Gatekeeping and factors underlying decisions not to refer to mental health services after self-harm: Triangulating video-recordings of consultations, interviews, medical records and discharge letters

Clara Bergen[1*], Matthew Lomas[2], Mary Ryan[3], Rose McCabe[4]

[1] Clara Bergen, PhD | cbergen@didihirsch.org
Division of Health Services Research and Management,
City University of London, School of Health Sciences
1 Myddelton Street, London, EC1R 1UB, UK
Health & Innovation Division
Didi Hirsch Mental Health Services
4760 Sepulveda Blvd, Culver City, CA 90230, USA

[2] Matthew Lomas, MRes | m.lomas@exeter.ac.uk
Department of Biosciences, University of Exeter
Stocker Road, Exeter, EX4 4QD, UK

[3] Mary Ryan, FRCP | mary@highbag.co.uk
Health Systems Innovation Lab
London South Bank University
103 Borough Road, London, SE1 0AA, UK

[4] Rose McCabe, PhD | rose.mccabe@city.ac.uk
Division of Health Services Research and Management,
City University of London School of Health Sciences
1 Myddelton St., London, EC1R 1UB, UK

[*] Corresponding Author:
Clara Bergen, PhD | cbergen@didihirsch.org
Division of Health Services Research and Management,
City University of London School of Health Sciences
1 Myddelton St., London, EC1R 1UB, UK
Health & Innovation Division
Didi Hirsch Mental Health Services
4760 Sepulveda Blvd, Culver City, CA 90230, USA

Gatekeeping and factors underlying decisions not to refer to mental health services after self-harm: Triangulating video-recordings of consultations, interviews, medical records and discharge letters

Abstract: When a person attends a UK Emergency Department (ED) for self-harm or suicidal ideation, practitioners may refer to mental health services. While some people ask for and receive support, others ask but do not receive support. We explored requests for support followed by decisions not to refer to mental health services. We analyzed and triangulated evidence from 46 video-recorded psychosocial assessments, one-week and three-month follow-up interviews with patients and carers, medical records, documentation of the referral proces, and ED discharge letters. We present three detailed cases, revealing four factors underlying these decisions: (1) self-control, self-help, social support, and current treatment as valid treatment plans ("Continue to use my coping strategies and deep breathing. But that ain't working."), (2) narrow referral criteria for services, including exclusion of those 'not ill enough' or 'too risky' ("It's about gathering evidence… She would monitor you over a period of weeks and then refer."), (3) accessing mental health care while using alcohol ("I'm being told that they can't deal with her mental health issues until she's not an alcoholic."), and (4) accessing more than one service ("Common with most therapeutic services, we would not work in tandem with another therapeutic provider."). These factors lead to people in crisis being excluded from additional professional support, with serious adverse outcomes including suicide attempts. Patients are pressured to align with these decisions as reasonable. Practitioners are required to act as gatekeepers, rationing under-resourced mental health services. This significantly undermines early intervention and patient recovery.

Content warning: Detailed descriptions of self-harming thoughts and behaviors including suicide, self-inflicted injuries and disordered eating. Discussions of sexual, physical and psychological abuse. Depictions of discriminatory attitudes and actions.

Keywords: Suicide prevention, self-harm, crisis intervention, mental health care, alcohol, medical sociology, qualitative methods.

Introduction

"I telephoned Jane, she answered the call and said she would not be returning to the hospital for treatment [of pharmaceutical overdose]. Jane confirmed she had received the letter that she was not eligible for [psychology/psychotherapy] services. Jane said she was sick of asking for help and not getting anywhere. I asked Jane to return to the hospital so we could talk about the situation. Jane said she would not, that she was going home to sleep and leave her life to chance if she wakes up tomorrow or not. Jane then hung up the telephone."

- Report in Jane's medical file

Self-harm and suicide are major public health priorities worldwide (WHO 2021) and in the UK (NHS 2019), where prevalence of self-harm has risen steeply to 6.4% in the population and 19.4% among young women (McManus et al 2019). Self-harm is the strongest predictor of death by suicide (Chan et al 2018). Public health campaigns strongly encourage people to ask for help if they are experiencing mental health difficulties (NHS 2021). In the UK, the Emergency Department (ED) "provides the main services for people who self-harm" (NICE 2004), with over 220,000 contacts annually in England (Hawton et al 2007). Over half of all EDs in the UK have 24-hour mental health teams including a liaison psychiatry service (NHS 2020). Practitioners conduct psychosocial assessments to identify needs and risks (e.g., risk of suicide) and make decisions around hospital admission, onward referrals to mental health services (e.g., community mental health team, crisis team), and signposting to self-referral options (e.g., a depression and anxiety psychological service).

Despite increased investment in mental health services in the ED and community (NHS 2020), many people presenting with self-harm report they are left without follow-up care (O'Keeffe et al 2021; Rassy et al 2020) and rates of repeat ED attendance for self-harm are around 20% within one year (Carroll 2014). Many service users report help-seeking as 'futile' (De Leo et al 2022), with some dying by suicide after repeated contacts with services (Jayanetti 2021). Indeed,

mental health services have been described as a "fortress" designed to defend themselves and keep people out (Fisher, 2022).

Access to timely and comprehensive care after high-risk ED presentation makes a significant difference in repeat self-harm (Cully et al 2020). Patients, carers and practitioners agree that "the wider system is failing people who self-harm", with systematic exclusion from services leading to unhelpful cycles of re-attending (O'Keeffe et al 2021). Many patients describe leaving these psychosocial assessments feeling "judged and unworthy of help" and receiving only a "trivial treatment plan" (Xanthopoulou et al 2021).

Experiential accounts from people who attend the ED with self-harm (e.g., Fisher 2022; Binns 2018) describe exclusionary practices involving layers of gatekeeping to access services (e.g., requiring multiple assessments to approve referrals), practitioners having to ration services rather than making decisions based on clinical need (see Fisher 2022) and referral criteria that place the burden of access back on the patient (e.g., exclusion from services on the grounds of missed appointments or alcohol use). To better understand how these exclusionary practices occur, this study asks: What rationales are systematically used in decisions not to refer to specialist mental health services after a patient request for support?

Literature

Past studies have analyzed video-recorded healthcare encounters to examine how treatment decisions are made in situ (Wang 2020; Stivers & Timmermans 2021; Tate 2022; McCabe 2021; Ostermann 2021; Dalby Landmark et al 2017; Kaminskiy & Finlay 2019; Pino et al 2020). These studies use Conversation Analysis (Sidnell & Stivers 2012; Tietbohl & White 2022) to micro-analyze video-recorded clinical interactions and identify systematic patterns in how practitioners

and patients discuss treatment options. For example, studies have examined the role that patient and caregiver pressure can play in treatment decisions (Wang 2020; Stivers & Timmermans 2021; Pino et al 2020), barriers to patient involvement in treatment decision making (Ostermann 2021; Kaminskiy & Finlay 2019), and how treatment discussions may be impacted by policy changes (Tate 2022). These observational studies have delivered important insights on aspects of treatment decision making that are morally charged (e.g., patient pressure for antibiotics) and therefore may not be disclosed in self-report data.

Conversation Analysis also provides important methodological tools for the study of evidential basis in treatment decision-making. The literature defines and operationalizes key communication practices such as presuppositions (e.g., assumptions communicated implicitly by practitioners during treatment discussions) (Heritage & Clayman 2010), displays of epistemic authority (e.g., where practitioners indicate they hold more knowledge than the patient about the treatment decision) (Heritage & Raymond 2005), and passive resistance to treatment (e.g., patients' subtle pushback against a treatment option) (Stivers 2005). Because of this, researchers can produce observational studies with high levels of transparency, replicability, and validity, while incorporating contextual information such as institutional power differentials and elements of social pressure.

While these tools are often used to explore 'how talk works', i.e. how social actions are produced in interaction, these same tools can also be used to study broader social trends and institutional norms. For example, previous studies have: examined how pediatricians may communicate differently with white, Black, and Hispanic children (Stivers & Majid 2007); identified cross-national differences in patient responses to over-the-counter treatment recommendations (Bergen et al 2018); and, explored how patient communication may impact on

mental versus physical health diagnosis (Tate 2019). The current study contributes to this literature, using the analytic tools from this field to identify and explore practitioners' implicitly and explicitly communicate rationales for not referring the patient to requested services.

Methods

Data. Healthcare services research typically relies on analysis of institutional records, self-report or observational data. We take a novel methodological approach by analyzing and triangulating evidence from video-recorded liaison psychiatry assessments, one-week and three-month follow-up interviews with participating patients and carers, participants' medical records, and documentation of the referral process.

Data collection and study protocols were developed in collaboration with a lived experience advisory group including six people who have attended the ED for self-harm, one carer and one mental health nurse. Written informed consent was obtained. Patient participants went through a three-step informed consent process (see Xanthopoulou et al., 2021). Data collection was carried out with on-site support of a lived experience researcher trained in ethnographic methods. The study obtained ethical approval from London Central Research Ethics Committee (17/LO/1234).

All practitioners who conducted psychosocial assessments in the team (N=43) were invited to participate and 33 consented (76.7% consent rate). Practitioners were mental health nurses (N=13), junior doctors (N=7), consultant psychiatrists (N=6), social workers (N=2) and other professionals (N=5). Practitioners were mostly female (N = 20/33) and white British (N = 28/33). Patients referred to Liaison Psychiatry for suicidal ideation or self-harm were approached by a practitioner who assessed capacity to give informed consent. Exclusion criteria were: aged under

16, cognitive difficulties, active psychosis, requiring an interpreter or being subject to a restriction order. 260 referrals were screened; 82 were approached to participate and 48 consented. 3 were later excluded due to not presenting with suicidal ideation/self-harm. One patient re-presented, undergoing 2 assessments. Patients' mean age was 35.5 (SD 15, range 18-71) and they were mostly female (N=31/45) and white British (N=43/45). Referrals were for suicidal ideation (N=20/46), self-harm by overdose (N=23/46) or self-harm by ligature or attempted drowning (N=3/46). Carers, typically parents, were present in 8 assessments.

Data were collected between September 2018 and April 2019 (see Xanthopoulou et al., 2021). Two GoPro cameras were set up in the room and the assessment recorded with no researcher present. A researcher conducted one-week and three-month post-visit interviews with participating patients and carers. These interviews included open questions about the participant's experiences of seeking mental health support, their feelings about the assessment and advice they were given, and contact with services in the weeks following the assessment. Patients' medical records were accessed to examine psychosocial assessment summaries, risk assessments and contact with other mental services in relation to referrals and discharge letters. All data extracts have been anonymized, with names, locations and other identifying information changed/omitted. For clarity, standard transcripts are used.

Participants. In 54% (N=25/46) assessments, patients communicated a preference for additional mental health support: asking where they could get further support, stating they needed more/different help or describing their current treatment plan as not enough. In 72% (N=18/25) of these assessments, practitioners signposted to crisis hotlines, charity organizations or primary care services (e.g., option to self-refer to a limited course of Cognitive Behavioral Therapy with

waitlist), but did not otherwise facilitate access to mental health services. In 7 cases, practitioners attempted to facilitate access:

- In 5 cases, practitioners initiated secondary care mental health referrals: 2 of these were denied.
- In 2 cases, practitioners initiated primary care mental health referrals.

At the time of the assessment, 20% (N=5/25) of patients seeking more/different support were accessing alcohol counselling but no mental health counselling, 8% (N=2/25) were accessing a primary mental health service (e.g., limited course of Cognitive Behavioral Therapy) and 16% (4/25) were accessing a secondary mental health service (e.g., Eating Disorders Service).

Analysis Video-recorded psychosocial assessments, patient and carer interviews, medical records and referral documents were analyzed and triangulated. For the video-recorded assessments, conversation analysis (Tietbohl & White 2022; Sidnell & Stivers 2012) was used to identify and analyze the treatment discussion. This included practitioners' accounts for not recommending treatment, presuppositions (communicated assumptions) about patient need, and indications that referrals would be contingent on patient behavior. Practitioners rarely state outright the reasons for their decision not to refer. This analysis allowed the authors to identify practitioner rationales that were communicated more implicitly and cumulatively over the course of the assessment. Once identified, practitioner rationales for not providing a referral were then compared across cases to identify which rationales were observed more frequently. As we demonstrate in the paper, it was common for multiple rationales to be observed across a single assessment.

To supplement conversation analysis of the video-recordings, we also explored and triangulated data from four other data sources focusing on whether rationales for not referring to mental health services were present in (1) assessment summaries written by practitioners in the

medical records after the assessment (2) risk assessments written by practitioners in the medical records after the assessment (3) communication between services reported by practitioners in the medical records after the assessment and (4) patient and carer interviews one-week and three-months after the assessment. This data was analysed on a simple descriptive level and we report direct quotes from these sources. The rationales in the medical records were content analysed and patient/carer perspectives were reported verbatim. This information was recorded in a summary document for each case.

Analysis of these assessments revealed four factors recurrently underlying grounds for no referral to mental health services. Three cases were selected as having clear examples of these factors across the observational, self-report, and medical records data, but having diverse presentations and mental health histories. The cases of these three patients, Ann, Jane, and Mary, are used to illustrate the four factors identified in the analysis of the wider dataset. An expert by experience co-authored the paper and contributed insights to earlier drafts.

Findings

We found that people asked for further support but this did not progress to a referral to a mental health service. We identify four factors that systematically underpinned decisions not to facilitate referral to mental health services for people seeking help for self-harm/suicidal ideation. The rationale presented by practitioners focused on: (1) self-control, self-help, social support, and current treatment as valid solutions ("Continue to use my coping strategies and deep breathing. But that ain't working."), (2) narrow referral criteria for mental health services ("It's about gathering evidence… She would monitor you over a period of weeks and then refer."), (3) accessing mental health care while using alcohol ("I'm being told that they can't deal with her

mental health issues until she's not an alcoholic."), and (4) accessing more than one form of mental health care ("Common with most therapeutic services, we would not work in tandem with another therapeutic provider."). People in crisis were pressured to accept these as reasonable grounds for not referring to mental health services.

We begin by introducing three patients, whose cases will be discussed across the paper. We then demonstrate how these four factors are invoked in assessments, where people request support but decisions are made not to refer them to mental health services.

Ann is a young university student with a history of depression, obsessive compulsive disorder, and an eating disorder. She began experiencing "a lot of intrusive thoughts about- suicidal thoughts… so many that I wasn't sure whether they were my own thoughts anymore, or something trying to tell me that I needed to do these things, so I didn't feel safe by myself." She was having frequent panic attacks, compulsions to limit food, and feeling unable to take her prescribed anti-anxiety medication (a benzodiazepine) due to intrusive thoughts of overdosing on the medication. She was allocated eight weekly counseling sessions from her University Counseling Service, but after three sessions realized that this was not enough support, as she was struggling to cope daily and university counseling seemed unequipped to address "really deep rooted" issues.

Jane presented to the ED after a pharmaceutical overdose and cutting with suicidal intent, seeking help for continuing thoughts of suicide. Jane received care in the ED five times in the past year after suicide attempts/suicidal ideation. Jane was physically dependent on alcohol and receiving weekly alcohol counseling sessions from the local drug and alcohol service. Jane experienced extensive sexual abuse and exploitation as a child and was living with family members that protected the perpetrator. Jane had not received specialized mental health support as a victim

of abuse. She received a limited number of Cognitive Behavioral Therapy (CBT) sessions with the Depression and Anxiety Service two years prior. She tells the practitioner that she needs "someone to talk to".

Mary was brought to the emergency department by ambulance after a seizure. She admitted that she stopped taking her seizure medication weeks ago because she felt ambivalent about being alive. Mary had been seen in the ED three times in the last two months for attempted drowning and pharmaceutical overdoses with suicidal intent. Mary had a history of alcohol use disorder and was receiving weekly alcohol counseling sessions from the local drug and alcohol service. She was trying to hide her drinking from her family and counselor, so it wasn't clear how much Mary was drinking. Mary's mother (her primary caregiver) joined for the second half of the assessment.

TABLE 1 ABOUT HERE

Self support, social support, and current treatment plan as viable solutions

In Ann's assessment, the practitioner took the stance that self-control and self-help, social support (reaching out to family, friends), and the existing treatment plan (medication, waiting list for mental health services) were reasonable solutions for Ann's mental health crisis. This went beyond acknowledging that these may be the only immediately available options in working to convince Ann that she already had the support she needed. This placed the burden of recovery back onto Ann.

Self-control and self-help as viable solutions. At the assessment, Ann disclosed she had not eaten anything in three days. She made multiple requests for professional support for eating disorders throughout the assessment.

Self-control (e.g., starting to eat again) was advocated along with self-help (e.g., learning about coping strategies online) as reasonable alternatives to professional support. At multiple points, the practitioner attempted to convince Ann that she should not be limiting what she eats, communicating an assumption that she can control this behavior. Extract 1 provides an example.

EXTRACT 1 HERE

Extract 1

1 Ann: I'm feeling unable to eat...
5 And having um kind of unpleasant thoughts about my body
6 shape.
7 LPS: Mm. Alright. Okay. **And I assume that you're really trying**
8 **with eating? As in you're- you know- trying to give yourself**
9 **permission to enjoy food or whatever. 'Cause I guess if**
10 **you're quite slim and you're worried about losing more**
11 **weight, it's not a time to start thinking 'Well I shouldn't**
12 **have any custard.' or 'I shouldn't have any-' You're try- Are**
13 **you trying to just have a- what- what you fancy when you-**
14 **when you could eat it?**
15 Ann: Um, [shaking head] it's-
16 LPS: Again it's easier said than done, but. [nods]
17 Ann: Whatever it is, it's not letting me.

Ann describes her experience as an *inability* to eat (line 1). The practitioner asks Ann to confirm that she is "really trying" (lines 7-8) to give herself permission to enjoy food (lines 8-9). The practitioner frames Ann's distress ("if you're… worried") as reason for Ann to change her thoughts and behaviors ("it's not the time to start thinking…") (lines 9-12), communicating an assumption that Ann is capable of this change. They ask whether Ann is "trying" to "have… what you fancy", which implies that she may simply have not been trying. Ann pushes back against this assumption when she responds in line 17 saying "Whatever it is. It's *not letting me*".

Later, the practitioner explains that Ann's General Practitioner could make a referral to the eating disorder service if they document sustained weight loss over a number of weeks. However, they assert a characterization of the situation that does not reflect Ann's experience or her multiple requests for professional support (Extract 2).

EXTRACT 2 HERE

Extract 2

LPS: [Your general practitioner] would make a referral into the eating disorder service **if that becomes necessary. Okay? And I guess, because you're motivated, I- I know you're motivated. You're gonna be thinking actually [head shake] I don't want any of that. I've got enough other stuff going on. What can I do to make sure it doesn't get to that point.**

While Ann has described feeling unable to address her eating problems alone, the practitioner alleges a different subjective experience; that Ann will be thinking what she can do to ensure "it doesn't get to that point" of referral to the eating disorder service. They frame this positively as motivation (lines 2-4), i.e., that her motivation can prevent an eating disorder referral (i.e., self-control) and resolve her eating problems.

The practitioner also advised self-help. In the written treatment plan, they recommend "accessing self-help resources on line i.e. www.getselfhelp.co.uk to explore positive ways of managing anxiety, OCD and eating difficulties." It is very common for self-help websites and charity crisis phone lines to be treated as reasonable alternatives to mental health services.

In Ann's three-month post-visit interview, she described her difficulties securing a referral to the eating disorders service (Extract 3).

EXTRACT 3 HERE

Extract 3

Ann: **I- in a way I kind of knew what was happening to me again. And I was trying to say 'Yeah, this is happening again.' Um but it wasn't until March [three months later] that I started getting help for it,** and by then- I mean- I've lost even more weight since then so I'm kind of firmly within the anorexic range.

Int: Right. Okay.

Ann: **So I think if I could've- I don't know- maybe if I'd been able to access the help sooner than it wouldn't have gotten to that stage.**

Ann experienced significant weight loss in the time it took her to get professional help, putting her body mass index "firmly within the anorexic range". She suggested that if she had been able to "access the help sooner" she may not have had to experience such drastic weight loss and worsening symptoms.

Social support as a viable solution. In addition to self-support, the practitioner took the stance that social support was a reasonable solution. Over 30 minutes into the assessment, the practitioner asks Ann for the fourth time how they can help her (Extract 4, lines 1-2). This places the burden back on Ann to make a case for seeking help and subtly undermines the legitimacy of her presentation. In this context, Ann re-introduces her concerns about eating.

EXTRACT 4 HERE

Extract 4

LPS: So I guess I've asked you before and I guess I'll have to ask you again Ann. How can we help you?

...

Ann: I'm at risk to myself in terms of starvation. That's the thing that's on my mind cause I've already lost a lot of weight and now I'm eating next to nothing and I feel very powerless in it.

LPS: Yeah. **I think that's where it would be really good to collaborate with somebody in a bit of a buddy way. It may only be for a few days until you start being able to do it.**

Ann makes an implicit bid for support, describing feeling "very powerless" (lines 11-14). The practitioner responds by reiterating an earlier recommendation to ask a friend for support (lines 15-17). They frame the recommendation as "really good" and embed the assumption that this will

be enough support to resolve the problem ("until you start being able to do it."). They also minimize Ann's needs, suggesting that she may "only" need support "for a few days" to resolve her eating problems.

A few minutes later, Ann asks again where she could get support for eating problems (Extract 5A, lines 1-2).

EXTRACT 5A HERE

Extract 5A

1 Ann: If I did get some short-term um support for eating problems
2 and kind of acute distress, who would that be? [voice breaks]
3 LPS: **I was thinking of you using people that you know already.**
...
11 Ann: 'Cause I've been relying on a lot of people already and
12 they're saying like they're- they're doing as much as they
13 can. [voice breaks] but um the strength of the thoughts is
14 kind of turning me into a horrible person so- there's only so
15 much they can help is what I'm saying.
16 LPS: Yeah and you'd need to have that debate with them. But quite
17 often you know actually sharing with people and being quite
18 honest on that front about how things are, **You know somebody**
19 **might say to you I'm happy to do that for a week, Or I'm**
20 **happy to do that for two days or three days** and you know I
21 think it's a starting point.

The practitioner reiterates Ann should ask friends for support (line 2). Ann is visibly distressed and crying. She explains that she has asked friends for support and indicates this support is not enough (lines 11-15). The practitioner counters ("But…" lines 16-21) that "actually sharing with people" can result with friends volunteering to support her for a few days at a time. This shows a lack of understanding or acceptance that Ann is already relying on people who are doing as much as they can (lines 11-13) and communicates an assumption that support from friends for a few days should be sufficient.

Current treatment plan as a viable solution. Before presenting to the ED, Ann called the mental health crisis phone service. They recommended that Ann self-refer for Cognitive Behavioral Therapy (CBT) with the Depression and Anxiety Service, and for her General

Practitioner (GP) to augment her medication with an antipsychotic medication. However, CBT had an extensive waiting list. Two days later, after experiencing daily panic attacks, inability to eat and worsening intrusive thoughts around overdosing on her prescribed medications, Ann sought help from the community-based mental health assessment team. Their recommendation was also to stay on the waiting list for CBT and for her GP to start a new antidepressant medication at maximum dosage.

Later that day, Ann presented to the ED. She told the practitioner that she was seeking psychological therapy (as opposed to more medication changes) and did not think she could cope with the current plan of university counseling and waiting for CBT. However, the practitioner recommended the same treatment plan; "continue attending arranged sessions with [university counseling]" and "explore the previous advice to start you on [antidepressant]", emphasizing "you have been referred to [CBT]". The assessment summary letter, sent to Ann and her General Practitioner, states; "we felt this was an appropriate care pathway".

We can observe a stance across these services that the waiting list for CBT and increased medication is sufficient for Ann, although she was struggling to cope, unable to take medications as prescribed, and felt she needed more help. Notably, Ann was also pressured to accept the stance that the current treatment plan was sufficient. For example, In Extract 6, the practitioner asserts that the number of counseling sessions offered by the university is "quite nice".

EXTRACT 6 HERE

Extract 6

1 Ann: I'm seeing someone at the university counseling center.
2 LPS: Okay, so |just to let you know that we-
3 Ann: |Really short term.
...
11 Ann: Eight. [session cap with university counseling]
12 LPS: Ah okay. And you think that's quite short?
13 Ann: Yes. [nod]
14 LPS: **I think that's quite nice really.**

The practitioner asks Ann to confirm that she believes eight sessions is short (line 12), indicating trouble with this characterization (Robinson & Kevoe-Feldman 2010). When Ann confirms this is short (line 13), the practitioner asserts that eight sessions is "quite nice" (line 14).

We see a similar alternative characterization to what Ann is reporting in Extract 7.

EXTRACT 7 HERE

Extract 7

1 Ann: **I think I've been worried about taking them [prescribed**
2 **benzodiazepine] as well because the- the overdose thought.**
3 Every time I think maybe I should- I probably need one now,
4 I-
5 LPS: Mm.
6 Ann: It's the kind of thing that would be very dangerous.
7 LPS: Yes. **But you're- you've only been issued with a small**
8 Ann: Yeah.
9 LPS: **quantity haven't you.** And I guess you've been given a finite
10 Ann: Yeah.
11 LPS: number of days. Yeah? That would be the usual thing.
12 Ann: [nod]
13 LPS: **And that's to reduce those temptations. Okay. So you've got**
14 **some medication for your mood.**

Ann describes intrusive thoughts about overdosing on her medication (lines 1-4, 6). The practitioner counters ("But…") that Ann has "only been issued" with a finite number of tablets, providing evidence for an alternative characterization; that Ann is not at risk of overdose and therefore her fears are unrealistic (anonymized, in prep). Rather than exploring the intrusive thoughts underlying Ann's medication nonadherence, the practitioner pushes back against Ann's fears about her medication and asserts that Ann has "medication for her mood" (lines 13-14).

Across the assessment, Ann's claims that the current treatment plan is not sufficient in the face of an eating disorder relapse are largely countered or left unaddressed. In her one-week post-visit interview, Ann summarizes the message she received about asking for more specialized therapeutic support: "don't get my hopes up".

Narrow referral criteria for mental health services

The stance that self-control, self-help, social support, and current treatment plan are viable solutions is tied to broader systemic limitations. Specifically, this stance is sustained in an environment of systemic issues. Practitioners are acutely aware of the narrow referral criteria for access to mental health services. Mental health services refuse access based on referral criteria that exclude people with complex needs, e.g. co-occurring mental disorder and substance use. In this context, practitioners warn patients that they are unlikely to qualify for services and can encourage them not to seek these services. They also decide not to refer patients due to the likelihood that they will not meet referral criteria. This can be seen in Extract 5B, a continuation of Extract 5A in which Ann is seeking help for her eating problems.

EXTRACT 5B HERE

Extract 5B

LPS: You know somebody [friends] might say to you I'm happy to do that for a week, Or I'm happy to do that for two days or three days and you know I think it's a starting point. But that- **those kind of things wouldn't [2s] be the domain of mental health services.**

Ann: [nods, looking down]

LPS: **That wouldn't be something that we would provide.** [nod] Yeah. So it's about thinking about where else you've got sources of support.

After reiterating their recommendation that Ann ask friends for support, the practitioner accounts for this by saying this is not "the domain of mental health services." (lines 3-5) and "short-term um support for eating problems" (Extract 5A, line 1) is not something "we would provide" (Extract 5B, line 7). The practitioner ties this back to the recommendation for social support ("So…" lines 8-9), framing this lack of professional support as a reason to seek support elsewhere.

Shortly after this, after Ann again requests professional help for eating problems, the practitioner clarifies that the only way to access eating disorder services is to demonstrate sustained and substantial weight loss over a number of weeks.

EXTRACT 8 HERE

Extract 8

Ann: So there'd be nowhere [crying] with kind of- with professional help for eating problems.
LPS: **Not in the early stages.** Because it would be deemed to your GP [general practitioner]. So basically **if you get to the point where the concern is that weight loss is there, and it's regular, and you're not picking it back up, or you're not getting any variations,**
Ann: [nods]
LPS: **Then your GP will probably put you on a weekly**
Ann: Yeah.
LPS: **attendance program.** And that could be-
Ann: [nods] She said- She said to me she's happy to see me
LPS: Yeah. Absolutely.
Ann: often. But she was saying that she's aware that she doesn't have the-
LPS: No.
Ann: the skills that some other people have.
LPS: Mm. That's right. But it's- it's her to start with.
Ann: Okay.
LPS: **It's about gathering evidence. So what is the speed of your weight loss. That would be determined by going every week and being weighed.**
Ann: [nod]
LPS: And cooperating in that. And then when that's looked at, and **they'll look at your BMI [body mass index], and the rate at which maybe you're losing on your BMI.**

The practitioner confirms that these services would not be available "in the early stages". They explain that the general practitioner must be concerned about "regular" weight loss with no "variations" and no "picking it back up" (lines 3-7), at which point they can gather "evidence" documenting weight loss (lines 20-21). A referral is framed as dependent on the "speed of your weight loss" and "cooperating" with weekly appointments.

This referral process would effectively exclude Ann from accessing the service if she struggled to attend weekly appointments to document weight loss, were to have some fluctuation

in her weight, or were to continue experiencing compulsions to limit food but not sufficient weight loss. The practitioner does not suggest that it would be beneficial for Ann to pursue referral. Instead, they emphasize self-control (Extracts 1, 2) and asking friends for support (Extracts 4, 5A, 5B). When Ann states that she feels her eating problems won't be taken seriously until she is underweight (Extract 9, lines 3-4), the practitioner accuses her of thinking of making herself underweight "so people will take you seriously" (lines 5-6).

EXTRACT 9 HERE

Extract 9

1 Ann: It's got out of control.
2 LPS: Okay.
3 Ann: But I feel like no one's gonna take me seriously until I'm
4 underweight. Which, I don't know. I-
5 LPS: **So you're gonna make yourself underweight so people will take**
6 **you seriously? Is that what you're saying?**
7 Ann: [voice breaks] I don't want that to happen.
8 LPS: We wouldn't either.
9 Ann: I don't want that to be the deciding factor in whether I get
10 help for it or not.

The accusation brings Ann to tears as she tries to explain that she does not want substantial weight loss to be the "deciding factor" in accessing professional support. (lines 7, 9-10).

In her one-week post-visit interview, Ann describes feeling "frustrated" with the outcome of the assessment and that she has "exhausted all the things I can do by myself". Ann was unable to secure a referral to the eating disorder service until three months later, after she had documented substantial weight loss with her GP (Extract 3). In her three-month post-visit interview, Ann said she felt it was important for services to understand that "Eating problems need to be taken not necessarily just in the context of someone's weight. That the behaviors and thoughts and feelings can exist independent of that."

While Ann's case illustrates a practitioner's role as gatekeeper to mental health services in the face-to-face ED psychosocial assessment, Jane's case illustrates what this can look like behind

the scenes, as service managers and referral triagers (professionals that evaluate and direct service receipt) access the patient's medical notes and make referral decisions following ED assessment.

During the assessment, the practitioner says they will try to help Jane get a "dual diagnosis" for co-occurring alcohol/mental disorder. This would allow Jane to access psychology/psychotherapy services alongside existing alcohol counseling. Jane agrees to the plan in the assessment. However, even where the practitioner believes the patient meets the threshold for services, referral triage and service managers may still decide the patient does not meet threshold based on the assessment and presentation documented in the medical records. After the assessment, the practitioner called the drug and alcohol service to initiate the dual diagnosis process (Extract 10).

EXTRACT 10 HERE

Extract 10

Report of contact from LPS to Jane's Alcohol Support Service:

"I explained the increasing risk and that yesterday's assessment evidenced **Jane is in need of more specialist support in that her underlying mental health issues are significant and Jane should not be treated for alcohol dependency alone.** I asked about referring to dual diagnosis [for alcohol use disorder and mental health disorder]… Person on the phone informed me she did not know the current process for making a dual diagnosis referral."

The practitioner states that Jane is in need of specialist psychological support alongside alcohol counseling (lines 1-4). They emphasize "increasing risk" and "significant" mental health issues. However, the staff member in the alcohol service did not know the process for making a dual diagnosis.

The next day, the alcohol service informed the practitioner that the referral must come through the Community Mental Health Team (CMHT). However, Jane must be assigned a CMHT care coordinator to be eligible for referrals through the CMHT. One week later, the community mental health team reviewed the request for Jane to access a CMHT care coordinator. They state

that Jane was referred "initially for psychological therapy with no indication of need for [a CMHT care coordinator]" but that the referral must be considered "on basis of meeting criteria for [a CMHT care coordinator]." The outcome was reported in the medical records as follows:

EXTRACT 11 HERE

Extract 11
Report of referral triage decision:

"Reviewed notes, assessment and risk… **Considered that needs currently identified could be met with primary care at this point** and recommend: [Sexual Abuse Service, Depression and Anxiety Service, Health Education Website*]."

* Local service names have been generalized to preserve anonymity.

Reviewing the summary of the assessment and Jane's medical records, they turn down the referral for a CMHT care coordinator and instead recommend that Jane self-refer to counseling sessions through the Sexual Abuse Service, CBT sessions through the Depression and Anxiety Service, and access a self-help website.

However, neither the Depression and Anxiety Service nor the Sexual Abuse Service accepted patients with a high risk of self-harm, alcohol dependency or who may have difficulty attending sessions sober or patients accessing other mental health services (Extract 12A). Moreover, there was a 6-8 month waiting list for people who did not fall into these categories.

EXTRACT 12A HERE

Extract 12A
Report of contact from Sexual Abuse Service to LPS:

"There would be further considerations such as **her current risk, and the extent of her alcohol use/abuse**… I need to make you aware that there is a **waiting time of approximately 6-8 months** for support… Common with most therapeutic services, **we would not work in tandem with another therapeutic provider.**"

Jane is in a position experienced by many people with a history of self-harm (Langan & Lindow 2004), where they have too many needs to meet the referral criteria for entry-level mental health services but do not meet the threshold for specialist services.

When Jane received a letter informing her that she would not be allocated a care coordinator with the CMHT, she re-presented to the ED. This time, she had taken a mixed polypharmacy and ethanol alcohol overdose with suicidal intent. She told a practitioner that she was "sick of asking for help and not getting anywhere", then left the hospital before treatment. She was confronted by police and forced to return to hospital against her will.

Accessing mental health services while using alcohol

As we saw with the Sexual Abuse Service and Depression and Anxiety Service, referral policies relating to alcohol use cause people to be excluded from secondary mental health and other specialist services. Moreover, practitioners commonly took the stance that it was the responsibility of the patient to stop/reduce alcohol to ensure they were in a fit state to receive other forms of care. This is highly problematic in the Liaison Psychiatry context, where alcohol misuse affects one in three patients (Hawton et al 2016). This relates to the stance that self-control is a viable solution for mental health problems.

Even though Jane's practitioner recognizes that "Jane should not be treated for alcohol dependency alone" (Extract 10), he states that "for you to work with" the sexual abuse service, she needs to be alcohol free (Extract 13).

EXTRACT 13 HERE

Extract 13

Jan: My younger cousin thinks he's [perpetrator] just gone on holiday. [perpetrator is incarcerated]
LPS: And-
Jan: [sobbing] [2s]
LPS: The important thing is- is-
Jan: [sobbing] [3s]
LPS: that **there are people who can work with that.**
Jan: [nods, deep breath, eye contact]
LPS: **But- But to work with it, and for you to work with it, it needs to be alcohol free.**
Jan: [nods]

At the opening of the extract, Jane is describing barriers to addressing her trauma with her family. She describes how family members have hidden her abuse (lines 1-2) and begins sobbing (lines 4, 6). The practitioner emphasizes that support is available, providing Jane with hope for the future (lines 5, 7). Jane shows signs of re-engagement (line 8), breathing deeply to stop her crying, making eye contact and nodding. The practitioner then re-frames this support as conditional on Jane being "alcohol free" (line 10). This passes the responsibility back onto Jane to stop using alcohol in order to receive this support.

As shown above, practitioners may take the stance that it is the patient's responsibility to stop/reduce alcohol use to receive support. While Jane's case illustrates how this may be experienced by the patient, Mary's case also illustrates what this means for family and other caregivers.

Mary's mother made it clear to the practitioner that she felt ill equipped to keep her daughter safe ("I'm frightened to take her home… we can't leave her on her own… it's not safe") and that she did not have sufficient support ("[I'm being told] it's okay for her to ring somebody once a week. I can't see how that's enough personally."). She asked about a referral to the Community Mental Health Team, a Community Psychiatric Nurse or inpatient alcohol rehabilitation. The practitioner did not agree to a referral. Mary's alcohol use was cited repeatedly.

For example, the practitioner accounts for their decision not to refer to the Community Mental Health Team (CMHT) in Extract 14. Mary's mother is aware that the CMHT had rejected a previous referral because of alcohol use.

EXTRACT 14 HERE

Extract 14

LPS: **Um with the alcohol use being really hit and miss, I think the Community Mental Health Team wouldn't take another referral at this stage, ...**
Mom: So if she can stay off the alcohol,
LPS: Yes. They can then say GP, make a referral at this stage. We are **on a reducing path.**

The practitioner states that they don't believe the CMHT will accept a referral, citing Mary's alcohol use (lines 1-2). The practitioner then describes a referral process involving Mary's drug and alcohol service gathering evidence of reduced alcohol use, then informing the General Practitioner (GP) that Mary is on a "reducing path". They frame the referral as contingent on Mary reducing her alcohol use, thereby placing the burden of care off of services and back onto Mary and her mother.

Mary's mother becomes visibly distressed and more overtly pushes back against these grounds for denying a referral to mental health services (Extract 15A).

EXTRACT 15A HERE

Extract 15A

Mom: It's just ridiculous. [begins crying] People won't touch her because she's an alcoholic. The Crisis Team apparently. Mental Health Crisis Team wouldn't touch her because she's an alcoholic. But she's an alcoholic because she can't cope with life. It's pretty bloody obvious isn't it. [sobbing]

...

LPS: The fact that you're worried is completely understandable. We get that. Um it is a difficult

Mom: I know.

LPS: situation. **And the fact that, yes, people do need to show their commitment to want to get better, improve things, but it does sometimes seem quite backwards [nod] in that respect.** Because when people have like alcohol issues, or mental health issues, it's very difficult to see the wood through the trees.

Mary's mother begins crying as she describes how the Mental Health Crisis Team "wouldn't' touch her because she's an alcoholic". She describes a contradictory system; Mary is drinking because she can't cope, but she can't get help to cope until she stops drinking. The practitioner validates this (lines 21-22, 23), but re-asserts that "people do need to show their commitment", upholding these as valid grounds for not referring. She acknowledges that it may "seem quite backwards", adding that "it's very difficult to see the wood through the trees".

Again, Mary's mother pushes back, asking why alcohol and mental health support cannot be provided simultaneously (Extract 16, lines 1-2).

EXTRACT 16 HERE

Extract 16

Mom: Why is that? I don't understand why they- they don't put the two together then. [alcohol and mental health services]

LPS: What, the mental health at the same time?

Mom: Yeah.

LPS: 'Cause um **the way that services look on alcohol use is that you can't really get a clear picture until somebody has been abstinent for a certain period of time. And also the fact of using the alcohol, we could destabilize somebody and make them want to use more alcohol**

The practitioner cites difficulty getting "a clear picture" of underlying mental health problems and concerns about psychological treatment destabilizing the person so they "want to use more alcohol" (lines 5-9). Alcohol use is treated as a risk factor that Mary is responsible for mitigating in order to access services as a 'whole person' with multiple psychological and social needs (anonymized, 2021).

One week later, Mary's mother described her feelings about the lack of referral in an interview (Extract 17).

EXTRACT 17 HERE

Extract 17

1 Mom: **I'm being told that they can't deal with her mental health**
2 **issues until she's not an alcoholic.** And actually although I
3 understand that, that doesn't make sense in one hand because
4 she is an alcoholic because of her mental health issues…
5 I just don't understand how she can keep having these
6 meetings [with Liaison Psychiatry], **she's getting more and**
7 **more desperate about wanting to go on, um and actually I'm**
8 **not quite sure who or what or who's going to be helping us**
9 and that's the bottom line. And I'm being told 'Go to your
10 GP'… **Why has this doctor not said 'Right. We need a mental**
11 **health referral and we need it now.'**

Mary's mother describes a paradoxical system, where Mary cannot access support to deal with her mental health issues "until she's not an alcoholic", but "is an alcoholic because of her mental health issues" (lines 1-4). She emphasizes Mary's suicidal ideation (lines 6-7) and shows uncertainty about why no practitioner has said there is a need for a referral (lines 10-11).

From Mary's case, we can see a related stance; that it is appropriate to manage mental health issues 'one at a time' rather than holistically, which are relevant to all three cases.

Accessing more than one form of mental health care

Practitioners and services recurrently took the stance that accessing multiple forms of care could be detrimental, and that people should not be trying to "tackle everything at once". We see this in Mary's assessment in Extract 15B. The practitioner has just re-asserted that people using alcohol "need to show their commitment to want to get better" to access mental health services (Extract 15A).

EXTRACT 15B HERE

Extract 15B

LPS: it's very difficult to see the wood through the trees.
Mom: [crying] Really. She can't think clearly. She can't think about getting better.
[3s]
LPS: **I guess- it- it is a case of looking at one thing at a time rather than trying to tackle everything at once. That's when- Often, when we try to sort of put too much in place, people often- that can destabilize and make people want to go back to things like alcohol.**

Mary's mother counters that Mary can't "think about getting better" and reduce alcohol (lines 2-3). The practitioner asserts that "it is a case of" addressing one issue at a time, reducing alcohol use before accessing other services. She contrasts this with "trying to tackle everything at once", warning that this could trigger relapse in alcohol use. Mary was not provided with a new referral from her contact with Liaison Psychiatry.

Four days later, her mother called the service saying Mary's alcohol use and mood had deteriorated further. She reported that she had to take Mary's children into her care because she didn't feel they were safe with her. She inquired again about inpatient alcohol rehabilitation services, but this was not discussed further. At the final point of contact in the study, Mary was in a coma.

Ann's assessment has many parallels with Mary's. Her practitioner also emphasizes that "accessing loads of different things" is not beneficial. At the start of Extract 18, the practitioner is

explaining how Ann can transition to Cognitive Behavioral Therapy after she completes her eight counseling sessions with the university.

EXTRACT 18 HERE

Extract 18

LPS: So it may be that when you've had your eight sessions, then you'll be explaining to somebody [from another service] what's been covered, what you've gained from that,
Ann: [nod]
LPS: what still needs working on, and then from that you'll formulate what's next.
Ann: [nod]
LPS: **I think that, you know, accessing loads of different things all at once, that's probably not gonna be very helpful.** Yeah.
Ann: [whisper] Okay.
LPS: Okay. Alright. So-
Ann: [crying] I'm sorry, I find |it really hard to get across
LPS: |It's fine.
Ann: like how- how bad things |are, so-
LPS: |Yeah you've done really well.

The practitioner states that accessing multiple mental health services is "not gonna be very helpful". This implies Ann should stop seeking additional mental health support while she is completing her university counseling sessions, on the grounds that accessing multiple services would not help her. Ann quietly accepts, but begins crying and attempts to articulate that she is finding it difficult to "get across… how bad things are." Here, the practitioner tells Ann that she has done well and asks her how she plans to get home.

After the ED assessment, Ann self-referred to the Depression and Anxiety Service. She received an initial assessment and was placed on the waiting list for Cognitive Behavioral Therapy for a number of weeks. However, she continued to struggle with intrusive thoughts of self-harm, anxiety attacks and difficulty eating. Ann's General Practitioner eventually referred her to be assessed by the Community Mental Health Team, and Ann described to a researcher what happened next (Extract 19, 3-month post visit interview).

EXTRACT 19 HERE

Extract 19

Pat: I self-referred [to the Depression and Anxiety Service] anyway at the beginning of December.
Int: Mhm.
Pat: And then uh my GP referred me to- referred me for an assessment with the Community Mental Health Team. The Depression and Anxiety Service found out about this, I don't know how. **Someone basically said 'Oh, you can't be seen by both of us at the same time.'**
Int: Oh.
Pat: **So they discharged me.**
Int: Oh.
Pat: After I'd done all the assessments and things. **And then [laughs] the outcome of the Community Mental Health Team assessment was that I should refer myself to DAS [the Depression and Anxiety Service].**
...
Pat: I ended up not re-referring myself because I didn't want to have to go through all the assessments again, because they'd already said- they'd already told me how long the waiting list- an idea of how long the waiting list was, and I thought 'No I- I'm not going to be able to get through this year without some form of help now.'

Ann explains that she was discharged from the Depression and Anxiety Service (DAS) waiting list for attending a Community Mental Health Team assessment. The outcome of this assessment was to self-refer to DAS. Ann's family ultimately decided to pay for her to attend private Cognitive Behavioral Therapy. Three months after the ED assessment, Ann told the researcher she believed she was finally getting the care she needed, but highlighted the diligence, time, and money required to access care months after asking for it.

Finally, Jane's story illustrates the barriers practitioners face when they do attempt to refer patients to access multiple services. After the failed referral seeking integrated psychotherapy and alcohol counseling, the practitioner contacted the Sexual Abuse Service seeking information about the type of care Jane would be eligible to receive. He highlighted his clinical assessment of need: "I made a referral to step 4 psychology/psychotherapy due to my view that the patient needs access to holistic support." The Sexual Abuse Service response follows from Extract 12A:

Extract 12B
Report of contact from Sexual Abuse Service to LPS:
"Common with most therapeutic services, **we would not work in tandem with another therapeutic provider**. So if, for example, she engages with DAS [Depression and Anxiety Service], she would need to complete her work with them before starting with us."

The Sexual Abuse Service states that they will not work in tandem with another therapeutic provider. Even where a practitioner is direct in communicating their assessment of clinical need, the pathway is blocked.

As discussed above, Jane took another overdose after receiving notice that her referral was denied. A second referral for a CMHT care coordinator is approved only after this suicide attempt. However, CMHT still emphasized in an email that "we continue to consider that she is on the borderline, not quite meeting the criteria." Liaison Psychiatry is warned that should Jane agree to care from the CMHT, she cannot go on the waiting list for or attend the Depression and Anxiety Service or the Sexual Abuse Service. In addition, "there will be a considerable wait… and we cannot guarantee therapy at the end of the [initial risk assessment] sessions." Jane is then posed with a choice; get on the waiting list for the CMHT in a wager for integrated support, or get on the waiting list for the Depression and Anxiety Service, then later the Sexual Abuse Service. At the end of the study period, Jane had not yet decided.

All three cases show how the responsibility for managing multiple complex or multifaceted mental health problems is placed back on the person seeking help, for example that they need to get more unwell or stop/reduce alcohol. In all three cases, the patients continued to deteriorate after attending the ED and requesting (further) professional help: Ann became clinically underweight, Jane made a suicide attempt and Mary was in a coma with her children in the care of her mother.

Discussion

This study examines how people attending the ED in crisis who request further professional support are excluded from specialist mental health services. Our analyses of recorded practitioner-patient assessments, patient medical records, communication between services and interviews with patients/carers revealed four factors: (1) practitioners deciding that the current treatment plan, self-control, self-help and social support were viable solutions; (2) patients not meeting narrow referral criteria for services (e.g., 'too risky', 'not ill enough'); (3) patients who used drugs/alcohol having to stop/reduce before accessing services; and (4) services not working with people if they are accessing another service. When these were cited as grounds for not facilitating referral to specialist mental health services, patients were pressured to accept these as reasonable and the burden of care was shifted away from health services. When practitioners tried to make a referral when this was deemed clinically necessary, they also encountered barriers in relation to narrow referral criteria, alcohol use and services not working with patients already accessing another service. These decisions have adverse consequences for patients, carers and families. In the three cases we presented, one person lost weight and was in the anorexic range, one made a suicide attempt and one was in a coma within three months.

Demand for mental health care is rising sharply in the UK (Baker 2021) but funding has not kept pace (Campbell 2021), leaving patients without access to necessary mental health care (Jayanetti 2021). This places practitioners in the role of gatekeepers who must ration peoples' access to limited services (Fisher 2022). In the ED and across services, practitioners find it difficult to ration care and report feeling professionally conflicted when placed in a gatekeeping role (Carlsen & Norheim 2005; Owen-Smith et al 2018; O'Keeffe et al 2021) and face feelings of powerlessness and burnout in the face of exclusionary referral criteria and long waiting lists

(O'Keeffe et al 2021). This unwanted role, and the psychological burden it imposes, might be a factor in the high rates of staff attrition and turnover in mental health services (Mental Health Taskforce 2016). The pandemic has highlighted the 'moral injury' experienced by healthcare staff when they have to justify (to themselves and their patients) denying people care in an under-resourced system (Beale 2021). Despite having a preference to share rationing decisions with patients, practitioners recognize significant practical and ethical barriers to disclosing the role rationing plays in treatment decision-making (Owen-Smith et al 2009, 2010). This can lead to difficulty identifying and communicating other reasons for declining to refer the patient to specialist services (Kushida et al 2021).

As far back as the 1990's, sociologists have demonstrated how practitioners turn to discourses of deservingness when care must be rationed (Hughes & Griffiths 1996). For example, in audio-recorded obesity clinic assessments, practitioners took the stance that patients must "earn" the right to access a highly rationed treatment option by proving they were able to lose weight (Owen-Smith et al 2018). These assessments frequently focused on personal responsibility to stop overeating and minimize service use. The current findings reveal similar patterns; for example, patients needing to demonstrate an ability to reduce alcohol use before referrals to mental health services would be accepted, and where practitioners encouraged patients to pursue social support or self-help instead of professional treatment, even in the context of a self-harm crisis. As observed in other healthcare contexts, such as treatment for obesity and heart disease (Hughes & Griffiths 1996; Owen-Smith et al 2018; Traina & Feiring 2020), this feeds back into wider stigmatizing attitudes that can discourage help-seeking. Almost two thirds (64%) of patients attending the ED in crisis leave the assessment feeling they weren't respected by staff (Mental Health Taskforce 2016).

These justifications for not providing treatment have the effect of subtly undermining people's decisions to seek help – even in crisis – and re-evaluating what counts as a legitimate problem worthy of medical attention (Liberati et al 2022; anonymized 2021). Peoples' judgements of what problems are worthy of attention are strongly impacted by their interactions with healthcare services (Liberati et al 2022). In turn, these judgements shape whether and how people assert their need for professional support (Dixon-Woods et al 2006). Patients report that this causes iatrogenic harm, as they are less likely to seek help in the future when their mental health deteriorates further (anonymized 2021).

National Health Service slogans like "talk to someone", "just talking can help", and "don't be afraid to ask for help" aim to encourage early intervention and help-seeking for mental health problems (Health and Social Care Committee 2021). In the context of the COVID-19 pandemic, NHS Trusts have run a wide range of public campaigns to promote help-seeking for mental health difficulties. In contrast, the current study demonstrates the ways in which the legitimacy of help-seeking can be undermined in interactions with mental health services for self-harm. This is reflected in how many people seeking support for self-harm describe feeling excluded from services and "unworthy of help" (O'Keeffe et al 2021; Xanthopoulou et al 2021; DeLeo et al 2022).

Methodological approach. Triangulation of observational, self-report, and institutional data using Conversation Analytic tools ~~and Phenomenological frameworks~~ allowed us to identify what factors are systematically accepted as 'normal' and 'valid' reasons not to refer a patient for specialist mental health support, and how this may impact on patients after the assessment. There has been increasing interest in longitudinal Conversation Analytic research (see Deppermann & Doehler 2021) and exploring how communication may impact on patients' satisfaction or

subsequent care (White 2021; White et al 2022; McCabe et al 2016). However, this is a relatively new area of research that has yet to be fully explored.

Strengths and limitations. The data were collected in one service and hence may not be representative of other services. Data were collected in 2018-2019 before the COVID-19 Pandemic. Two years into the pandemic, NHS Mental Health Services and the ED are more strained than ever, so the systemic problems described may be even more severe. Analyzing and triangulating multiple data sources in routine care and interviews with patients sheds important light on how people with high levels of need are excluded from specialist mental health services. Moreover, the longitudinal perspective after discharge from the ED allows us to see the downstream consequences for patients and carers. Future research could triangulate multiple data sources (self-report, observation, institutional records) taking a longitudinal perspective on patients' mental health service journeys to investigate the impacts of patients, carers and wider families over longer timescales.

Conclusion. Practitioners are acting as gatekeepers of under-resourced and overwhelmed mental health services. This is highly problematic for patients attending the ED in a mental health crisis, with serious adverse outcomes. This significantly undermines public health initiatives to promote early intervention and improve long-term mental health outcomes.

References

Baker, C. (2021). "Mental health statistics: prevalence, services and funding in England." *UK Parliament House of Commons Library*, 13 December. https://commonslibrary.parliament.uk/research-briefings/sn06988/

Binns, R. (2018). "Psychiatric Liaison – Adding insult to injury?" *Recovery in the Bin*, July. https://recoveryinthebin.org/2018/07/08/psychiatric-liaison-adding-insult-to-injury/

Beale, C. (2021). "Magical thinking and moral injury: Exclusion culture in psychiatry." *BJ Psych Bulletin* 46(1):16-19.

Bergen, C., Stivers, T., Barnes, R. K., Heritage, J., McCabe, R., Thompson, L., & Toerien, M. (2018). Closing the Deal: A Cross-Cultural Comparison of Treatment Resistance. *Health Communication*, *33*(11), 1377–1388. https://doi.org/10.1080/10410236.2017.1350917

Campbell, D. (2021). "Strain on mental health care leaves 8m people without help, say NHS leaders." *The Guardian*, 29 August. https://www.theguardian.com/society/2021/aug/29/strain-on-mental-health-care-leaves-8m-people-without-help-say-nhs-leaders

Carlsen, B., Norheim, O.F. (2005). "Saying no is no easy matter: A qualitative study of competing concerns in rationing decisions in general practice." *BMC Health Services Research.* 5(70). https://doi.org/10.1186/1472-6963-5-70

Carroll, R., Metcalfe, C., & Gunnell. (2014). "Hospital presenting self-harm and risk of fatal and non-fatal repetition: Systematic review and meta-analysis" *PLoS ONE* 9(2):e89944.

Chan, M.K.Y., Bhatti, H., Meader, N., Stockton, S., Evans, J., O'Connor, R.C., et al. (2018). "Predicting suicide following self-harm: Systematic review of risk factors and risk scales. *The British Journal of Psychiatry* 209(4):277-283.

Cully, G., Leahy, D., Shiely, F., & Arensman, E. (2022). "Patients' experiences of engagement with healthcare services following a high-risk self-harm presentation to a hospital Emergency Department: A mixed methods study." *Archives of Suicide Research* 26(1):91–111.

DeLeo, K., Maconick, L., McCabe, R., Broeckelmann, E., Rains, L.S., Rowe, S., et al. (2022). "Experiences of crisis care among service users with complex emotional needs or a diagnosis of 'personality disorder', and other stakeholders: Systematic review and meta-synthesis of the qualitative literature." *BJ Psych Open* 8(2), E53. doi:10.1192/bjo.2022.1

Dixon-Woods, M., Cavers, D., Agarwal, S., Annandale, E., Arthur, A., Harvey, J., et al. (2006). "Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups." *BMC Medical Research Methodology* 6(35). https://doi.org/10.1186/1471-2288-6-35

Fisher, J. (2022). "The fortress of mental health services." *Mad in the UK*, January. https://www.madintheuk.com/2022/01/the-fortress-of-mental-health-services/

Jayanetti, C. (2021). "Coroners warned of mental health care failings in dozens of inquests." *The Guardian.* https://www.theguardian.com/society/2021/sep/05/coroners-warned-of-mental-health-care-failings-in-dozens-of-inquests

Hawton, K., Casey, D., Bale, E., Ryall, J., Brand, F., & Geulayov, G. (2016). *Self-Harm in Oxford 2014*. University of Oxford Centre for Suicide Research, Oxford.

Health and Social Care Committee. (2021). "Children and Young People's Mental Health." *House of Commons Committee Report*, 9 December. https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/17/report.html

Heritage, J., & Raymond, G. (2005). The Terms of Agreement: Indexing Epistemic Authority and Subordination in Talk-in-Interaction. *Social Psychology Quarterly*, *68*(1), 15–38. https://doi.org/10.1177/019027250506800103

Heritage, J., & Clayman, S. (2010). *Talk in Action: Interactions, Identities, and Institutions*. Wiley-Blackwell.

Hughes, D., & Griffiths, L. (1996). "'But if you look at the coronary anatomy…' Risk and rationing in cardiac surgery." *Sociology of Health and Illness* 18(2):172-197.

Kaminskiy, E., & Finlay, M. (2019). It Does Take Two to Tango: An Applied Conversation Analysis of Interactions between a Psychiatrist and Service-Users Discussing Medication. *Health Communication*, *34*(13), 1628–1636. https://doi.org/10.1080/10410236.2018.1517633

Kushida, S., Kawashima, M., Abe, T. (2021). "Recommending no further treatment: Gatekeeping work of generalists at a Japanese university hospital." *Social Science & Medicine* e:290. https://doi.org/10.1016/j.socscimed.2021.113891

Landmark, A. M. D., Ofstad, E. H., & Svennevig, J. (2017). Eliciting patient preferences in shared decision-making (SDM): Comparing conversation analysis and SDM measurements. *Patient Education and Counseling*, *100*(11), 2081–2087. https://doi.org/10.1016/j.pec.2017.05.018

Langan, J., & Lindow, V. (2004). *Living with Risk: Mental Health Service User Involvement in Risk Assessment and Management*. Bristol: Policy Press.

Liberati, E., Richards, N., Parker, J., Willars, J., Scott, D., Boydell, N., et al. (2022). Qualitative study of candidacy and access to secondary mental health services during the COVID-19 pandemic. *Social Science and Medicine*. 296:e114711

McCabe, R., John, P., Dooley, J., Healey, P., Cushing, A., Kingdon, D., ... & Priebe, S. (2016). Training to enhance psychiatrist communication with patients with psychosis (TEMPO): cluster randomised controlled trial. The British Journal of Psychiatry, 209(6), 517-524.

McCabe, R. (2021). When patients and clinician (dis)agree about the nature of the problem: The role of displays of shared understanding in acceptance of treatment. *Social Science & Medicine*, *290*, 114208. https://doi.org/10.1016/j.socscimed.2021.114208

McManus, S., Gunnell, D., Cooper, C., Bebbington, P.E., Howard, L.M., Brugha, T., et al. (2019). "Prevalence of non-suicidal self-harm and service contact in England, 2000–14: Repeated cross-sectional surveys of the general population." *The Lancet Psychiatry* 6(7):573–81.

Mental Health Taskforce. (2016). *Five year forward review for mental health.* https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

National Health Service (NHS). (2019). *The NHS Long Term Plan*. https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

National Health Service (NHS). (2020). *Next Steps on the NHS Five Year Forward Review: Mental Health*. https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/mental-health/

National Health Service (NHS). (2021). *Help for Suicidal Thoughts.* https://www.nhs.uk/mental-health/feelings-symptoms-behaviours/behaviours/help-for-suicidal-thoughts/

National Institute for Health and Care Excellence (NICE). (2004). *Clinical Guideline for Self-Harm in over 8s: Short-Term Management and Prevention of Recurrence*. https://www.nice.org.uk/guidance/cg16/chapter/1-guidance

Neubauer, B.E., Witkop, C.T., Varpio, L. (2019). "How phenomenology can help us learn from the experiences of others." *Perspectives on Medical Education* 8:90-97.

O'Keeffe, S., Suzuki, M., Ryan, M., Hunter, J., & McCabe, R. (2021). "Experiences of care for self-harm in the Emergency Department: Comparison of the perspectives of patients, carers and practitioners." *BJPsych Open* 7(5):e175.

Ostermann, A. C. (2021). Women's (limited) agency over their sexual bodies: Contesting contraceptive recommendations in Brazil. *Social Science & Medicine, 290*, 114276. https://doi.org/10.1016/j.socscimed.2021.114276

Owen-Smith, A., Coast, J., Donovan, J.L. (2018). "Self-responsibility, rationing and treatment decision making – managing moral narratives alongside fiscal reality in the obesity surgery clinic." *Health Expectations* 21(3). https://doi.org/10.1111/hex.12651

Owen-Smith, A., Coast, J., Donovan, J.L. (2010). "The desirability of being open about health care rationing decisions: Findings from a qualitative study of patients and clinical profesionals." *Journal of Health Services Research and Policy* 15(1):14-20.

Owen-Smith, A., Coast, J., Donovan, J.L. (2009). "'I can see where they're coming from, but when you're on the end of it … you just want to get the money and the drug.': Explaining reactions to explicit healthcare rationing." *Social Science and Medicine* 68(11):1935-1942.

Pino, M., Doehring, A., & Parry, R. (2021). Practitioners' Dilemmas and Strategies in Decision-Making Conversations Where Patients and Companions Take Divergent Positions on a Healthcare Measure: An Observational Study Using Conversation Analysis. *Health Communication*, *36*(14), 2010–2021. https://doi.org/10.1080/10410236.2020.1813952

Rassy, J., Daneau, D., Larue, C., Rahme, E., Low, N., Lamarre, S., et al. (2022). "Measuring quality of care received by suicide attempters in the Emergency Department." *Archives of Suicide Research* 26(1):81–90.

Robinson, J.D., & Kevoe-Feldman, H. (2010). "Using full repeats to initiate repair on others' Questions." *Research on Language & Social Interaction* 43(3):232–59.

Sidnell, J., & Stivers, T., eds. (2012). *The Handbook of Conversation Analysis*. Chichester, UK: John Wiley & Sons, Ltd.

Stivers, T. (2005). "Parent Resistance to Physicians' Treatment Recommendations: One Resource for Initiating a Negotiation of the Treatment Decision." *Health Communication*, *18*(1), 41–74.

Stivers, T., & Majid, A. (2007). Questioning Children: Interactional Evidence of Implicit Bias in Medical Interviews. *Social Psychology Quarterly*, *70*(4), 424–441. https://doi.org/10.1177/019027250707000410

Stivers, T., & Timmermans, S. (2021). Arriving at no: Patient pressure to prescribe antibiotics and physicians' responses. *Social Science & Medicine*, *290*, 114007. https://doi.org/10.1016/j.socscimed.2021.114007

Tate, A. (2020). Matter over mind: How mental health symptom presentations shape diagnostic outcomes. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *24*(6), 755–772. https://doi.org/10.1177/1363459319834991

Tate, A. (2022). Death and the treatment imperative: Decision-making in late-stage cancer. *Social Science & Medicine*, *306*, 115129. https://doi.org/10.1016/j.socscimed.2022.115129

Tietbohl, C. K., & White, A. E. C. (2022). Making Conversation Analysis Accessible: A Conceptual Guide for Health Services Researchers. *Qualitative Health Research, 32*(8–9), 1246–1258. https://doi.org/10.1177/10497323221090831

Traina, G., & Feiring, E. (2020). "'There is no such thing as getting sick justly or unjustly' – a qualitative study of clinicians' beliefs on the relevance of personal responsibility as a basis for health prioritisation." *BMC Health Services Research, 20*(497). https://doi.org/10.1186/s12913-020-05364-6

Wang, N. C. (2020). Understanding antibiotic overprescribing in China: A conversation analysis approach. *Social Science & Medicine, 262*, 113251. https://doi.org/10.1016/j.socscimed.2020.113251

World Health Organization (WHO). (2021). *Suicide Fact Sheet*. https://www.who.int/news-room/fact-sheets/detail/suicide

Xanthopoulou, P., Ryan, M., Lomas, M., & McCabe, R. (2021). "Psychosocial assessment in the Emergency Department." *Crisis* 0227-5910/a000786.

Cases	Rationale for not referring to requested mental health services
Ann	Self support, social support and current treatment plan are viable solutions
Ann & Jane	Narrow referral criteria for mental health services
Jane & Mary	Accessing mental health services while using alcohol
Mary, Jane & Ann	Accessing more than one form of mental health care

Table 1: Rationale for not referring to requested mental health services

Hereby, I Clara Bergen consciously assure that for the manuscript “Gatekeeping access to mental health services after self-harm: A novel methodological approach analyzing video-recordings of consultations, interviews, medical records and discharge letters” the following is fulfilled:

1) This material is the authors' own original work, which has not been previously published elsewhere.

2) The paper is not currently being considered for publication elsewhere.

3) The paper reflects the authors' own research and analysis in a truthful and complete manner.

4) The paper properly credits the meaningful contributions of co-authors and co-researchers.

5) The results are appropriately placed in the context of prior and existing research.

6) All sources used are properly disclosed (correct citation). Literally copying of text must be indicated as such by using quotation marks and giving proper reference.

7) All authors have been personally and actively involved in substantial work leading to the paper, and will take public responsibility for its content.

The violation of the Ethical Statement rules may result in severe consequences.

To verify originality, your article may be checked by the originality detection software iThenticate. See also http://www.elsevier.com/editors/plagdetect.

I agree with the above statements and declare that this submission follows the policies of Solid State Ionics as outlined in the Guide for Authors and in the Ethical Statement.

Date: 6/5/2022

Corresponding author’s signature:
Clara Bergen

Declaration of interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.