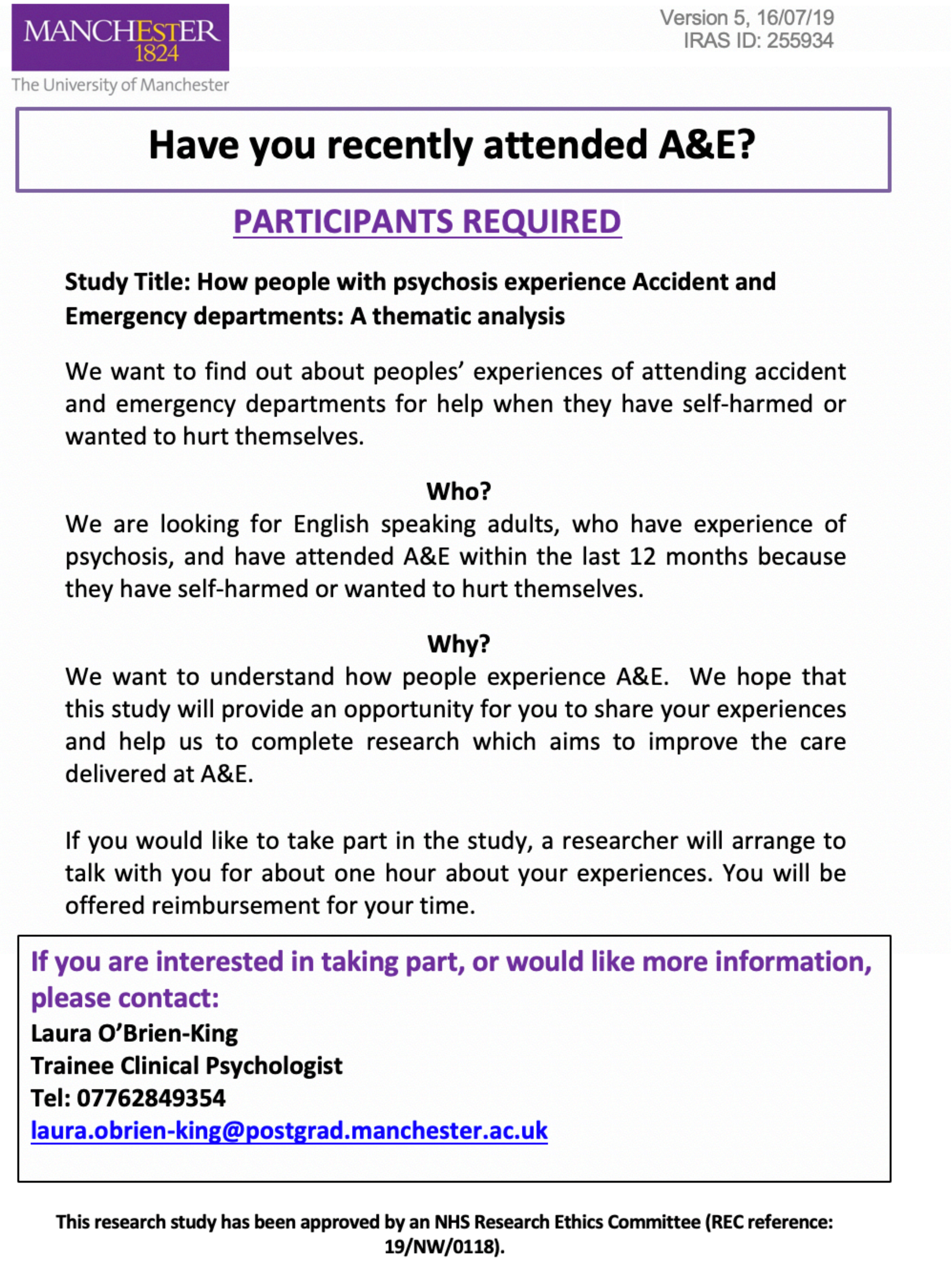
- As you look back on your experience of attending A&E, what sense do you make of it?
- Is there anything else you think I should know to understand your experience better?
- Can you think of any other questions that could be asked in future interviews?
- Is there anything you would like to ask me?

<u>General Prompts:</u>

- Can I just ask you to clarify which experience you are referring to when you mentioned…

- Can I just check what you meant by XYZ…
- Can you tell me more about that…

Appendix D: Study poster



The University of Manchester

Version 5, 16/07/19
IRAS ID: 255934

Have you recently attended A&E?

PARTICIPANTS REQUIRED

Study Title: How people with psychosis experience Accident and Emergency departments: A thematic analysis

We want to find out about peoples' experiences of attending accident and emergency departments for help when they have self-harmed or wanted to hurt themselves.

Who?

We are looking for English speaking adults, who have experience of psychosis, and have attended A&E within the last 12 months because they have self-harmed or wanted to hurt themselves.

Why?

We want to understand how people experience A&E. We hope that this study will provide an opportunity for you to share your experiences and help us to complete research which aims to improve the care delivered at A&E.

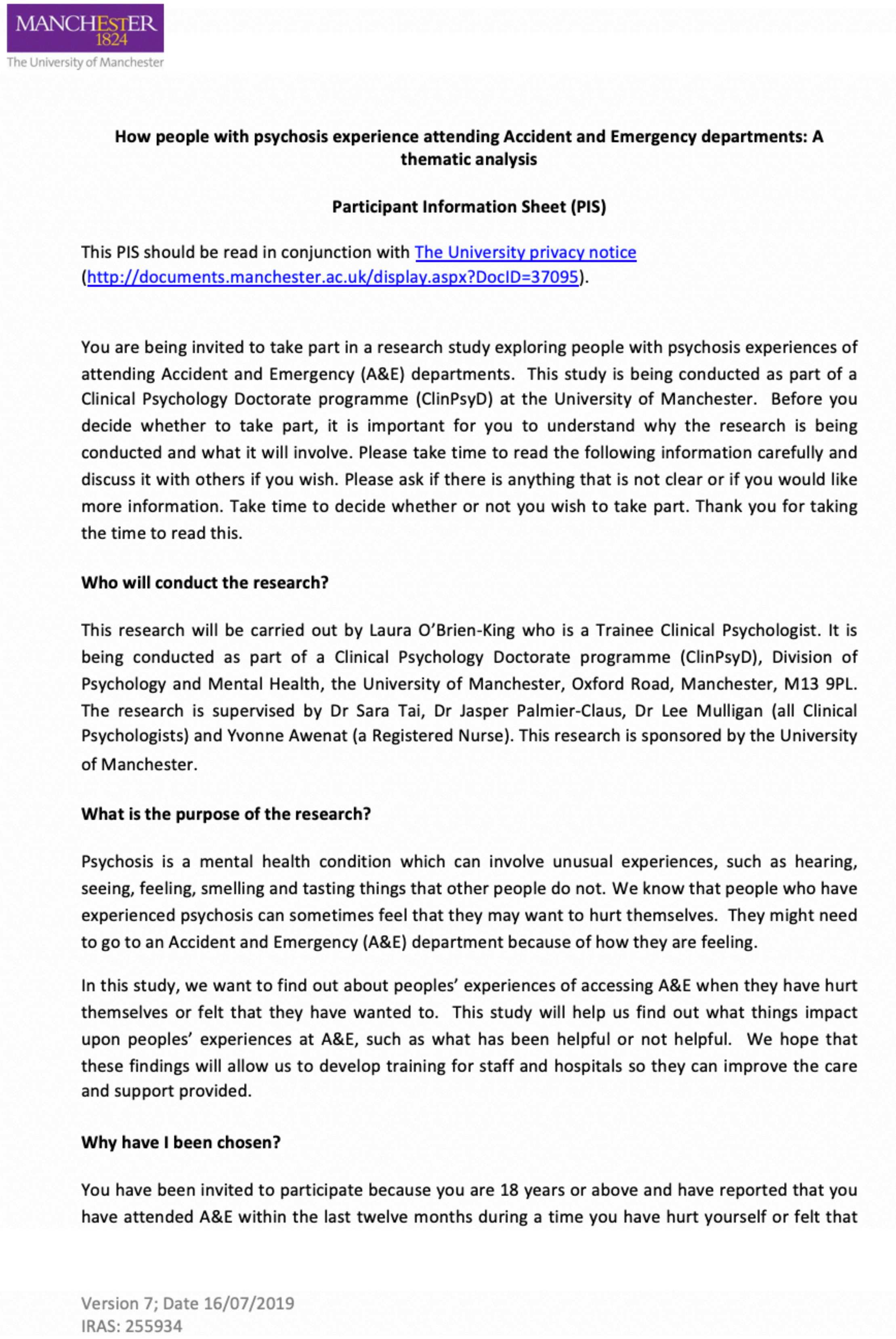
If you would like to take part in the study, a researcher will arrange to talk with you for about one hour about your experiences. You will be offered reimbursement for your time.

If you are interested in taking part, or would like more information, please contact:

Laura O'Brien-King
Trainee Clinical Psychologist
Tel: 07762849354
laura.obrien-king@postgrad.manchester.ac.uk

This research study has been approved by an NHS Research Ethics Committee (REC reference: 19/NW/0118).

Appendix E: Participant information sheet



MANCHESTER
1824
The University of Manchester

How people with psychosis experience attending Accident and Emergency departments: A thematic analysis

Participant Information Sheet (PIS)

This PIS should be read in conjunction with The University privacy notice (http://documents.manchester.ac.uk/display.aspx?DocID=37095).

You are being invited to take part in a research study exploring people with psychosis experiences of attending Accident and Emergency (A&E) departments. This study is being conducted as part of a Clinical Psychology Doctorate programme (ClinPsyD) at the University of Manchester. Before you decide whether to take part, it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for taking the time to read this.

Who will conduct the research?

This research will be carried out by Laura O'Brien-King who is a Trainee Clinical Psychologist. It is being conducted as part of a Clinical Psychology Doctorate programme (ClinPsyD), Division of Psychology and Mental Health, the University of Manchester, Oxford Road, Manchester, M13 9PL. The research is supervised by Dr Sara Tai, Dr Jasper Palmier-Claus, Dr Lee Mulligan (all Clinical Psychologists) and Yvonne Awenat (a Registered Nurse). This research is sponsored by the University of Manchester.

What is the purpose of the research?

Psychosis is a mental health condition which can involve unusual experiences, such as hearing, seeing, feeling, smelling and tasting things that other people do not. We know that people who have experienced psychosis can sometimes feel that they may want to hurt themselves. They might need to go to an Accident and Emergency (A&E) department because of how they are feeling.

In this study, we want to find out about peoples' experiences of accessing A&E when they have hurt themselves or felt that they have wanted to. This study will help us find out what things impact upon peoples' experiences at A&E, such as what has been helpful or not helpful. We hope that these findings will allow us to develop training for staff and hospitals so they can improve the care and support provided.

Why have I been chosen?

You have been invited to participate because you are 18 years or above and have reported that you have attended A&E within the last twelve months during a time you have hurt yourself or felt that you wanted to. We hope to recruit approximately 20 people who have had similar experiences to take part in this study.

What would I be asked to do if I took part?

You will be invited to meet the researcher, Laura O'Brien-King, at a convenient location for you to discuss the study in more detail. Here she will explain the exact nature of and reasons for the research, and answer any questions you may have. If you decide that you wish to participate in this study, you will be asked to sign a consent form.

Following this, you will be asked to complete a short questionnaire detailing demographic information (such as your age and gender). You will then talk to the researcher for about 1 hour about your experience of attending A&E and what this was like. You can take as many comfort breaks during the interview as you like. If you do decide to participate, you will be asked to sign a consent form. However, you can withdraw from the interview at any time by telling the researcher that you no longer wish to continue.

It is possible that talking about some of these issues may be upsetting. You will have the opportunity to discuss any concerns that you have with the researcher. You are free to have a break or end the interview at any time should you feel upset or distressed. You can also talk to your care coordinator, GP, psychiatrist, friends and family about participation in this study and any concerns that you may have. The researcher will ask you at the end of the interview how you have found it.

What will happen to my personal information?

In order to undertake the research project we will need to collect the following personal information about you:

- Name
- Contact details:
  - Telephone number
  - Address
- Demographic questionnaire data:
  - Gender
  - Ethnicity
  - Age
  - Higher education level
  - Living status
  - Employment status
  - Diagnosis
  - Length of time since diagnosis
  - Service currently providing care
  - Length of time accessing care from current mental health care team
  - Length of time accessing care from mental health care services
  - Anti-psychotic medication
  - Date of most reason A&E attendance
  - Reason for attendance
  - Outcome of A&E attendance

  - How many times you have attended A&E for reasons relating to risk to self in the past 12 months
  - Reasons for previous attendances
- Audio recordings of interview

We are collecting and storing this personal information in accordance with the General Data Protection Regulation (GDPR) and Data Protection Act 2018 which legislate to protect your personal information. The legal basis upon which we are using your personal information is "public interest task" and "for research purposes" if sensitive information is collected. For more information about the way we process your personal information and comply with data protection law please see our [Privacy Notice for Research Participants](http://documents.manchester.ac.uk/display.aspx?DocID=37095)
(http://documents.manchester.ac.uk/display.aspx?DocID=37095).

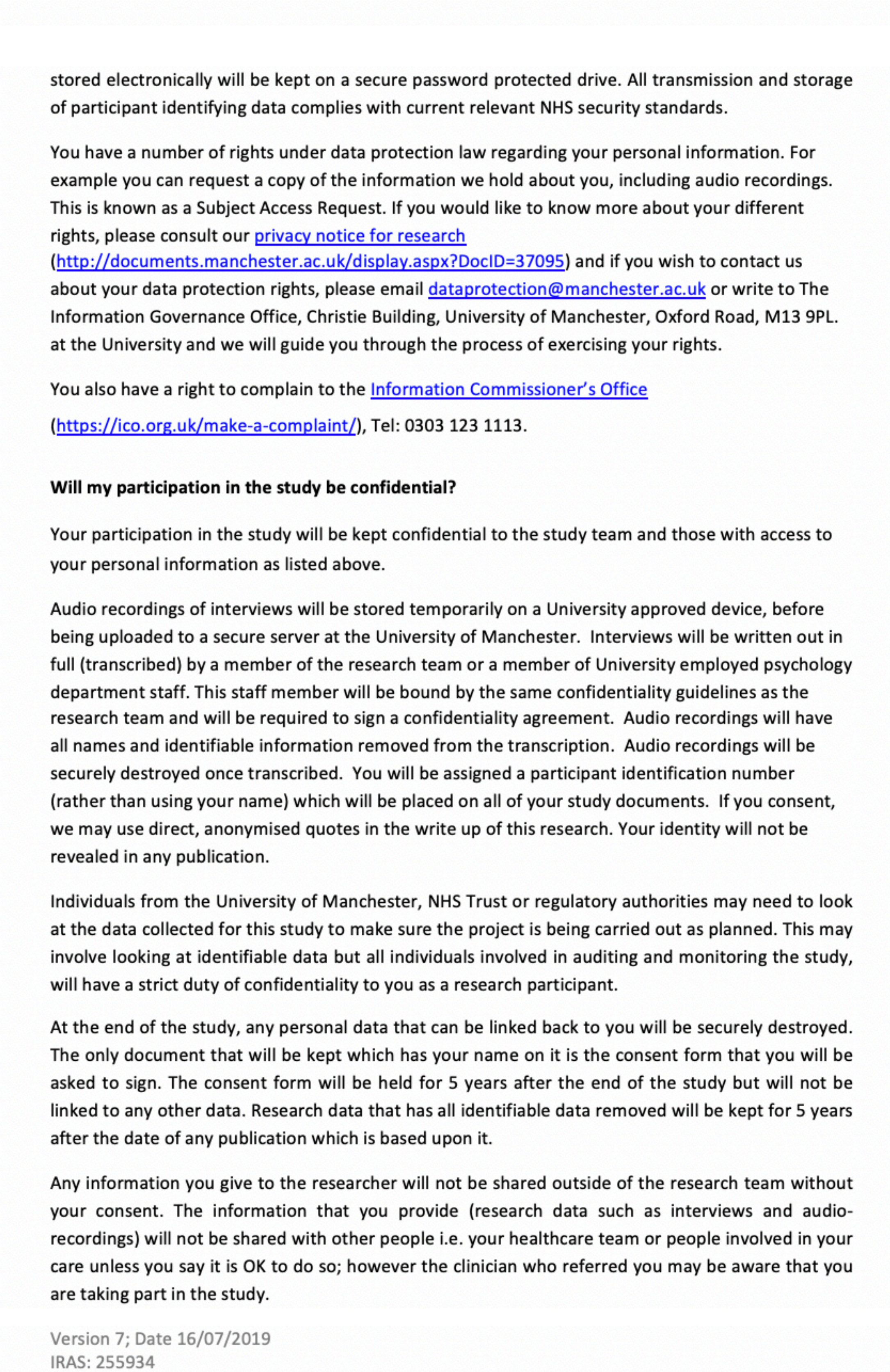
The University of Manchester, as Data Controller for this project, takes responsibility for the protection of the personal information that this study is collecting about you. In order to comply with the legal obligations to protect your personal data the University has safeguards in place such as policies and procedures. All researchers are appropriately trained and your data will be looked after in the following way:

Your interview will be audio-recorded, which will consist of your voice-only. These recordings will then be transcribed and analysed. The research team at the University of Manchester will have access to your personal information, which is data which could identify you. Audio-recordings will be accessible to the research team and a University employed psychology department staff member for transcription purposes. All audio-recordings will have all identifiable information removed as soon as is practical when they are transcribed. This means that all names and any other personally identifiable data will be replaced by pseudonyms. The audio-recordings will be securely destroyed following transcription. All interviews will be transcribed on University premises. Transcribed non-identifiable data may be analysed via a University secure server at the researcher's home.

Your consent form will be retained for five years, which will be stored separate to the research data in a secure filing cabinet at the University of Manchester. If you consent, your contact details will be retained until 6 months after the study has ended, in order to provide you with the research findings. Your contact details will be kept separate from any other research data in a locked cabinet at the University of Manchester.

Audio-recordings of interviews will be stored temporarily on a University approved USB device, before being uploaded to a secure server at the University of Manchester, specifically for storing confidential information. No data will be transferred out of the University. If you have consented for your non-identifiable transcribed interview data to be used for future research, this will be stored on a secure server at the University of Manchester.

We will follow ethical and legal practice and all information about you will be handled in confidence. Personally identifying information will be stored in paper and electronic format and will be stored separately from research data (the interviews you complete). All personally identifiable information will be kept confidentially and securely; information that is in paper format will be kept in a locked filing cabinet in a locked office on University premises. Personally identifiable information that is



stored electronically will be kept on a secure password protected drive. All transmission and storage of participant identifying data complies with current relevant NHS security standards.

You have a number of rights under data protection law regarding your personal information. For example you can request a copy of the information we hold about you, including audio recordings. This is known as a Subject Access Request. If you would like to know more about your different rights, please consult our [privacy notice for research](http://documents.manchester.ac.uk/display.aspx?DocID=37095) (http://documents.manchester.ac.uk/display.aspx?DocID=37095) and if you wish to contact us about your data protection rights, please email dataprotection@manchester.ac.uk or write to The Information Governance Office, Christie Building, University of Manchester, Oxford Road, M13 9PL. at the University and we will guide you through the process of exercising your rights.

You also have a right to complain to the [Information Commissioner's Office](https://ico.org.uk/make-a-complaint/)

(https://ico.org.uk/make-a-complaint/), Tel: 0303 123 1113.

Will my participation in the study be confidential?

Your participation in the study will be kept confidential to the study team and those with access to your personal information as listed above.

Audio recordings of interviews will be stored temporarily on a University approved device, before being uploaded to a secure server at the University of Manchester. Interviews will be written out in full (transcribed) by a member of the research team or a member of University employed psychology department staff. This staff member will be bound by the same confidentiality guidelines as the research team and will be required to sign a confidentiality agreement. Audio recordings will have all names and identifiable information removed from the transcription. Audio recordings will be securely destroyed once transcribed. You will be assigned a participant identification number (rather than using your name) which will be placed on all of your study documents. If you consent, we may use direct, anonymised quotes in the write up of this research. Your identity will not be revealed in any publication.

Individuals from the University of Manchester, NHS Trust or regulatory authorities may need to look at the data collected for this study to make sure the project is being carried out as planned. This may involve looking at identifiable data but all individuals involved in auditing and monitoring the study, will have a strict duty of confidentiality to you as a research participant.

At the end of the study, any personal data that can be linked back to you will be securely destroyed. The only document that will be kept which has your name on it is the consent form that you will be asked to sign. The consent form will be held for 5 years after the end of the study but will not be linked to any other data. Research data that has all identifiable data removed will be kept for 5 years after the date of any publication which is based upon it.

Any information you give to the researcher will not be shared outside of the research team without your consent. The information that you provide (research data such as interviews and audio-recordings) will not be shared with other people i.e. your healthcare team or people involved in your care unless you say it is OK to do so; however the clinician who referred you may be aware that you are taking part in the study.

There are specific circumstances where information you provide may be shared outside of the research team. If you tell us something that makes us believe there is a risk to either yourself or others, we will need to inform the appropriate agency/person to provide support (e.g. your health or social care practitioner or the police). However, we will do our best to discuss this with you beforehand. If any risk arose whilst the researcher is lone working, we may need to share the address where the interview is taking place with the appropriate agency/person (e.g. the police). This is to ensure everyone is kept safe and well.

What happens if I do not want to take part or if I change my mind?

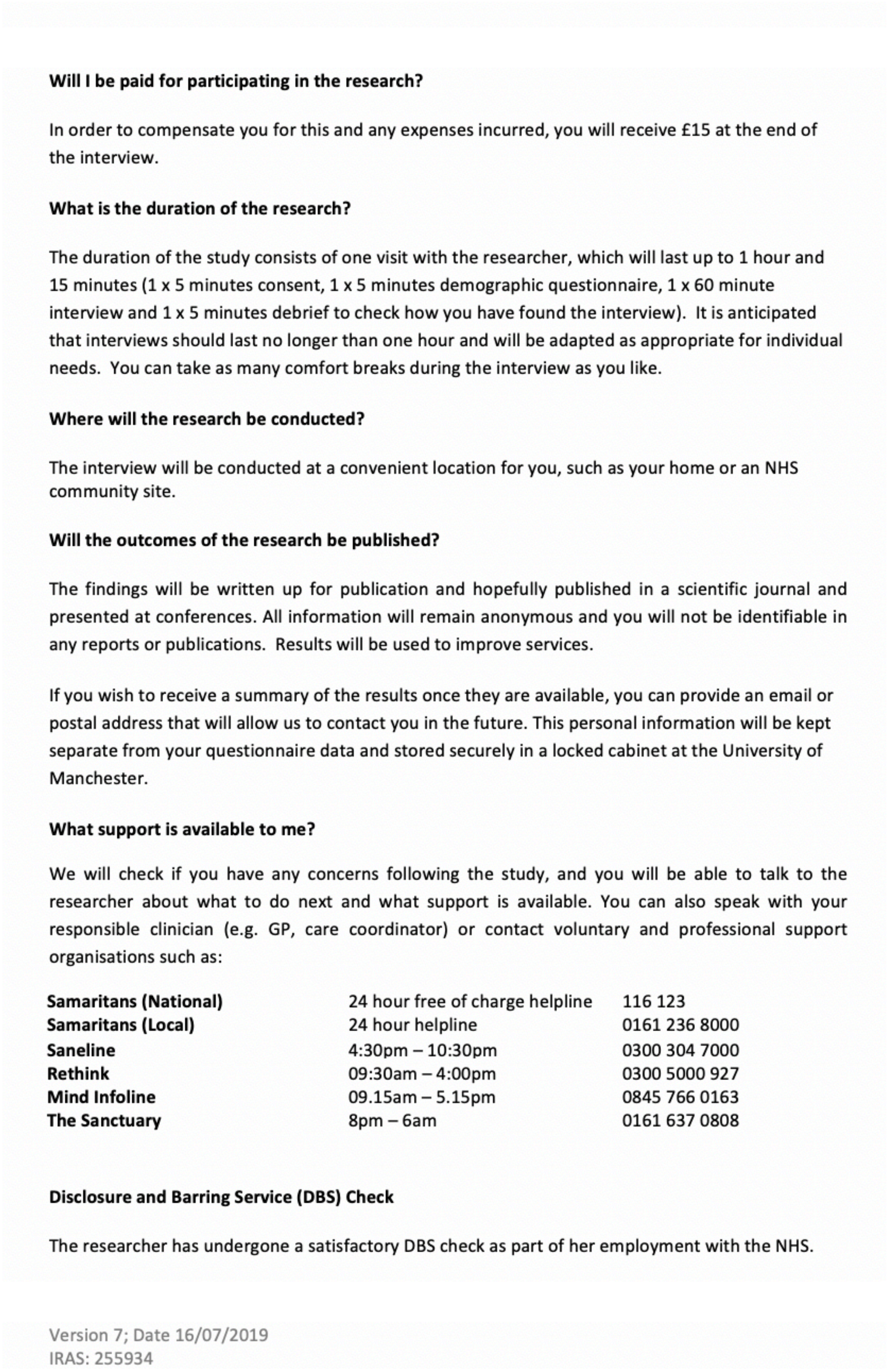
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason and without detriment to yourself. No questions will be asked about your decision and there will be no consequences to your current or future treatment. However, it will not be possible to remove your data from the project once it has been anonymised and forms part of the dataset as we will not be able to identify your specific data. This does not affect your data protection rights. You can also request for your data to be withdrawn from the study, before it is transcribed, which will be up to 48 hours after your interview has taken place. When the interview is transcribed it will not be personally identifiable. All participants will need to be audio recorded. However, it is important that you should feel comfortable with the recording process at all times and you may ask to stop recording and withdraw from the study at any time during the interview.

Will my data be used for future research?

When you agree to take part in a research study, the information about you may be provided to researchers running other research studies in this organisation. The future research should not be incompatible with this research project and will concern mental healthcare experiences. These organisations may be universities, NHS organisations or companies involved in health and care research in this country or abroad. Your information will only be used by organisations and researchers to conduct research in accordance with the UK Policy Framework for Health and Social Care Research (https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/).

This information will not identify you and will not be combined with other information in a way that could identify you. The information will only be used for the purpose of health and care research, and cannot be used to contact you regarding any other matter or to affect your care. It will not be used to make decisions about future services available to you.

You will be asked if the transcriptions of your interview with all identifiable information removed can be retained for future research. It is up to you whether or not you agree to this. If you do, transcriptions will be stored on a secure server at the University which is specifically designed for confidential research data stored. If you do not consent to this, the transcriptions will be securely destroyed after 5 years after the date of any publication which is based upon it.



Will I be paid for participating in the research?

In order to compensate you for this and any expenses incurred, you will receive £15 at the end of the interview.

What is the duration of the research?

The duration of the study consists of one visit with the researcher, which will last up to 1 hour and 15 minutes (1 x 5 minutes consent, 1 x 5 minutes demographic questionnaire, 1 x 60 minute interview and 1 x 5 minutes debrief to check how you have found the interview). It is anticipated that interviews should last no longer than one hour and will be adapted as appropriate for individual needs. You can take as many comfort breaks during the interview as you like.

Where will the research be conducted?

The interview will be conducted at a convenient location for you, such as your home or an NHS community site.

Will the outcomes of the research be published?

The findings will be written up for publication and hopefully published in a scientific journal and presented at conferences. All information will remain anonymous and you will not be identifiable in any reports or publications. Results will be used to improve services.

If you wish to receive a summary of the results once they are available, you can provide an email or postal address that will allow us to contact you in the future. This personal information will be kept separate from your questionnaire data and stored securely in a locked cabinet at the University of Manchester.

What support is available to me?

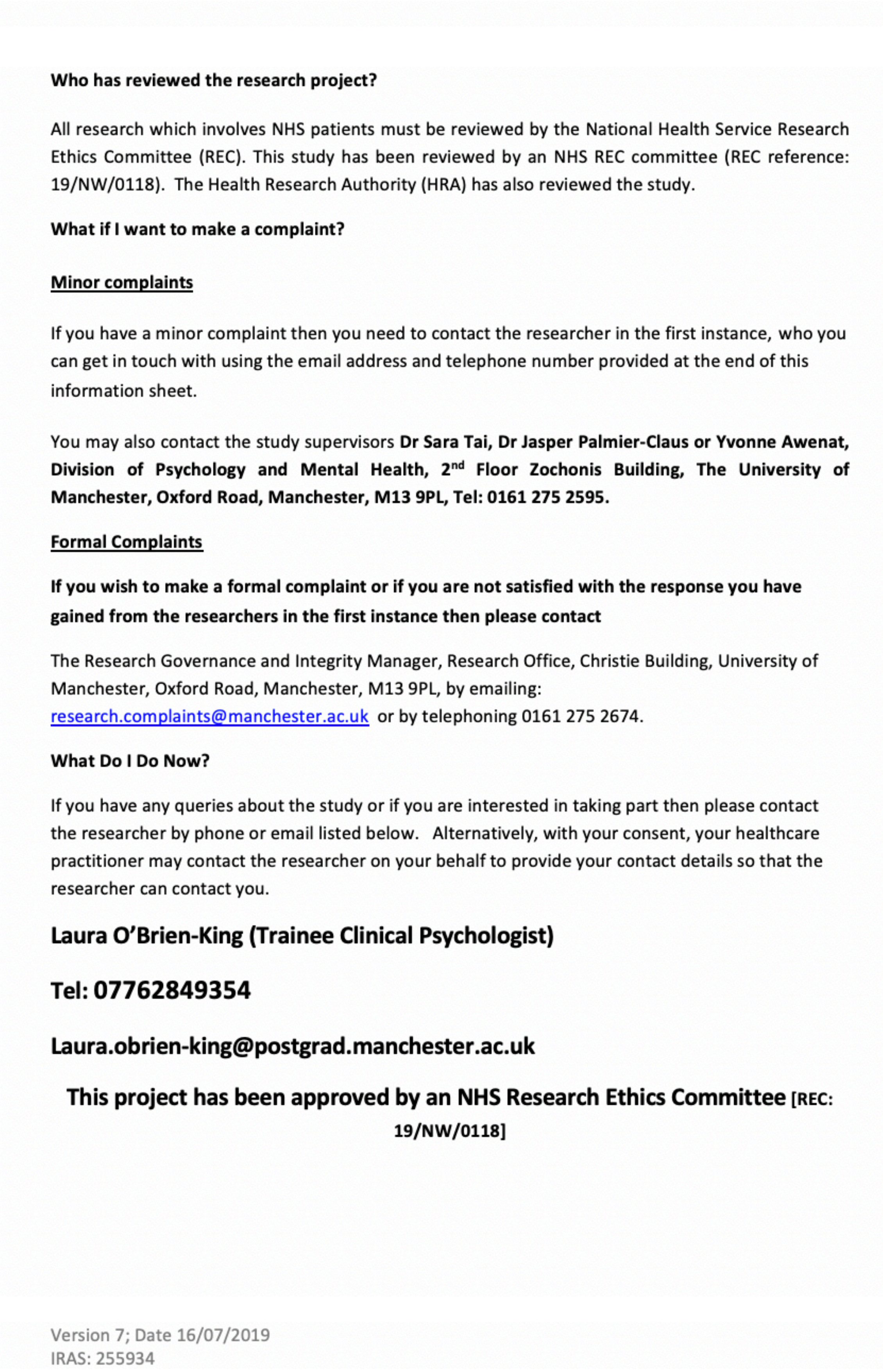
We will check if you have any concerns following the study, and you will be able to talk to the researcher about what to do next and what support is available. You can also speak with your responsible clinician (e.g. GP, care coordinator) or contact voluntary and professional support organisations such as:

Samaritans (National)	24 hour free of charge helpline	116 123
Samaritans (Local)	24 hour helpline	0161 236 8000
Saneline	4:30pm – 10:30pm	0300 304 7000
Rethink	09:30am – 4:00pm	0300 5000 927
Mind Infoline	09.15am – 5.15pm	0845 766 0163
The Sanctuary	8pm – 6am	0161 637 0808

Disclosure and Barring Service (DBS) Check

The researcher has undergone a satisfactory DBS check as part of her employment with the NHS.

Version 7; Date 16/07/2019
IRAS: 255934



Who has reviewed the research project?

All research which involves NHS patients must be reviewed by the National Health Service Research Ethics Committee (REC). This study has been reviewed by an NHS REC committee (REC reference: 19/NW/0118). The Health Research Authority (HRA) has also reviewed the study.

What if I want to make a complaint?

<u>Minor complaints</u>

If you have a minor complaint then you need to contact the researcher in the first instance, who you can get in touch with using the email address and telephone number provided at the end of this information sheet.

You may also contact the study supervisors **Dr Sara Tai, Dr Jasper Palmier-Claus or Yvonne Awenat, Division of Psychology and Mental Health, 2nd Floor Zochonis Building, The University of Manchester, Oxford Road, Manchester, M13 9PL, Tel: 0161 275 2595.**

<u>Formal Complaints</u>

If you wish to make a formal complaint or if you are not satisfied with the response you have gained from the researchers in the first instance then please contact

The Research Governance and Integrity Manager, Research Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL, by emailing:
research.complaints@manchester.ac.uk or by telephoning 0161 275 2674.

What Do I Do Now?

If you have any queries about the study or if you are interested in taking part then please contact the researcher by phone or email listed below. Alternatively, with your consent, your healthcare practitioner may contact the researcher on your behalf to provide your contact details so that the researcher can contact you.

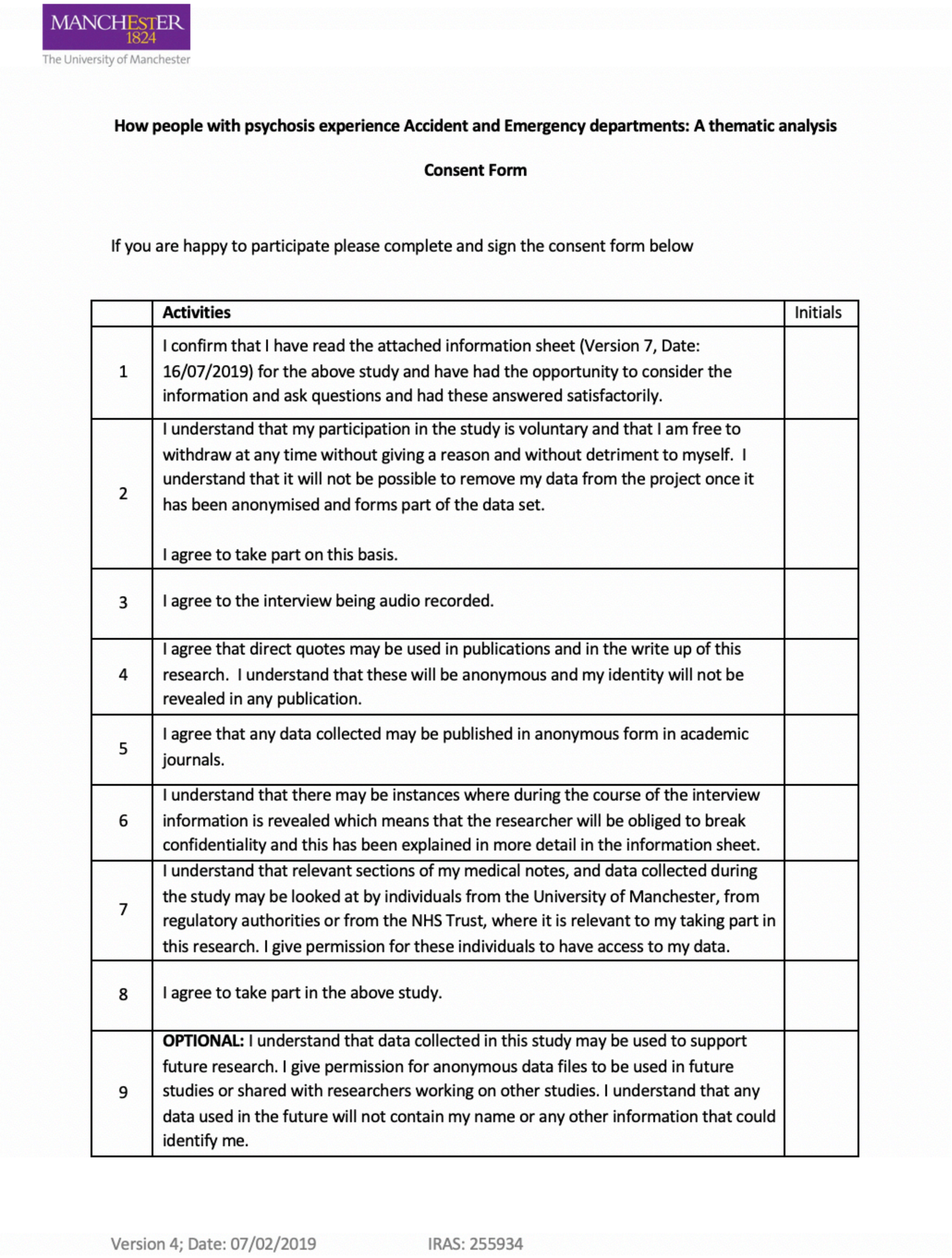
Laura O'Brien-King (Trainee Clinical Psychologist)

Tel: 07762849354

Laura.obrien-king@postgrad.manchester.ac.uk

This project has been approved by an NHS Research Ethics Committee [REC: 19/NW/0118]

Appendix F: Consent form



MANCHESTER
1824
The University of Manchester

How people with psychosis experience Accident and Emergency departments: A thematic analysis

Consent Form

If you are happy to participate please complete and sign the consent form below

	Activities	Initials
1	I confirm that I have read the attached information sheet (Version 7, Date: 16/07/2019) for the above study and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.	
2	I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to myself. I understand that it will not be possible to remove my data from the project once it has been anonymised and forms part of the data set. I agree to take part on this basis.	
3	I agree to the interview being audio recorded.	
4	I agree that direct quotes may be used in publications and in the write up of this research. I understand that these will be anonymous and my identity will not be revealed in any publication.	
5	I agree that any data collected may be published in anonymous form in academic journals.	
6	I understand that there may be instances where during the course of the interview information is revealed which means that the researcher will be obliged to break confidentiality and this has been explained in more detail in the information sheet.	
7	I understand that relevant sections of my medical notes, and data collected during the study may be looked at by individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.	
8	I agree to take part in the above study.	
9	**OPTIONAL:** I understand that data collected in this study may be used to support future research. I give permission for anonymous data files to be used in future studies or shared with researchers working on other studies. I understand that any data used in the future will not contain my name or any other information that could identify me.	

Version 4; Date: 07/02/2019 IRAS: 255934

10	**OPTIONAL:** I agree that the researchers may retain my contact details in order to provide me with a summary of the findings for this study.	

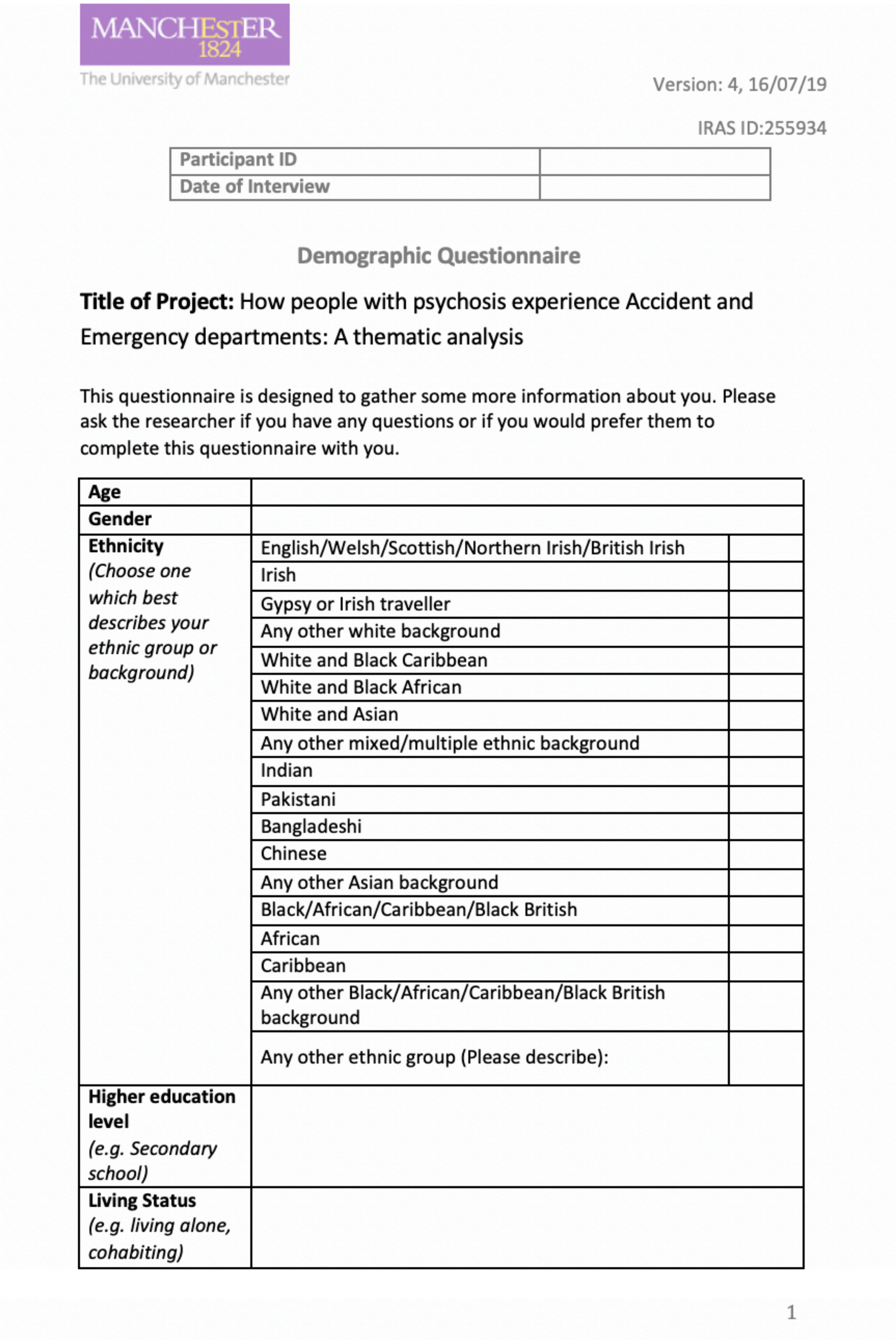
Data Protection

The personal information we collect and use to conduct this research will be processed in accordance with data protection law as explained in the Participant Information Sheet and the Privacy Notice for Research Participants (http://documents.manchester.ac.uk/display.aspx?DocID=37095).

Name of Participant	Signature	Date
Name of the person taking consent	Signature	Date

1 copy for the participant, 1 copy for the research team (original).

Appendix G: Demographics form



The University of Manchester

Version: 4, 16/07/19

IRAS ID:255934

Participant ID	
Date of Interview	

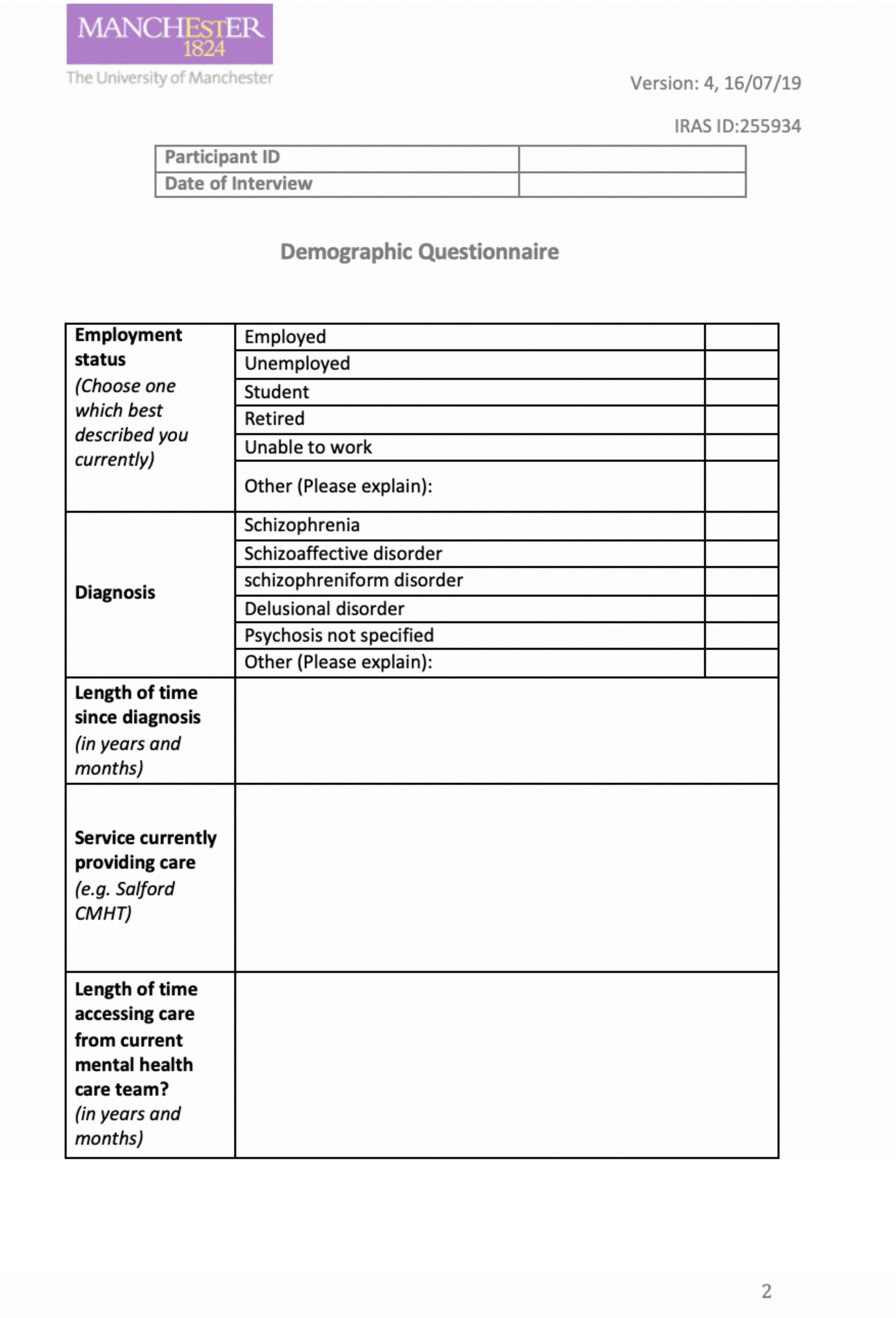
Demographic Questionnaire

Title of Project: How people with psychosis experience Accident and Emergency departments: A thematic analysis

This questionnaire is designed to gather some more information about you. Please ask the researcher if you have any questions or if you would prefer them to complete this questionnaire with you.

Age		
Gender		
Ethnicity *(Choose one which best describes your ethnic group or background)*	English/Welsh/Scottish/Northern Irish/British Irish	
	Irish	
	Gypsy or Irish traveller	
	Any other white background	
	White and Black Caribbean	
	White and Black African	
	White and Asian	
	Any other mixed/multiple ethnic background	
	Indian	
	Pakistani	
	Bangladeshi	
	Chinese	
	Any other Asian background	
	Black/African/Caribbean/Black British	
	African	
	Caribbean	
	Any other Black/African/Caribbean/Black British background	
	Any other ethnic group (Please describe):	
Higher education level *(e.g. Secondary school)*		
Living Status *(e.g. living alone, cohabiting)*		

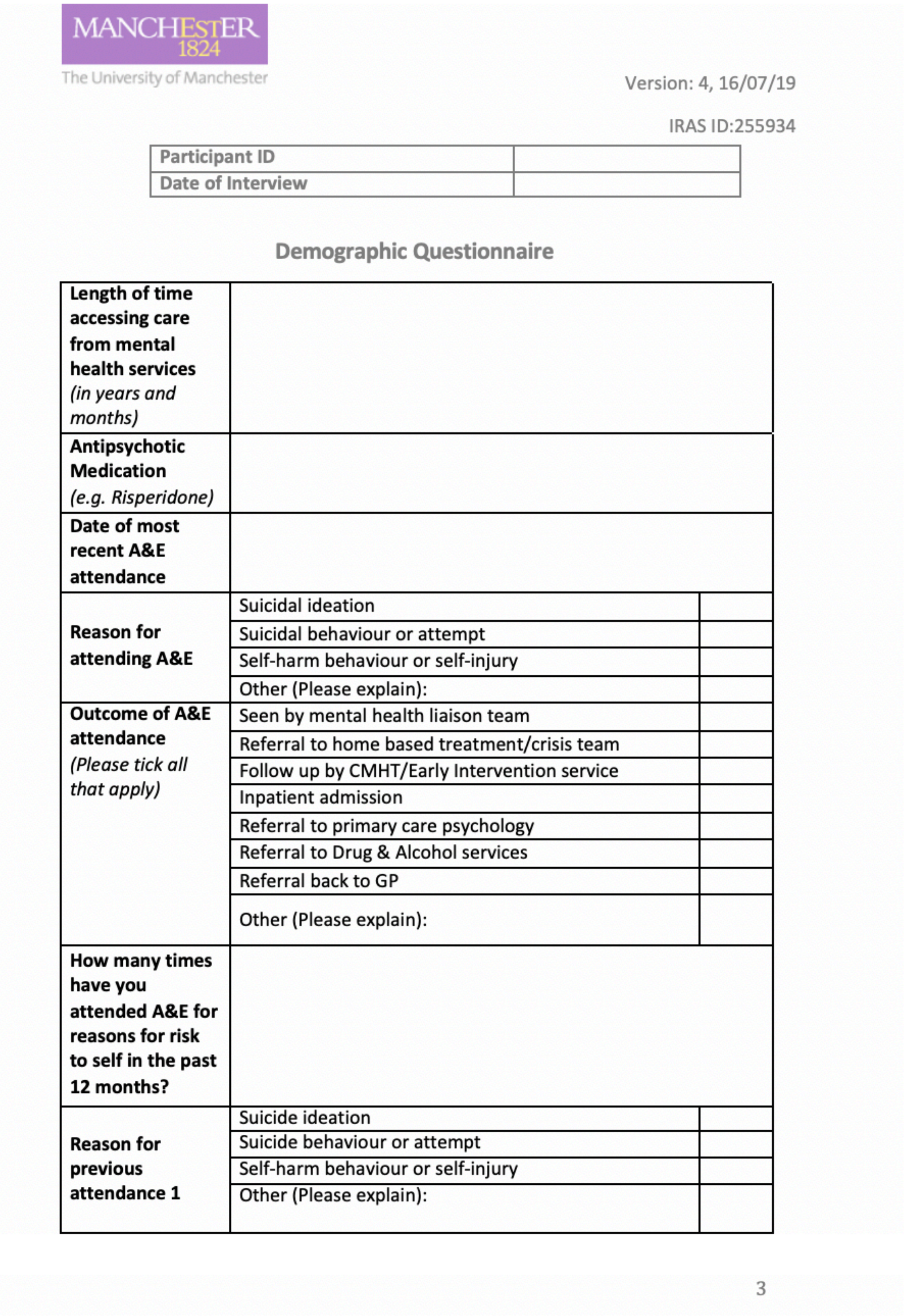
1



Participant ID	
Date of Interview	

Demographic Questionnaire

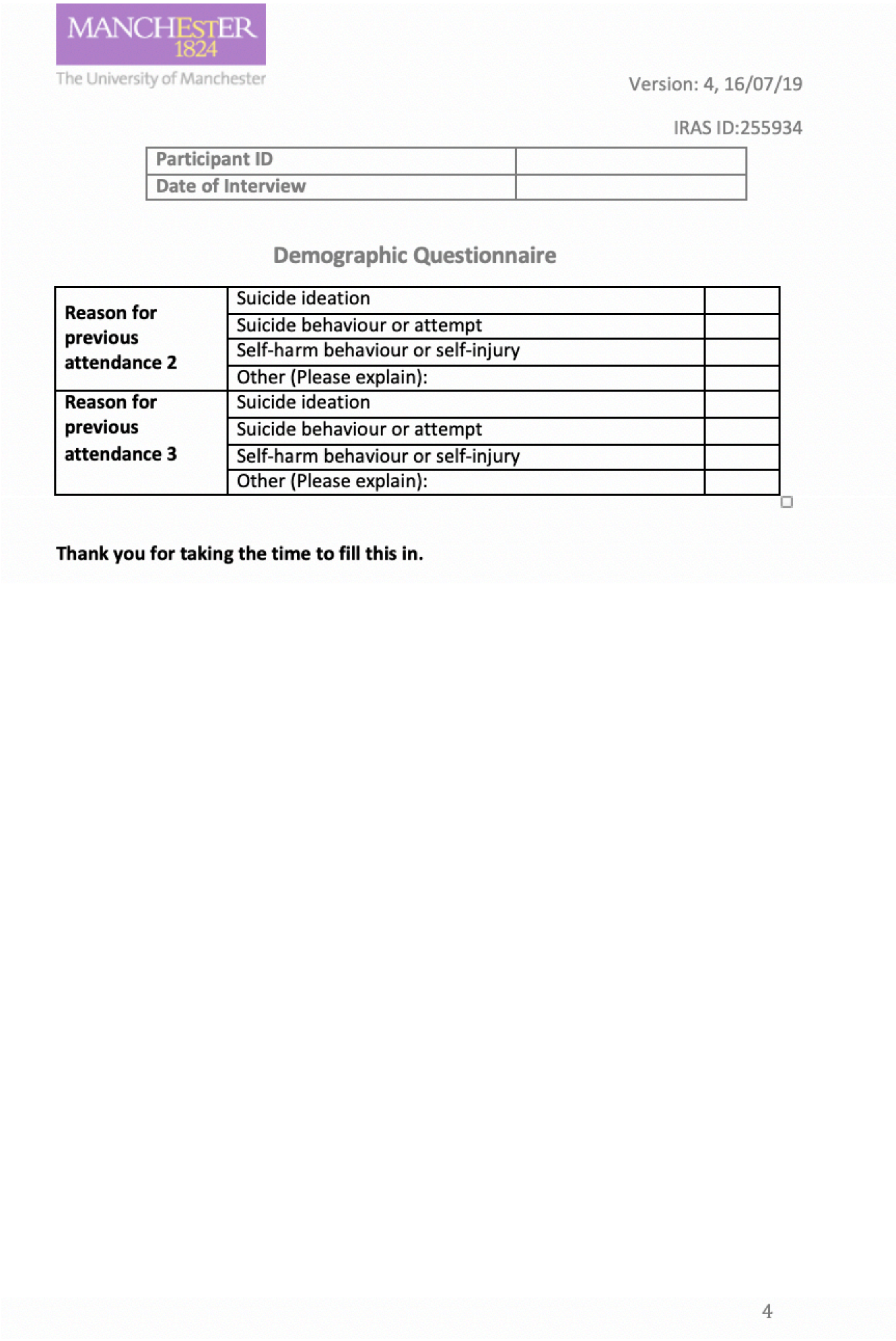
Employment status *(Choose one which best described you currently)*	Employed	
	Unemployed	
	Student	
	Retired	
	Unable to work	
	Other (Please explain):	
Diagnosis	Schizophrenia	
	Schizoaffective disorder	
	schizophreniform disorder	
	Delusional disorder	
	Psychosis not specified	
	Other (Please explain):	
Length of time since diagnosis *(in years and months)*		
Service currently providing care *(e.g. Salford CMHT)*		
Length of time accessing care from current mental health care team? *(in years and months)*		



Participant ID	
Date of Interview	

Demographic Questionnaire

Length of time accessing care from mental health services *(in years and months)*		
Antipsychotic Medication *(e.g. Risperidone)*		
Date of most recent A&E attendance		
Reason for attending A&E	Suicidal ideation	
	Suicidal behaviour or attempt	
	Self-harm behaviour or self-injury	
	Other (Please explain):	
Outcome of A&E attendance *(Please tick all that apply)*	Seen by mental health liaison team	
	Referral to home based treatment/crisis team	
	Follow up by CMHT/Early Intervention service	
	Inpatient admission	
	Referral to primary care psychology	
	Referral to Drug & Alcohol services	
	Referral back to GP	
	Other (Please explain):	
How many times have you attended A&E for reasons for risk to self in the past 12 months?		
Reason for previous attendance 1	Suicide ideation	
	Suicide behaviour or attempt	
	Self-harm behaviour or self-injury	
	Other (Please explain):	



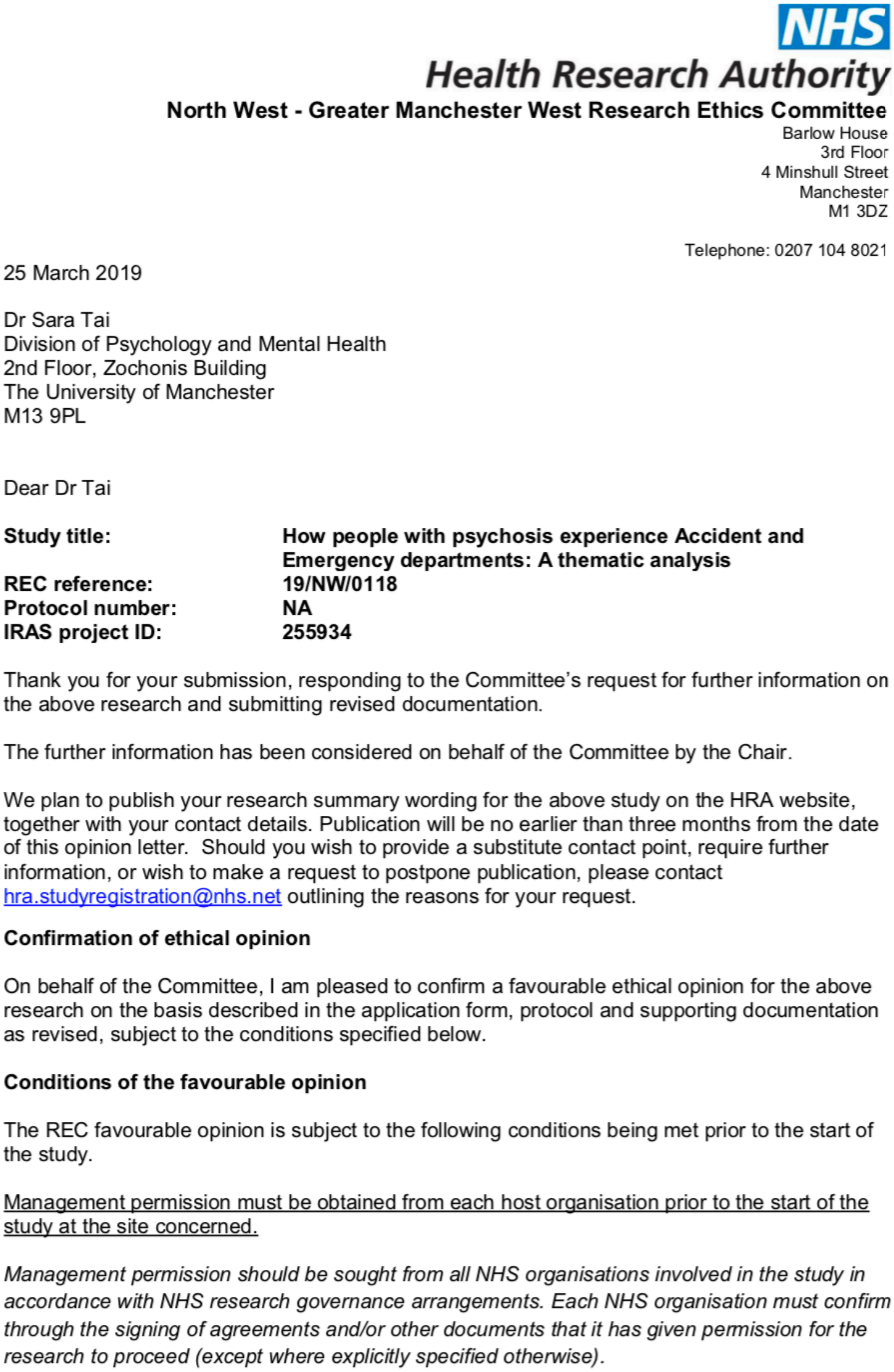
Participant ID	
Date of Interview	

Demographic Questionnaire

Reason for previous attendance 2	Suicide ideation	
	Suicide behaviour or attempt	
	Self-harm behaviour or self-injury	
	Other (Please explain):	
Reason for previous attendance 3	Suicide ideation	
	Suicide behaviour or attempt	
	Self-harm behaviour or self-injury	
	Other (Please explain):	

Thank you for taking the time to fill this in.

Appendix H: Letter confirming NHS ethical approval



NHS
Health Research Authority
North West - Greater Manchester West Research Ethics Committee
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0207 104 8021

25 March 2019

Dr Sara Tai
Division of Psychology and Mental Health
2nd Floor, Zochonis Building
The University of Manchester
M13 9PL

Dear Dr Tai

Study title:	**How people with psychosis experience Accident and Emergency departments: A thematic analysis**
REC reference:	**19/NW/0118**
Protocol number:	**NA**
IRAS project ID:	**255934**

Thank you for your submission, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Participant Poster]	4	11 March 2019
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance confirmation letter]		07 May 2018
Interview schedules or topic guides for participants [Topic Guide]	3	10 December 2018
IRAS Application Form [IRAS_Form_15032019]		15 March 2019
IRAS Application Form XML file [IRAS_Form_15032019]		15 March 2019
IRAS Checklist XML [Checklist_15032019]		15 March 2019

Letter from sponsor [Sponsor Letter]		28 January 2019
Letters of invitation to participant [Letter/Email to potential participant]	1	05 January 2019
Other [Insurance letter]		28 January 2019
Other [Liability insurance certificate]		01 June 2018
Other [Insurance letter]		31 May 2018
Other [Distress and Risk Protocols]	2	10 December 2018
Other [Lone working protocol]	1	11 January 2019
Other [Staff Poster]	4	11 March 2019
Other [Demographics questionnaire]	3	11 March 2019
Other [Ethics Response Letter]		13 March 2019
Participant consent form [Consent form]	4	07 February 2019
Participant information sheet (PIS) [PIS]	6	11 March 2019
Research protocol or project proposal [Protocol]	4	13 March 2019
Summary CV for Chief Investigator (CI) [CI CV]		
Summary CV for student [CV Laura O'Brien-King]		
Summary CV for supervisor (student research) [Academic supervisor CV]		23 January 2018
Summary CV for supervisor (student research) [Academic Supervisor CV]		
Summary CV for supervisor (student research) [Academic Supervisor CV]		08 January 2019

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

19/NW/0118	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

pp

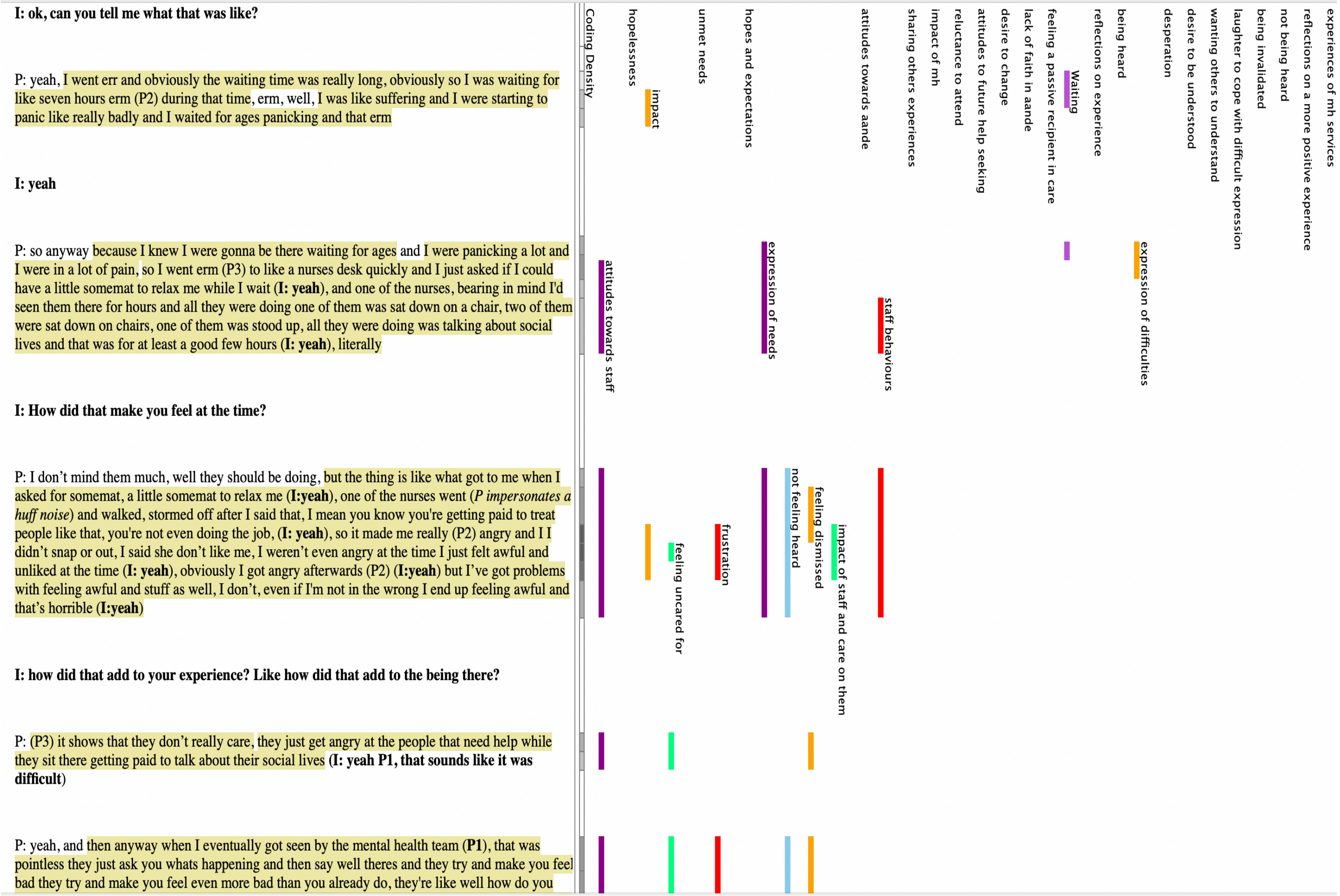
Dr Lorraine Lighton
Chair

Email:nrescommittee.northwest-gmwest@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Ms Lynne Macrae*

Appendix I: NVivo analysis extract



I: ok, can you tell me what that was like?

P: yeah, I went err and obviously the waiting time was really long, obviously so I was waiting for like seven hours erm (P2) during that time, erm, well, I was like suffering and I were starting to panic like really badly and I waited for ages panicking and that erm

I: yeah

P: so anyway because I knew I were gonna be there waiting for ages and I were panicking a lot and I were in a lot of pain, so I went erm (P3) to like a nurses desk quickly and I just asked if I could have a little somemat to relax me while I wait (**I: yeah**), and one of the nurses, bearing in mind I'd seen them there for hours and all they were doing one of them was sat down on a chair, two of them were sat down on chairs, one of them was stood up, all they were doing was talking about social lives and that was for at least a good few hours (**I: yeah**), literally

I: How did that make you feel at the time?

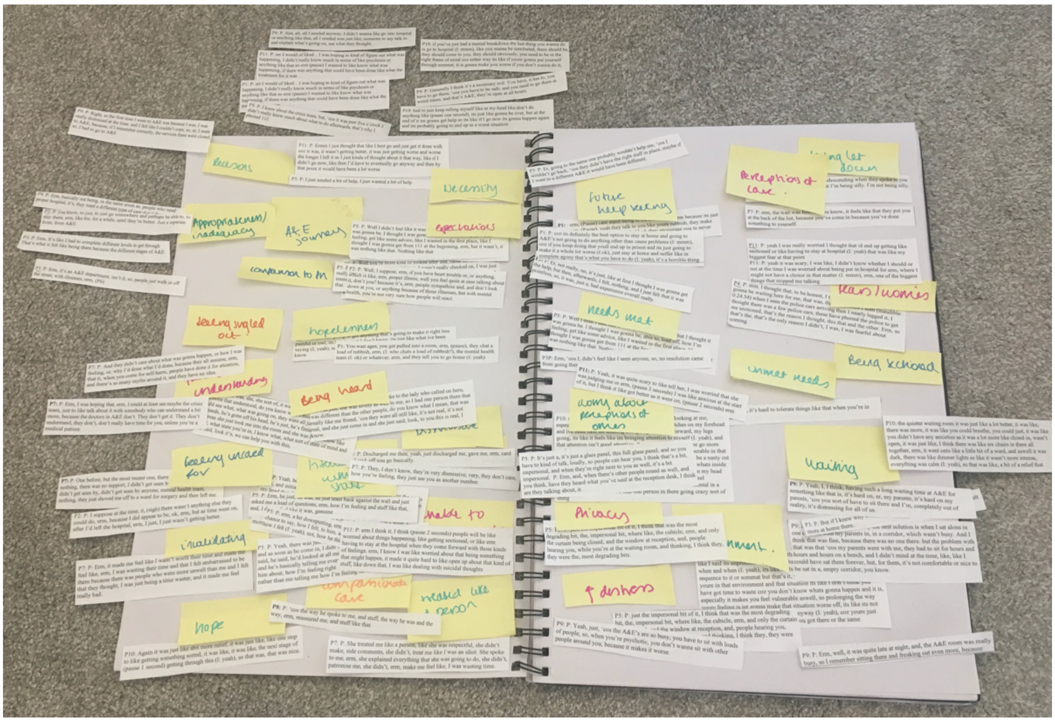
P: I don't mind them much, well they should be doing, but the thing is like what got to me when I asked for somemat, a little somemat to relax me (**I:yeah**), one of the nurses went (*P impersonates a huff noise*) and walked, stormed off after I said that, I mean you know you're getting paid to treat people like that, you're not even doing the job, (**I: yeah**), so it made me really (P2) angry and I I didn't snap or out, I said she don't like me, I weren't even angry at the time I just felt awful and unliked at the time (**I: yeah**), obviously I got angry afterwards (P2) (**I:yeah**) but I've got problems with feeling awful and stuff as well, I don't, even if I'm not in the wrong I end up feeling awful and that's horrible (**I:yeah**)

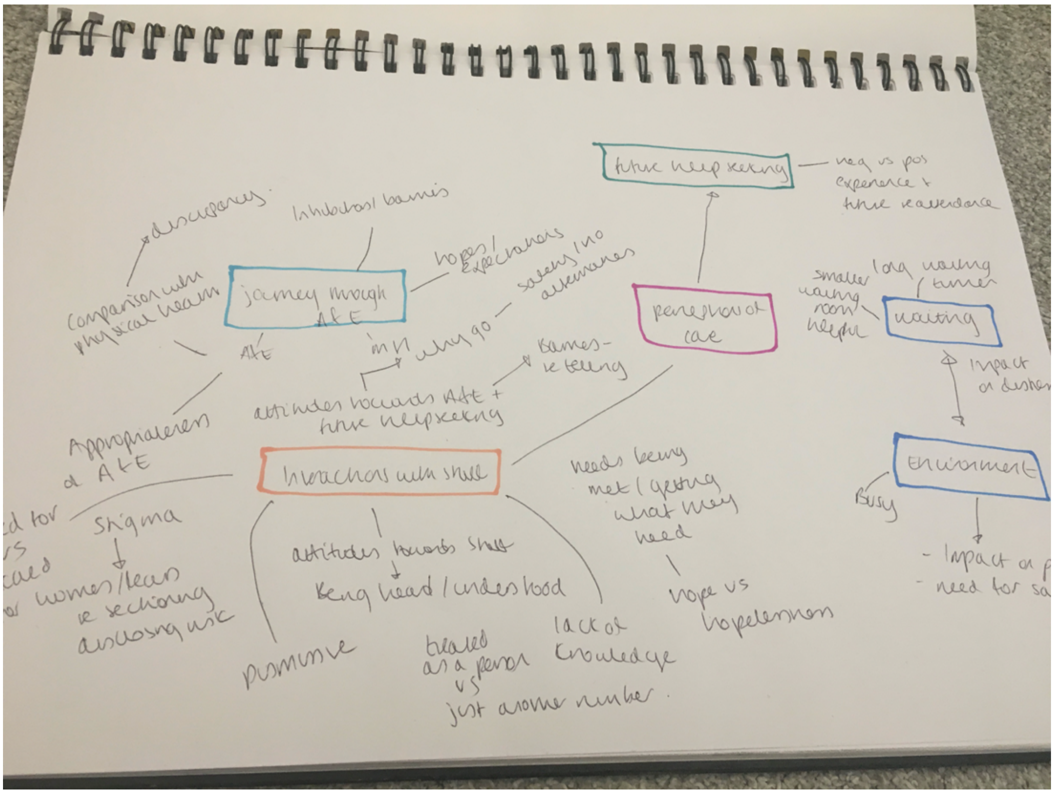
I: how did that add to your experience? Like how did that add to the being there?

P: (P3) it shows that they don't really care, they just get angry at the people that need help while they sit there getting paid to talk about their social lives (**I: yeah P1, that sounds like it was difficult**)

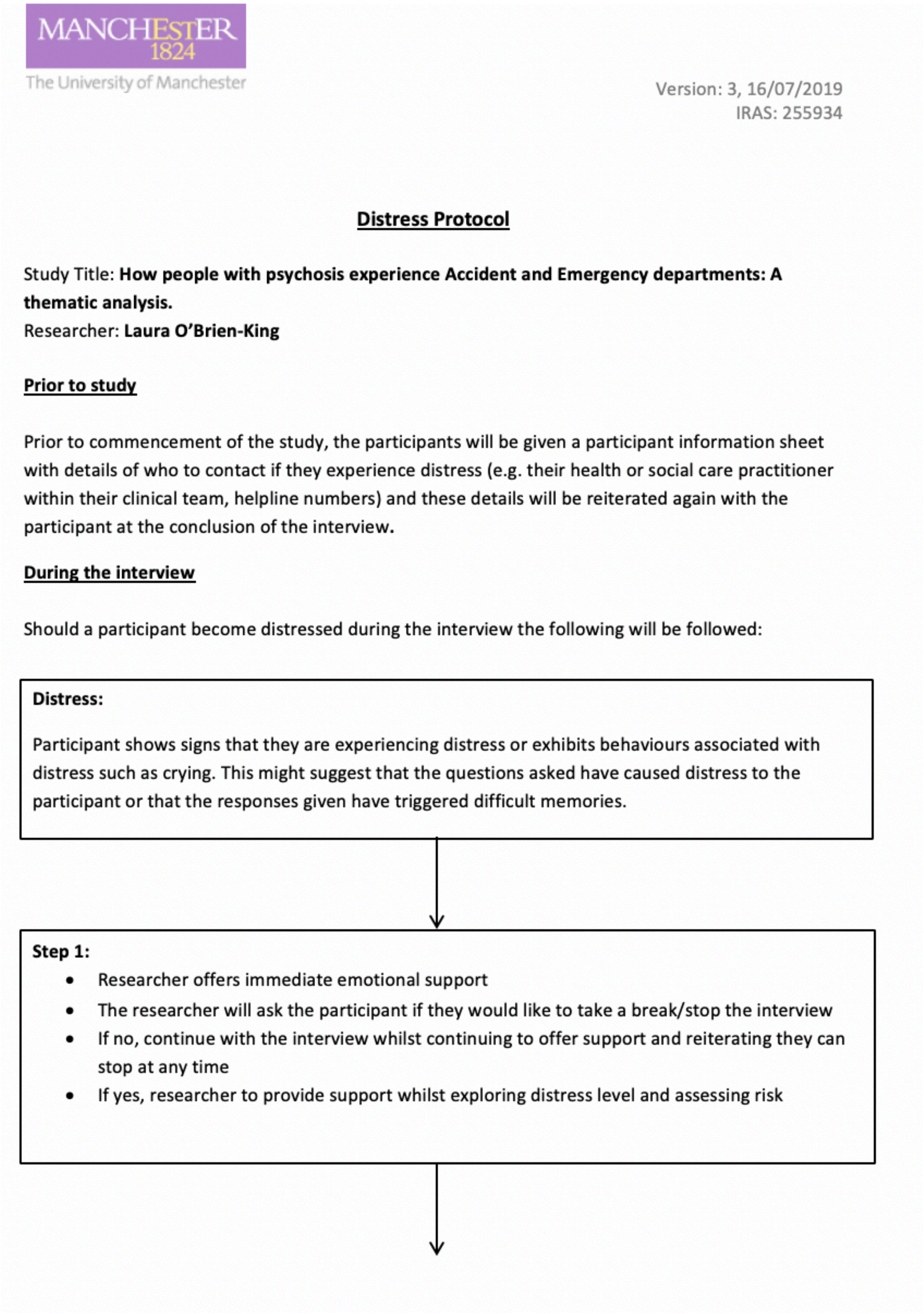
P: yeah, and then anyway when I eventually got seen by the mental health team (**P1**), that was pointless they just ask you whats happening and then say well theres and they try and make you feel bad they try and make you feel even more bad than you already do, they're like well how do you

Appendix J: Initial mapping extracts





Appendix K: Risk and distress management protocols



MANCHESTER 1824
The University of Manchester

Version: 3, 16/07/2019
IRAS: 255934

Distress Protocol

Study Title: **How people with psychosis experience Accident and Emergency departments: A thematic analysis.**
Researcher: **Laura O'Brien-King**

Prior to study

Prior to commencement of the study, the participants will be given a participant information sheet with details of who to contact if they experience distress (e.g. their health or social care practitioner within their clinical team, helpline numbers) and these details will be reiterated again with the participant at the conclusion of the interview.

During the interview

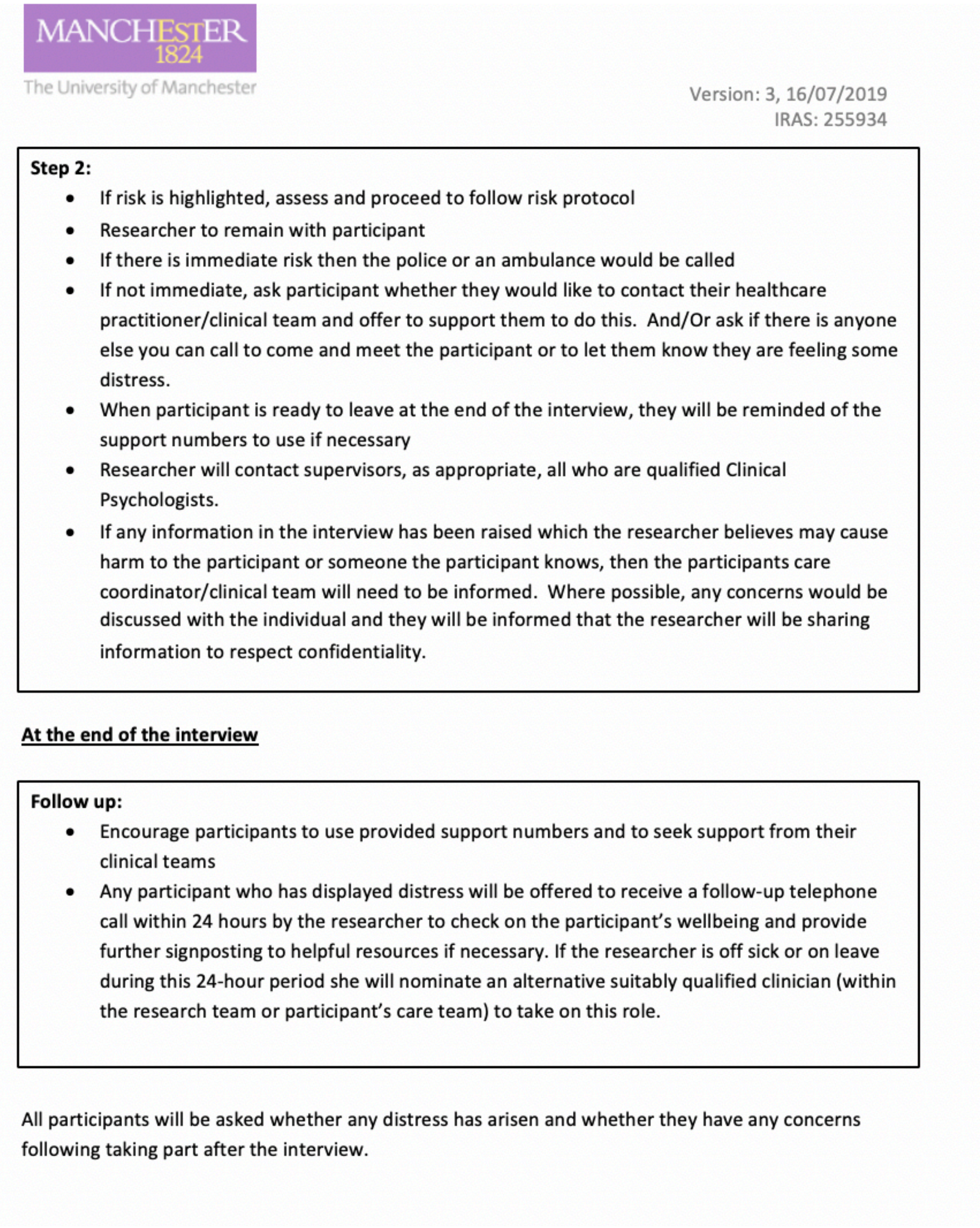
Should a participant become distressed during the interview the following will be followed:

Distress:

Participant shows signs that they are experiencing distress or exhibits behaviours associated with distress such as crying. This might suggest that the questions asked have caused distress to the participant or that the responses given have triggered difficult memories.

Step 1:

- Researcher offers immediate emotional support
- The researcher will ask the participant if they would like to take a break/stop the interview
- If no, continue with the interview whilst continuing to offer support and reiterating they can stop at any time
- If yes, researcher to provide support whilst exploring distress level and assessing risk



Step 2:

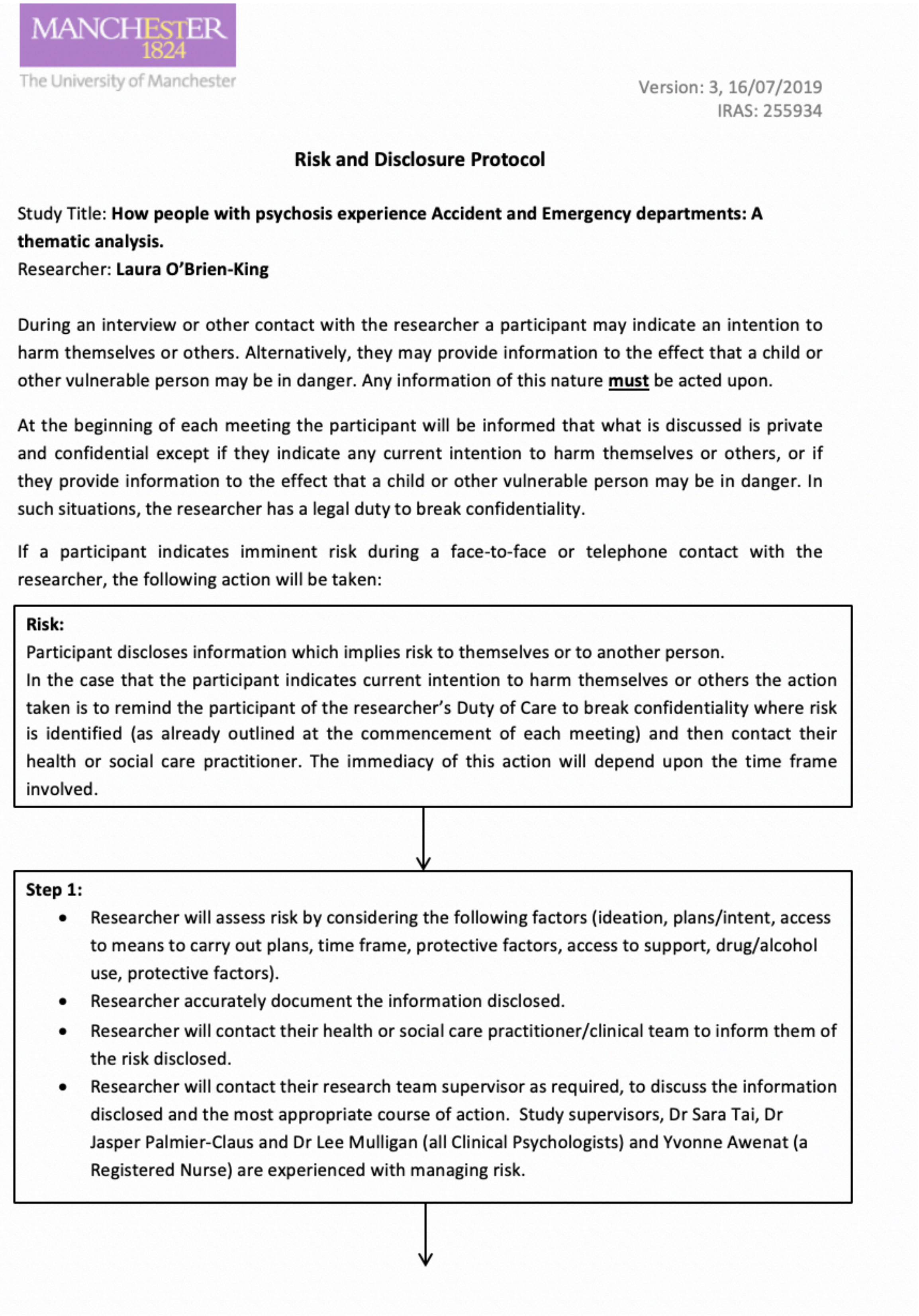
- If risk is highlighted, assess and proceed to follow risk protocol
- Researcher to remain with participant
- If there is immediate risk then the police or an ambulance would be called
- If not immediate, ask participant whether they would like to contact their healthcare practitioner/clinical team and offer to support them to do this. And/Or ask if there is anyone else you can call to come and meet the participant or to let them know they are feeling some distress.
- When participant is ready to leave at the end of the interview, they will be reminded of the support numbers to use if necessary
- Researcher will contact supervisors, as appropriate, all who are qualified Clinical Psychologists.
- If any information in the interview has been raised which the researcher believes may cause harm to the participant or someone the participant knows, then the participants care coordinator/clinical team will need to be informed. Where possible, any concerns would be discussed with the individual and they will be informed that the researcher will be sharing information to respect confidentiality.

<u>At the end of the interview</u>

Follow up:

- Encourage participants to use provided support numbers and to seek support from their clinical teams
- Any participant who has displayed distress will be offered to receive a follow-up telephone call within 24 hours by the researcher to check on the participant's wellbeing and provide further signposting to helpful resources if necessary. If the researcher is off sick or on leave during this 24-hour period she will nominate an alternative suitably qualified clinician (within the research team or participant's care team) to take on this role.

All participants will be asked whether any distress has arisen and whether they have any concerns following taking part after the interview.



MANCHESTER
1824
The University of Manchester

Version: 3, 16/07/2019
IRAS: 255934

Risk and Disclosure Protocol

Study Title: **How people with psychosis experience Accident and Emergency departments: A thematic analysis.**
Researcher: **Laura O'Brien-King**

During an interview or other contact with the researcher a participant may indicate an intention to harm themselves or others. Alternatively, they may provide information to the effect that a child or other vulnerable person may be in danger. Any information of this nature **must** be acted upon.

At the beginning of each meeting the participant will be informed that what is discussed is private and confidential except if they indicate any current intention to harm themselves or others, or if they provide information to the effect that a child or other vulnerable person may be in danger. In such situations, the researcher has a legal duty to break confidentiality.

If a participant indicates imminent risk during a face-to-face or telephone contact with the researcher, the following action will be taken:

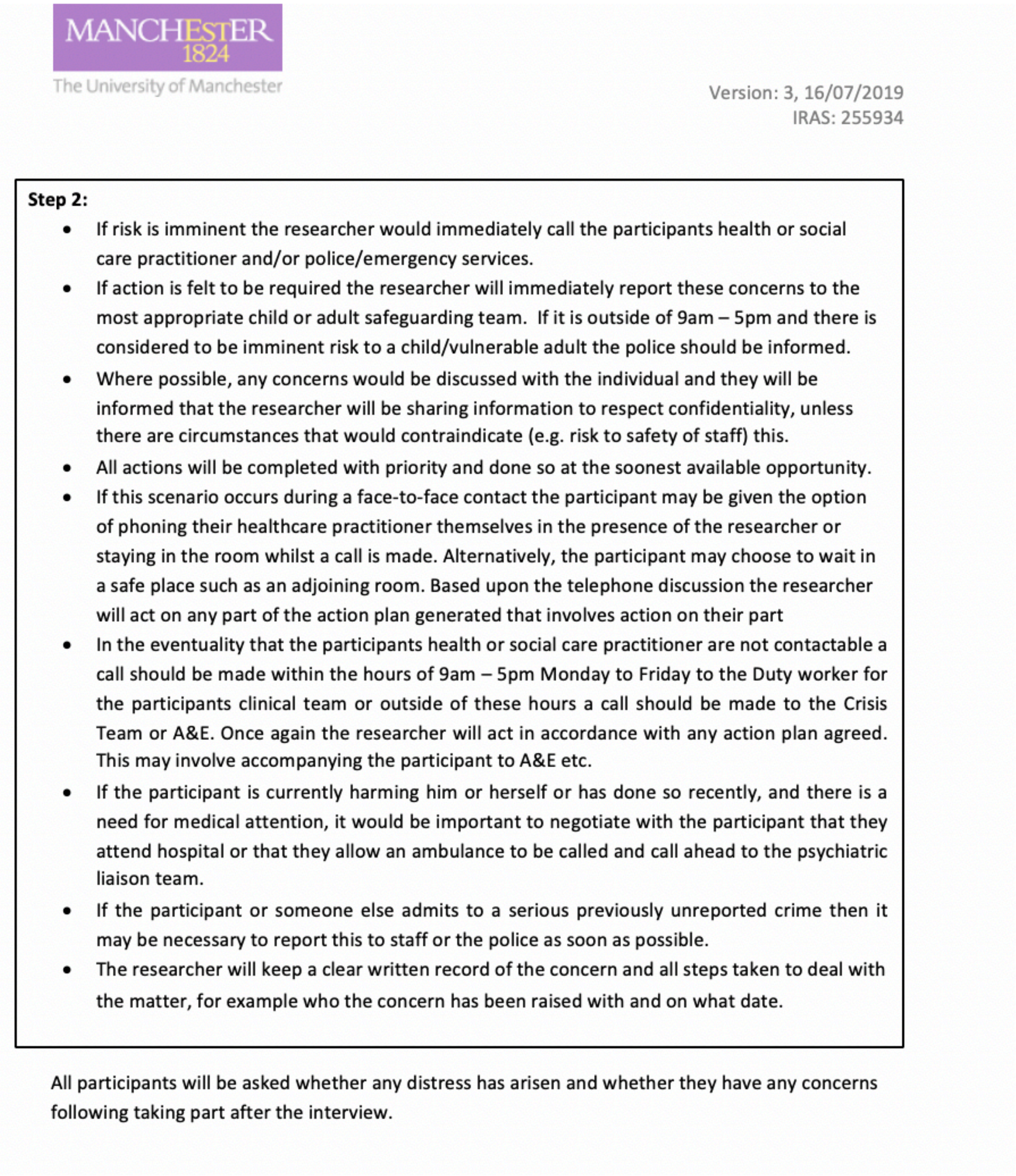
Risk:
Participant discloses information which implies risk to themselves or to another person.
In the case that the participant indicates current intention to harm themselves or others the action taken is to remind the participant of the researcher's Duty of Care to break confidentiality where risk is identified (as already outlined at the commencement of each meeting) and then contact their health or social care practitioner. The immediacy of this action will depend upon the time frame involved.

↓

Step 1:

- Researcher will assess risk by considering the following factors (ideation, plans/intent, access to means to carry out plans, time frame, protective factors, access to support, drug/alcohol use, protective factors).
- Researcher accurately document the information disclosed.
- Researcher will contact their health or social care practitioner/clinical team to inform them of the risk disclosed.
- Researcher will contact their research team supervisor as required, to discuss the information disclosed and the most appropriate course of action. Study supervisors, Dr Sara Tai, Dr Jasper Palmier-Claus and Dr Lee Mulligan (all Clinical Psychologists) and Yvonne Awenat (a Registered Nurse) are experienced with managing risk.

↓



Version: 3, 16/07/2019
IRAS: 255934

Step 2:

- If risk is imminent the researcher would immediately call the participants health or social care practitioner and/or police/emergency services.
- If action is felt to be required the researcher will immediately report these concerns to the most appropriate child or adult safeguarding team. If it is outside of 9am – 5pm and there is considered to be imminent risk to a child/vulnerable adult the police should be informed.
- Where possible, any concerns would be discussed with the individual and they will be informed that the researcher will be sharing information to respect confidentiality, unless there are circumstances that would contraindicate (e.g. risk to safety of staff) this.
- All actions will be completed with priority and done so at the soonest available opportunity.
- If this scenario occurs during a face-to-face contact the participant may be given the option of phoning their healthcare practitioner themselves in the presence of the researcher or staying in the room whilst a call is made. Alternatively, the participant may choose to wait in a safe place such as an adjoining room. Based upon the telephone discussion the researcher will act on any part of the action plan generated that involves action on their part
- In the eventuality that the participants health or social care practitioner are not contactable a call should be made within the hours of 9am – 5pm Monday to Friday to the Duty worker for the participants clinical team or outside of these hours a call should be made to the Crisis Team or A&E. Once again the researcher will act in accordance with any action plan agreed. This may involve accompanying the participant to A&E etc.
- If the participant is currently harming him or herself or has done so recently, and there is a need for medical attention, it would be important to negotiate with the participant that they attend hospital or that they allow an ambulance to be called and call ahead to the psychiatric liaison team.
- If the participant or someone else admits to a serious previously unreported crime then it may be necessary to report this to staff or the police as soon as possible.
- The researcher will keep a clear written record of the concern and all steps taken to deal with the matter, for example who the concern has been raised with and on what date.

All participants will be asked whether any distress has arisen and whether they have any concerns following taking part after the interview.