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Relevance statement

In community psychiatric nursing, asking questions about risk is a fundamental part of the mental health assessment. This paper examines actual assessments in a Child and Adolescent Mental Health (CAMH) community setting, with a focus on the ways that questions about self-harm and suicidal ideation were composed. The research highlights the issue that in many cases self-harm and suicide questions were not routinely asked. Of those that were a particular way of asking was found to be successful. The relevance to psychiatric nursing practice is to demonstrate how to introduce conversations about self-harm and suicide with children and young people.

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"This is a question we have to ask everyone": Asking children about self-harm and suicide

Abstract

Introduction: Questions about self-harm and suicide are essential in risk assessments with children and young people, yet little is known about how mental health practitioners do this.

Aim: The core aim was to examine how questions about self-harm and suicidal ideation are asked in real world practice.

Method: A qualitative design was employed to analyse 28 video-recorded naturally occurring mental health assessments in a child and adolescent mental health service. Data were analysed using conversation analysis (CA).

Results: In 13 cases young people were asked about self-harm and suicide, but 15 were not. Analysis revealed *how* practitioners asked these questions. Two main styles were revealed. First was an incremental approach, beginning with inquiries about emotions and behaviours, building to asking about self-harm and suicidal intent. Second was to externalise the question as being required by outside agencies.

Discussion: The study concluded that the design of risk questions to young people had implications for how open they were to engaging with the practitioner.

Implications for practice: The study has implications for training and practice for psychiatric nurses and other mental health practitioners in feeling more confident in communicating with young people about self-harm and suicidal ideation.

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Accessible summary

What is known on the subject:

- An essential part of mental health assessment is to evaluate the risk of harm to self. Fundamentally this involves asking directly about self-harming behaviour and suicidal thoughts or urges, but practitioners often find it difficult to open up these conversations.
- This evaluation of risk is particularly important as self-harm and suicidal thoughts are frequently found in young people who attend mental health services.

What this paper adds to existing knowledge:

- Young people are not always routinely asked directly about self-harm or suicidal thoughts when they are assessed.
- There are two ways that mental health practitioners introduce this topic: first, by building up to it by asking first about general feelings, second by stating that it is a requirement to ask everyone.

What are the implications for practice?

- These questions should not be avoided by mental health practitioners because they are difficult.
- We offer suggestions as to how to ask questions about self-harm and suicide based on real-world practice.

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Introduction

The Department of Health (UK) (2012) defines suicide as a deliberate act with intention to end one's own life. Globally suicide risk is an important issue for all age groups, but of particular concern are those under 18 years. Internationally suicide is the most common cause of death in female adolescents aged 15-19 years (Patton et al., 2009) and causes 19.2 deaths in every 100,000 males aged 15-24 years (Bertolote & Fleischmann 2002). Aside from death by suicide, suicidal thoughts are more common; with a British study showing a 15% prevalence amongst young people (Hawton & Rodham, 2006). The urgency of addressing this issue amongst vulnerable groups, including young people, has been recognised by the World Health Organization (2013) in its global targets to reduce suicide rates by 10% by 2020.

In order to achieve this, improving early detection of risk factors that may predict suicide attempts is necessary. A significant factor associated with suicide and suicidal ideation is prior engagement in self-harm. In the general population the risk of suicide is estimated at 50 times more likely for those who have engaged in self-harm than those who have not (Dower et al., 2000). Amongst young people, findings have shown that non-suicidal self-injury may triple the risk of concurrent or later suicidal ideation/ behaviour (Whitlock et al., 2012). Indeed, in a community sample of adolescents 89% of those who had attempted suicide had also self-harmed (Lay-Gindhu & Schonert-Reichl, 2005).

Background

There are many different ways in which young people inflict harm to themselves physically. These include (but are not limited to), self-cutting, poisoning, jumping from heights, non-recreational risk-taking, self-battery and burning (Hawton et al., 2012). Research has suggested that such actions function as a way of regulating and coping with difficult or overwhelming emotions (Nixon et al., 2002). Notably, although one might expect these emotions to be triggered by major life events, young people themselves report that they self-harm as a response to daily stresses such as academic pressure, feeling isolated, and low self-esteem (Brophy & Holstrom, 2006). There are additional known risk factors that particularly affect children and young people, including bullying and negative body image (Department of Health, 2012). There is also a relationship between suicide in young people and the presence of mental disorders (Fleischmann et al., 2005), such as depression, ADHD, anxiety, and alcohol and substance misuse (Hawton et al., 2012). Brophy and Holstrom (2006) noted that the majority of young people who self-harmed felt ashamed or guilty, and tended to turn to their friends for support rather than professionals, because of the stigma associated with it. This finding has been supported by research which has indicated that the main barrier for young people not seeking help for mental health problems generally was 'embarrassment' and 'not wanting to talk' (Chandra & Minkovitz, 2006).

For young people whose injuries caused by self-harm require medical treatment, emergency departments play a crucial role (Department of Health, 2012). Problematically research has indicated that some professionals in emergency departments have shown negative attitudes towards those who present with self-harm (McCann et al., 2007), with some nurses indicating that self-harming patients are troublesome (Watkins, 1997) or attention-seeking (Dower et al., 2000). An essential component of treating patients presenting with self-harm injuries is to conduct a risk assessment. The purpose of risk assessments with young people presenting to

emergency services is to identify, manage and recommend treatment interventions (Wood, 2009). The negative attitudes from staff however may affect the quality of care that is provided (Rayner et al., 2005) and means that young people are less likely to get the support and information they need (Brophy & Holstrom, 2007).

However, only a small percentage of young people present to hospital (Hawton et al., 2012) and recent surveys have indicated that the prevalence of self-harm in adolescents is greater than indicated by hospital figures (Green et al, 2005; Hawton et al, 2002). Wherever the young people present for help it is important that a thorough risk assessment is conducted, and this is particularly essential for young people who present to mental health services for an initial assessment. It is a key responsibility of the assessing practitioner in these contexts to help young people communicate things that are difficult to talk about (Hartzell et al., 2009). Thus the quality of the interaction between the practitioner and client can have consequences for the disclosure of full and accurate information, which can inform the trajectory of any health care intervention (Drew et al., 2001). Notably however, practitioners conducting initial assessments frequently report feeling anxious about assessing for risks (Sands, 2009). When undertaking an assessment, it is important for practitioners to find was to encourage young people to explain their feelings and the way that they understand their self-harm in their own words (NICE, 2011; 1.1.1.4). Evidently, assessing mental health presentations is a practice that requires skills, knowledge, confidence and experience (Sands, 2004).

Rationale

The UK government has produced a series of clinical guidelines that offer specific recommendations for mental health practitioners assessing and managing risk (National

Institute of Clinical Excellence; NICE, 2004). Additionally, the Royal College of Psychiatrists (2008) and Child and Adolescent Mental Health Services (CAMHS) (Roth et al., 2011) guidance stipulate that an essential component of the mental health assessment is the evaluation of self-harm and suicide (Doebbeling, 2012; Grigg et al., 2002). This is especially important as identifying whether an individual is at risk of suicide is a core task for the initial assessment (New South Wales Health, 2004), and suicidal intent is an issue that must be addressed specifically (Wood, 2009).

Aims of the paper

Despite the central role of initial assessments in identifying risk, there has been little empirical evidence that has explored this area (Mash & Hunsley, 2005), with limited qualitative evidence on first encounters (Hartzell et al, 2009), but is an area that is receiving growing attention. However, on examining the literature there is little evidence that has focused on *how* practitioners talk to young people about these risks. The aim of this paper is to examine the real world practice of how psychiatric nurses and other mental health practitioners introduce questions specifically about self-harm and suicide.

Method

In the context of research into self-harm NICE (2004) have recommended the use of rigorous qualitative methods to explore client experiences. While outcomes-focused research is essential for developing recommendations for evidence-based practice, there is growing recognition that process research plays an important role (Stafford et al., 2014). Qualitative research has potential to unveil interactional processes and provide recommendations for

clinical practice. Within the different approaches for examining self-harm, conversation analysis (CA) has the benefit of being a systematic, in-depth and scientific methodology. The quality criteria COREQ were used to ensure methodological rigour in the study (Tong et al., 2007). Congruence of theoretical framework, including methodology, sampling, data collection and analysis was ensured by adhering to the core principles of CA.

Conversation analysis

Conversation analysis is an observational science, in that it does not make interpretations of what people mean, but is based on directly observable aspects of the data and how these are taken up by the recipient in conversation (Drew et al., 2001). CA is an approach to talk-in-interaction examining the way in which talk is ordered and performs social actions (Hutchby & Wooffitt, 2008). Thus, conversations are shown to be organised, patterned and have stable characteristics (Drew et al., 2001). CA is theoretically founded in the epistemological positon of social constructionism and is an inductive approach which seeks to discover the ways in which people construct their realities and make meaning from their experiences. From this methodological theoretical foundation, it is an objective approach which analyses the turns at talk, without making assumptions about the theoretical clinical or therapeutic models utilised by the practitioners.

CA is a popular approach for analysing interactions between doctors and patients in physical health settings (Robinson & Heritage, 2006; Stivers, 2002). Additionally, CA has been recognised as particularly well-suited to examining mental health interactions because it is able to facilitate a turn-by-turn investigation of actual communication (O'Reilly & Lester,

2015). CA is especially valuable in identifying the kinds of choices health practitioners make in relation to how they design their turns of talk (such as questions) (Drew et al., 2001).

CA uses naturally occurring data which captures what really happens in practice as opposed to retrospective reports, such as interviews or focus groups (Potter, 2002). While some may argue that the introduction of a recording device discounts the 'naturalness' of the data, the CA distinction what constitutes naturally occurring, is that the interaction would have gone ahead whether it was recorded or not (Speer & Hutchby, 2003). The process of conducting CA research requires collecting occurrences of particular interactional practices in the data corpus so that recurrent and systematic patterns can be extracted (Drew et al., 2001). Once a corpus of extracts which characterise a particular interactional process have been gathered from across the data, these examples are analysed to identify recurrent sequential patterns within the talk. Because the process is data-driven, sequential patterns are reported and evidenced through the data and the co-analysis from multiple team members ensures methodological rigour and objectivity.

The research team was a collaborative partnership between clinical-academics and academics. One aspect of reflexivity within qualitative research relates to the reflective awareness of the potential impact of the relationship between the researcher and the practitioners and families. Thus, the purely academic members of the team did the majority of data collection and liaison with families and participating practitioners to minimise the possibility of participants feeling obligated. As CA specifies the collection of naturally occurring data, video-recordings of routine assessments were utilised for this project rather than conducting interviews. Thus, the requirements of all 32 items in the COREQ, particularly those specific to interviews, were not applicable.

In order to interrogate the specific communication patterns between clients and mental health practitioners, a detailed transcription is required including intonation, pauses and volume (Jefferson, 2004). However, to promote readability we have only included the most interactionally significant features; which were emphasis (represented by underlining), timed pauses (in seconds, 0.2), and overlapped speech (represented by [square] brackets).

Context and participants

The study context was a UK CAMH service, where a purposeful sample of all consenting first assessment appointments, excluding urgent referrals were included and video-recorded. These appointments followed a general trajectory and agenda, moving from introductions, reasons for attendance and problem presentation, to decision-making and decision-delivery by the assessing practitioners (O'Reilly et al., 2015). Initial assessments were multidisciplinary in nature and the format of assessments was not informed by any specific theoretical approach apart from institutional requirement and assessment guidelines. Children were assessed by a minimum of two practitioners (except one) and all 29 practitioners within the team participated. This included consultant, staff-grade and trainee child and adolescent psychiatrists, clinical psychologists, assistant psychologists, community psychiatric nurses (CPNs), occupational therapists and psychotherapists.

Each assessment lasted approximately 90 minutes and 28 families participated; 64% were boys and 36% were girls, with a mean age of 11 years (6-17 years). Referred children attended with one or both parents, and sometimes with siblings, members of the extended family and/or other practitioners. In total 83 families were approached initially by letter and

subsequently verbally on the day; of these 7 were excluded by practitioners, 48 families either did not consent or could not be included due to limitations of recording facilities (only one room had cameras) and 28 of those who consented were included through random selection.

In 15 cases practitioners did not ask specifically about self-harm or suicidal ideation. We thus address those cases where they did focus on this aspect of risk assessment. This constituted a sample of 13 different families totalling approximately 19.5 hours of data; which is a sufficient sample size for a CA study, as saturation is not an appropriate marker for research of this kind (O'Reilly and Parker, 2013). The transcripts for this sub-set of data were scrutinised for examples of questions about self-harm and/or suicide. Twenty-seven sequences of talk were identified and given closer analytic attention. A sequence of talk is a series of corresponding turns between participants that are connected through a dynamic process where what one participant says has an influence on the way another responds (Drew et al., 2001).

Ethics

The study was approved by the UK National Research Ethics Service (NRES). Families and young people provided informed consent/assent together, before and after the assessment, and were assured of their right to withdraw. Practitioners also provided informed consent separately. For the purposes of dissemination pseudonyms were used to protect anonymity. A general thematic report about the project findings has been sent to the families. Workshops to report and discuss the study findings, with a view to share good practice and improve service delivery have been planned for practitioners.

Analysis

The aim of the research was to interrogate data extracts relating to how practitioners asked young people about self-harm and suicide. In the 13 cases where these were discussed, analysis revealed three identifiable styles of asking. The first and most frequent style was characterised to use an incremental approach; beginning with asking about emotions to asking specifically about suicidal behaviours. The second style was to externalise and normalise the question. The third style was simply to respond to volunteered information.

Style A: Incremental approach

This style of introducing the 'suicide question' shares a rhetorical similarity to the well-established 'foot-in-the-door technique' used to gain agreement for a small request in order to increase the likelihood of establishing agreement to a greater request (Freedman & Fraser, 1966). This technique operates on the 'principle of consistency', which specifies that larger requests are more likely to be agreed if consistent with the prior smaller request (Patrova et al., 2007). The similarity between the 'foot-in-the-door' technique and the incremental approach in relation to questions about self-harm and suicide is its incremental nature. In relation to self-harm/suicide questions, practitioners incrementally asked questions along a spectrum, starting with emotions and building up to asking specifically about suicidal intent. The data demonstrated that on some occasions this incremental approach was used across the full spectrum, and on others only aspects of it were employed. For clarity the first extract presented is an example of how the whole spectrum was utilised.

Extract 1: Assessment 18[i] (Prac = Psychiatrist – YP = young person)

1	Prac	Is there any other way you show your frustration(0.91)
2		you said you hit
3	YP	Yeah I h[it doors] hit doors
4	Prac	[doors]
5	YP	there's a massive hole in my door
6	Prac	Yeah so you hit doors anything else?
7	YP	No
8	Prac	Or hurting yourself?
9	YP	Yeah
10	Prac	What d'you do?
11	YP	I slit my wrists once
12	Prac	When was that?
13	YP	Erm (1.44) when we went doctors and they referred to
14		CAMHS
15	Prac	Is that a one-off thing or have you done it before?
16	YP	Er (0.32) done it a couple o' times
17	Prac	Couple of times is what's the purpose of doing that?
18	YP	I don't know I didn't want to hurt anyone an' just (0.35)
19		it relieves it relieves the anger an' it just gets it
20		away
21	Prac	So so relieves anger?
22		(4.53)
23	Prac	Is there an intention to kill yourself?
24	YP	I (0.31) like (0.39) stupid things like taking loads of
25		paracetamol or som'ing (0.78) somfing like that
26	Prac	Have you ever done that?
27	YP	Yeah

This extract demonstrates that the first question typically asked was about difficult emotions that the young person had experienced, '*frustration'* (line 1). This was followed by a question about how those emotions were expressed through behaviour, *'you hit doors, anything else?'* (line 5). Practitioners then typically moved onto specific questions about the link between emotion and self-harm. This was accomplished by offering a suggestion of '*or hurting yourself '*(line 7), which functioned as a generic conceptualisation of self-harm. This provided a basis for asking several follow-up questions in order to gather details about frequency, recency and type of self-harm. This extract illustrates the pursuit of clarification about whether the self-harm reported by the young person was an isolated incident or a frequent behaviour (line 13) and the pursuit of detail in the request for information about its function *'what's the purpose of doing that?'* (line 15). Finally, in this incremental approach the practitioner had already established a basis for asking about such matters. For example, in this extract the practitioner eventually asked '*is there an intention to kill yourself?'* (line 20). The use of this incremental technique appeared to increase the likelihood of response to the question, and in this case the young person responded with an affirmative *'yeah'* (line 27) and allowed the intentions to be pursued further.

Extract 2: Assessment 7 (prac = Community Psychiatric Nurse - CPN)

1	Prac	When you feel sad (0.44) 'ave you ever had any
2		thoughts to harm yourself at all?
3	YP	No never
4	Prac	Never?
5	YP	That's just uh weird
6	Prac	Well okay so you've not
7	YP	No

8 Prac never experienced that?

9 YP No

In this extract the psychiatric nurse started with the lower level of the spectrum by reintroducing the topic of a previous discussion, the young person's emotional state, feeling *'sad'* (line 1). This represents a slightly more concise version of the full spectrum, with less prefacing being used before moving into the self-harm question. Nonetheless an incremental building from talking about emotion to asking about thoughts of self-harm was evident *'have you ever had any thoughts to harm yourself?' (lines 1-2).* The young person denied this and the denial was strongly asserted, despite the practitioner's pursuit of confirmation. Notably, the latter part of the incremental spectrum was not pursued, although in lines 4, 6 & 8, the practitioner continually checked for certainty of the young person's position on this matter. As the young person firmly denied thoughts of self-harm *'that's jus' weird'* (line 5), the practitioner did not ask about suicidal thoughts.

Extract 3: Assessment 2 (prac = psychotherapist)

1 Prac Just coming back to that time you were you were very low
2 and also your self-harming generally (1.04) are there
3 times where (0.32) you feel um (1.48) y- (1.19) it goes
4 beyond you want to hurt yourself [and you want to kill]
5 YP [yeah I've tried to
6 commit sui]cide twice
7 Prac right (0.54) w- when was that?
8 YP about (0.32) six seven months ago

In this assessment the young person volunteered the topic of his self-harm earlier in the session. The relevance of the early incremental stages of the spectrum were therefore not relevant in this instance. However, the practitioner demonstrated that the latter part of the spectrum was still pertinent. This was evidenced by the practitioner asking tactfully whether the urge for self-harm ever escalated to suicidal intention *'are there times where you feel it goes beyond you want to hurt yourself and you want to kill'* (line 2-4).

Style B: Normalising and externalising

An alternative approach used by some practitioners to talk about self-harm/suicide was the normalising and externalising style. This style was characterised by the use of a rationale of being required by an external authority to ask this question. In doing so there was also a normalising quality that was inherent in the procedurisation and impersonalisation of the question.

Extract 4: Assessment 21 (Prac = CPN)

1	Prac	This is a question we have to ask everybody an' I'm sure
2		that you've been asked it before (1.38) when you feel
3		(0.92) a bit frustrated or a bit sad (0.63) an' I know
4		that you've punched walls before have you ever thought
5		about (0.41) really hurting yourself
6	YP	no

This extract is a good example of the use of externalisation to provide a rationale for asking a potentially accountable question. Although in this extract the authority was not named explicitly it was implied through the use of the phrase *'we have to'* (line 2). Through this

minimisation of agency the social action of 'face saving' (Goffman, 1955) served to mitigate against any potential implication that the practitioner was making a personal judgement. In doing so the question becomes more socially acceptable, even within the institutional context. In addition to externalisation, this type also functioned to normalise. In particular this is demonstrated by the generalisation utilised by the practitioner through the claim that the question is one asked of *'everybody'* (line 2). Having carefully prefaced the question, the young person was then asked directly about prior self-harm ideation or behaviour *'have you ever thought about really hurting yourself?'* (lines 5-6).

Extract 5: Assessment 8 (Prac= CPN)

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1  Prac      What we've been asked to do is to think about (0.57) the
2            time that Simon's been hurting himself with (1.12) school
3            because they're really worried about that so we the idea
4            was that we would check that out (0.79) today (0.97) okay
5  ((Mother and Family Support Worker nod))
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Similar to extract 4 this extract demonstrates the externalisation style of questioning. However, rather than stating *'we have to ask*' the psychiatric nurse on this occasion used the phrase *'we've been asked to'* (line 1). One of the particularly delicate features of this interaction (like many of them) was that 'Simon' was present when the topic was addressed. This is important as earlier in the talk the mother demonstrated resistance to the claim that 'Simon' had self-harmed. Thus the externalising strategy employed by the practitioner functioned to both raise a delicate topic while simultaneously maintaining therapeutic alignment. The topic was emphasised by highlighting that the school were *'really worried'* (line 3), while also softening the asking with *'think about'* (line 1) and *'check that out'* (line 4). What these types of phrases do is reduce the emphasis on the line of inquiry and help to

balance the view of the mother against that of the school, without avoiding the topic altogether. Notably this was conflated with the euphemism *'hurting himself'* (line 2) as opposed to the direct term 'deliberate self-harm'. This attended to the potential accountability that might be felt by the mother of a child who has been referred to mental health services for possible suicidal ideation.

Style C: Young person volunteers information and it is pursued

The final style of asking questions about self-harm/suicide observed in the data was when the young person or family member offered information as newsworthy. In these cases the questions asked by practitioners were in response to that information and therefore were slightly different in nature.

Extract 6: Assessment 2 (Prac = Psychotherapist)

1	Prac	Um ↑do you ↑know (0.88) why you're here ↓tod↑ay?
2		(0.83)
3	Prac	Can you tell me a bit ab↓out that
4	YP	(er) it's ab↓out self-↓harming
5	Prac	Ab↑out self-↓harm (0.63) ok↓ay (1.77) i- and what do you
6		mean by ↓that Call↑um °in what ↑way°
7	YP	What (0.42) em: (0.38) it's (mainly) ↓I self-harm

In the absence of a response from the young person to the initial question, the practitioner reformulated the question from a closed *'do you know'* (line 1) to an open *'can you tell me'* (line 3). This precipitated a response from the young person to immediately introduce the topic of *'self-harming'* (line 4). Therefore, it was 'Callum' who volunteered the discussion

about self-harming, negating the need for the practitioner to initiate risk questions. Thus, the practitioner took up the afforded opportunity to discuss the issue at hand. In this case the practitioner successfully used this volunteered information to pursue further inquiry about self-harming *'what do you mean by that'* (line 5/6) and *'in what way'* (line 6). The additional use of 'Callum's' name reiterated the focus on his perspective and exemplified a child-centred way of working.

However, in other instances where young people initiated self-harm topics, the opportunities for further exploration of risk were less well-utilised. We present two examples below for illustration. In the first (extract 7), the practitioner downgraded and reformulated the young person's account of *'felt like killing myself'* (line 5), to *'decided that you don't want to go to school'* (line 11/12). In the second (extract 8) the practitioner did not take the opportunity to pursue the information about the young person's self-harm and instead refocused on the original topic of conversation, the mother's drinking.

Extract 7: Assessment 28 (Prac = Psychiatrist)

1	YP	I just (0.57) went school for one day or two days I think
2		it ↓was and then the next day I couldn't take it anymore
3		(0.59) 'cos I come home crying my eyes out I just felt
4		like I could I felt (0.81) like I co- like I felt like
5		killing myself basically c[uz I] couldn't take it
6	Prac	[yeah]
7		So you (1.20) you you've come to a stage now where:
8		(0.39) >we're just thinking about time now we've come to
9		the stage now where the bullying's become so much it's
10		overwhelming (.) you can't tolerate any more (0.42) so

11 you've come home and you've decided you don't want to go
12 to school
13 YP mmm

Extract 8: Assessment 14 (Prac = CPN)

1 Prac So you've got a few local (0.51) policeman who are
2 in↓volved
3 YP Yeah
4 Prac Okay
5 Mother They're often knocking on my ↓do:or an
6 Prac Right (0.40) an wha- are they knocking on (0.32) abo:ut
7 YP see[ing if (I'm) ok]
8 Mother [Just checkin' up on] Candice coz she's been self-
9 harmin as well
10 Prac Okay (0.68) right (2.58) °can I just go back to you said
11 something about you used to ↓drink quite heavily°
12 Mother Yea:h

In the first example the young person used an extreme formulation to express the depth of her emotions *'crying my eyes out'* (line 3) and '*couldn't take it'* (line 5), which led to her reported suicidal feelings. In the second example the young person's likely risk to self was strongly implied through the narrative that the police were regularly *'checking up on'* her (line 8). This marks the risk as necessitating attention, as the police would not normally be involved in monitoring a young person's wellbeing unless there was significant due cause. This demonstrates that in both cases there was reasonable evidence to suggest that the young people were at significant risk of harming themselves. However, in both examples the practitioners did not respond to the opportunity presented to elaborate on this potential risk,

by seeking further information and clarification. Although eventually the topic was returned to in family 14, this was not the case for family 28 as the topic of risk of self-harm was not revisited.

Discussion

Suicide prevention is a global issue (WHO, 2013) and one that all mental health practitioners take seriously. For example, the British Psychological Society (BPS) recommends that in order to ensure long-term mental health, including suicide reduction, child mental health is 'sensitively and routinely measured' (BPS, 2011). It makes sense therefore that an essential aspect of assessments is the evaluation of risk, specifically including information about self-harm and/or suicidal urges, behaviour or intention (Royal College of Psychiatrists, 2008). While this is the recommended guideline for practitioners, research has not fully explored how this happens in actual practice with young people. If we are to fully appreciate the quality and effectiveness of any health care interaction it is essential to identify what happens during these encounters and how (Drew et al., 2001). In this data set when self-harm/suicide questions were asked of young people there were different approaches to introducing the topic.

Having taken an inductive approach to the analysis of the data, examining sequentially the kinds of responses that were delivered following particular ways in which questions were structured, the data revealed two ways that practitioners introduced questions about self-harm and suicide risk. These two ways were either what we have called an 'incremental approach' or by 'externalising' and/or 'normalising' the question. The incremental approach was a gradual building of information towards talking about suicide. We suggest that this approach

is a less threatening strategy for working towards asking difficult questions that may potentially be quite uncomfortable for young people. This has been recommended by an independent inquiry which suggested that practitioners listening to young people's self-harm narratives allow them to discuss the issues at their own pace in order to foster trust (Brophy and Holmstrom, 2006). For the externalising/normalising type, practitioners positioned a third party as the reason for asking the question which included normalising the question by generalising to other young people avoided singling out that young person. There were occasions within the assessments where young people volunteered information about their self-harm without being directly asked. In these instances, the practitioners either responded by pursuing a line of inquiry with additional questions, or chose not to by reformulating or redirecting the topic of conversation.

Our research has demonstrated that not all clinical assessments included questioning about self-harm and suicide, despite national guidelines stipulating that self-harm should be a central component of these assessments, alongside other risks (Department of Health, 2007; NICE, 2004; Royal College of Psychiatrists, 2008). Given that the Department of Health (2007: 15) stated that it is the "fundamental duty" of "all mental health practitioners" to reduce the risk of self-harm and suicide, it is perhaps surprising that this was not always prioritised during the assessments. One explanation may be that some practitioners hold the belief that asking about self-harm/suicide increases the risk; this is despite evidence to the contrary from research summarised in a systematic review that "talking about suicide may in fact reduce, rather than increase suicide ideation" (Dazzi et al., 2014; 3362). In this study, of those not asked about self-harm or suicide risk, there were no similarities between them in terms of age or gender of the young person that might explain the omission. However, of those that were not asked, in two thirds of the cases the families discussed Autism Spectrum

Disorder as a potential presenting problem. It is possible, therefore, that practitioners in these cases may have felt that it was not as necessary to discuss self-harm and suicide risk. However, self-harm and suicidal ideation can still occur in this group (Karim et al., 2014), and notably a recent study by Baron-Cohen et al found that those diagnosed with Asperger's are more likely to have suicidal thoughts than the general population (BPS, 2014).

Practice implications

It is recognised that one of the most complex areas in healthcare interactions remains the quality of communication between practitioners and young people, and their co-present family members (Stafford et al., 2014). Notably, conversations about self-harm and suicide in those under aged 18 years are arguably a challenging area for mental health practitioners to engage with. Thus, this emotionally demanding work requires a high level of communication skill (NICE, 2011). While the guidelines are clear that this is a topic that must be discussed, there seems to be a gap between evidence-based recommendations and what actually happens in practice.

- Clinical implications

From a clinical perspective, in the cases in the data where self-harm is discussed this was either precipitated by the young person volunteering the information or the practitioner specifically asking about this topic. The implications for clinical practice in situations where young people or family members volunteer information about the self-harm are that it would be beneficial for clinicians to respond flexibly when these topics are introduced in order to adequately address the issue of risk to self. While child mental health assessments typically

follow a pre-determined agenda, opportunities to assess self-harm risk that are initiated by clients, present appropriate space to pursue this important component of the assessment.

In situations where information about self-harm or suicidal ideation is not volunteered by young people, the onus rests upon the assessing practitioner to introduce this topic as an essential element. There are however implications for the style of asking the relative questions. We suggest from analysis of the data that the normalising and externalising approach appears to be most suited to those situations in which the practitioner anticipates from the referral information that self-harm is unlikely given the presenting difficulties. Alternatively, this approach might be used in situations where the practitioner feels that the issue is particularly sensitive for the family or young person, due to prevailing stigmatisation. In situations where the practitioner may have some sense that self-harm or suicidal ideation is a possibility, given the young person's presenting difficulties, we propose that the incremental approach, which leads up to asking specifically about this difficult topic may be more appropriate.

- Training implications

Appropriate training is essential for those who work with individuals who self-harm (NICE, 2004) and to help practitioners recognise warning signs of suicide (Hawton et al., 2012). Ultimately practitioners in UK CAMHS are expected to ask all young people presenting to mental health services about the risk of suicide and self-harm. There are a range of practices within CAMHS for assessing risk through a combination of formal risk questionnaires and clinical assessments. Yet, there is no single test or panel of tests that is able to specifically identify the emergence of a suicide crisis (Fowler, 2012). Given the variability of suicide risk

over time, we argue that it would be beneficial for psychiatric nurses and other mental health practitioners to be specifically trained in *how* to ask young people these questions. Additionally, it is important for practitioners to engage in clinical supervision, which is particularly necessary given the emotional impact of this kind of work (NICE, 2011; 1.1.1.2)

- Research implications

Evident from our analysis is that the way in which research is conducted in self-harm has implications for the quality of the findings. We argue that qualitative research using naturally occurring data avoids researcher bias or demand characteristics, and is therefore a valuable source of knowledge. CA particularly offers a systematic methodology for analysing sequences of naturally occurring talk in mental health settings (Drew et al., 2001). Notably, however, while CA is an excellent approach for the sequential analysis of question-answer adjacency pairs and can provide important information about the detail of how questions are formulated in the most effective ways, there are some limitations. As this approach uses naturally occurring data, the researcher cannot influence the type of data collected (such as asking questions about how practitioners conduct the assessment; for example, asking why some practitioners did not ask the self-harm risk question). Another limitation is that the researcher does not have direct access to the clinical notes, and can only infer what this information might be from what is said during the assessment.

Nonetheless, it is important that research has direct relevance to service development and service implementation (WHO, 2013). In order to have direct relevance, the use of actual recordings of what practitioners do is an excellent resource for critically evaluating practitioner interventions as they occur. We recommend therefore that the question of *how* to

have conversations with young people about self-harm and suicide is focused on in more detail through further research to inform clinical practice. We also recommend the cultivation of collaborative partnerships between practitioners and academic researchers as this can promote this process (O'Reilly & Parker, 2014).

Conclusions

We have demonstrated that the ways in which questions around self-harm and suicide were formulated impacted on the efficacy of the question in eliciting an appropriate response. Both the incremental approach and externalising approaches were found to successfully engage young people in talking about self-harm and suicide. Therefore, by helping practitioners to learn the skills of question design in this area, is likely to increase their confidence in asking questions of this nature to children and young people.

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[i] Please note that Prac refers to practitioner