Recruiting youth consumers for suicide research: A mental health clinician's dilemma

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Abstract

Background

This study investigated the perceived barriers among mental health clinicians towards introducing research participation to young male consumers presenting with suicidal behaviours. The need for the present study arose from a study exploring consumer perspectives on the influences of social media on self harm and suicidal behaviours. Following the very low recruitment of young men to the study, the present study was developed to proactively explore clinician barriers to consumer recruitment.

Suicide researchers' understanding of recruitment and retention of mental health consumers to research is in its infancy. In particular, little consideration has been given to understanding the clinicians' perspectives on the participation of young male consumers in research. Increasing participation of young male consumers has been compounded by the absence of literature identifying specific age and gender related barriers. A critical analysis of selected literature highlights numerous complex barriers to participation in suicide research including; the low priority of research in clinical practice, clinician concerns about protecting vulnerable patients and mistrust between services and universities. Literature provides insights into factors influencing clinician decisions to support recruitment of hard-to-reach groups.

Data Collection

Using a face-to-face, semi-structured interview 13 clinicians involved in the original study were recruited and interviewed. This approach and resultant thematic analysis was applied to explore the issues which impeded data collection with consumers in the original study.

Findings

Factors impacting on clinicians' decisions to collaborate and subsequently recruit consumers to the original study were complex and multi-faceted. The themes identified were related to contextual, disciplinary and relational influences on clinicians' decision making. Contextual influences included a lack of consensus on research priorities within integrated teams, multiple priorities for clinicians and the perceived complexities of engaging users of mental health services. Disciplinary influences included clinicians' perceptions relating to their role as mental health clinicians and associated clinical

accountabilities to consumers in protecting them from potential harm. Relational influences on decision making illustrated the value that clinicians placed on relationship development, and developing partnerships between universities and clinical services were as important to clinicians as the inter-personal relationships between clinicians and individual researchers. Findings also highlighted a potential role for universities in providing leadership and support to enable clinical services and consumers to form effective research partnerships.

Conclusions

This study provides an explanatory model for why recruitment failure can occur in studies involving clinicians as intermediaries in recruiting consumers to suicide research. Specific barriers to the successful implementation of the original study were identified and the outcomes of this study enhance understanding of the complex social processes of recruiting a clinical sample of vulnerable young men. The findings from this study can also be used to inform the development of future research partnerships between universities, clinical services and consumers.

Key words

Mental disorders, recruitment, research, barriers, minority participation, mental health consumers, adolescents, males

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Chapter 1

Introduction

1.1 Introduction

Young men are a priority population for suicide prevention. Suicidal behaviours are a significant public health concern as the prevalence of these behaviours provides an indicator of mental health and social wellbeing in the population. Youth suicide is an important focus for prevention efforts at policy level. Youth suicide is also a priority for population mental health research, which seeks to increase the contribution of consumer perspectives in research. Despite these foci, public health researchers face complex challenges in engaging mental health service consumers in suicide research. Increasing knowledge of the factors influencing consumer participation in research is important for developing consumer perspectives.

This thesis presents the outcomes from an original study that investigated youth consumer perspectives of media influences on suicidal behaviours. Following low recruitment of the potential sample, the research was modified to investigate the factors affecting mental health clinicians' decision making to recruit young male consumers for the original study. In this chapter the factors leading to the study's development are described. Definitions of key terms used in the thesis and an overview of the thesis structure are provided.

1.2 Aim

The aim of this study was to investigate the barriers among mental health clinicians to recruiting young male mental health service consumers for suicide research.

This study also aimed to answer three related questions:

a) What is the perceived clinical relevance of research addressing the social context of suicide to priorities in mental health practice?

b) What factors influence clinicians' decisions to introduce a request for research participation within a sensitive clinical consultation?

c) What are clinicians' perspectives on the use of online tools for gathering data on sensitive topics?

1.3 Setting

The study took place in the Greater Wellington region. It involved community mental health services in Wellington, Lower Hutt, Porirua and the Kapiti coast.

1.4 Context

Promoting positive mental health and preventing morbidity and mortality associated with suicidal behaviours is a public health priority for New Zealand government (Associate Minister of Health, 2006). Young people are a sub-population at higher risk for suicide and suicide attempt (Beautrais, 2000), and deaths from suicide in 2009 made up more than one quarter of all deaths in the 15-24 year age group, accounting for 32.6 per cent of all male youth deaths (Ministry of Health, 2012). Gender disparities are concerning as young males continue to have a significantly higher suicide rate than females (Ministry of Health). Consequently, youth suicide is an important focus for prevention efforts at policy level and is a priority for public health, which is concerned with reducing disparities and improving the health of the whole population.

1.5 Challenges in recruiting young consumers

Youth suicide is also attracting the attention of public health researchers. Youth have been identified as under-represented in mental health research (Oliver, Pearson, Coe, & Gunnell, 2005; Patel, Doku, & Tennakoon, 2003) and the challenges in representing young consumer perspectives is problematic in research (Iwamasa, Sorocco, & Koonce, 2002). The reluctance of young men to seek professional help for mental health problems is acknowledged in the literature (Skegg, 2005) and as young men tend not to access clinical services, they constitute a 'hard-to-reach' population.

The difficulties in accessing young men to undertake research on sensitive topics presents challenges for researchers who are interested in bringing consumer perspectives to the peer-reviewed literature. Researchers are concerned with increasing the understanding of factors that hinder consumer participation in research. It is imperative that mental health services and universities engage youth consumers in making decisions concerning research participation. An exploration of factors within a clinical context that influenced clinicians' decisions not to involve consumers in shared decision making is the focus for this research.

1.6 Modification of the study

My original research interest, presented in Chapter 2, was to explore young men's perspectives on how social media environments influence suicidal behaviours. I selected a participatory research method which would engage this hard-to-reach population in suicide research. However, the intended sample for this study was not able to be recruited. The potential participants were recipients of primary and secondary care mental health services and providers were involved in facilitating access to the sample. Barriers to recruiting the sample were noted during the study's implementation and the existence and nature of these barriers resulted in my decision to discontinue data collection attempts, and to develop an in-depth investigation of the factors restricting access to this clinical population. Modifying the study presented opportunities for understanding the factors influencing clinicians' decisions to recruit consumers to suicide research. There is little literature addressing gender and age related barriers to consumer recruitment (Woodall, Morgan, Sloan, & Howard, 2010), so exploring why some clinicians made decisions not to inform consumers about the original study will inform future research strategies.

1.7 Ethics

Ethics approval for the original study was obtained from the Multi-region Ethics Committee, March 2010 (Appendix 1). I advised the committee of the modification of the study in May 2011 (Appendix 2). Approval to conduct the new study with mental health clinicians was subsequently provided by the same committee in June 2011 (Appendix 3).

1.8 Epistemological stance

Discussing the underlying philosophical assumptions of qualitative research, Guba and Lincoln (1994) argue that questions of philosophical position are the fundamental starting point guiding qualitative inquiry. Avis (2005) further emphasises this and suggests that evidence gathered in the course of a research project cannot be separated from the standpoint of the researcher. The inter-connectedness of my own theoretical position with the research question and design facilitated a transparent and rigorous approach to analysing and interpreting the data from clinicians.

A further positioning occurred through my disciplinary socialisation to particular research approaches (Ray, 1999). Through my disciplinary affiliation to public health I am familiar with qualitative approaches to inquiry. The semi-structured interview is a traditional approach to collecting data in social sciences (Bowling, 2002), and I have become familiar with this method through collecting data for small-scale health service research and evaluations. However, I was interested in emerging methods intended to increase

participation in research, especially among marginalised or hard-to-reach groups. For the original study I chose an online method to study online behaviour, as this had the 'promise' of a more egalitarian approach and might create a more 'level playing field' for the researcher and the research participants.

1.9 Introduction to the researcher

I work as a public health analyst in Wellington Regional Public Health. Our approach to health improvement is concerned with addressing factors that determine health status and seeking solutions to improve health outcomes. Pivotal to this is a concern for equity and increasing participation in health care. My disciplinary affiliation to public health has guided my efforts to explore and better understand how social environments influence health outcomes. I am motivated by public health approaches which increase the voices of marginalised communities. Following a period of clinical midwifery practice, my early understandings of healthy environments were obtained from the 'bottom up'. My practice in community development provided me with a foundational knowledge of theories of engagement and participation in communities and instilled a strong patient focus in participating in health care and decision making. Consequently my understanding of how people constructed communities and the role communities have in nurturing health deepened.

My interest in mental health emerged during a period of formal volunteering. As a volunteer listener with Wellington Samaritans I became aware of the emotional and social care needs of young people. I noticed their difficulties with self-perceived stigma and their reluctance to participate and seek support in physical communities. Instead, young people described how engaging with online media was increasingly likely to meet their emotional and mental health needs. Hearing these perspectives challenged my conception of new media as constituting insincere and 'unreal' forms of communication. I was interested in how social media can benefit young people and influence the way they interact and seek support. My need for increased understanding of young peoples' participation in online social spaces and the potential protective effects on health directed this original inquiry.

1.10 Definitions of key terms

1.10.1 Suicidal behaviours

Suicide is defined as the act of intentionally ending one's own life (Nock et al., 2008). Suicidal behaviour is often distinguished from self harm in the literature (Pattison & Kahan, 1983) with self harm being defined as non-suicidal self injury (e.g., cutting) in which a person has no intent to die. However, while suicide is not always the intention of self

harm (Hawton, Saunders, & O'Connor, 2012), there is an increased risk of suicide among individuals who self harm (Hawton et al., 1998; Skegg, 2005; Welch, 2001). Self harm is therefore considered to be a related phenomenon for the purposes of this study.

My original study involved a sample of male youth consumers with a history of suicide attempt, suicidal ideation and/or self harm. The term 'suicidal behaviours' as used in this thesis includes three kinds of behaviours: suicide ideation (which refers to thoughts of engaging in behaviour intended to end one's life), suicide attempt (which refers to engaging in potentially self injurious behaviour in which there is at least some intent to die) and intentional self-harm (non-suicidal self injury).

1.10.2 Young male mental health service consumers

For the purposes of my original study, young male mental health service consumers were defined as males aged between 16 and 25 years who were formally engaged in community mental health services. They were receiving services provided by child and adolescent mental health services and general adult services providing community care.

1.10.3 Community mental health services

Community mental health services are the primary providers of care for people with mental illness or mental health difficulties in a domiciliary setting. Services provide mental health assessments and treatment to children and adolescents who have moderate-severe mental health problems.

1.10.4 Mental health clinicians

Multidisciplinary teams working in community mental health services employ clinicians representing a variety of disciplines including, but not limited to, nursing, medicine, social work and psychology. Unless specifically referred to, when the term 'mental health clinicians' is used, this relates to a clinician within a multidisciplinary mental health team.

1.10.5 Online data collection

The internet is a medium for conducting health research. For the purposes of this thesis, online data collection refers to a technique using asynchronous in-depth email interviewing Further information about this term is provided in Chapter Two.

1.11 Thesis structure

Chapter One introduced the topic and outlined the context of the study. This chapter provided a rationale for the modification of the research and revision of the research aim.

Chapter Two presents a case study of the original research which attempted to engage young male mental health consumers in online research. The chapter outlines the challenges associated with online data collection and offers a descriptive analysis of the challenges to recruiting the sample. It concludes with the rationale for the modification of the study.

Chapter Three presents the findings of a critical review of the literature on barriers to young male consumer participation in research.

Chapter Four presents the research design. I discuss my approach to selecting a method to explore influences from clinicians' perspectives. The theoretical perspective that informed my methodological decisions for answering the research question is outlined.

Chapter Five contains the research findings, revealing the influences on clinicians' decision making that impeded data collection with young male consumers.

Chapter Six discusses the issues impacting on successful collaboration and subsequent access to consumers, and concludes by arguing the significance of the outcomes of the study for practice and future research.

Chapter 2

Going online to interview young male mental health consumers: A case study

2.1 Introduction

In this chapter I present the original study that was not completed because of low recruitment of young men. I have used the original incomplete study as a case study, on which to base the main study. The 'case' is an original qualitative study which aimed to explore the influences of social media on suicidal behaviours in young men. A retrospective case study approach was used as it enabled a description of the contextual conditions influencing consumer recruitment to an asynchronous email interview study involving young male consumers. First, the case is fully described. The history of the case including the chronology of events and features of the original research design are provided. Then, four vignettes are introduced which describe successful features of the online approach and exceptions which contributed to low recruitment of young men and subsequent discontinuation of the study. Finally, this chapter concludes with a discussion of implications of using online approaches to engage young consumers in suicide research.

2.1.1 Development of the original study

The *New Zealand Suicide Prevention Strategy* (Associate Minister of Health, 2006) outlines measures to promote the safe reporting and portrayal of suicidal behaviour in the media. In light of evidence suggesting that media can influence suicidal behaviours (Collings et al., 2011; Pirkis, Burgess, & Francis, 2007; Stack, 2005) goal five of the strategy addresses the negative influences that the media may have on suicidal behaviour. The conclusion that traditional media can influence suicide has raised concern that participatory social media may have a similar impact (Becker, Mayer, Nagenborg, El-Faddagh, & Schmidt, 2004). Such concerns have arisen despite little detailed examination of the newer forms of social media. Exploring the potential protective factors associated with social media is a relatively new area of investigation. However, the potential of social media in facilitating recovery from self harm remains highly contested in the literature (Collings, et al., 2011; Hawton, et al., 2012; Messina, 2011). Despite questions being raised there has been no

detailed examination of the influences of social media on young men's mental health (Zahl & Hawton, 2004) and conceptual perspectives have only been discussed to a limited extent in the literature.

2.1.2 The original study: Aim and questions

The original study aimed to investigate how participatory social media environments influenced suicidal behaviours in young men and arose from a larger study conducted by the Social Psychiatry and Population Mental Health Research Unit (Collings, et al., 2011).

The two research questions were:

a) How do young men socially construct their experiences of inclusion in the virtual reality of cyberspace?

b) What role do these alternate social worlds play in creating enriching supportive networks that facilitate recovery from mental illness?

2.1.3 Choosing a contemporary method for the original study

When collecting data, the "qualitative researcher-as-*bricoleur* picks and chooses from the tools of their methodological trade" (Denzin & Lincoln, 1994, p. 2). Despite the common utilisation of qualitative approaches in public health, traditional data collection methods continue to present challenges for increasing the voices of marginalised populations (Kvale, 1996; Miles & Huberman, 1984; Taylor & Bogdan, 1998). In view of this, researchers have begun to explore the use of the internet for increasing access to such populations (Meho, 2006). I adopted the internet as a research medium as it represented an authentic and congruent approach to exploring the influences of social media on mental health and suicidal behaviours. My approach was based on four assumptions.

First, young men are under-represented among mental health service users. In a service context, this group is concerning for mental health clinicians; often described as "slipping through the net" and "service resistant" (Doherty, Stott, Kinder, & Harradine, 2004, p. 12). As a consequence, this group is relatively inaccessible from a sampling perspective which is a challenge for research. It has been suggested by Skinner (2003) that online platforms provide innovative opportunities for engaging young people, particularly due to the increasing use of the internet as a help-seeking tool (Gray, Klein, Noyce, Sesselberg, & Cantrill, 2005; Nicholas, Oliver, Lee, & O'Brien, 2004). Given the growth of social media technologies and the known use of these by youth (Livingstone, 2003) I assumed consumers may experience the internet as an acceptable research tool.

Second, the fragility of relationships between the researcher and the researched (Darlington & Scott, 2003) is concerning for academics who value the development of more egalitarian research methods (James & Busher, 2006). Concurring, Dahlberg (2001) considers there is merit in using tools that foster democratic discourse and participation. In view of this, such tools may be especially important for engaging consumers in research on sensitive topics, such as suicidal behaviours. I sought an approach which had the potential to offer a democratisation of exchange of much greater capacity than traditional approaches (Selwyn & Robson, 1998). Unless research goals align with the public health concern for equity, consumer perspectives will remain absent in the literature.

Third, as my investigation was focused on collecting sensitive data I was aware participants may be uncomfortable in a traditional face-to-face setting. Hence, I was interested in how an online environment might more readily elicit open and reflective responses. Online data collection is an extension of existing approaches of qualitative inquiry and the internet represents a new research environment: a new medium for conducting health research (Mann & Stewart, 2000). Asynchronous in-depth interviewing conducted via email is semi-structured in nature and involves multiple email exchanges between the interviewer and interviewee over an extended period of time (Darlington & Scott, 2003; Meho, 2006). The researcher and the researched interact in non-real time using text-based modes of communication. Multiple contacts over time present opportunities for research on sensitive topics as they may facilitate the development of rapport, potentially leading to increased disclosure.

Finally, increasing consumer perspectives in a literature dominated by professional opinion on the negative influences of social media on suicidal behaviours will balance the perspectives on this topic (Baker & Fortune, 2008). Accessing these hidden populations requires tailored approaches. There is a developing trend in using online approaches in health research to access hard-to-reach consumers (Baker & Fortune; Zhang, 2000). However, the challenges are relatively unexplored. The suitability of the internet for conducting research with vulnerable groups remains unknown and little guidance exists on navigating the barriers to recruiting young consumers to suicide research.

2.1.4 Case for my decision to 'go online'

Evaluating the choice of method is important for future research decisions which aim to engage consumers. My decision to apply the semi-structured interview online was influenced by different filters. First, my disciplinary affiliation to public health brought my concern for social determinants to the fore. Inequities in access to health care may contribute to inequities in consumer focused research. The literature indicated that mental health professionals dominate the debate on social media use and suicide. I was

concerned that using a traditional approach to data collection would fail to engage consumers in this study. Therefore, I chose an online approach which prioritised the researcher/participant relationship and one that would facilitate the relational aspects of research with vulnerable people. Second, the personality of the researcher is another filter, often not acknowledged in the literature, and is linked to the chosen method. As a novice researcher I chose this approach as it created an opportunity for 'reflection in action'. I recognised my personal vulnerabilities as having no clinical background in mental health and I was also aware of the vulnerabilities of consumers. Concerned about managing risk, I hoped to respond appropriately to safeguard the participant in this process. Third, the semi-structured interview is regarded as a 'tried and tested' method in public health (Tong, Sainsbury, & Craig, 2007). However, I wanted to push our disciplinary understandings of new ways of accessing mental health consumers. Limitations are evident in the literature and available evidence highlights traditional methods have failed to capture young people's perspectives. I was excited about exploring the potential of a different approach to facilitate a different understanding of this research problem.

2.2 Context of the case

This research project is a good example of a case with implicit boundaries (Luck, Jackson, & Usher, 2006). Case study research is described by Luck et al. as a detailed, intensive study of a particular contextual and bounded phenomenon that is undertaken in contemporary situations. As a research strategy which focuses on understanding the dynamics present within a setting (Eisenhardt, 1989), case study approaches are used extensively within health and social sciences.

A case study approach has been described as a valuable tool in health services research, being used as a teaching method for learning (Flyvbjerg, 2006); as a form of record keeping to strengthen practice (Yin, 2003); and as a problem solving strategy (Hammersley, Foster, & Gomm, 2000). Despite its flexibility, the potential of case studies in evaluating research outcomes has been overlooked in the literature. Thus, the case study remains an underdeveloped tool for exploring both the methodological issues associated with online data collection and contextual conditions impacting on recruitment of research participants. Given the value of case studies in discovering new processes (Meyer, 2001) and revealing contextual knowledge about an issue of interest (Luck, et al.) the case study approach is useful for evaluating studies using innovative approaches to data collection.

This case study contains multiple sources of data including literature, interview transcripts and participant observation. The analysis focuses on the case in its entirety, with a particular focus on themes related to recruitment and retention. In addition, vignettes are used to illustrate successful and exceptional aspects related to going online to research sensitive topics. Finally, a descriptive explanation for the recruitment outcomes is provided together with factors influencing the decision to discontinue the study.

2.2.1 Procedure

The original study was approved by the Health and Disability Multi-region Ethics Committee with the condition that locality organisations agreed the study met established clinical standards. Locality assessment was completed by two district health boards. In accordance with the University of Otago's policy for research consultation with Māori (University of Otago, 2003) the research proposition was approved by the Ngāi Tahu Research Consultation Committee.

The locality assessments constituted high-level collaborative agreements between the university and the district health boards, providing me with authority to approach individual services. My approach at the service level involved participation in individual and multidisciplinary team meetings. These engagement opportunities enabled me to provide information on the study and distribute an information pack including: evidence of ethical approval, locality assessments, participant information sheets and consent forms. Current literature on online methods for exploring sensitive topics was also provided as supplementary information. Clinicians were informed of what participation for the young men would entail, including the format and nature of involvement in the research interview. This comprehensive approach was designed to positively market the research and position clinicians to make an informed decision about assisting with recruiting consumers.

2.2.2 Recruitment process and outcomes

The approach to recruitment of potential participants covered a broad spectrum of services including secondary recruitment from a major qualitative interview study exploring the influences of a variety of medium on suicidal behaviours (Collings, et al., 2011); district health board mental health services; youth development services; secondary school health services and university student health services. Collaboration was additionally requested from two professional websites (the Lowdown and Youthline) which provided online health services. The requirement for participants to be enrolled in mental health services was applicable to all recruitment approaches.

During the recruitment period measures were introduced to increase recruitment of participants. First, the sampling frame was revised. The inclusion criteria were amended to include: a history of self harming behaviour in the previous six months, as opposed to three months, and a history of suicide attempt or self harm were expanded to include suicidal ideation. Revising the sampling frame was not intended to affect the scope of the study but rather was identified as a strategy to increase recruitment of participants. Therefore it was outside the scope to extend the recruitment criteria to include older males and females as the sample of interest was young men. Second, a direct approach to recruitment commenced. Approval was requested to place marketing material in clinic settings. It was hoped this marketing would encourage consumers to self-refer. Third, incentives were introduced to increase response rates. This was in accordance with ethical guidelines for observational studies (National Ethics Advisory Committee, 2012, p. 16). Accordingly, two cinema vouchers were offered to increase motivation for consumer participation. Despite some services agreeing to collaborate in principle, recruitment of participants was still not achieved. Amending the sampling frame did not result in new referrals. Similarly, placing marketing material in clinic waiting rooms did not result in any self-referrals from consumers. The usefulness of incentives was not clear although it was likely that incentives had little impact.

The sample size was not pre-determined as the aim was to recruit until there was sufficient depth and richness in the data to answer the research question. However, when barriers to negotiating access to the sample were identified, further efforts to increase the sample size were discontinued. No data were collected on the number of participants approached, how many and who declined to consent or their reasons for declining, as that was outside the boundary of ethical approval. A summary of the services involved in supporting recruitment are shown in Table 1.

Table 1. Outcomes of clinical services' decisions to support recruitment of participants

Location of service	Services invited to support recruitment	Services agreeing to collaborate (*n*)	Services withholding agreement (*n*)
Mental health services in primary care	Includes treatment and preventive services: - child and adolescent mental health services - youth health development organisations - regional specialist mental health services - youth speciality services - adult mental health and addiction services - university student health and	4	9

Location of service	Services invited to support recruitment	Services agreeing to collaborate (*n*)	Services withholding agreement (*n*)
	counselling services - secondary school counselling services		
Mental health services in general hospitals	Includes specialist institutional services: - inpatient units - specialist services for Māori	1	1
Community specialist mental health services	Includes formal and informal community-based services provided by mental health professionals and district health board consumer teams: - population health non-government organisations - youth mental health web-based services	1	3

2.2.3 Selection of participants

Clinicians were involved as recruiters and were invited to identify young male consumers to participate in the study. My intention was to generate a sample with sufficient variation to capture different experiences and achieve depth of understanding of the issues relating to social media use. Variety in the sample was important and variables included age (between the ages of 16 and 24) and ethnicity. Despite the broad approach to recruitment of participants, the sample was obtained from the existing clinical sample of young people participating in the major study (Collings, et al., 2011).

Nine participants consented to participate during the 18-month recruitment period. Consent forms were received and participants were followed up with an introductory email asking them to confirm if they wished to proceed. Four individuals responded to this initial communication and agreed to be interviewed. Despite contacting the remaining five participants on two occasions, their non-response indicated a withdrawal prior to the interview commencing. The characteristics and outcomes of the interviews for the four participants are outlined in Table 2.

Table 2. Participant characteristics and interview outcomes

Characteristics	Participants (*n*)
Gender	
Male	4
Self-identified age	
17 years	1
24 years	1
Unknown*	2
Self-identified ethnicity	
NZ European	2
Unknown*	2

Duration of interview	
6 weeks	2
8 weeks	1
12 weeks	1
Outcome	
Completed interview	2
Withdrawal	2

*The unknown data is a consequence of participant withdrawals early in the study before age and ethnicity data were requested.

2.2.4 Development of the data collection tool

A semi-structured topic guide was designed to collect data that would help obtain a better understanding of how young male consumers participate in social media environments, and the resultant influences on their mental health. Asynchronous email interviews aim to create a more stable process of social interaction compared with traditional approaches to data collection. To enable the participants to influence the direction of the research they were advised that the questions would be sent one at a time. In addition, by staging the questions, it would be possible for analysis to occur in parallel with data gathering. Participants were asked to provide their responses to each question within five days and I indicated that I would also aim to respond within this time period. They were also informed of the longitudinal nature of the interview in that it would take around four months to complete.

Four key areas associated with interactive social media technologies were to be explored in the interview. First, the interview was directed towards establishing participants' motivations for internet use and their understandings of the benefits of this media. The first theme was deliberately broad and then became more focused on influences of the technology on suicidal behaviours. Investigating the potential protective effects of social media formed the second part of the topic guide and the third theme asked the participants to reflect on their experiences of participation in online peer support forums. Finally, demographic data were collected in the concluding section of the interview.

2.2.5 Asynchronous interview vignettes

The following vignettes illustrate themes relating to retention of participants using online data collection techniques. Analysis reveals characteristics leading to successful and unsuccessful outcomes in the original study. The responses of the four participants are portrayed and pseudonyms are used to protect confidentiality of participants. The quotations used are verbatim and include spelling typical of text and email.

2.2.5.1 Vignette - Oliver

The interview with Oliver lasted for a period of six weeks (10 April – 23 May 2010). During the interview period 12 emails were exchanged: six emails sent by me and six responses. These interactions provided data on the first theme in the interview topic guide. Oliver's email responses were unpredictable with no consistent pattern. His response time varied from one to 10 days. I planned to respond to each of his emails either on the same day or the day after I heard from him. However, at an early stage in the interview process I was unable to respond for three days, which may have represented an unstable social engagement from Oliver's perspective.

Following my introductory email, Oliver didn't respond for 10 days. Despite this long response time, a rapport began to develop between us. This was evidenced by his engagement with the interview process. For example, Oliver assumed control of the interview and suggested I send a few questions at once. This was opposed to the single question and single answer format which I had proposed. Over time, Oliver's responses became longer and more descriptive with Oliver sharing aspects of his self. I interpreted Oliver's motivation for participating stemmed from an altruistic desire to facilitate health professionals' understanding of mental illness:

> *I really don't mind answering these questions because i no what is like to suffer from depression and i also suffer from a few otha things but lyk i reli don't lyk seeing people go through these things when i no just how much it hurts so if this research is going to help someone down the track or help professionals understand more than that's alright.* (Oliver, 18/04/10)

In this early writing Oliver acknowledged his own sadness from observing other people's experience of mental illness. He also shared his personal experience of clinical depression. At this time I appreciated the fragile state of his illness and his own social construction of the experiences of others who were perhaps significant peers in his life.

A further email from Oliver involved an intimate sharing of his mood and feelings. This communication signalled a 'cue' that his mental health was progressively worsening. His discourse highlighted his disillusionment about a lack of societal understanding of mental illness and reflected his sense of isolation:

> *tbh with you im actually in a very down mood right now and I just feel like ending it all…you didn't ask but i just thought i should share…because people that suffer from depression and bipolar and shit lyk that, can go from one extreme to another in the click of a finger and it really sucks…i no i need help but its hard to get it when it seems like no one cares…people that suffer from mental disorders often find themselves on a one way street and it seems like no one cares an no one wants to help you but the difference with me is that i actually have no one that wants to help me so idk what to do anymore.* (Oliver, 18/05/10)

On reading this email, which became his final one, I was immediately concerned about Oliver's mental wellbeing and physical safety. I consulted with my research supervisor (a senior clinician/clinical psychiatrist) and following discussion with her I forwarded her a copy of Oliver's email transcript. My supervisor reviewed the case and indicated she was sufficiently concerned that Oliver may have been at imminent and serious risk of harming himself. As Oliver was recruited from a clinical sample, my supervisor was able to make a referral to the Crisis Assessment and Treatment Team. The team arranged a telephone intervention following the referral and feedback was later received that Oliver was categorised as low risk and would remain at home with his family. It was further indicated that Oliver had an action plan to be put in place if the feelings returned.

While this referral was being placed, I sent Oliver a further email providing him with an explanation of my researcher responsibilities. The purpose of this email was not consultatory but was to inform Oliver of my actions:

> *I was really concerned you were in a bad space when I read your last email. When this happens, part of my responsibility to you is to let people who can support you know. The senior clinician in our research group decided to contact the emergency service in your area to let them know of our concerns.* (SK, 19/05/10)

I anticipated that the circumstances relating to Oliver's referral may adversely affect our research relationship. I had reminded Oliver, in my email of 19/05/10, that he could withdraw from the research at any time and that any decision to withdraw would not impact on his access to services. As he did not respond I sent Oliver a follow-up email on 23/05/10. This communication was an opportunity to explore how Oliver felt about continuing to be part of the study. I felt it was important to hear his interpretation of his experience as a participant in the study and I wanted to understand his reasons for withdrawal from the interview. I indicated to Oliver, albeit a little awkwardly, that I had a desire to learn about his reaction to events and I was open to hearing how my researcher role may have contributed to this research outcome. Oliver did not respond and this was my last contact with him.

2.2.5.2 Vignette – Matt

The interview with Matt lasted just over 15 weeks (29 March – 15 July 2010) with 25 emails exchanged: 13 emails sent by me and 12 responses. The first two themes in the topic guide were explored with Matt. At the beginning of our interview, Matt and I established rapport quickly. He took only two days to respond to my introductory email and he communicated his excitement about being part of the study. Our rapport was strengthened by Matt communicating his reasons for delayed responses in the early phase of the interview:

Sorry for not replying back i couldn't go on my email because my sister was on the net…ummm I'm looking forward to it i hope u will reply back soon. (Matt 31/03/10)

Although Matt provided emails indicating his reasons for not responding sooner, his responses to my questions constituted short, un-emotive statements. His language did not convey emotion or description and it became difficult to identify any thoughtful or value statements in his writing which conveyed meaningful answers to my questions. When asked about the importance of the internet Matt responded: *"a lot intill my sister was useing it".* (Matt, 05/04/10)

Many of the emails I sent provided clarification on the questions, or introduced prompts and re-phrased questions in a different way. This may have contributed to the 'distance' that later developed between Matt and I. The following excerpts from the transcript show how events unfolded:

Do you chat on the online forums on websites? (SK, 10/04/10)

I don't understand that question sorry can you give me a example?? (Matt, 10/04/10)

I'm really interested to find out how you chat on the internet. People do this in a few ways. For example, you might chat on an internet discussion forum or a message board in a website. Or, you might use instant messaging in a chat room. People also chat on social network websites, for example Facebook. (SK, 10/04/10)

Yes i do talk to other people on the game and its ok umm i talk to people on msn and sometimes ebuddy if that what you mean. (Matt, 11/04/10)

Matt, in this email, did not expand on the answer to my question. Instead, as our interview developed Matt began to take greater ownership of the process of narrative construction by responding to questions in an unexpected way. The following narrative demonstrates how online interviewing led to enhanced disclosure with Matt working outside of the original interview schedule.

I gota question for you but it's not about what we are talking about u can answer it or not it's up to you if you really love something would you hold onto it, and never let it go???…talk too you soon. (Matt, 11/04/10)

On consultation with one of my research supervisors, we agreed that while it was important to acknowledge and validate his question, I should not attempt to answer it. In an attempt to maintain rapport I indicated to Matt that it was acceptable to ask me a question like this and that I was happy to work outside of the original interview agenda.

It sounds like you might have something on your mind. I'm glad you feel you can ask me a question that's not really part of the study. That's OK. Sometimes we

> might go 'off track' for a bit before we can move on to the next question…it sounds like this question may be important for you right now. Often we find the answers to our problems though talking about them and this can help us come to our own solutions. Who would you normally talk to when something's on your mind? Is this the kind of question that you might also share with others on ebuddy? *(SK 11/04/10)*

Following this, Matt's responses became a little more inconsistent. His answers were vague and lacked clarity and Matt took a period of four weeks to respond to my subsequent questions. Based on this, I sent him a follow-up email stating: "*I understand if things are busy for you right now and I'm thinking that you are probably ready to close the study* (SK 25/06/10). Matt sent two further emails indicating that he wanted to progress with the study. Despite this, he appeared disinterested and his written responses contradicted his earlier indication that he wished to continue: *"hello sorry i forgot what web site i go on"* (Matt, 13/07/10).

> *When i wanta look up on google and look at the piz and see the ways you can do it and i go on the chat sites and talk about it. did that help you i hope it did.* (Matt 14/07/10)

The email from Matt on 14/07/10 was his final communication despite one further follow-up email from me that prompted him to explore how online chatting influenced his self harm. I interpreted his non-response as an indication that he had withdrawn from the study.

2.2.5.3 Vignette – Earl

Earl's interview lasted a period of 19 weeks (10 April – 22 August 2010). During this period 34 emails were exchanged: 18 emails sent by me and 16 responses. All themes of the interview guide were covered. Earl was excited about taking part in the study and we developed rapport immediately. He responded to my introductory email on the same day and his response time to my emails was between one and five days. Earl's case illustrates an exemplar approach to collecting data online. This vignette provides examples of narratives which reveal Earl's voice on the theme of online friendships. Earl's self-perception is evident in these narratives and he skilfully conveys his construction of this theme and the related aspect of 'acceptance', a concept that he often referred to when he was online. He used language to convey his construction of realities relating to inhabiting two different worlds. His writing displayed many personal qualities and I could easily relate his construction of concepts to theories evident in the literature. Earl's discourse on his existence in online and offline worlds extend our understanding of these contradictory social spaces:

> *Since i was quite highly ranked in the guild* [World of Warcraft] *lots of people knew me and things like that so it gave me a feeling of importance and like someone actually wanted me around.* (Earl, 18/05/10)

> *It* [the internet] *provides like an escape from the real world so it gives me a comforting place to be i guess, especially because I have a lot of friends whom are very close to me because when we met we didn't know what each other looked like just personalities so the bonds are much stronger.* (Earl, 19/04/10)

> *I'm not saying that online friendships have stronger bonds im just saying that it's easier to get to that level of friendship because you don't focus on how each other looks in the beginning you just have the personalities to focus on.* (Earl, 23/04/10)

> *Being online is basically my second world and a lot of the time is where I prefer to be.* (Earl, 23/05/10)

> *For me they* [online friendships] *are vital really as i use the internet as basically a second reality…also the friends i make online are much more like me and interested in the same things i am and kind of think the same way i do which ive found very difficult to do in the normal world.* (Earl, 24/05/10)

While Earl's rich discourse on online friendship illustrates the value of using an online approach to generate reflexive data, in contrast, the following narrative reveals that going online doesn't necessarily achieve democratic narrative exchanges (James & Busher, 2006): "*sorry again for the horrendously late reply, wont happen again☺ "* (Earl 03/05/10). Earl apologised on numerous occasions for his late response. His regretful acknowledgement indicated he may have perceived our interaction as an inequitable process, with the researcher being in control.

Our interview was completed on 22 August, at which time Earl confirmed he was happy to close the interview. Completing this interview enabled me to review the entire interview transcript with my supervisors and allowed me to ask Earl additional questions, to extend his answers. Looking back over transcripts can enable participants to consider the accuracy of the texts and establish the authenticity of them (James & Busher, 2006). Joint agreement to close the interview also enabled demographic information to be collected from Earl and provided him with an opportunity for debrief: to share his experiences of being an online participant.

2.2.5.4 Vignette - Alex

The interview with Alex similarly was completed in 19 weeks (10 April – 21 August 2010) and during this period 25 emails were exchanged to complete the interview: 13 emails sent

by me and 12 responses. All themes in the topic guide were covered in this completed interview. Alex responded to my introductory email in one day, however as the interview progressed his responses were inconsistent and varied from between one and 19 days.

Although this case is characterised by periods of absence when Alex was admitted to an inpatient unit, this vignette depicts Alex's high level of engagement with the online process. Despite being absent at times, Alex communicated his reasons for not responding: *"Hi sorry for the slow reply I was rehospitalised with depression"* (Alex, 06/07/10). I sent a series of three emails to Alex after he indicated he had been admitted to the inpatient unit. These were sent on 7 July, 21 July and 19 August and enquired if Alex needed to make a decision to withdraw at this time. He replied on 19 August reassuring me he was fine and could continue the interview again. This event led me to consider the effect of this interview on Alex's mental health. In a later narrative, Alex described how his involvement as a research participant had a positive outcome:

> *I appreciate the intellectual exercise answering these questions gives me. I have found it more helpful then therapy has been so far in uncovering some of the limiting thoughts and feelings that I have which keep me isolated. I've realised that a lot of my concerns about the net are largely amplified to avoid the awkwardness and sometimes embarrassing attempts to socialise. Alot of my pessimism serves that function too. I'd put less value on my comments as I definately don't represent any sort of community.* (Alex, 10/06/10)

> *I started trying to get help about a year ago and it has unlocked a lot of anxiety and new issues with psychosis sometimes it seems as though I'm worse off now, therapy is getting there now it seemed kind of pointless for the first couple of months but now I think we've agreed on the areas which i need to work on-negative debilitating emotions etc. During this time it was helpful to try and formulate my issues in words so sending these emails helped.* (Alex, 22/08/10)

Alex may have found that writing his email narratives was a meaningful activity and this may help explain why he considered his involvement in the research therapeutic.

2.2.6 Case analysis

A researcher going online to collect data becomes a participant in the process (Sade-Beck, 2008). While my involvement with participants was over a relatively small time period, it provided "a far more expansive canvas than the frozen snapshot associated with many qualitative and quantitative studies" (Seymour, 2001, p. 160). Being a participant enabled me to reflect on the activities and events to provide the basis for analysis. A key theme emerging from my analysis focused on maintaining ethical integrity.

Protecting confidentiality and maintaining wellbeing of participants is the cornerstone of ethical research. The units of analysis provide two examples where maintaining ethical integrity was challenging. First, Oliver's withdrawal from the study provided an opportunity to review my ethical duties and responsibilities to participants. While the intervention by the Crisis Assessment and Treatment Team resulted in a safe outcome from a clinician's perspective, I felt concerned about the effect of the intervention on my researcher/participant relationship with Oliver. How did he construct his experience of participation in research? Might he have perceived it as a betrayal of trust? The lack of response from Oliver following this action led me to review the factors which were important in my initial decisions to use a contemporary approach for data collection. For example, I chose an online approach as this reflected my motivation to create a more egalitarian approach to data collection (Sade-Beck, 2008; Seymour, 2001). Oliver may have constructed this as an imbalance of power as clinician obligations for the patient's safety were prioritised over his perspective. For Oliver, his experience of participation may have reinforced and further confirmed the low social power that mental health consumers often report (Link & Phelan, 2006).

This situation also represented a complex and challenging dilemma and presented an opportunity to review the ethical procedures. Following consultation with the Multi-region Ethics Committee on 27 May, 2010, the participant information sheet was updated to reflect the action that the researcher would take if concern arose over wellbeing status. Retention in studies may be improved by clearly communicating the role and responsibilities of a researcher and the boundaries of such a role in the event of an emergency. Additionally, maintaining confidentiality helps to establish trust and promotes autonomy within the research process. This event further confirmed that recruiting a clinical sample was the most appropriate approach to prioritise participants' safety.

Second, in research involving participants with a higher risk of destructive behaviours, gaps in communication may assume heightened importance (Seymour, 2001). Alex's vignette presented an ethical dilemma as Alex's re-admission to the inpatient setting indicated that his mental health status had progressively worsened. Understanding why a participant might be slow to respond might elude the researcher who may be left to speculate on the meaning of a break in communication.

Third, creating a neutral research environment is also an important aspect of ethical research. The overriding intention of the study was to enable participants to influence the direction of the research and therefore participants were provided with one question at a time. While it was apparent from Matt's narratives that he was attempting to change the direction of the research according to his motivations, I was unsure how to respond. My

hesitancy and uncertainty about how to proceed may have been a factor in Matt's commitment to the research. His disengagement from the research interview was apparent prior to his actual withdrawal. Although his emails stated he wished to continue with the study, his discourse contradicted his stated intentions. Given the vulnerabilities of this population I couldn't fully support Matt to move the interview in a direction that matched his motivations and this may have affected his ability to remain engaged when his priorities changed.

2.3 Discussion

2.3.1 Managing risk in sensitive research

Sensitive research has been defined as research that "potentially poses a substantial threat to those who are or have been involved in it" (Lee, 1993, p. 4). The author argues that this definition should encompass not simply the consequences of undertaking the research but also examine the methodological issues from the perspectives of both researcher and participants. However, Lee's definition fails to acknowledge the importance of clinician perspectives. In mental health research clinicians are key stakeholders due to their involvement in enabling access to a sample. Further, a conflict of interest may arise for clinicians as promoting research participation potentially presents ethical dilemmas for clinicians' duty to care.

Ethical dilemmas are also common for online researchers who need to ensure ethical integrity is maintained throughout a study. The literature offers little guidance on how to achieve this. While much of the discourse is focused on data security and protecting the confidentiality of participants the few available studies (Hunt & McHale, 2007; Kraut et al., 2004; Mann & Stewart, 2000; Meho, 2006) present perspectives indicating that online research poses no more risk to participants than comparable research collected using traditional methods. These authors consider online research may even be less risky, because the reduced social pressure in online interviews provides participants with the freedom to withdraw whenever they feel discomfort. However, it is important to consider the challenges in sensitive research which are associated with manipulating participants' sense of self worth that may provoke mental or emotional harm. Conducting research online changes the nature of risk and the researcher's ability to assess it. However, the level of risk depends on the context of the study and may be especially relevant in suicide research exploring sensitive topics. In the absence of robust investigations, it follows that solutions for maintaining ethical integrity and safeguarding the mental and emotional health of vulnerable groups have not yet been identified.

2.3.2 Recruitment barriers: Impact of re-formulation of research proposal

Clinicians acted in the role of gatekeepers or intermediaries, and exercised control over access to the sample. During the recruitment phase clinicians identified issues which influenced their decisions to provide access to the sample. These issues were documented as field notes. Concerns and ethical dilemmas were raised by clinicians concerning not only access to vulnerable participants, but included potential harm to participants, researcher competency, the research medium and the potential negative effects of recruiting consumers on the clinician/consumer therapeutic relationship. Additionally, a variety of institutional barriers were expressed. Table 3 describes the informal data obtained during my scoping discussions with clinicians which led to modification of the research proposal.

Table 3. Informal observations of clinician bias and institutional barriers

Clinician bias	Institutional barriers
Clinician perceptions that direct recruitment would compromise the clinician/client therapeutic relationship	Clinicians/service managers balancing multiple research priorities
Clinicians not informing potential participants of the study	Clinician/service managers allocating low clinical priority to supporting research concerned with the social/environmental influences on mental health
Clinician assumptions that clients would not meet the inclusion criteria (i.e. assumptions that clients of low socio-economic status would not have access to the internet)	Service pressures resulting in pragmatic constraints (i.e. clinician time in attending meetings, time to liaise with the researcher)
Clinician concerns relating to online methods and their perceptions of risks associated with online data collection approaches	

A number of lessons from this case study were immediately applied which resulted in changing the research question and modifying the research design. Revising the thesis objectives presented opportunities for the field of study. First, the data collection phase of this study identified critical issues relating to sampling bias. Following these challenges I was motivated to explore the wider issues around the relationship between participatory research methods and sampling bias. Further, few papers provide guidance on how best to approach and interact with vulnerable populations which constitute a clinical sample.

2.4 Conclusion

Conducting sensitive research online is a relatively new domain. While online approaches to data collection may be advantageous for finding innovative ways to increase consumer perspectives in research, maintaining ethical integrity is a challenge. A case study

approach was utilised to illustrate the issues inherent in recruitment and retention of an online sample for suicide research. In this case, a range of factors affected recruitment of consumers and contributed to the eventual discontinuation of the study. The very low recruitment of consumers created an opportunity to explore clinician perspectives in a formal research interview. Re-formulating the study design enabled an exploration of clinicians' conceptualisation of risk and the perceived impact of research participation on consumers' mental and emotional wellbeing. In addition, as issues of risk are traditionally hidden in published research it provided scope to extend knowledge and bring these risks into sharper focus in the research literature. Success in conducting sensitive research using online data collection depends on many factors. It is clear there is no single strategy that will increase response rates in similar situations and this is due to variations in study characteristics and to the unique factors involved in the setting. Future studies should examine the specific theoretical and methodological problems inherent in researching sensitive topics as little is reported in research evidence. The future focus should be on investigating ways to recruit and retain participants while ensuring their safety and wellbeing. This will be important to furthering the debate on the use of online approaches to gather data on sensitive topics.

The next chapter presents a qualitative review of the literature related to barriers to recruiting young male consumers in mental health research.

Chapter 3

Literature review

3.1 Introduction

Little consideration has been given to understanding factors that hinder participation of young male consumers in mental health research. The case study in Chapter 2 identified challenges associated with the recruitment of young male consumers to suicide related research. These challenges have not been adequately addressed in the literature to date. To address this gap in knowledge, the present study explored barriers to participation in research from the perspective of mental health clinicians. This chapter presents findings from the review of the literature and discusses related theories and concepts in the literature on barriers to participation in mental health research.

3.2 Context for the review

Young men are under-represented in mental health research (Oliver, et al., 2005). As this group is less likely to access mental health services this means that they are not readily available for studies that recruit through service contacts (Strike, Rhodes, Bergmans, & Links, 2006). Little consideration has been given to understanding the factors that hinder the research participation of this group (Woodall, Howard, & Morgan, 2011) and the challenges associated with recruitment to research are often not reported adequately in the literature (Dowling & Wiener, 1997). This might be because researchers often prioritise the publication of research findings over research methodology (Sanghera & Thapar-Björkert, 2008). In the absence of a systematic and transparent approach to documenting challenges it is difficult to assess the trustworthiness of qualitative studies (Mays & Pope, 1995; Sandelowski & Barroso, 2003).

Recruitment and retention of participants is arguably one of the most challenging aspects of research and constitutes a major barrier to completing studies. Sample recruitment has been described as the dialogue which takes place between a researcher and a potential participant prior to the initiation of the consent process (Patel, et al., 2003). Retention is a related aspect of recruitment strategies and often involves building relationships with participants to encourage continuing participation (Patel, et al.). Howard et al. (2009)

suggest that difficulties in recruiting young men with mental illness may be related to concerns about their potential vulnerability. Supporting this, Copeland (2007) recommends that mental health researchers give special consideration to research design as the severity and episodic nature of some mental illness may affect capacity of some consumers to comprehend information about research participation (Copeland). Additionally, the fluctuating course of some mental illnesses may affect consumers' capacity to sustain participation in research. Given the evidence that this group may be hard to engage in research endeavours, it is important that specialised research techniques are designed to access, gain the trust and foster the co-operation of young men in research (Klein, Lambing, Moskowitz, Washington, & Gilbert, 2010). Further, Claveirole (2004) highlights a need to balance increasing the presence of young men's voices in the literature with clinical responsibilities for their best interests as individual mental health consumers.

It is important to enable consumers to provide their perspectives on research topics whilst protecting them in the process, for two reasons. Firstly, engaging consumers directly in the research process should lead to the development of a more balanced understanding of the topic under investigation. Rugkåsa and Canvin (2011) consider that failure to include all sections of society in health research precludes a comprehensive understanding of public health issues. Secondly, failure to recruit enough participants can result in unanswered scientific questions, wasted research resources and result in a study being abandoned (Howard, et al., 2009). These authors raise an ethical concern for researchers who gather data which is not utilised to advance knowledge. Therefore, increasing the evidence base on barriers to recruitment of consumers for mental health research could inform and improve future recruitment strategies for young male mental health service consumers.

3.3 Aim of review

The aim of this review was to evaluate qualitative research evidence on the barriers to participation and assess what is known from both clinicians' and consumers' perspectives in published literature.

3.4 Scope of the review

Difficulties associated with recruitment of participants are not specific to qualitative mental health research. While the dialogue about difficulties in recruiting mental health consumers spans a number of disciplines, the focus has been predominantly on recruitment difficulties in clinical trials. The extensive literature on recruitment difficulties in clinical trials (Abrams, 2010; Furimsky, 2008; Hunninghake, Darby, & Probstfield, 1987; Lovato,

Hill, Hertert, Hunninghake, & Probstfield, 1997; Ross et al., 1999) assumes that quantitative methodologies lead to specific differences in sampling goals and strategies. Further, this literature is concerned with barriers to recruiting minority ethnic groups. Given that people from minority ethnic communities have historically been under-represented in health research (Giuliano et al., 2000) the literature on increasing ethnic minority participation in research is underpinned by a research agenda focused on increasing equity of participation for minorities (Levkoff & Sanchez, 2003; Yancey, Ortega, & Kumanyika, 2006).

While this research enhances our knowledge of factors associated with participation of ethnic minority consumers, there is little analysis of potential barriers related to age and gender. Additionally, the barriers identified in clinical trials may not be meaningful for enhancing consumer recruitment to other kinds of study. The current research, therefore, focused on qualitative studies, concerned with sampling for meaning (Lincoln & Guba, 1985) and achieving theoretical depth, (Curtis, Gesler, Smith, & Washburn, 2000) and reflecting diversity as opposed to seeking representativeness (Barbour, 2003).

3.5 Search strategies

Criteria for considering studies in this review were developed and literature was selected according to defined inclusion and exclusion criteria. The criteria for inclusion in the review were: literature on minority recruitment where it refers to mental health, and publications of theoretical significance from studies with samples of older adults. Studies were excluded if they were unrelated to mental health research with no focus on recruitment strategies. The search was not limited by gender or age group.

An electronic literature search of articles published between 1996 and 2012 was conducted using the following databases: MEDLINE, CINAHL, EMBASE, PsychInfo, PROQUEST and SCOPUS. The following key search terms were used: *mental disorders, recruitment* and *research*. Terms were exploded and medical subject headings resulted in a retrieval of 574 references. A large number of these papers were not directly relevant to the research question. I refined the search by simultaneously adding the keywords: *barrier*, adolescent*, minorit** and *participation.* This reduced the number to 261 papers. Abstracts were reviewed for subject relevance. Articles (*n*=256) were discarded because they were not directly related to my research question. Articles (*n*=5) were included in the review where the primary focus was on barriers to participation and recruitment of participants in mental health research.

Table 4. Characteristics of studies included in the review

Author(s), date and country	Aim	Design and method	Participants	Key findings
Woodall, Morgan, Sloan & Howard (2010)	"Review literature on the nature of barriers to participation in mental health research with particular reference to gender, age and ethnicity and to review evidence on the effectiveness of strategies to overcome barriers"	Systematic review including studies published up to December 2008 using MEDLINE, PsychInfo and EMBASE	n/a	49 papers identified barriers including transportation difficulties, distrust/suspicion of researchers and stigma attached to mental illness
Mason et al. (2007), UK	"Investigate the perceived barriers among GPs towards introducing participation in randomized controlled trials to patients presenting with depression during consultations"	Primary descriptive qualitative study involving semi-structured interviews	41 GPs from five primary health care trusts	Themes identified included concern about protecting vulnerable patients, perceived lack of time to introduce a request for research participation and priorities relating to clinical issues over research participation
Rugkåsa & Canvin (2010), UK	"Describe issues involved in recruitment for two related studies on experiences of mental health problems in Black and minority ethnic communities"	Qualitative interview study	65 caregivers and mental health consumers	Key issues affecting recruitment included gatekeepers' attitudes, non-payment of participants and reciprocal arrangements with service providers
Shellman & Mokel (2010), US	"Describe the challenges and successes associated with conducting a pilot study to test the effects of an intervention on depression in older African Americans"	Qualitative process evaluation using a pre-test and post-test design	56 older African American mental health service consumers	Mistrust between gatekeepers and universities, recruitment and retention of participants, culturally insensitive instruments and stigma associated with depression were barriers
Woodall, Howard & Morgan (2011), UK	"Investigate why people with a first episode of psychosis choose or decline to participate in mental health research"	Primary qualitative interview study	26 mental health consumers	Barriers to participation included consumers' conceptualisations of mental health problems and the influence of other patients

3.6 Results

Four qualitative studies and one systematic review met the inclusion criteria and were subject to critical appraisal. No additional studies for inclusion were identified from the bibliographies of key references. Each paper was read to identify the main concepts of the study, the study setting and participants (Table 4). Quality assessment of the papers was carried out in accordance with the framework produced by Spencer, Ritchie, Lewis and Dillon (2003). Underpinning the framework are four key principles which indicate that qualitative research should be contributory in "advancing knowledge, defensible in design, rigorous in conduct and credible in claim" (Mays & Pope, 2006, p. 93). These authors consider transparency to be fundamental to good research practice. Transparency is the key feature of the appraisal tool, as without transparency at different stages in the research process, quality assessment cannot take place. Additional criteria from Oxman and Guyatt (1988) were also used for assessing the quality of the research in the review. Those related to transparency of the search methods used to locate relevant studies and evidence that the reviewers' conclusions were supported by the data cited. Papers were then systematically compared for common and recurring concepts to establish similarities and differences in scope and findings.

The papers presented in the table are discussed in order of their relevance to my study. In discussing these five papers I will draw on related literature to enhance the particular perspectives.

The first paper, the systematic review of the literature by Woodall, Morgan, Sloan and Howard (2010), identified the nature of barriers to participation in mental health research with a specific focus on gender, ethnicity and age related barriers and on the effectiveness of strategies to overcome barriers. The barriers identified were broad ranging and included fear, suspicion and/or distrust of researchers, concerns about confidentiality, transportation difficulties, severity of illness, lack of financial reward, inconvenience, fear of relapse as a result of participation and the stigma of mental illness.

The reviewers also discussed barriers that were not explicitly linked to the population being studied but which constituted more complex external barriers. These were described as: competing academic centres studying the same group, tensions between academic centres and mental health services, and relying on referrals from clinicians who have misconceptions about the research design and consequently have difficulty explaining the study to prospective patients. The reviewers acknowledged that older participants were more difficult to recruit in some studies. However, they suggested that rather than age itself serving as a barrier to recruitment of participants, barriers may be more related

to specificity of the mental disorder. The one study of younger adults experiencing their first episode of mental illness also highlighted the difficulty of accepting a diagnosis as a barrier to research participation (Furimsky, 2008).

The review provides a useful orientation to the evidence on barriers to participation. Comprehensive search methods were used to locate relevant studies and this is indicative that relevant primary studies have been included. Clear evidence of search strategies enables replication of the review. The review included articles from a broad range of disciplines to produce open and qualitative analysis of results. Extensive referencing enabled the reviewers' conclusions to be verified. Their conclusions were supported by the data cited and results showed that there was little evidence on the effectiveness of recruitment strategies for increasing participation.

A clear statement on the purpose of the review was provided. While the review question was multi-faceted in that it sought to explicate specific barriers related to gender, ethnicity and age, this was appropriate given the emerging literature on the topic. Notwithstanding this, the broad focus of the review presents limitations. For example, it is unclear if the reviewers only intended to include studies focusing on adult research participants, as there was no mention of efforts to locate references exploring barriers to recruiting younger research participants. There was no discussion of missing coverage in the achieved sample, and the reviewers failed to provide a rationale for the selection of the target sample in the review. Given the lack of clarity on inclusion criteria, it is unclear if findings from studies involving adult populations of interest are transferrable to younger research participants.

A further limitation may be evident in the search strategy for the review. Despite a large number of relevant studies being identified through the major biomedical databases and specialist databases, searching other databases which do not have a clinical focus would have been useful. Databases such as CINAHL and PsychLIT provide greater coverage of European journals and journals including the broader social sciences disciplines. Additionally, papers identified in the review included a combination of qualitative and quantitative methodologies. Analysis did not distinguish between barriers identified in primary qualitative studies and clinical trials and therefore there are limitations of drawing wider inferences from this review to qualitative research methodologies alone. A further weakness of the review is that the reviewers did not assess the primary studies against an evidence based criteria for quality assessment. This limits the ability to make informed decisions about the quality of the reviewed articles and therefore dilutes the significance of the evidence generated. The findings illustrate how the majority of recruitment methods have not been formally evaluated. Therefore there is a gap in our

understanding of barriers to participation. The reviewers proposed specific directions for further research and suggested that studies systematically investigate strategies to overcome barriers. They also identified that further research on age related barriers would be beneficial as little information was found on this.

The second study, a qualitative interview study by Woodall et al. (2011), the same authors who completed the review investigated why mental health consumers choose or declined participation in mental health research. While the systematic review (Woodall, et al., 2010) identified barriers to recruitment of participants from clinician perspectives, this primary study investigated factors influencing participation from the perspective of research participants, thereby adding an important perspective to the literature. Reasons for research participation included a desire to help others, curiosity and positive experiences with clinicians. The findings showed that barriers were influenced by practical issues such as timing, communication, conceptualisation of mental health problems, the influence of other inpatients and individuals' concerns that participation may be potentially harmful to their mental health.

Individual interviews were conducted with a sample of 26 mental health consumers who were recruited via referrals from the Genetics and Psychosis (GAP) study (Woodall, et al., 2011). A total of seventeen people who had consented and nine who had declined participation in the prior clinical study were interviewed and asked about their attitudes towards participation in mental health research. Findings were linked to the purpose of the study and it was intended that they would inform ongoing recruitment of participants to the GAP study. This study, with its action research component, effectively addressed recruitment issues within the context of a research study and aimed to maximise inclusion of the intended sample. A strong rationale for the study's qualitative exploration of perspectives from patients was provided. A further strength of this study relates to the findings which offered new insights on issues. In particular, findings showed that participants' reasons for declining participation were associated with the belief that involvement in research could be potentially distressing and impede recovery from mental illness.

Further, the discord between participants' and researchers' conceptualisation of mental health problems illustrated alternative ways of thinking about recruitment barriers. The term mental illness had negative connotations for participants with a first episode of psychosis. As such, some participants were reluctant to accept mental illness as a diagnosis. Findings showed that one participant acknowledged experiencing stress but did not agree with a diagnosis of mental illness. This finding correlates with other evidence

relating to barriers associated with stigma and illustrate scope for improving effectiveness of recruitment strategies through careful use of non-stigmatising language.

Limitations identified in this study affect the significance of the evidence generated. First, the population of interest was not effectively described. There was a specific target relating to recruiting ethnic minority groups enrolled in the initial study, but no discussion of targets for inclusion of other variables in the sample. As the original study was not published at the time of writing, it is difficult to identify targets for inclusion of other variables.

While the sample included male and female adults in the age range of 20 to 53 years, findings were not categorised into themes relating to age or gender. Therefore, the relevance of this study in informing knowledge specifically on age and gender related barriers was not established. Participation in the GAP study involved collecting extensive genetic, biological, neuropsychological, social and clinical information, and it is likely that some barriers to participation in the GAP study were due to the specific nature of the study. Other identified barriers related more specifically to the target sample and the setting for research participation. The recruitment strategy included a focus on inpatient facilities and one barrier related to the influence of other patients on the ward. While there is some discussion about the scope for making wider inferences about the findings, it is difficult to assess the importance and relevance of the identified barriers for studies with a differing research design.

A second limitation relates to the minimal inclusion of other literature summarising previous knowledge on the topic. A description of the context on the recruitment process for the GAP study together with a statement about the level of participation achieved for the study would have usefully increased understanding of the relative ease or difficulty in recruiting participants. It remains unclear how findings contribute to enhancing recruitment strategies or developing new theory on recruitment of participants. For example, although Woodall et al. (2011) alluded to findings which identified how culturally complex explanatory models have facilitated culturally capable psychiatric practice, they did not extend this discussion to include insights on the role of explanatory models in influencing research participation. Though Woodall et al. make reference to the operating culture of the research team there is no description of the process of recruitment or the role of clinical gatekeepers in facilitating access to the sample. This omission leads me to question if the role of gatekeepers is overlooked as a potential barrier. In the absence of studies specifically investigating gatekeepers' influences on recruitment of participants, providing analysis beyond description would enhance understanding of this factor.

While the successful recruitment of participants in a clinical setting is dependent on achieving a collaborative agreement, the second study showed that a further set of barriers are presented once an agreement in principal has been obtained. Similarly, Patel et al. (2003) consider two issues relating to collaboration that should be addressed. First, there is a need to identify barriers associated with securing a collaboration agreement between academic centres and mental health services. Second, once approval has been granted from the collaborating sites, barriers to recruitment of the potential sample should be identified. These barriers may be related to different factors and the latter may be associated with practical constraints within a clinical setting, thereby minimising the likelihood of consumer participation in qualitative research.

In contrast to Woodall et al. (2011) and their focus on reporting consumer perspectives, the third study Mason et. al. (2007) explored barriers to recruitment of patient participants from the perspective of general practitioners (GPs). This study investigated the perceived barriers among GPs towards introducing participation in randomised controlled trials (RCTs) to patients presenting with depression. Semi-structured interviews were conducted with 41 GPs who were collaborating with a university on a RCT recruiting patients with depression. The authors indicate that a considerable literature is available on understanding the barriers to collaborative research with primary care. While these studies provide insights into engaging clinicians in research there is a need to increase understanding of the barriers to recruiting patients once the clinician has agreed to collaborate. Findings offer insights into such barriers. Three themes were found including: GPs' concern about protecting vulnerable patients and the impact on the doctor/patient relationship; GPs' perceived lack of skill and confidence; and the priority given by GPs to clinical and administration issues over research participation.

The study was designed to explore the process of recruiting patients to enhance understanding of the reasons for low recruitment rates despite practitioners' favourable attitudes towards research. A key strength of the study relates to the sample composition. Maximum variation sampling was used to identify GPs from a range of practices with a variety of experiences of recruiting patients. Structuring the sample by the number of patients recruited provides an opportunity to explore the factors underpinning GPs' decisions about introducing participation to patients presenting with depression. However, one limitation relates to the lack of inclusion of broader literature. While the authors acknowledge other literature reporting similar themes, a summary of findings is not offered, making it unclear how findings resonate with other knowledge.

While the study is descriptive, a more detailed interpretation of findings would have yielded further insights. There was considerable diversity in GPs' opinions and beliefs

across all themes and while a rich descriptive analysis was provided, there was further scope for examining reasons for GPs' differing positions. For example, the authors noted that patients with depression were characterised as vulnerable, often leading to protectiveness on the part of the GP. This was reported as a general trend, with GPs being less likely to introduce the study to eligible participants whom they deemed vulnerable. A rich analysis and interpretation of findings based on the demographics of the sample may have usefully presented analysis based on GPs' levels of experience and practice involvement in research. There was no indication of how many GPs held such beliefs, given the sample size of 41 GP participants. Variables such as age, gender or ethnicity were not analysed in relation to GPs' perceptions of vulnerability. This finding has implications for both clinicians and consumers. While it might present a dilemma for GPs concerned with protecting vulnerable patients, this evidence of paternalism raises debate on how to enable consumers to participate in mental health research. Are GP attitudes advancing the goals of consumer participation in research? The authors reported that nine GPs had failed to identify any patients for the trial. This represents a limitation as there was no description provided on the number of participants meeting the inclusion criteria. Therefore, it is difficult to judge whether this sub-sample had the opportunity to identify participants. GPs constitute one of the disciplines in primary care and there are lessons to be learned from including experiences of groups with different disciplinary affiliations. Creating a dialogue across disciplines on this topic would produce valuable findings.

The fourth study in the review (Rugkåsa & Canvin, 2011) addressed difficulties associated with recruiting participants from minority ethnic groups. These challenges have been reported elsewhere (Yancey, et al., 2006). Rugkåsa and Canvin described issues involved in recruitment of participants for two linked projects on mental health in black and ethnic minority communities in the UK. Sixty-five caregivers and mental health consumers were recruited to these projects and three main issues affecting sample recruitment including gatekeeper attitudes, the non-payment of participants, and reciprocal arrangements with service providers were examined. The strengths of this study relate to the transparent account of assumptions, theoretical perspectives, recruitment strategies and researcher values that shaped the research process. A highly reflective account of recruitment difficulties with black and minority ethnic groups with mental health problems has extended knowledge and understanding of recruitment difficulties.

Gatekeeping practices were reported as a key finding in this study. Findings showed that gatekeepers chose to protect 'their' community and exerted influence to restrict access to the population if mistrust was present. A further finding revealed that different recruitment methods had different rates of success according to sample characteristics, such as socio-economic status, and education level. This finding correlates with other

research reporting differential response rates according to gender (McLean & Campbell, 2003; Preloran, Browner, & Lieber, 2001) and ethnicity (McLean & Campbell). This has implications for adopting flexible research strategies which seek to maximise inclusion of all sections of the population. Additionally, findings relating to negative attitudes to mental health and the social stigma associated with mental health issues were identified as a barrier to participation. Similarly, this finding correlates with other research evidence. However, the authors concluded that there was insufficient data from the study to assess if recruitment challenges were related to stigma, cultural factors, being unwell or a combination of these factors.

Limitations of the study include features relating to design, sample processes and data collection. Discussion of the overall research strategy including the rationale for the study design was largely absent and there was insufficient detail on the population of interest and how the sample related to it. For instance, the rationale for why caregivers were included in the sample was not provided and there was no specific analysis related to caregivers' perspectives on recruitment barriers. While a breakdown of participant characteristics by recruitment strand was provided there was no analysis of different segments. A comparison of findings in relation to perspectives of the two types of participants would have been useful to explore diversity of perspectives and would have added new knowledge to the existing literature. Additionally, while the recruitment strategies were explicitly described there was minimal focus on method of data collection. It may be that providing a high level theoretical discussion was prioritised over providing a formal account of the research process.

A fifth study, a qualitative process evaluation (Shellman & Mokel, 2010), illuminated issues discovered while conducting a study with older African Americans with mental health problems (Shellman & Mokel). The aim of the study was to describe barriers and strengths of a study testing the effects of an intervention study of depression in this minority group. The overall goal of the process evaluation was to assess for barriers throughout the study's implementation. Older African Americans are an under-represented minority in mental health research (Crystal, Sambamoorthi, Walkup, & Akıncıgil, 2003) and the authors suggest that under-representation of minorities in mental health research is a cause of inequities affecting depression treatment of older African American males. Barriers identified included mistrust between gatekeepers and universities, recruitment and retention of research participants, culturally insensitive instruments and stigma associated with depression.

Compounding the challenges to recruitment and retention of participants was that depression is a disorder that is stigmatised in this minority group. Findings showed that

this ethnic minority group have distinct beliefs about stigma related to depression which posed practical problems for recruitment to studies. While this finding may be specific to the contextual conditions of the study, it is similarly plausible that stigma may be a barrier to help-seeking and participation in research in the setting of mental health services for adolescents and young adults (Rickwood, Deane, & Wilson, 2007). It has also been suggested (Thornicroft, 2006) that stigma associated with mental illness may also affect willingness to participate in research and the presence of mental illness reflects a reason for non-participation (Woodall, et al., 2011). Authors noted that this perspective posed practical problems when recruiting this population in mental health research.

The attitudes of gatekeepers was found to be a key barrier affecting recruitment of participants. Gatekeeping is a major factor involved in recruitment of not only mental health participants but other vulnerable populations. Gatekeeping is the process whereby healthcare providers prevent access to eligible patients for research recruitment (Sharkey, Savulescu, Aranda, & Schofield, 2010). Gatekeepers can assume a degree of power in the research process because they can withhold access to the potential sample. Sanghera and Thapar-Bjorkert (2008) contend that gatekeepers carry out their role in a way which can "facilitate, constrain or transform the research process and the production of the data" (p. 558). Gatekeeping further presents a problem for developing quality in qualitative research. If clinicians are able to decide who should, or should not, participate in a research project, the project is open to accusations of samples being unrepresentative of the populations of interest. Shellman and Mokel (2010) found that engaging the community and enlisting the help of opinion leaders or community gatekeepers was a successful strategy for recruiting participants.

Another critical challenge found by Shellman and Mokel (2010) related to the levels of mistrust between gatekeepers and universities. In this study, mistrust was expressed as refusals to participate and extensive questioning by gatekeepers during initial meetings. Daunt (2003) considers that developing trust is important for conducting research with diverse populations, especially since academic institutions often complete their research with little or no feedback to the community (Dancy, Wilbur, Talashek, Bonner, & Barnes-Boyd, 2004). Shellman and Mokel concluded that involving gatekeepers in decision making about the research and regular progress reporting about the study helped establish trust. They considered an approach to recruitment based on increased community participation was likely to enhance recruitment of participants and overcome challenges associated with mistrust.

3.7 Gaps in knowledge

The review of the literature identified only five studies that met the criteria for inclusion. These studies were limited by their broad emphasis on mental health consumers as a homogenous group. Aspects of social identity such as age, gender or social class may present specific barriers to recruitment and future research should take such complexities into account. The lack of specificity of these findings makes it difficult to relate findings to young male mental health service consumers. This represents a significant limitation in the knowledge base. Further research on the barriers to engaging young men as research participants is necessary to improve the evidence base.

In particular, potential limitations to what is known include:

- studies that included men and women rarely had a specific gender or age focus. The barriers cited in these studies related specifically to an adult population. While this literature is not specifically about barriers relating to young male consumers, it is erroneous to assume that findings from these studies are directly transferrable to factors associated with participation of young men with mental illness

- further research is required to unravel the subtleties of barriers to the recruitment of young male mental health service consumers to small-scale qualitative research studies. While an extensive literature on barriers to recruitment for RCTs exists, it is difficult to generalise from this literature and it seems simplistic to assume that learnings from RCTs are directly applicable to qualitative studies

- young male consumers have not been identified as constituting a vulnerable or hard-to-reach research population and have therefore not received the same research attention as ethnic minorities

- there is little focus on the influence of research design and data collection method on participation in mental health research, in particular the use of emergent media as tools for data collection

- literature on recruitment barriers within the specific cultural context in New Zealand is absent. This is significant as barriers may be related to a specific cultural and organisational context for mental health consumers.

3.8 Conclusion

The review of literature sought to increase understanding about barriers to the recruitment of young male consumers to mental health research. Increasing participation of young male consumers has been compounded by the absence of literature identifying specific age and gender related barriers to participation. The review highlighted the numerous barriers to participation in mental health research. Barriers related to the characteristics of young male consumers present complexities and recruitment challenges in qualitative research. Factors associated with stigma, fluctuating symptoms of mental illness and concerns about the impact of participation on recovery were identified in this review. The complexity of research with young mental health consumers is therefore influenced by the heterogeneity of presentations which may account for increased paternalism by gatekeepers. Studies have focused on factors affecting participation of a diverse group and there is a growing urgency for research to identify barriers affecting young male consumers, as these may be specifically related to age and gender characteristics. However, there is little research which has specifically focused on barriers relating to young male consumers and it cannot be assumed that findings from the studies in this review are transferrable to increase the recruitment of young male consumers to suicide research. Consequently, there is great scope to add to the current understanding through further research. In light of the case study and the themes found in the literature review, the decision was made to design my study focusing on clinicians' perspectives on recruiting this hard-to-reach population.

Chapter 4

Research design and method

4.1 Introduction

This chapter presents the research design and method chosen to explore clinicians' perceptions of barriers to recruiting young male consumers. The chapter begins by outlining my theoretical perspective and the methodological approach to the study of the barriers to consumer participation in suicide research. First the reasons for the research focus are explained, followed by an outline of the theory that influenced the research design. Literature on the semi-structured interview is introduced which justifies the suitability of this technique to answer the research questions. The method is outlined, and a description of the processes of data analysis and theme development are provided. I then illustrate my reflexive considerations on the research process and the techniques I applied to enhance the trustworthiness of this research. I conclude this chapter by discussing procedural ethics and provide an overivew of the key ethical issues arising in this research.

4.2 Working in a qualitative research paradigm

Not only can qualitative approaches be utilised for studying the relationship between illness and environmental factors which influence suicidal behaviours, but there is also an important role for qualitative inquiry in understanding social processes that contribute to research outcomes. Therefore, a qualitative approach was suitable to identify contextual influences, including factors within the culture and set-up of health services, on decision making in the original study. I wanted to understand 'how' and 'why' clinicians conceptualised risk in relation to consumer participation in suicide research. As well as exploring clinicians' attitudes towards decision making in relation to research, the approach needed to capture the organisational and cultural norms influencing clinicians' decisions in the original study. Such an emphasis enables clinicians to express their thoughts and perspectives in their own words and their own terms (Avis, 2005). Given there is little published evidence on the barriers to recruiting young male consumers to suicide research from a clinician's perspective, an exploratory approach was required.

4.2.1 Research aims

The study aimed to answer three questions:

a) What is the perceived clinical relevance of research addressing the social context of suicide to priorities in mental health practice?

b) What factors influence clinicians' decisions to introduce a request for research participation within a sensitive clinical consultation?

c) What are clinicians' perspectives on the use of online tools for gathering data on sensitive topics?

4.2.2 Social constructionist theory

Social constructionist tradition recognises that all social facets are not simply discovered, but instead, are created through the application of social norms (Creswell, 2007; Schwandt, 2000). From a constructionist viewpoint, meaning and experience are socially produced and reproduced, rather than occuring within individuals (Burr, 1995). Creswell's emphasis on social constructionist traditions provides a framework for understanding the historical and cultural setting of research participants. In this research I wanted to explore clinicians' construction of social and disciplinary norms influencing their decisions to support recruitment of young male consumers.

Mental health clinicians are a diverse workforce and represent a number of related disciplines. My interest was in capturing whether and how this diversity related to the clinicians' ways of thinking about consumer participation in research. My researcher role involved teasing out and exploring the contextual factors influencing consumer participation to address their subjective viewpoints from a holistic perspective. Accordingly, I present my research findings not simply as another social perspective but one which is an authentic representation of the particular social perspectives of mental health clinicians involved in the original study (Guba & Lincoln, 1994). Given I was interested in obtaining the clinicans' perspectives and experiences on research recruitment I decided to use semi-structured interviews as the method of data gathering.

4.2.3 The semi-structured interview

Patton (2001) suggests the semi-structured interview can provide meaningful data which is capable of being articulated and made explicit. Although assumed to be a generic approach to data collection, individual interviews come in a variety of forms (Bernard, 2002). These different forms have emerged from the multitude of disciplinary perspectives within public health research and result in a wide variation of approaches to

interviewing. The literature loosely differentiates between approaches, including structured, un-structured, semi-structured and in-depth interviews. Mason (2002) considers that the research interview cannot be entirely devoid of structure, even if that structure is the use of a single open question to prompt thought and discussion. This has implications for researchers new to qualitative research who are concerned with selecting an approach appropriate to the context of their study. For instance, the underlying philosophical assumption of social constructionist theory implies reliance on semi-structured rather than structured research techniques because a loosely structured format is based on a set of pre-determined open-ended questions. Its value lies in providing the researcher with scope to identify areas on which to gain participants' perceptions. In doing so, the researcher will discover the interviewees' own framework of meanings (DiCicco-Bloom & Crabtree, 2006) whilst remaining open to the possibility that the concepts that emerge may be different from those anticipated at the outset. Therefore, a semi-structured research tool with broad and general questions enables participants to construct the meaning of a situation.

As the primary data source for a qualitative research study, semi-structured interviews are highly interactive. Holstein and Gubrium (1995) describe such approaches as a collaborative enterprise in which both interviewer and interviewee are engaged in constructing meaning, whether this is acknowledged or not. The high level of interaction is essential for the interviewee to activate the different aspects of their knowledge with the researcher's help. For this reason, Cox (2005, p. 569) describes qualitative interviewing as an art as well as a science as it requires "intelligent planning and execution, excellent communication and interpersonal skills and an almost intuitive sense of what can and cannot be pursued".

Although semi-structured interviews represent a rich data source, potential negative consequences of this approach are debated in the literature (Appleton, 1995). Such debate is concerned with the position and location of the researcher in the process of data collection and the potential influence of the researcher in that process. While a researcher's own personal, cultural and historical experiences is integral in a process guided by the social constructionist tradition, the literature indicates that as a 'participant' in the process the researcher may inadvertently affect the trustworthiness of research findings. Lambert and Loiselle (2008) caution that although researchers may wish to adopt a neutral role, they may unintentionally reveal their own unique world views during interviews, and in the process affect the trustworthiness of the research findings. These authors further consider the problematic assumptions which may arise due to the researcher's (re)presentation of language and expression as an accurate indicator of participants' inner experiences. Participants may skillfully manipulate the conversation

and withhold or even exaggerate descriptions when the 'truth' is inconsistent with their preferred self image (Fielding, 1994).

4.2.4 Enhancing rigour in qualitative studies

The aim of trustworthiness, or rigour, in a qualitative study is to support the argument that the study's findings are "worth paying attention to" (Lincoln & Guba, 1985, p. 290). There is debate in the literature as to the constructs that demonstrate rigour in qualitative studies. However, in any qualitative study, three issues relating to rigour are worthy of attention: credibility, transferability and dependability (Guba & Lincoln, 1989). Assessing for credibility involves determining how congruent findings are with reality (Merriam, 1998). Transferability, or relevance, refers to the usefulness of the findings to the context and phenomenon under study (Kitto, Chesters, & Grbich, 2008). Dependability refers to the quality of the interconnections between data collection, analysis, and generation of theory.

Koch (2006) argues that the trustworthiness of a study may be established if the reader is able to audit the events, influences and actions of the researcher. The decisions taken in this research to ensure trustworthy findings are outlined later in this chapter. These decisions demonstrate that the researcher is central to the process of data collection and outcomes of the research. Reflexivity is one of the pillars of critical qualitative research (Fontana, 2004) and relates to the degree of influence that the researcher exerts, either intentionally or unintentionally, on the findings. A reflexive approach and awareness of how the researcher is located in the process is important for producing credible research (Jootun, McGhee, & Marland, 2009). Therefore through reflexivity, my influence on the research process is discussed later in the chapter.

4.3 Method

4.3.1 Setting

The study took place in the Greater Wellington region. It involved mental health services in Wellington, Lower Hutt, Porirua and the Kapiti coast. The research was conducted in a naturalistic setting and clinicians were invited to specify the setting of their choice. Of the 13 participating clinicians, 11 chose their own clinical setting. One chose to be interviewed in my public health workplace and the thirteenth in a home setting.

4.3.2 Sample

A critical case sample (Patton, 2001) was chosen to select information-rich cases which purposefully fitted the study. The sample was a relatively homogenous group of mental health clinicians who were identified from services which were invited to collaborate in

the original study. Narrow inclusion criteria were established to select the most productive sample which was responsive to the real-world conditions that influenced clinicians' decisions (Coyne, 1997).

Therefore, I interviewed individuals who met two basic criteria. These included clinicians who were actively involved in recruitment discussions in the original study and clinicians who had a role in decision making in the original study. The sample included clinicians from diverse professional backgrounds and from a variety of service settings including: child mental health; adult mental health; and student health and counselling services.

4.3.3 The interview

In making the choice of research method my aim was to start from the research problem and allow fluidity depending on the emerging lines of inquiry. A topic guide comprising of open-ended questions and prompts enabled me to be responsive to the clinicians' operating context. The topic guide was developed based on theoretical concepts from the literature and field notes collated during the implementation of the original study. These data provided a basis for a detailed examination of the issues that occurred as a product of undertaking the prior study and facilitated the development of the topic guide (Appendix 4).

Four key areas were explored. The first area was designed to establish views about the clinical relevance of research investigating the socio-cultural influences on suicidal behaviours. The second area explored the clinicians' concerns about the perceived risks of research participation. This included risks to consumers' wellbeing and risks to the impact of research participation on the therapeutic relationship. The third asked clinicians to reflect on the acceptibility of online methods for collecting data on sensitive topics. Investigating perceptions of factors which impeded recruitment of the potential sample to the original study formed the fourth part of the topic guide. Finally, demographic data were collected in the concluding section of the interview.

4.3.4 Procedure for implementation of the present study

As the original study had been approved by the Multi-region Ethics Committee, when the decision was made to change the foci of the study I requested and gained approval from the committee for the modification to the study.

Gaining access to mental health services involved liaison with each of the service managers. My existing relationships with service managers were developed during the early stages of recruitment of the sample to the original study. I contacted the service managers by phone and email to arrange a face-to-face visit to discuss the modification to

the study. The purpose of the modified study was discussed and managers were asked to approve their staff to be approached to participate in the research. All managers agreed to the request. Following a verbal discussion and an emailed letter of invitation (Appendix 5) 13 clinicians were sent an information sheet (Appendix 6) and all clinicians agreed to participate. Before commencing the interviews, consent forms (Appendix 7) were signed by clinicians. The interviews were held over a six-week period in July and August 2011 and the mean duration of the interviews was 35 minutes (range 30-47 minutes). All participants agreed to the interviews being audio recorded. Following each of the 13 interviews, I transcribed them verbatim.

4.3.5 Data analysis

The approach to analysis was informed by Braun and Clarke's (2006) theory of thematic analysis. Due to its theoretical freedom, these authors suggest this form of analysis is compatible with constructionist paradigms. I utilised thematic analysis to explore the ways in which events, realities and meanings are the effects of a range of discourses operating within the disciplines of mental health. This form of analysis provided the framework to guide the development of data collection.

Thematic analysis offers a 'thick' description of the entire data set and supports the development of theory on the socio-cultural contexts and structural conditions that enable the individual clinicians' accounts to be provided. Analysis involves searching for themes that emerge as being important to the description of the phenomenon (Daly, Kellehear, & Gliksman, 1997). This process involves the identification of themes through careful reading and re-reading of the data (Rice & Ezzy, 1999) and is a form of pattern recognition within the data, where emerging themes become the categories for analysis. I outlined a step-by-step proposal for analysis which constitutes a transparent audit trail from the data transcripts to the resultant theory so that the findings are considered as dependable and confirmable.

QSR NVivo (Version 8) qualitative data analysis software was used to manage the data. Transcripts were entered into the programme and a comprehensive process of data coding and identification of themes was undertaken. My aim was to explore and identify a range of issues and perspectives and not to assess the prevalence of the different perspectives among clinicians.

4.3.6 Data reduction and theme development

Qualitative research uses analytical categories to describe and explain social phenomena (Pope, Ziebland, & Mays, 2000) and these categories may be derived inductively or used

deductively. In my analysis I utilised a combined technique of inductive and deductive thematic analysis to reduce the data and develop themes (Figure 1).

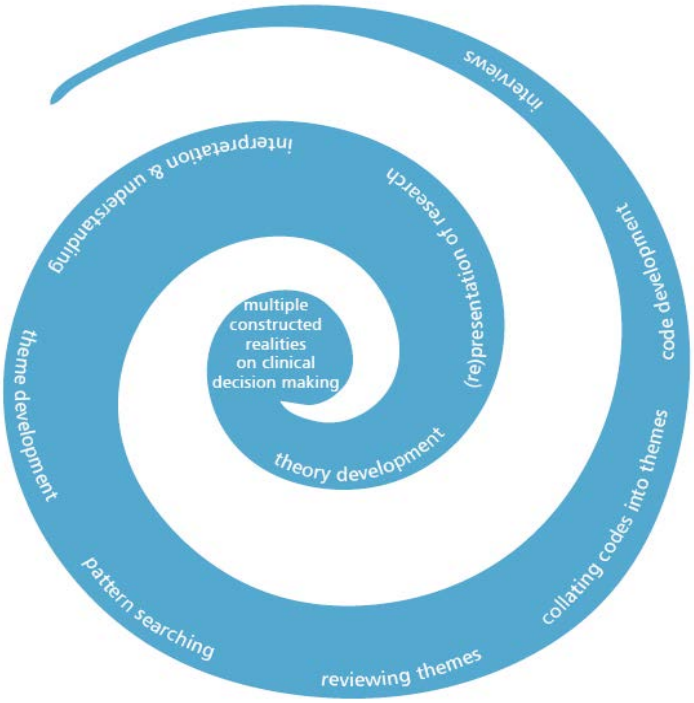


Figure 1. Processes of data reduction and theme development

This approach integrates data driven codes with theory driven codes and incorporates both the data-driven inductive approach of Boyatzis (1998) and the deductive *a priori* template of codes outlined by Miller (1999). This hybrid approach to thematic analysis involved a balance of deductive and inductive coding. First, I identified themes *a priori*. Using a deductive approach I drew on issues derived from my research objectives as well as from pre-defined themes from my reflective field notes made during the research. This approach pre-determined the concepts that would be explored in the interview schedule. Second, I identified themes inductively as concepts and issues from the data which I had not previously considered emerged. I allowed for perspectives and understandings that had not yet been revealed from participants' discussions.

A coding framework was developed based on the theoretical interests guiding the research questions and on the basis of salient issues that arose in the text itself. These two foci were combined and by going through the transcripts the most salient constructs in the discussion were identified and shaped into a finite set of topic codes (tree nodes) that were discrete enough to avoid redundancy and global enough to be meaningful. Explicit boundaries (definitions) were established to limit the scope of coding categories and I

established criteria including key terms, recurrent issues and theoretical concepts in order to explore them systematically. Finally, when the coding was complete themes were abstracted from the coded text segments. I then read and re-read the text segments within the context of the codes and this re-framing allowed me to identify underlying patterns and themes. Table 5 illustrates an example of three topic nodes and shows the frequency of the coding references at the node.

Table 5. An example of topic nodes created in NVivo8

Node 1	
Name:	Research fatigue
Description:	Clinicians' attitudes towards research and the association of research with increased demands on clinician time
Sources:	4
References coded:	6
Theme category:	Multiple clinical priorities
Node 2	
Name:	Clinician accountability
Description:	Issues associated with clinicians' perceptions of their role in safeguarding consumers in relation to their role and function as a responsible clinician
Sources:	5
References coded:	12
Theme category:	Risk holders
Node 3	
Name:	Research relevance
Description:	Perceptions of the relevance of social research to clinical practice
Sources:	13
References coded:	76
Theme category:	Reaching consensus in integrated team

Themes were refined further until they were non-repetitive and broad enough to encapsulate a set of ideas manifesting in numerous text segments. I was then able to reduce the data into a set of significant themes that succinctly summarised the text. Following this I re-read the transcripts to ensure all content related to the research question were captured in the themes together with data extracts relating to exceptional cases. Analysis focused on the discursive themes common across the interviews. I was interested in the themes that were common through both the interviews with practice-based clinicians and clinicians in a leadership position. Another level of analysis focused on individual narratives to explore differences based on disciplinary affiliations. Exceptional case analysis involved a re-examination of the analysed data to determine

whether any cases (i.e. themes) were contradicted by the evidence. This re-examination was important to establish credibility of findings (Silverman, 1989). When no negative case or disconfirming evidence was identified the analysis was considered complete. My aim was twofold and involved both reporting and describing the thematic groupings.

4.4 Reflexivity and evaluative rigour

4.4.1 My influence on the research process

The researcher is actively involved in the social construction of the research reality (Hewitt, 2007). This suggests the role a researcher assumes can influence the outcomes of research. My use of reflexivity in this section enables me to illustrate how my professional and social identity influenced the research process and outcomes.

My role as a researcher evolved during the course of this thesis. While the original research topic was identified by my research supervisors, I was motivated to develop the study. I was motivated by a learning role, and I saw my research as enabling my journey of discovery about the social context of mental health and illness. However, I was reflexive even before stepping into the field and my reservations were related to my suitability to explore this topic, based on my positioning. I was an outsider to the original research topic in many respects. I had limited personal experience with participatory social media, and no prior knowledge of using social media as a data collection tool. I was concerned about my research relationship with consumers even before ethical dilemmas began to emerge. Was I capable of being a responsible researcher? Could I trust myself to be accountable to young people? Was it my responsibility to assess consumers' changing mental health status and make decisions in their best interests? My presupposition about researcher capability and the authority of researchers who were best positioned to undertake clinical research may have affected my ability to engage clinicians and successfully market the original research.

When the present study was being implemented my stance as a researcher changed as the present inquiry became explicitly focused on the clinicians in their role as intermediaries in recruiting consumers. From a position of open curiosity I looked through the interpretive lens of clinicians to consider their obligations to a 'duty to care' and the conflict of interest this presented for them. In the present study, my role was to encourage clinicians to share factors that influenced recruitment failure in the original study. As some clinicians had previously alluded to my non-clinical status as influencing their decision making, my topic guide was constructed to explore their values and attitudes related to a non-clinical researcher's ability and authority to conduct 'clinician research.

Two aspects of my stance as a researcher influenced clinician decision making. The first aspect was related to being an outsider to clinical services. I was outside of and different to the disciplinary backgrounds and mental health subject positions of clinicians as I have a midwifery and public health background. I expressed my need as a researcher to get to know the research setting 'from the inside'. Webb (1992) discusses the overtly social nature of the research process and states that "in a research encounter [others] make judgements about researchers' backgrounds, motives, intentions, beliefs and preferences and respond as they judge appropriate" (p. 749). I was aware of factors influencing trust in my relationships with clinicians, such as inequalities of knowledge, power and environment (Richards & Emslie, 2000).

The second aspect was related to my position as a novice researcher. This positioning may have influenced the trustworthiness of data. For example, my interview style during the early interviews with clinicians mirrored a therapeutic style involving techniques such as reflection, paraphrasing and summarising. Whilst gaining experience in interviewing, these initial interviews could be described as two-way discussions about the challenges I faced in accessing consumers. My inexperience as an interviewer may have compromised the data obtained through inadvertently asking leading questions. A further limitation was related to my attempts to develop rapport with participants. Driven by a sense of reciprocity I became involved in answering clinicians' questions when the 'table was turned' during the interview. For example, on one occasion I asked a clinician to describe the issues involved in online data collection with vulnerable groups. His response was to ask me my opinions about the suitability of this approach. Reciprocity may have been compromised when I imparted my own perceptions of risks in the original study.

As my positioning resulted in a disconnection with clinicians during the data collection period in the original study, I was motivated to engage clinicians in the present study through strengthening my inter-personal relationships and building trust. I attempted to negotiate my outsider position by locating and acknowledging the differences of my positioning in this research. This disclosure helped me to articulate my ethical responsibilities as a researcher in that I shared their concerns of 'doing no harm' and protecting consumers in the process of research. This stance acknowledged the trust I created with clinicians and enabled me to create a safe environment for clinicians to be constructively critical about the original study.

4.4.2 Practical strategies to enhance trustworthiness

In addition to my reflexive approach, trustworthiness of the findings was enhanced through the four strategies detailed below.

First, in designing the research procedure, I deliberately chose the individual semi-structured interview to interview clinicians as during early discussions with clinicians I recognised that clinicians, affiliated to particular disciplines, dominated the discussion. As interdisciplinary tensions were evident during these discussions, my intention here was to capture data based on equity of contribution and freedom to participate without challenging debate arising. Using an individual semi-structured interview approach therefore constituted an appropriate tool to engage clinicians and gather data to address my research question.

Second, I invited all participants to verify transcripts for accuracy as part of a process towards error reduction (Bloor, 1997). Seven participants accepted the invitation to review the transcripts. They each confirmed the transcripts represented an accurate reflection of their viewpoints and perspectives and requested no changes. It was outside the scope of the study to extend the process of member checking (Lincoln & Guba, 1985) and provide participants with a summary of analysis and conclusions.

Third, to address the issues of resonance, I relied on an independent peer review of my study by an audience with no direct experience with the topic. Resonance refers to a study's ability to meaningfully reverberate and affect an audience (Tracy, 2010). I shared my draft with seven readers in Wellington's Regional Public Health service and requested they provide feedback on how they identified with the topic and the experiences of participants. Resonance also emerges through a study's potential to be valuable across a variety of contexts or situations and one reader commented on the transferability of findings to a different public health context. Fourth, I utilised an audit trail process which involved documenting clinician responses during data collection in the original study. I also created an audit trail during the stages of analysis, updating my records after analysis of each interview. This process supported the development of a highly contextual topic guide, increasing the trustworthiness of the research.

4.5 Procedural ethics

Anonymity and confidentiality are two ethical issues that are particularly important when undertaking qualitative research (Goodwin, 2006). Protecting the confidentiality of participants was a priority in this study due to the small number of settings and individuals participating. I took the following steps to maintain confidentiality. First, the research design was adapted to include more than one clinical setting in the greater Wellington region. Second, in reproducing participants' verbatim responses I removed potentionally identifiable information about the clinician's setting or nuances of speech that could identify them. Data in this study could also be considered as sensitive due to its focus on

exploring culture and norms in clinical practices. Was there potential harm for participants in the present study? Participants were asked questions about organisational norms and practices related to supporting research and collaborating with research institutions. In doing so, they were prompted to share information on the unique characteristics of their service culture. This had the potential to expose negative team practices related to involving consumers in research. Taking this step to protect data was therefore important to avoid compromising the identity of participants in ways that had potential to be harmful to participants and their teams. Therefore, where clinicians' exact words are reproduced, clinicians are identified only by their professional discipline.

Notwithstanding the ethical requirements discussed above, there was minimal risk of harm to participants. Due to the professional status of mental health clinicians, they did not constitute a group with dinimished autonomy or competence.

4.6 Synopsis of chapter

This chapter introduced my rationale for working in a qualitative research paradigm. The semi-structured interview constituted the data collection tool to explore clinicians' perspectives on barriers to involving young male consumers in the original study. An outline of the steps of my analysis from data management, to data reduction and resultant development of themes was presented. I provided a reflexive account of my positionality in the research process and illustrated how my assumptions related to my positioning as an outsider and novice researcher may have influenced trustworthiness of the research. The chapter concluded with a review of ethical problems arising throughout the data collection with clinicians. The next chapter will report and describe the thematic groupings, and shows how analysis moves beyond simple description to interpret how clinicians' constructions of themes are interconnected.

Chapter 5

Findings

5.1 Introduction

The thematic approach to analysis identified key concepts and categories which illustrated the influences on clinicians' decisions to recruit consumers to the original study on suicidality. This chapter discusses the factors influencing clinicians' decision making. Influences on clinicians' decision making were complex and multi-faceted and findings show a variety of contextual, disciplinary, and relational aspects on clinicians' decisions (Figure 2). The presentation of each theme displays the dominant influences on clinicians' decisions to recruit consumers. This chapter concludes with findings which were identified as enabling future efforts to increase participation of consumers in suicide research.

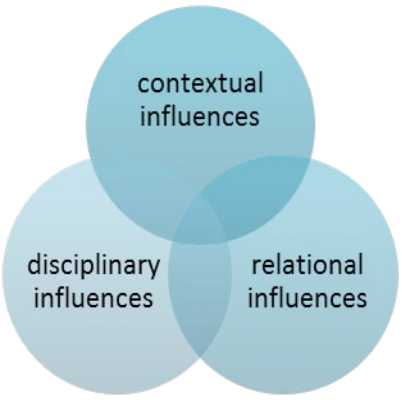


Figure 2. Influences on clinicians' decision making

5.2 Overview of clinicians

Thirteen mental health clinicians were recruited to the study. These clinicians had a variety of disciplinary backgrounds and worked in different clinical environments. The characteristics of the clinicians and the services in which they were located are summarised in Table 5.

Table 6. Clinician characteristics and setting

Clinician characteristics	Clinicians (*n*)
Gender	
Male	5
Female	8
Discipline	
Social work (SW)	3
Nursing (N)	4
Clinical psychology (CP)	5
General practice (GP)	1
Managerial/leadership role	
Yes	6
No	7
Previous research experience	
Social work	1
Nursing	2
Clinical psychology	2
No research experience	8
Setting	**Clinicians (*n*)**
Service type	
Child/adolescent	6
Adolescent/adult	4
Adult	3
Agreement to support recruitment in the original study	
Yes	7
No	6

5.3 Contextual influences on clinicians' decision making

This theme describes the contextual influences on decision making in the community mental health services operating environment (Figure 3). The theme incorporates a variety of factors inherent within the clinical setting which impacted on clinicians' decisions to introduce consumer participation in the original study. These factors included reaching consensus on research priorities within integrated teams, balancing multiple priorities in the day-to-day work of clinicians, and the complexities of engaging users of mental health services.

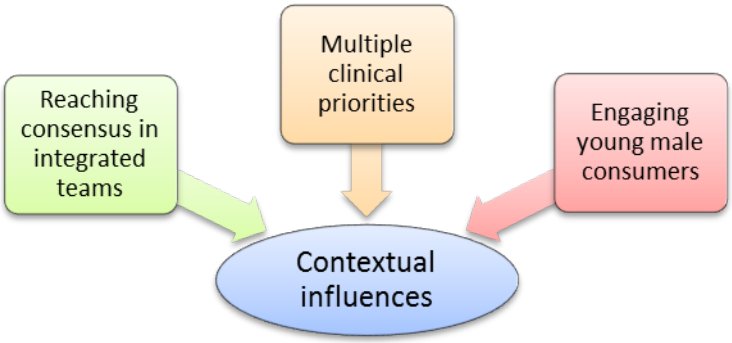


Figure 3. Contextual influences on decision making

5.3.1 Reaching consensus in integrated teams

Multidisciplinary team working is a recognised model for working in community based child and adolescent mental health services. This approach to service delivery enables different professions to work together. While clinicians in heterogeneous teams provided an integrated approach to care, it was observed that the multidisciplinary teams did not have shared goals and values when it came to deciding on research priorities. The essence of this sub-theme is perhaps best captured by the metaphor, "*it's a research minefield*" (N). For the most part, there was little inter-disciplinary consensus on issues concerning research within the teams.

> *Because we are such an integrated* [multidisciplinary] *team it's very hard to have a team perspective...we don't have one clear clinical identity or view really. We're very much an integrated service…and that's why it makes for such an interesting and sometimes challenging job in trying to manage such a range of conflicting clinical views really.* (SW)

While managerial paternalism was evident for some clinicians, there was an example of a differing approach to decision making in another team. One manager described how his multidisciplinary team took a democratic approach and adopted a shared decision making model:

> *It's usually a case of either hearing about a study or being approached by researchers and then there being a discussion in the team about whether it's felt to be appropriate to promote to clients or not.* (SW)

It was apparent, from what the clinicians shared, that there was considerable affinity between clinicians from different disciplinary backgrounds regarding the relevance of research investigating the socio-cultural influences on suicide and self-harm. There were seven participants who supported research with a health determinants focus. These positions acknowledged that "*all of the kids that we work with exist in a social context"*

(SW) and these clinicians recognised the influence of broader social and environmental factors on mental health. They considered it important to undertake research which increased understanding of how the social context impacts on consumers.

> *It's relevant because it provides a broader perspective of what's impacting on self-harm among young people and I think that we need to be aware of all the influences that come into why someone might be self-harming. Taking into account the social aspect is really important and especially on a topic like self-harm where beginning that behaviour can often be influenced by...external factors.* (CP)

Clinicians, supporting this position, considered the media's influence on young people as a relevant research topic as "*so much of what affects young people's physical health comes from the environment"* (SW).

Despite these positions supporting research on social context, some clinicians (*n*=6) conveyed that because the original research was not directly related to clinical practice they did not view the research relevant, *"every service has its own idea about what is useful"* (N). The topic in the original research was considered a low priority in comparison to other topics and clinicians holding leadership and managerial roles were more likely to perceive research exploring social determinants of mental illness as a lesser priority. These clinicians assigned greater relevance to service evaluations and research on treatment programmes as they perceived these topics to be more closely related to improving health outcomes for consumers.

> *It* [the original study] *is distally related to our clinical practice…it looks at factors that are potentially influencing self-harm but by the time they get to us they are already self-harming so while that's theoretically interesting it's not directly related to clinical practice.* (CP)

One social worker manager commented: *"We are just seeing such a growth in young people's needs around mental health services at the moment"* (SW). He went on to say his team were *"more interested in* [research] *that's going to make a stronger case for youth health services and meeting those big gaps in mental health services...so outcomes …evaluations"* (SW). Similarly, a different team leader stated *"the main types of research …that we would be interested in…would be treatment studies so looking at the efficacy of a particular form of treatment"* (CP).

There was also an association between the relevance of the research and the level of interest that clinicians had in the topic. Having stated the importance of research as being related to clinical practice, a psychologist explained "*the more removed it is from direct clinical practice the less emphasis...the less interest people will have"* (CP).

Clinicians valued being involved in discussions following closure of a research project. They expressed interest in the outcomes of research *"something beyond a research summary or research report"* (SW). In particular, clinicians described their expectations that researchers analyse findings in relation to the clinical priorities of mental health services.

> *We don't just want a copy of the research at the end. We want to know how this affects us, what does this mean for what we are doing out here ...certainly there's been examples of being involved in research and we've heard nothing...once they've* [the researchers] *got their focus groups or whatever it is that's the last we've ever heard of them and it's certainly the last the young people ever heard of them and I think that responsibility to come back and let people know what you did with that information you got from.* (SW)

Where clinicians had prior negative experiences of being involved in studies they were less likely to agree to support research: *"We get asked to do a lot of things and we don't necessarily always get to see the results of what we actually do…it* [the research] *just disappears into a black hole"* (N).

5.3.2 Multiple clinical priorities

Clinicians in managerial and leadership roles discussed the difficulties for their staff in balancing clinical priorities, primarily client contact time with research activities: "*When you're as ridiculously busy as what they currently are…all that stuff falls by the wayside and we use every hour of their 37.5 hours a week in clinical time"* (SW). Even when a research topic has high clinical relevance: "*our day-to-day work, our clinical work, takes over everything else and it's very difficult to allocate the time to research"* (N).

> *We don't prioritise research as much as we would say the…therapeutic work, so it's trying to find that balance and were we can fit in with our caseload management. How do we contain our work day? If we start getting into research and we've got somebody who's presented acutely and we've got two deadlines…the research is going to be pushed back and then people would really worry that it would spill out into their own time.* (CP)

In addition, clinicians stated that due to the constraints on services they are supporting a higher number of consumers in crisis. One manager commented that a key influence on her decision not to support research in general was related to increased service pressures in a changing operating environment:

> *On a much more strategic kind of level within primary care certainly we're seeing a whole lot of stuff that previously would have been dealt with in specialist services. So for example, our GPs will be managing young people with serious mental health issues...no longer just the mild depression but serious mental health stuff...those*

secondary services don't have the capacity either to be picking up all of the referrals that we're sending their way. (SW)

Another key influence on decision making in research involved the concept of benefit: benefit to clinicians and to consumers.

There are so many different sorts of research that goes on and it's all part of research fatigue but it's like a lot of things that we're asked to do we don't necessarily see the results of the effort and it's not only for us but for the clients as well they might not necessarily see the results of what they've taken part in …they're quite happy to take part and sometimes they don't necessarily want to see what the results are…they would be just happy to take part because they think probably what they're experiencing might benefit somebody else later on down the track. (N)

Managerial paternalism occurred at a high level within the multidisciplinary team whereby managers protected clinicians from collaborating with the original study to minimise competing priorities. Paternalistic attitudes and behaviours by clinicians in the management structure often meant that individual team members were not involved in shared decision making practices. Three of the five team leaders/managers identified paternalism as a positive, protective behaviour which was necessary of clinicians with managerial duties. These clinicians identified different factors and dimensions relating to their decision making on behalf of the teams. A key factor influencing two managers' decisions not to collaborate in the original study was the impact of the high number of research requests they had on already busy clinicians. For one of these managers, the concern was about 'finding' consumers to participate:

It's wearying...it's really wearying....often we will look at it and say "yeah I would love to find young people for that" but where do you draw the line? ...Where do we take that from?...Where do you want me to do this kind of ten hours worth of work that's going to do that for you? You don't just walk out into the waiting room and go "you, you, you and you...can you come over here and do this". (SW)

A manager in a different service explained his decision not to recruit consumers was related to clinicians' workloads:

Even though this is a very, very, small request, it's just another thing that you are asking people to do and all of those very, very, small requests all build up to end up being quite an unmanageable amount and so you have to be very, very, careful about what you are asking people to do, constantly do, because there's always something new. (SW)

This manager made a judgement about not supporting the original study to "*protect the time of the clinicians"* (SW). However, in relation to his management role he said:

> *I'd hate to think of myself as the gatekeeper but with the best interests of the staff at heart I know that they have no capacity to be able to spend four hours hearing about this…so I guess I need to make those judgement calls.* (SW)

5.3.3 Engaging young male consumers

This sub-theme describes challenges clinicians identified in relation to the client group of mental health services. It discusses the complexities in recruiting young male consumers to suicide-related research. Generally, clinicians described factors associated with the client group's characteristics as presenting obstacles to the recruitment of consumers in the original study. Young men who experienced mental health problems were described as a vulnerable and high-need client group. Clinicians reflected that young men in crisis experience difficulties in obtaining mental health care and many clinicians commented that this was a barrier to undertaking research with this group: "*I don't know how you are gonna access those clients because they would be so hidden"* (N).

> *A large proportion of the population that you're aiming for do not have contact with the mental health services…I would say that is arguably…one of the biggest* [challenges]*. They're* [young men] *less likely to present and from my knowledge of young men at risk of suicide and self-harm, particularly young Māori, young Pacific, young migrant, young same-sex attracted people, we don't see them here and so being able to find them where they are would definitely be a recruiting challenge.* (SW)

Challenges in engaging young male consumers affected rapport between consumers and clinicians and this played a key role in influencing clinicians' decisions to invite consumers to participate in the original study. Additionally, clinicians talked about the social pressures and unique complexities of this client group: "*You're dealing with a population that obviously has very high levels of distress and so as a clinician the focus needs to be on that client's priorities"* (CP).

Clinicians were aware of the broader social influences that may affect consumers' motivation to participate in research.

> *The simple fact is that a lot of the people we support are people that are just struggling with day-to-day concepts and day-to-day kind of living skills really and it can be hard to introduce an academic piece of work for someone to be involved in and quite often people just simply don't wanna be involved.* (SW)

Some clinicians also considered that the longitudinal features of the online design in the original study were not congruent with the motivation of the client group:

> *To talk about something that's happening over the next four months when they* [the consumers] *don't know where they're sleeping tonight or they don't know how long their benefit is going to keep going for or they are completely consumed by trying to find a job and there's nothing in their life that's important and by feeling absolutely depressed because they can't find a job...all that other stuff just feels frivolous to them.* (SW)

One clinician reflected on the differences in how young men and young women engage in services. He considered that building relationships with female consumers was more likely to result in clinicians inviting the females to participate in research. Concerned about jeopardising already fragile relationships with male service consumers, he said:

> *We don't get heaps of males who are presenting for self-harming...we might get males presenting who have attempted suicide...but they're a much small proportion of the population that we see and often engagement with them is more tricky than it is with young women and so they don't engage as well. In contrast some of our adolescent females are more engaged and there's a better rapport with them and therefore we would feel more comfortable asking them.* (CP)

5.4 Disciplinary influences on clinicians' decision making

This theme explores disciplinary influences on clinicians' decision making within the multidisciplinary team (Figure 4). It describes the disciplinary viewpoints from the four disciplinary groups on factors influencing decisions to collaborate in the original study. Clinicians' perceptions of their role as 'holders of risk' are presented, together with an illustration of the dilemmas they experienced in relation to their different perspectives on autonomy and paternalism. In addition, clinicians' use of safety nets, designed to minimise risk to consumers are discussed.

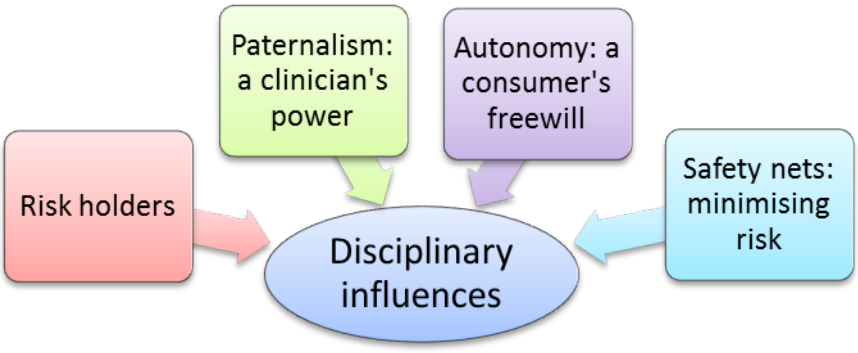


Figure 4. Disciplinary influences on decision making

5.4.1 Risk holders

Risk assessment is a key component of mental health services and clinicians did not dispute the importance of good practice in this arena. When presented with an invitation to collaborate with university research teams, clinicians revealed how they carefully considered their response to the request. In estimating the level of risk for consumers, one clinician asked: *"Is it going to be safe for those young people?"* (N).

Clinicians' perception of their role as risk holders, containing risk for consumers, was a dominant theme. In a similar way to managers and team leaders use of paternalistic behaviours, these clinicians used paternalistic behaviours to protect consumers from potential harm. Clinicians reflected on the ethical and professional dilemmas they faced when they were asked to introduce a research request to consumers. They emphasised a continuum of views from their role in protecting consumers, from potential research harms to enabling consumers to make their own decisions about research participation. Clinicians discussed their accountabilities to consumers and these differences were related to their perceptions of 'who' has autonomy in decision making.

> *In mental health services there is a lot of emphasis put on responsibility. Who is responsible? How responsible are the clinicians for what happens with the client? Some of the really serious adverse outcomes that there has been for clients of mental health services in the past...it creates fear about how responsible we are for what happens to our client regardless of who else is involved in that young person's life.* (SW)

> *If a client misinterpreted the therapeutic relationship with the researcher and maybe disclosed more to them about how they were feeling and things rather than perhaps the clinician who thought that they were perhaps improving and then the person self-harmed or...and then in retrospect you would look back and see the warning signs there but if the researcher is not somebody whose trained in mental health field?* (GP)

5.4.2 Paternalism: A clinician's power

There was a continuum of positions on paternalism and autonomy. The concept of paternalism was a dominant finding and clinicians from different disciplinary backgrounds exercised their 'duty to care' for clients by restricting access to consumers. Clinicians holding this position (*n*=8) expressed their anxiety about consumer participation in suicide research. Their paternalistic attitudes were linked to concerns about consumers' fluctuating mental health symptoms and clinicians justified their approach especially when a client was perceived to be in crisis.

> *Sometimes it's hard to know how much* [of the decision] *is abiding paternalism...these are young people in distress and part of our professional role from experience and training is to assist them through that. However alongside that kind of swims that paternalism…making decisions for...I'm acting in your best interests...I'll make this decision for you and not let you chose for yourself because we know best.* (SW)

The majority of clinicians said they would not introduce a request to participate in research if the client was in crisis.

> *If it was a clinically sensitive time…no way, I'm not gonna talk about that with them today because it's a pretty heavy session for them. There might be some people who are a little protective of their clients and people think "oh no they might be too...it's not the right time for them...they're too vulnerable or too fragile at the moment to participate in doing that".* (CP)

One way in which clinicians reduced their 'own' anxiety related to consumer participation in research was to minimise the impact of any potential harm. These clinicians chose to protect consumers where the potential harm of research participation was unknown: *"maybe this young person couldn't manage it…maybe we're being a bit protective"* (CP).

The influences from the external environment or social spaces that the consumer exists in were also recognised by clinicians.

> *We do run into that trap of thinking that we know everything about what our clients do and who they interact with and we can control it all which is actually a myth* [laughter] *but we like to perpetuate it because it helps us feel that we have been responsible and doing everything that we can to make sure that young person is safe.* (SW)

> *Of course sometimes with mental health clients that can change. At the beginning of the study they might be quite well…in the beginning they might be suitable…but their mental health might deteriorate in say the next time that you actually see them so it kind of fluctuates.* (N)

Additionally, the sensitive nature of the research was described as a factor influencing paternalistic behaviours.

> *I think the clinicians themselves have to weigh up whether or not a person is suitable or whether they are ready to take part in research and it may actually bring up some topics or subjects that might be a bit too sensitive for them so in a way the research has to be guided by the clinician.* (N)

Clinicians also attempted to construct their client's interpretation of the relationship that could develop between the researcher and the consumer. In some cases, clinicians

thought that the consumer would perceive the relationship as therapeutic and therefore have potential to impact on the clinician/client therapeutic relationship. A social worker expressed the following view:

> *I think that the client would see it as a therapeutic relationship even if you set it out quite clearly at the beginning that it…wasn't. For a lot of our clients we try and encourage just one therapeutic relationship…they often have multiple relationships…there often is lots of people involved in their care…because you know exactly what's been discussed, what advice has been given...and I think different people have different opinions and give different advice...it just causes sometimes conflict.* (SW)

Conversely, one nurse rejected this view and considered there to be little risk to the clinician/client therapeutic relationship if developing multiple contacts.

> *I don't see anything wrong with that…that a relationship develops…they know that you're a researcher…they know that contact will stop at the end…they know that if they express something to you…you will refer them back to who's the most appropriate person...and people need relationships…they need to be able to have short-term relationships for a purpose and move on.* (N)

The concept of recruitment coercion presented a dilemma for clinicians. I discerned in these views that concern about coercive practices was a dominant theme that impacted on decision making. Some clinicians considered that clients may seek clinician acceptance by participating in research: *"for some clients it might be quite coercive if they are vulnerable and wanting to please"* (CP).

Clinicians reflected that the relationship between mental health workers and their clients can be quite strained at times and it was important to these clinicians that there was no attempt to influence consumers to undertake research activities.

> *As a leadership group here, we do have concerns that we don't want the people who are using our service, particularly younger people who are easily influenced, to feel that we are asking them to undertake research or to be involved in research projects or that it will improve our interaction with them in any way if they appease us by undertaking that particular piece of work or to be a part of that study.* (N)

5.4.3 Autonomy: A consumer's free will

In contrast to the dominant theme relating to a clinician's power and authority in relation to decision making, the alternative position of consumer free will emerged from the interview data. Converse to clinicians making a decision on behalf of their clients there were a few instances of clinicians (*n*=5) constructing the client as an autonomous

consumer: "*they're* [consumers] *in charge of who they relate to"* (N). Clinicians from different educational backgrounds shared these views and disputed that inviting consumers to participate in research constituted coercive practices.

> *I don't necessarily see it as a form of coercion…but it's how you present it to a client...there's no coercion as I would explain* [to the client] *"you don't have to take part if you don't want to, if you change your mind then that's OK as well, I will leave it up to you".* (SW)

Clinicians supporting consumer autonomy constructed a different kind of need, namely their client's asserted need to make an independent judgment about their ability to participate.

> *This has to be the young person's choice as to whether they are gonna be involved or not and I don't really think it's for us as a service to be making the decision for someone as to whether they are OK or not to be involved in it.* (SW)

One clinical leader disputed that approval from case managers was necessary. This clinician suggested that informing case managers as opposed to securing their permission to recruit consumers was appropriate to protect autonomy of consumers:

> *I don't know that they need to give their approval…I think the young person can make their decision mostly…but I think it would be useful for them* [the case manager] *to know that the research is taking place.* (CP)

Despite this viewpoint, another clinical leader who also supported consumer autonomy in decision making was still concerned with the importance of risk assessment and management of the client with a view to minimising the risk of harm from research participation:

> *The case manager has most contact with the client and they would be a good judge as to whether they're suitable or whether they're able at this moment in time to actually take part in the research.* (N)

5.4.4 Safety nets: Minimising risk

Clinicians illustrated that where relationships between research institutions and clinical services were not well established, clinicians imposed 'safety nets' which represented obstacles for the research process. One of the safety nets described by clinicians related to monitoring safety and minimising risk throughout the duration of a study.

> *I think it's a sensitive topic for them to be opening up about to someone and it would be important for their safety to be monitored...just in case they divulge something that they didn't really expect they would…and then having someone that they could talk to about that and seek extra support if they feel triggered at*

all…so I think it's about that ongoing management, skills to manage and monitor basic mental health through that period and relationship building skills to make sure that that therapeutic relationship is maintained. (CP)

Busy clinicians said that unless additional resources were provided to meet the increasing burden, individual practitioners might settle for the 'safest' option. The safe option was unlikely to favour increased choice for consumers. A clinician's dilemma focused on whether the principle of respect for autonomy, and giving clients the decision making authority should have priority in clinical services.

Clinical safety nets were also constructed as a way of safeguarding the researcher from any risk.

My worry would be around the relationship…that you would be put into a position of having to manage risk. It would be their relationship with you on the line because clients have relationships with all sorts of people that deal with all their risk. Like their parents, their GPs and their teachers so you know that's not unusual for a clinician to have other people involved in a trusting way and you know that they go to and you know containing risk as a clinician you are mostly not the only person containing risk so you know it would be your risk in that position. (N)

5.5 Relational influences on clinicians' decision making

This theme explores relational influences on decision making (Figure 5). Clinicians' perspectives on inter-institutional relationships, together with inter-personal relationships, between individual clinicians and researchers, are discussed. Factors relating to the importance of trust between potential partners in a research project were discussed.

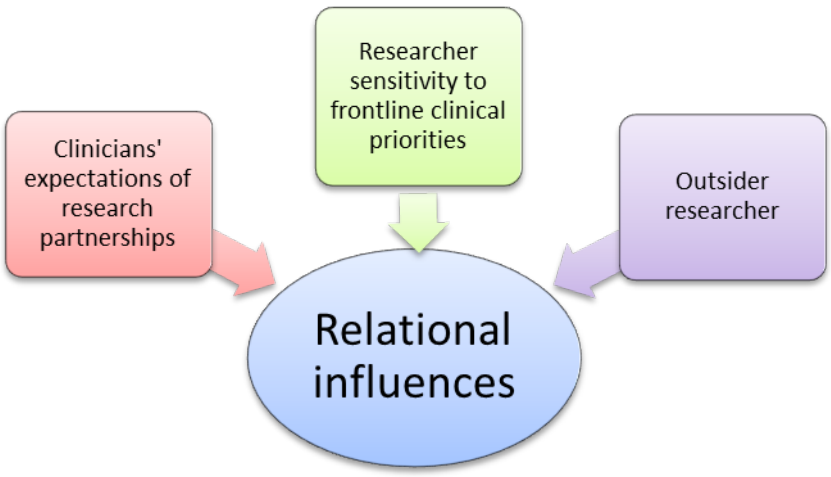


Figure 5. Relational influences on decision making

5.5.1 Clinicians' expectations of research partnerships

Many clinicians considered relationships between universities and clinical services to be fragile. Factors influencing clinician decision making in the original study were related to clinicians' prior experiences of research partnerships with other academic institutions. Clinicians highlighted that they expected partnerships to be reciprocal in nature: *"If* [the university] *want to involve us and work with us in true partnership there needs to be a really good relationship…how can we help you and how can you help us?"* (N)

Reciprocity was discussed in terms of 'giving back', not only to the clinical workforce but to consumers participating in the research. One team leader discussed the positive outcomes of her service's collaboration with a different university team.

> *When we saw it* [the different research study] *we thought that's fantastic because it gave our young people something…they were assessed by clinical psychologists at the beginning and half way through and at the end so there were lots of safety checks for the young people. We were provided with equipment that we could use at the end of it…a computer…we were provided with some money from it…so that was a way of revenue for us…staff were getting training…it was growing staff, they're paying us and she* [the lead investigator] *provides mentoring for me…she provides mentoring for other staff so there's a lot given back.* (N)

Where clinicians had a negative experience of research partnerships, this had a direct impact on decision making. The same team leader compared her prior experience of research partnerships with her decision not to collaborate with the original study:

> *It's very hard when there are one-off researchers coming at you all the time and you're getting them from everywhere. It feels like* [single researchers] *come and take… they've got to get their degree or their masters…it was so different working with* [the other university team]*…it was a true partnership and that relationship is on-going.* (N)

Clinicians had little recollection of universities approaching clinical services to forge research partnerships: *"Some team members do their own research related to their practice but we don't have academic institutions often come in and say that they want to be involved with us"* (CP). Clinicians commented that when partnerships were established they were often informal in nature and based on *"a few conversations every now and then"* (CP).

5.5.2 Researcher sensitivity to front-line clinical priorities

University research priorities were viewed as representing different needs from those identified by clinicians working in practice settings. In community mental health settings,

clinicians' research needs were related to improving health outcomes for young consumers.

> *Are they* [universities] *interested in youth health and social services…are they interested in youth? Come down and talk to us about what we perceive the needs as…get a feel for actually what's happening at the coalface and then build that relationship. Make it real.* (N)

> *It would be a rare synchronicity for a researcher to say "oh I was just thinking about doing that…how about collaborating"…unfortunately there is a disconnect between research and clinical practice.* (CP)

Clinicians perceived that there was little sensitivity displayed by university researchers in terms of researcher understanding and insight into the factors which could adversely affect the relationships between clinicians and their clients.

> *I didn't feel pressured by when you came and presented to us and I haven't felt particularly pressured at other times. I just do think that the universities…should be perhaps mindful of…the privileged relationship that we, as clinicians, have.* (N)

> *I think the days are long gone, or should be long gone, where we just bumble our ways through relationships with people. We have a peculiar position of power…we have privileged knowledge. They tell us things that they may not choose to tell a family member.* (N)

5.5.3 Outsider researcher

Another factor influencing clinicians' decision making with my earlier study was my role as an outsider researcher. Clinicians' discourse conveyed emotive terms such as "*meddling around"* and "*worried".* These were evident in the following statement:

> *I think you probably saw that when you initially presented the research you were doing, that people's first reaction to it particularly with the population you're looking at will be worry…"I'm worried with you kind of meddling around* [laughter] *with these clients* [laughter] *and making things more difficult" and so I think you'd need a very good relationship with the people who you are working with to get past that initial worry…they'd need to know what you're doing and how you're doing things.* (CP)

This anxiety was related to the position of the researcher. Where the researcher did not share clinicians' characteristics in terms of professional training, this increased clinician anxiety about recruiting consumers. Two clinicians suggested that unless the researcher has a clinical background in mental health there would be an increase in clinician anxiety about the research.

> *Having non-clinician interviewers…that adds a level, a degree of difficulty…the unknown is scary…so if there's something to take away from this experience it's finding ways of doing that groundwork to help people feel comfortable with you.* (SW)

However, divergent opinions were evident in the multidisciplinary team. Some clinicians considered that non-clinicians could undertake research with consumers, so long as researchers had an understanding of the broader context of mental health. This clinical psychologist said this would help gain trust of clinicians:

> *As long as the researcher has up-skilled in the area in which they are researching. So, for example if it is self-harm or suicide, having a background in that and perhaps some basic training in the area and then being able to apply that knowledge…not necessarily needing a complete mental health background but I think having some background in that area would be really helpful.* (CP)

Other clinicians, instead, focused on the personal qualities necessary for a researcher to have. A team leader reflected:

> *I don't think the researcher needs to have been a mental health clinician…I think that we need to know that the researcher is going to interact with the young person in a way that's respectful and non-threatening. Personality is quite important but how do you get that across when you don't spend a lot of time with the team…it's quite a tricky one.* (CP)

Clinicians felt it was important to know the researcher in a professional context. Where clinicians didn't know the researcher, trust was absent and clinicians were unlikely to recruit consumers.

> *Potentially by that point clinicians are on a kind of a thinking track…of let's see how many ethical dilemmas we can come up with* [laughter]*…could there be any difficulties with this research rather than let's see how we can make this research...work.* (CP)

A nurse also shared this perspective and discussed her rationale for not supporting consumer recruitment in the original study:

> *We work really hard…our staff work really well with youth…and if we recommend you and put your name forward, in a way you're aligned with our service, so you represent us as well.* (N)

A clinical psychologist explained that the researcher being *"an outsider and working with a population that most often has us worried as well"* (CP) was likely to result in clinicians not providing access to young consumers.

5.6 Strategic enablers

This theme explores strategic level enablers identified by clinicians as being likely to improve recruitment of young male consumers to suicide research. The sub-themes represent specific leadership practices which could be initiated by research institutions and individual researchers for more effective engagement with mental health services. These include clinicians' perspectives on minimising research-practice disconnect, involving consumers in research partnerships and building research competencies in the clinical workforce. Such university-led leadership practices could potentially offer solutions for increasing consumer participation in suicide research.

5.6.1 Minimise research-practice disconnect

The research-practice disconnect reflects both cultural and social factors within universities and clinical services, as well as how knowledge is exchanged between agencies. The following quotation illustrates a social worker's perspective for developing a shared dialogue:

> *That* [the clinician's preferred] *relationship with the research institutions is that we have the ability to say to them...look in our practice...here's what we are seeing is important ...we're not really interested in what you've identified over there* [laughter]*...the day to day reality for us here is...so I guess meeting our needs kind of stuff. We're not involved in any way in research programmes in any of the universities...having more of a relationship with* [universities] *and saying* [the service] *is interested in anything you are doing around youth mental health.* (SW)

One clinician discussed factors in the clinical environment that hindered knowledge exchange across the sectors:

> *One of the issues about the CAMHS* [Community Adult Mental Health Services] *is that they are very closed…even though I'm on the inside and I can't feel that, I do know that's quite a difficulty. It is a little bit like your head's down, you're working hard, you're getting on with the business, you don't have time to maintain a relationship. We don't have particularly open relationships with the community…the business siloing of our institutions, actually broke down all the networks that existed …so it's not good…the community's not built for research.* (SW)

Improving the connection between research and practice was identified as a desirable outcome by clinicians. Building a collaborative partnership between services and universities was recognised as an essential pre-requisite for engaging consumers in research.

> *I know of an example where the university is working with an NGO* [non-government organisation] *and these guys are responsible for bringing in the young people…they've been trained in interview techniques and all that sort of stuff…it has real potential…using the youth work skills of this agency over here to keep those young people involved on a much wider level.* (SW)

Clinicians shared their perspectives on solutions to establishing a shared dialogue to minimise research-practice disconnect. Solutions included utilising professional clinical leaders to engage in partnerships with university researchers.

> *Probably a connection with the researcher and/or research institution...my guess...is that some disciplines would probably be more open to it than others and I'm thinking psychiatry and psychology because of their backgrounds in research are probably more au fait with research and potentially therefore are more open to doing it...a large number of our clinical psychs* [psychologists] *have relationships with* [a university] *and therefore know the people...it's who you know…they're more likely to feel a connection with the researcher or research institution and that would bump it up in their priority.* (CP)

5.6.2 Involve consumers in partnerships

Some clinicians communicated that young people would be more likely to engage in studies which incorporated youth participation principles in the research design. This involves researchers:

> *Learning about ways to involve young people in research design…going back to real basic youth participation principles and in the set up of your research saying if I'm going to research some young people perhaps have a chat to a few about how it's gonna work…"what's the best way to do that?"* (SW)

This social worker considered the advantages of this approach*:*

> *Young people attract other young people so if you have a group of young people that you pull together that have a real interest in this research… you might sit down with them and say "here's how the questions are shaping up give me a little bit of feedback around this"… but part of the real value will be...that they will then go back out into their networks... groups and...schools or wherever it is where they're going and they will pull people back in...hook people back in. I think we need to be figuring out what's in it for them.* (SW)

5.6.3 Build research competencies in clinical teams

Building research skills and competencies in the clinical workforce was identified as an important step towards increasing the relevance of research for clinicians. Developing the

clinical workforce to include clinicians with specific research roles in the multidisciplinary team was also considered a solution to enable clinicians to improve their research and inquiry skills. It was also suggested this could support a culture change towards a research orientated culture. In particular, one team leader considered the potential for developing new roles:

> *We are a clinical service and we've never done research and I know that clinicians from time to time have talked about it...maybe having somebody like a research fellow for example embedded in the team because that would at least give research more of a prominence ...a face really in the team which it doesn't have at present…there are clinicians interested at present...but they say "we're never gonna do that...we've never got enough time…we've got clinical stuff".* (CP)

This leader suggested that while there was a recent move towards research given its importance in mental health competency frameworks, it remained challenging to influence high level clinical managers: *"As a service what we need is to have it supported all the way up the management line"* (CP).

A solution for making research more meaningful for clinical services was suggested by this team leader. She talked about the potential for influencing clinical leaders and operations managers who provide leadership and management to *"make it more present in their minds"* (CP).

> *Having some relationship with …Planning and Funding* [district health board unit] *or certainly with the mental health managers up a level from me so when they co-ordinate and think about the plan for all the service that something in there might include research…and if part of that bigger plan* [the annual plan] *included research then that would be something.* (CP)

5.7 Summary of findings

A thematic analysis showed the influences on clinicians' decisions to recruit young male consumers in the original study. Findings from 13 mental health clinicians identified a variety of complex and multi-faceted perspectives on recruitment barriers. Contextual influences showed that multidisciplinary teams didn't have shared goals or values which supported decision making on involving consumers in suicide research. These factors included competing clinical priorities and young men being under-represented in clinical services. Disciplinary influences discussed perspectives on risk and this was identified as being a prominent factor influencing decision making. Team leaders and managers displayed paternalistic behaviours to protect clinicians from the risk of being overburdened from managing competing priorities. Clinicians in non-leadership roles also identified how paternalism acted to protect consumers from potential harm related to research

participation. These clinicians identified benefits associated with not inviting consumers to participate in the original study and these included protection of the client/clinician therapeutic relationship and avoidance of coercion. Relational influences on decision making illustrated the value that clinicians placed on relationship development. Developing reciprocal learning partnerships between universities and clinical services were as important to clinicians as the inter-personal relationships between clinicians and individual researchers. Finally, strategic enablers identified a potential role for universities in providing leadership and support to enable clinical services and consumers to form effective partnerships. These findings offer a useful explanatory model as to why recruitment failure can occur in studies involving clinicians as intermediaries in recruiting of consumers to suicide research.

Chapter 6

Discussion

6.1 Introduction

In this chapter I discuss what this study revealed about the factors influencing clinicians' decisions to recruit young male mental health service consumers to participate in research about suicide. This chapter commences with an overview of key findings. Clinicians' perspectives on construction of risk in sensitive research, the relevance of research exploring socio-cultural influences on suicidality, and the impacts of paternalism on consumer recruitment are discussed. Participatory approaches to partnerships are presented as a mechanism for universities to negotiate relationships with clinical services and mental health consumers to increase consumer perspectives in shaping research. Recommendations for universities, which focus on providing leadership to the sector in creating a collaborative environment sensitive to the needs of clinicians and consumers, are outlined. This chapter also presents the strengths and limitations of the study. In addition, areas for new research directions are indicated, together with implications for research practice.

6.2 Overview of key findings

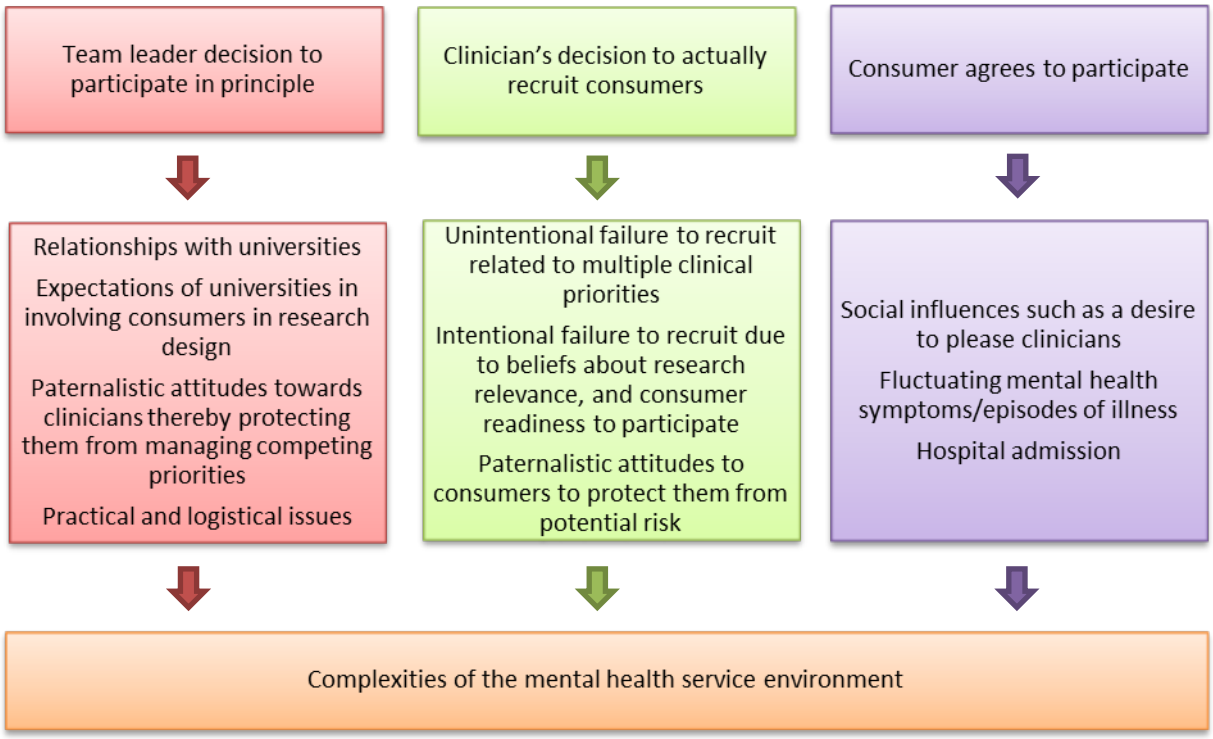
A range of factors influenced clinicians' decisions to grant access to consumers. In order of importance, themes were categorised as contextual, disciplinary, and relational influences on clinicians' decision making. The first theme on contextual influences included a variety of factors existing within the clinicians' organisational environment. These factors included differing professional values on research priorities, competing priorities for clinician time and the complexities of engaging young male consumers in clinical services. The second theme illustrated disciplinary influences on decision making. In particular, it was shown that clinicians faced ethical and professional dilemmas when requested to recruit vulnerable populations. The third theme presented findings related to clinicians' perceptions of professional relationships with academic institutions. The role and positioning of the researcher, as well as a relationship built on reciprocity were important for building trust between research partners. A lack of consensus among clinicians reflected differences in clinicians' perspectives within the multidisciplinary

teams. While the study did not specifically set out to identify facilitators to consumer recruitment, some important lessons for increasing consumer perspectives in suicide were identified.

6.3 An explanatory model: Influences on clinician decision making

An explanatory model (Figure 6) illustrates the factors influencing clinicians' decisions to grant research access to consumers. This model outlines the interplay of factors found to be relevant at the different stages of the recruitment process in the original study. Underpinning these factors were influences relating to the complexities of the mental health service environment. The model shows how these factors resulted in the low recruitment in the original study.

Figure 6. Explanatory model: Factors affecting decision making during the stages of recruitment in the original study



The findings build on previous research undertaken by Campbell et al. (2007), Sharkey, Savulescu, Aranda and Schofield (2010), Woodall, Howard and Morgan (2011), Woodall et al. (2010), Mason et al. (2007), Rugkåsa and Canvin (2011) and Shellman and Mokel (2010). While these earlier studies have documented challenges in accessing mental health consumers, such as prioritising clinical priorities over research, gatekeeping attitudes and behaviours and mistrust between services and universities, my study identified some additional influences not previously addressed in the literature. First, these were related to the clinical norms existing within the multidisciplinary setting where a 'tier system' of decision making identified paternalistic attitudes and behaviours at two levels. Managers

and team leaders adopted paternalist behaviours to protect clinical staff from the burdens of research. Paternalist attitudes were also displayed by clinicians to protect consumers from potential harms of participating in research. Second, this study added a new perspective on clinicians' expectations of partnership. Findings showed that clinicians were more likely to display favourable attitudes towards research when reciprocal partnerships were formed prior to the research being implemented. In addition, clinicians identified the importance of involving consumers as equal partners in the research process and highlighted that research approaches incorporating youth development principles were more likely to receive support. Third, literature has not reported any explorations of clinician perspectives on barriers related to the use of online tools for collecting sensitive data. Findings from my study identified contextual issues associated with the research approach in the original study. Finally, the study adds new knowledge on the relevance of the research topic as a factor affecting clinician attitudes to consumer recruitment. It illustrated that clinicians were less likely to grant access to consumers if the research was not perceived as relevant to clinical priorities.

6.3.1 Complex populations: Clinicians' construction of risk in sensitive research

Findings are mostly consistent with other studies which identified barriers related to the same population. The study showed that engaging young male consumers in suicide research represented high levels of risk for clinicians who constructed risk as affecting interactions between the clinician and the client, and risk to consumers' emotional health and recovery from mental illness. Mental health consumers have been described as problematic, in part because of the complexity and episodic nature of their mental health problems, but also because of the interconnected behavioural, interpersonal and substance use issues (Richards & Emslie, 2000). For young male consumers, it may be their first episode of major mental illness and failure to identify with their illness could affect their motivation to be involved in research. If individuals are ambivalent about their need for care and neither resist nor agree (Goodwin, 2006), their motivation to participate in research may be low. Therefore, the presence of a mental disorder introduces additional complexity and uncertainty into the clinician/client relationship (Dew, Dowell, McLeod, Collings, & Bushnell, 2005). This not only affects clinicians' ability to manage ill-health but reduces the opportunity to engage consumers in research (Strike, et al., 2006). These population characteristics represent an interesting barrier to research participation that may be specific to the recruitment of young male consumers in mental health research. Importantly, these characteristics lead to an increased perception of risk and present challenges for clinicians and therefore researchers.

6.3.2 Clinicians' acceptance of research on socio-cultural influences on suicidality

The perceived clinical relevance of socio-cultural influences on suicidality was a factor affecting recruitment of consumers to the original study. My study showed clinicians were concerned about the research-practice disconnect in the original study. Clinicians considered that failure to engage clinicians and consumers in the original study design contributed to disconnect and contributed to the recruitment difficulties.

The reluctance of clinicians to recruit consumers due to perceptions of relevance was a barrier that has not been explicitly discussed in other qualitative studies. However, there is reference to the irrelevance of research to clinical practice in clinical trials (Silverman, 2009). Research addressing socio-cultural influences does not necessarily align with research priorities in clinical settings. In the context of the original study the researcher was guided by national strategic suicide prevention priorities, whereas in community mental health services research priorities are focused on improving practice and treatment outcomes for consumers. For clinicians, quick solutions to pressing clinical issues may be more important than solving social problems or linking clinical issues to social problems.

Biegel, Johnsen and Shafran (2001) reported that researchers often demonstrate indifference to the context in which clinicians operate and this raises an important question: how can socio-cultural research be made relevant to clinicians? These findings that researchers are not attuned to the practical constraints of the service environment may adversely affect forming a collaboration agreement between universities and clinical services (Biegel, Kola, Meeks, Stevenson, & Beimers, 2010).

Developing a collaborative research agenda is an important step towards improving acceptability of research. Using this approach, the research agenda is decided in collaboration with and guided by the needs of the community, not the needs of the researcher (Yardley, 1997b) and partners influence the research agenda from the beginning (Ministry of Health, 2012). This approach enables researchers to explore both the attitudes of clinicians and clinical priorities for research, and is an important step towards aligning agendas of research partners.

6.3.3 Impacts of paternalism on recruitment of consumers

Paternalistic behaviours and attitudes of clinicians were identified as a significant barrier relating to recruitment failure in the original study. Young male mental health consumers constitute a hard-to-reach population (Baker & Fortune, 2008; Strike, et al., 2006). As this population is less likely to access mental health services researchers often depend on clinical referrals and recruitment of participants through services (Rickwood, et al., 2007).

As the potential sample in the original study relied on recruitment of consumers through service contacts, clinicians were therefore involved as intermediaries or gatekeepers in the process.

Clinical gatekeeping has been defined as the process whereby healthcare providers prevent access to eligible participants for research recruitment (Alderson, 2007). Literature has identified concern that gatekeeping practices violate ethical principles including respect for autonomy, beneficence (a favourable balance of the risks and potential benefits) and justice (a fair distribution of the benefits and burdens of research) (Sharkey, et al., 2010). However, these authors' intent is not to devalue clinicians' concerns, but instead they assert that gatekeeping is not an ethical approach to resolving the issues. The reasons discussed by Sharkey et al. for gatekeeping practices include: a lack of time, concerns about research design, the patient burden, the potential effects of participation on the client/clinician relationship, and a lack of interest in the research question.

My findings also showed at two levels how clinicians' paternalistic attitudes and behaviours restricted access to the potential sample. First, managers and team leaders identified paternalism as providing a clinical safety net in response to the service pressures and displayed paternalistic attitudes to protect clinicians from managing competing demands. Second, clinicians adopted paternalistic behaviours in response to protecting consumers from potential research harm. Paternalism at this level hindered consumer access to the research system, thereby limiting consumers from making an independent decision about participating in the original study.

A variety of factors may have underpinned clinicians' paternalistic behaviours towards their clients. First, it was likely that paternalistic attitudes were associated with the characteristics and complexities of the research population. Clinicians' primary responsibility is to prioritise patient care. Their role in protecting the welfare of those with whom they work and treat the presenting issue is understandably the most pressing clinical priority. Clinicians assess research for potential harm and benefits and ask the question "what is sacrificed when research becomes part of practice?" Second, the goal in a therapeutic context is to avoid new challenges (Howard, et al., 2009) and my findings show that some clinicians perceived research participation as constituting a new challenge.

Clinicians expressed competing viewpoints on the concept of paternalism in relation to decisions on consumer recruitment and this resulted in a dilemma for some clinicians. While clinical psychologists were more likely to express paternalistic tendencies, other clinicians in social work and youth development roles were more in favour of consumers being involved. Discourse from clinicians with social work and youth development

backgrounds focused on involving consumers from an ethical perspective, not simply as research participants, but they also considered that consumers should be involved in designing and contributing to the research process.

6.3.4 Community mental health services: Complex social systems

Clinicians' decisions were influenced by systemic barriers and norms present in clinical operating environments. Factors underpinning decision making were associated with the complexities of the clinical setting. Community mental health services are small and complex social systems with their own needs and priorities. Each service had its own culture and idiosyncratic features particular to the setting, including characteristics of the disciplines representing the workforce, the populations they served and the geographic community in which they are located. The distinct culture of the clinical setting informs clinicians' decisions to collaborate with research partners and grant access to consumers.

In New Zealand these services are undergoing fundamental change as they are increasingly expected to manage more complexity and be accountable for their practice (Mental Health Commission, 2012). As services are expected by policy makers and funders to demonstrate effectiveness, it is not surprising that demands of clinical workload are prioritised above pursuing academic-driven research goals. My findings were consistent with these policy concerns. Many clinicians identified time pressure and competing clinical demands as a reason for not recruiting consumers. In mental health consultations competing demands resulted in a 'mindful prioritising' (Dew, et al., 2005) on the part of the clinician. Resistance was expressed by many clinicians in terms of time constraints which acted to limit clinicians' willingness to become significantly involved in research studies.

The lack of time was central to clinicians' accounts and perceived as a further obstacle to obtaining their support. Identifying eligible consumers and sharing information on the study during consultations was perceived as creating extra work demands for clinicians. Clinicians other studies have blamed lack of time for not being involved in implementing research studies (Silverman, 2009) and this constraint has become widely accepted as a critical barrier to research and other developments in clinical practice. Salmon et al. (2007) further describe lack of time as "vocabularies for mitigating responsibility when behaviour is questioned" (p. 273). That is, 'having no time' for something typically means that it is of lower priority than other activities. Horobin and McIntosh (1983) noted this use of the language of limited time in primary care to justify, rather than explain, the pattern of GPs' activities. Consistent with this view, clinicians in my study used the discourse of time constraints as a barrier to research collaboration. While some clinicians were supportive of research they felt overwhelmed by other issues within their clinical

setting. This discourse is important as it highlights barriers at an institutional level even where clinicians are supportive of research collaborations.

6.4 Research collaboration

6.4.1 Academic and clinical partnerships

Forming collaborative relationships between clinicians and university-based researchers has been recommended as an important mechanism to address recruitment barriers (Biegel, et al., 2010). However, Merzel et al.(2007) describes collaborations between academic and clinical sectors as representing an uneasy fit. This may be due to differences in organisational purpose, priorities and operating environments. There is current fragmentation between academic and clinical sectors and most often researchers are the ones approaching clinical services.

The original study was designed using a traditional model of 'researcher control' with little consideration to understanding clinician or consumer perspectives. The development of collaborative community-academic partnerships, however, reflect a major shift from this traditional approach (Hawton, et al., 2012). The literature illustrates the increasing importance of collaboration in terms of partnerships which are designed to achieve outcomes that no single organisation can achieve acting independently (Wood & Gray, 1991).

There are many drivers for collaboration. Successful collaboration is driven by trust, the right approach, clear purpose and commitment. Strong partnerships are reciprocal and are focused on sharing values and goals and draw on the strengths of each partner. Building research collaborations from the 'bottom up' facilitate a richer awareness of the values and motives driving each partner. Further, a key element of a partnership's success is its ability to build capacity and share learning. While each partner may be willing to engage in a community partnership they may have very different agendas or reasons for their involvement. For example, clinicians in my study wanted to see increased access to training and resources as an incentive for establishing a research partnership.

6.4.2 Involving consumers in partnerships

There is a growing emphasis on inclusive and participatory approaches to research (Mays & Pope, 2006) that goes beyond academic and clinical partnerships. In suicide related research the ideal collaborative model is based on partnerships that not only involve clinicians, but consumers of services. Coyne (1997) suggested it is critical to define research goals with those being researched. Therefore, this involves not simply framing consumers as 'subjects' in research but instead involving them in driving the research.

This focus should be inclusive of researchers, clinicians and consumers for the single purpose of addressing a specific research concern. It is likely that these collaborations will yield research agendas that are of practical use to policy makers and practitioners, and empower consumers in the process.

Consumer participation in research teams is still a relatively new practice and there is some evidence to show that advances in consumer participation in research have been slower than those on service delivery (Patton, 1999). While the expectation for consumer participation is outlined in policy (Mental Health Commission, 2012) there is no acknowledgement of the value of forming collaborative partnerships to support consumers to engage as equal partners. Collaborative working is a critical aspect of health services research and there are a number of reasons why involving consumers is significant for improving outcomes for consumers.

First, Phillips (2006) defines the reasons for the promotion of consumer participation as a necessary aspect of social research as being founded on ethical issues. The pressures for including consumers in shaping social research can be described as a way to reduce exclusionary practices and marginalisation, and is about redressing the ethical balance for consumers (Phillips). Peterson (1999) extends this argument and states that ethically-based research can be a very effective way of ensuring that consumers' experiences are not discounted. A balance must be struck between protecting consumers' best interests and recognising their right to participate (Claveirole, 2004). This can be achieved by careful consideration of the ethical and methodological issues involved in a study (Coyne, 1998).

Second, the process of consumer engagement enhances the likelihood that research will be socially and contextually appropriate, thereby increasing the relevance of research. Literature shows that direct involvement of people affected by the problem under study facilitates a more accurate and authentic analysis of their social reality. Fontana (2004) suggests the enquiry process should evolve to develop shared constructions that will enable the meaningful expansion of knowledge. By stepping outside of the traditional researcher-led approach, researchers are opened to new learning and understanding that otherwise may not have been realised (Jootun, et al., 2009).

Third, a participatory approach is particularly significant for marginalised communities as it embraces the goals of empowerment and control for consumers. Empowerment has been referred to as "an ongoing process of mutual respect, critical reflection and group participation by which people, organisations, or communities gain access, control and mastery over their resources and affairs" (Suarez-Balcazar, Harper, & Lewis, 2005, p. 92).

Establishing and maintaining collaborative partnerships with consumers should be a goal which contributes to the pursuit of the empowerment agenda. However, collaboration with consumers also involves acknowledging the differences in status and power (Byas et al., 2002). Building collaborative partnerships would go some way towards addressing the power imbalances between services, universities and consumers and enable consumers to make their own decisions about research participation.

While in theory involving consumers in research partnerships is a desirable outcome, my findings showed that clinicians identified challenges to engaging young male consumers in research. As young men are under-represented in clinical services, this limits the opportunity to involve these consumers in research. However, even where consumers were engaged in services, clinicians were concerned that directly inviting consumers to take part in research may adversely affect the therapeutic relationship they had with consumers. Until there is a framework at service level for involving consumers as partners in care their active participation in research decision making will not be achieved. Consumers engaged in decisions about their care, including decisions on research participation, may be more likely to feel satisfied with the quality of their care and interactions with their caregivers. I consider a shared decision making approach is important for consumers. In this process, the consumer is a fully informed partner who is knowledgeable about the risks and benefits of research participation. If this principle is embedded in clinical practice, shared decision making may result in a better decision which reflects the consumer's own values.

6.5 Reflections on collaboration in the original study

The study took place in a clinical setting in which clinicians were autonomous but could also act within an integrated multidisciplinary team. The process of collaboration in the original study was loosely defined and planning was largely informal and flexible. Recruitment of participants relied on mental health clinicians in practice-based services. The original study was focused on 'doing' the research and the fact that it flowed from the earlier major qualitative study meant that building relationships to enhance recruitment strategies was not viewed as an essential component of earlier planning. Consequently, the need for establishing collaborative partnerships came to the fore as difficulties in accessing consumers were experienced.

Engaging in a community-based research partnership, to a large extent, is based on each individual's capacity to develop relationships grounded in mutual trust and respect (Yardley, 1997a). Trust is an important element of university-clinical practice research collaborations (Hammersley, 1992) and literature has shown the importance of relationship

building as a key factor in the success of the study (Biegel, et al., 2010). It could be assumed that prior relationships across sectors are viewed by partners as a helpful and positive factor in conducting research. However, while an existing relationship had been established by a senior clinical researcher, a previous 'insider' to the services, this did little to smooth the way for a researcher with a non-clinical standing. My outsider status was a factor influencing some clinicians' decision not to recruit consumers to the original study. Where clinicians decided to collaborate with a researcher, they considered the researcher as a 'representative' of their services. Given the challenges that clinicians experienced in sustaining relationships with consumers in a service setting, clinicians considered involving a researcher whose credibility had not been established as constituting avoidable risk.

Entry into the community has been described as the stage in which the basis for the research relationship is formed (Tolan, Keys, Chertok, & Jason, 1990). Many factors may interact in this relationship formation stage which either facilitate or hinder the entry phase. Findings show that at least seven factors presented barriers at the entry stage.

First, entry may be hindered when clinical services have a history of being 'overused' by academic institutions which can lead to clinicians being cautious and suspicious about doing research with academicians (Ministry of Health, 2012). Clinicians' previous experiences of research 'vanishing into a black hole' had a negative effect on clinicians being involved in the study. Only recently there has been increased attention to the need for the dissemination of study findings and clinicians have reported that they are unaware of research findings from studies they had been involved in. Clinicians' concerns have been related to data not being presented in a way that was useful to them and research findings not being available at a time when services needed to make practice or service decisions (Messina, 2011). Findings in my study are synonymous with this and clinicians identified reasons for non-collaboration as related to negative prior experiences of engaging with research institutions.

Second, effectively marketing the study at the entry stage requires the researcher being able to clearly articulate the research goal and potential benefits for all involved. Finding common ground, agreeing on the principles and goals for the research are critical for building a sustainable partnership. Many clinicians in my study identified that lack of involvement of consumers and clinicians in research design was a key factor in their decision not to collaborate. Clinicians expressed concern that consumers were involved in the study in the role of research subjects rather than partners in research and this was seen as a contributory factor to the low recruitment and retention of participants. Literature also concurs with the importance of this factor (Byas, et al., 2002).

Third, establishing a culture of learning and a two way learning environment involves recognising the strengths of the setting and the learning opportunities for all members of the partnership. Establishing a supportive environment based on a foundation of shared learning involves the exchange and cycling of resources and the process of reciprocity (Mental Health Commission, 2012). Several clinicians in my study identified the importance of reciprocity. Findings illustrated clinicians' expectations of research partnerships and suggested that the basis of research partnerships involve universities in providing knowledge and resources in exchange for service and consumer participation in research. Clinicians were less likely to support independent research and were most interested in forming longer term reciprocal partnerships at the level of university teams.

Fourth, resistance was expressed in terms of fear of consequences associated with the research. Clinicians' discourse focused on their concern about consequences of consumer participation. This was related to clinicians' perceptions of the vulnerabilities of the population group, as fluctuating mental health was frequently mentioned as a barrier to consumer participation. While online data collection approaches enable researchers to achieve prolonged engagement with participants, this feature increased clinicians' perceptions of risk: risk to consumers and risks for the clinician/client therapeutic relationship.

Fifth, front-line clinicians are a logical referral source for potential study participants. However, during the initial stages of treatment when therapeutic alliances are being formed, some clinicians may be reluctant to inform clients of research opportunities, for fear research participation will lead to multiple research contacts. This finding concurs with research in other areas of medicine which identifies interference with the doctor-patient relationship as a significant barrier to clinicians encouraging research participation (Bower et al., 2009).

Sixth, clinicians' conceptualisation of mental illness was a further barrier to collaboration. Attitudinal barriers concerning consumers' conceptualisation of illness and competency to take part are perhaps specific to research in mental health. Some clinicians thought that participation could potentially be distressing or impede recovery. This view is not dissimilar to caregivers of patients with dementia being concerned that research experiences could cause further distress (Kitto, et al., 2008). While the original study involved an exploration of the effects of social media on behaviour, some clinicians voiced concerns about the study's focus on suicide, believing that the potential for adverse consequences were too high. From the clinicians' viewpoint there were perceptions about the cost of participating being greater than the potential gains.

Finally, the timing at which consumers are approached also had an impact on clinicians' decision making. Clinicians discussed consumers' readiness to participate and that research participation may be more 'timely' when the consumer is ready to exit the service. This suggestion that recruiting consumers on admission to a service may be particularly challenging has been found by others (Howard, et al., 2009). Also, the reluctance of clinicians to refer clients to research may be increased with young consumers in a first episode of mental illness compared to other populations of consumers. Both the issues of eligibility and concern for consumers' safety reflected the conflict between the dual roles of the clinician: recruiting to research and safeguarding of clients' wellbeing (Howard, et al.). Clinicians focused more on their perception of consumers' clinical need for treatment rather than providing clients with the opportunity to decide whether or not they would like to participate in the research.

All of these factors had a negative impact on collaboration in the context of the original study.

6.5.1 Reflexivity

The original study aimed to extend the major qualitative interview study (Collings, et al., 2011) by exploring one aspect of media influences on suicidal behaviours. Therefore, my decisions on the original study's design were influenced by the procedures which were applied in the major study. My decisions on sample selection and recruitment reflected the processes used in the major study and represented limitations which affected completion of the original research. My research model framed consumers as subjects. I did not take consumer perspectives into account during the design of the research; instead, I viewed the consumer's role as simply providing data to answer the research question. Although I have skills in applying community development approaches in public health practice, I failed to consider how my skills were transferable to a research setting to enable consumers to identify their perspectives on research priorities.

Reflecting on my research journey, my position on consumers as 'subjects' has changed to viewing consumers as leaders in mental health research. In light of the challenges I experienced in recruiting consumers to the original study, involving consumers as participants in the research process and working together to identify priorities from consumer perspectives are important for further research. What value did my research have for consumers when they were simply involved as research subjects? Consumers' research priorities are likely to be different to priorities perceived by clinicians and may be different to research priorities set in policy. Can we be sure that consumer perspectives are adequately reflected in the New Zealand Suicide Prevention Action Plan (Associate Minister of Health, 2006) or research literature? Enabling consumers to emerge

as leaders in research involves supporting consumers in the various processes of research, including setting the research agenda, identifying research priorities, selecting the design, undertaking the research and interpreting and disseminating the results. Such collaboration with consumers necessitates establishing an active ongoing partnership where control over the research is shared and one in which the locus of power and decision making is split between consumers, carers, clinicians and researchers.

One of my key learnings centres on the value of conducting research in collaboration. I recognise that even as a student researcher I could have established dialogue with different stakeholders in the original study. It would have been valuable to hold initial consultation with mental health consumer consultants, consumers who represent the potential sample characteristics, professional clinical leaders and clinicians who were likely to be involved in decision making. In the future, this might be best achieved by establishing a research advisory committee prior to the development of the research proposal. Reflecting on what is the most important outcome in research involves a balance between achieving what I set out to achieve while ensuring that stakeholders are fully involved in steering the research. This approach would increase the likelihood of achieving positive outcomes for consumers and clinicians.

Collecting data from clinicians was an unexpected outcome for me. My research identifies important lessons for universities and it recognises universities' unique position in negotiating and building sustainable research relationships. The findings from the present study offer lessons for universities and their role in supporting new researchers. Findings offer a salient reminder that universities have a role in educating students about the value of partnerships which are inclusive of consumers and enhance researchers' knowledge and awareness of key processes for involving consumers.

Findings enhance knowledge of the tiers of decision making within clinical services. Even though high level agreement was achieved at senior management level, this had little direct impact on clinicians' recruitment decisions. Clinicians are autonomous practitioners and as decision making was at the level of each individual clinician, developing personal and trusting relationships at a very personal level was important to this study. I mistakenly assumed that as locality assessments were completed, clinicians would actively support the study. Findings also enhance understanding of the ethical dilemmas clinicians are presented with when asked to make a decision about research participation. Although adapting the research design could have improved recruitment rates, other contextual factors influencing decisions were more difficult to address. Clinicians were transparent about these factors, even though such findings have the potential to highlight practices which are unsupportive of research.

A new research question has been raised on completion of this thesis and this question is underpinned by ethics. My findings showed there was no clear consensus on the question: should clinicians decide if consumers can participate in research? My research did not set out to answer this question and a dilemma remains. To answer this question, a dialogue should ensue with consumers, carers, clinicians and researchers. While consumers should also not be exploited by research, they should not be excluded from research processes. Consumers have the right to participate in research.

6.6 Strengths and limitations

6.6.1 Strengths

A key strength of this study is associated with the factors that led to the study's inception. The poor recruitment outcomes in the original study resulted in the development of a well planned and executed exploration of clinician perspectives on recruitment barriers to suicide research. Therefore this topic emerged from contextual priorities identified during data collection in the original study, making it a theoretically relevant study. In particular, strengths relate to the sample. First, the sample was contextual in that all the participants had been invited to collaborate in the original study, thereby avoiding idealised and generalised perspectives which may have arisen from a study exploring clinician attitudes to a hypothetical practice scenario. Second, the sample was diverse and represented the perspectives of a range of clinicians with differing disciplinary backgrounds and roles within the multidisciplinary teams. Third, the sample was drawn from a number of services in primary mental health care, including youth services and young adult addiction services. This study adds unique perspectives, from clinicians operating in community services, to a literature which has not addressed recruitment barriers from this disciplinary grouping. Perspectives, from an original study on barriers to recruiting young male consumers are provided together with practical strategies for addressing recruitment obstacles.

A further strength relates to the fact that every participant invited to participate accepted the invitation. This study may have been perceived by some participants as representing sensitive research for clinical practice as the study had potential to illuminate factors related to clinician attitudes and behaviours. However, the sample were willing to participate in frank and open conversations and the good audit trail (including informal data gathered during scoping discussions and formal interview transcripts) enhanced the quality of data and trustworthiness of findings. A further aspect enhancing rigour relates to involving participants in a process of respondent validation. Lincoln and Guba (1985) regard respondent validation as the strongest available check on the credibility of a research project. Finally, the findings are relevant for increasing consumer perspectives in

suicide literature. This research has the potential to contribute to service planning through building an evidence base that positions consumers at the centre of the approach, thereby enabling services to meet individual needs and incorporate consumers' personal choices. I anticipate the findings may be used to improve understanding of the structures and factors that affect decision making about research in a clinical environment.

6.6.2 Limitations

There are a number of limitations.

First, due to the nature of a masters study the data were coded and themes identified mainly by a single researcher. Asking other researchers to independently code was not feasible. However, to mitigate the risk of analysis from a single perspective and increase the value of my findings I discussed excerpts of my coded transcripts with my research supervisors to identify potential flows in the coding process. When using this method for another study, the coding of data could involve triangulation of coding and comparison of findings to provide a more reflexive analysis from multiple perspectives.

Second, my experience and competencies as a novice researcher were factors important in shaping the data collected and resultant analysis. My interview style during the initial clinician interviews mirrored a therapeutic style involving therapeutic interview techniques including reflection, paraphrasing and summarising. Reflecting on this after three interviews, I identified a potential pitfall that arose during the data collection. Initial transcripts revealed that whilst providing a context for the open-ended questions, this opened a discussion about my perceptions of the challenges I faced in recruiting consumers. Although I corrected this at an early stage in the data collection process through reviewing my transcripts with my research supervisors, this may have compromised the data obtained and affected the trustworthiness of the data through leading respondents.

Third, although I invited participants to verify transcripts for accuracy no further data were generated from this. Participants were not asked for their reactions to the data or preliminary analyses and hence no reactions were incorporated into the study findings. Instead of aiming for accuracy of transcripts, credibility of study findings could be enhanced further by seeking input from participants during the process of analysing data and producing the research report. Although findings will be shared and reactions noted, a dialogue could have been established with clinicians on the study's findings. Providing opportunities for questions, critique, feedback, and affirmation would enhance rigour through participants' recognition of findings as true or accurate, enhancing the

opportunity for meaningful coherence (Tracy, 2010) within a social constructionist framework.

Fourth, the relative importance of the identified barriers is unclear as some may be very specific and idiosyncratic. This suggests a need for caution in assigning significance to some of the less commonly expressed barriers to recruiting consumers. In addition, findings from this study relate to a specific project with particular characteristics, i.e. collaboration with mental health clinicians in primary and tertiary services to recruit young male consumers using online methods. Therefore, findings from my study may not be transferable to different settings. Finally, the clinicians in this study cannot be assumed to represent the wider mental health workforce. Data collection with clinical and operational directors and professional leaders may have provided different discourse in relation to high-level barriers or influences on clinicians' decision making.

6.7 Recommendations for universities and researchers

6.7.1 Using 'insiders' to access a hidden population

Creating a role for consumer consultants as research navigators could assist with participant recruitment and may constitute a practical solution to increasing access to a clinical sample. As consumer consultants work alongside clinicians in multidisciplinary teams, they could provide leverage, increase understanding of the potential risk of the research, know how to mitigate the risks and advocate for consumer participation in research design. Using insiders could also provide emotional support for participants and act as a bridge between services and universities. However, using consumer consultants as research navigators does not negate the need to involve consumers directly, as consumers are not a homogenous group (Fluehr-Lobban, 1998) and there is a likelihood that representatives may not adequately reflect the interests of consumers. Further scoping is required with youth consumer advocates working in the sector to consider how such roles could be developed and the value of the insider roles in research collaboration.

6.7.2 Building collaboration from the bottom up

Collaborative partnerships between universities and mental health services should be inclusive of consumers. A goal is to develop long-term, mutually advantageous relationships and promote a collaboration model where consumers lead the research agenda and influence the design. The partnership would identify the aims of consumer participation in research, develop a model of participation in research and manage the outcomes of participation. Involving consumers in research design would work towards reducing participation barriers. For example, tapping into consumer knowledge on the appropriateness of an online data collection from a transient and vulnerable population

with low motivation to participate in research may have increased the likelihood of completing the original study. Building collaboration from the bottom up will ensure the data collection approach matches the population's characteristics and priorities. An organisational approach to consumer participation is needed rather than trying to implement it on a project-by-project basis (Peterson, 2005).

6.7.3 Educating gatekeepers on the value of qualitative research

Researchers have a role in increasing awareness about research, including the pivotal role of recruitment and sampling in research integrity, in clinical mental health services. Efforts to promote the development of social research skills in multidisciplinary teams and build clinician knowledge of the social good from research participation are pressing priorities. This would help ensure teams are highly informed about public health research and the potential contribution research on social context can make to consumers. Raising awareness about researchers' needs in regard to sample selection may lift some of the external barriers to achieving desired sampling strategies. This could be achieved by promoting representation from research units within the multidisciplinary teams and could make a difference in how decisions, requirements and stipulations are made concerning qualitative proposals and projects. A potential enabler to collaboration involves integrating researchers from public health research units directly into clinical teams. This action would build the capability and capacity of the team, and engage clinicians in a dialogue to promote the value of qualitative research to clinical practice.

6.7.4 Developing leadership competencies of the research sector

Research provides an opportunity to work together and public health research units are well placed to take an increasing leadership role in creating and developing participatory partnerships. Wood and Gray (1991) consider key competencies for agencies with a convening role in collaboration. These include the ability to induce stakeholders to participate, legitimacy among the stakeholders, and appreciative, envisioning and processual skills to establish a collaborative process and context. Some ways for research units to enhance collaboration involve working with the mental health sector in policy formulation, setting up information networks that involve agencies and individuals from these sectors and establishing local research advisory committees with representatives of relevant agencies. However, the challenge is to determine how clinicians and consumers can collaborate and universities can best encourage them to do it. There is an opportunity for public health research units to identify leadership competencies required in order to be a major player in implementing a collaborative process.

Given the level of influence and leadership expected it will be important for research leaders to consider the attributes and positioning of individual researchers leading research collaborations. A leadership role will involve using strategies and techniques to support services to prioritise research throughout their contracting, resourcing and training activities to promote a culture of research in clinical services. Encouraging services to make research 'core' or look at ways for more creative approaches to collaboration will involve strategies which appeals to both management and leadership within services, and to the individual clinician. Exploring and influencing core values of clinical practice might therefore be necessary if research is to acquire professional significance for clinicians, and universities could have a pivotal role in communicating the value of research on the social context of suicide.

6.8 Implications for further research

Further research on age and gender related barriers would be beneficial as little literature was found. Several themes that emerged from the findings and literature regarding participation barriers could potentially be addressed by other researchers. For example, a more in-depth exploration of how clinicians perceive the relevance and value of studies with a focus on suicide and their negative impact on participants could be addressed. Factors associated with methodology and research methods may also be important barriers to engaging clinicians. Given there has been no such exploration of this barrier in the literature this is an important area to be explored in future research.

Establishing a new research direction with the consumer movement to understand a way forward for building collaborative partnerships from the bottom up will provide new knowledge on consumer involvement in collaborative research partnerships. As little is known about the participation of consumers in mental health research it would be a useful area for new research to assess the motivators and barriers to participation from consumer perspectives. Studies with this aim may be important for framing recruitment strategies in a context that is relevant and empowering for consumers. Using an action research approach to study the research setting holds implications for learning. As the vast majority of research collaborations between universities and services are informal a potential new research direction could study existing informal collaborations between academics, clinicians and consumers.

Understanding the influences of social media on young men's self harm and suicidal behaviours still remains a research priority and innovative approaches to engaging consumers in answering this research question is a current practice and policy concern.

6.9 Conclusion

The perspectives on research of young male mental health consumers have seldom been sought. Suicide researchers' understanding of recruitment and retention of mental health consumers is in its infancy. There is a dearth of information on the under-representation of consumers as research participants and this population challenges researchers to develop an understanding of the factors influencing clinicians' decision to collaborate in sensitive research. Investigating the barriers associated with low recruitment of participants in the original study presented a valuable opportunity to study the influences on decision making within a clinical mental health environment. To my knowledge it is the only study of barriers to research participation which explores clinicians' perspectives on recruiting young male consumers to an online study. There is a growing recognition that undertaking sensitive research can pose many challenges for researchers. It also presents challenges for clinicians, who are often asked to act as intermediaries in the research process. The responsible position that clinicians hold understandably creates ambivalence about research especially when there is little theory which illuminates the actual risk for consumers' outcomes and the outcomes for the clinician/client therapeutic relationship. Clinicians supporting qualitative research on sensitive topics need to be able to make an assessment of the impact of the research and in order for this to occur, they need to be informed of the possible issues that may arise. It is a delicate balance between being responsible for the welfare of consumers and respect for their competence to participate in research. University researchers should be sensitive to the dilemmas that clinicians face when invited to collaborate and support research.

Understanding the barriers that inhibit participation of a clinical consumer sample is imperative if researchers are to be successful in designing study protocols and recruitment strategies tailored to the concerns of consumers and clinicians. There is scope for a much wider discussion of the barriers to young male consumers participating in sensitive research, especially the complexities involved in negotiating collaborative relationships with clinicians and consumers. These findings offer an explanatory model as to why consumer recruitment was not successful and specific barriers to the successful implementation of the original study were identified. It is concluded that due to the lack of an existing collaborative relationship between research partners, fragile trust made it difficult to recruit consumers and hence shaped the outcome of the investigation into social influences on suicide. A key recommendation for universities is to engage multidisciplinary teams as partners in research which promotes consumer participation as a necessary aspect of social research. This study shows the urgent need to re-shape research practices and demonstrates the value of including the consumer's perspective in

qualitative research. In doing so, the literature will begin to portray previously untold stories and hidden knowledge.

This thesis draws attention to factors involved in conducting sensitive research with a hard-to-reach population. While inclusion of young male consumers creates unique challenges, their inclusion also creates new scientific questions and methods with which to approach the research. Identifying innovative approaches to collaborate with young male consumers and increase their voices on research priorities from consumer perspectives is a pressing priority.

In being transparent about the limitations of the original study, this may inform other qualitative researchers engaging a similar population. However, it is important to state that due to the specific features and processes of this investigation, the challenges and implications for practice outlined in this thesis are specific to the context of the original study. These lessons serve as recommendations for enhancing the practice of public health research collaborations. The commitment of all partners to a collaborative and community driven approach is of primary importance. Partners can be united by making shared goals and values explicit, which is important to creating trust and enabling a collaboration to move forward. Although challenges remain, this study demonstrates the potential for positive research collaborations. Such alliances are necessary in order to increase research in the field of suicide research and this study will guide efforts to do this.

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Appendices

Appendix 1 – Multi-region Ethics Committee Approval

Health and Disability Ethics Committees

Multi-region Ethics Committee
Ministry of Health
133 Molesworth Street
PO Box 5013
Wellington 6145
Phone (04) 470 0655
(04) 470 0646
Fax (04) 496 2340
Email: multiregion_ethicscommittee@moh.govt.nz

5 March 2010
Amended 1 April 2010
Amended 27October 2010

Susan Knox
Social Psychiatry and Population Mental Health Research Unit
University of Otago - Wellington
PO Box 7343
Wellington 6242

Dear Susan

Ethics ref: **MEC/10/01/003**
Study title: Influences of the virtual social environment on suicidal behaviours: a qualitative investigation of the perspectives of young male adult website users
Investigators: Susan Knox, Dr Sunny Collings, Dr Sarah Fortune
Localities: **Hutt Valley District Health Board, Capital and Coast District Health Board**

The above study has been given ethical approval by the Multi-region Ethics Committee.

Approved Documents

- Study Protocol, version 1, dated 23rd of October 2009
- Interview Outline, version 2, dated 29th of January 2010
- Participant Information Sheet, version 2, dated 5th of March 2010
- Participant Consent Form, version 1, dated 18th of December 2009
- Māori Consultation letter from Ngāi Tahu, dated 27th of January 2010

Accreditation
The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

Progress Reports
The study is approved until the **1st of September 2012** The Committee will review the approved application annually and notify the Principal Investigator if it withdraws approval. It is the Principal Investigator's responsibility to forward a progress report covering all sites prior to ethical review of the project on the **5th of March 2011**. The report form is available at

http://www.ethicscommittees.health.govt.nz. Please note that failure to provide a progress report may result in the withdrawal of ethical approval. A final report is also required at the conclusion of the study.

Amendments
It is also a condition of approval that the Committee is advised of any adverse events, if the study does not commence, or the study is altered in any way, including all documentation eg advertisements, letters to prospective participants.

Please quote the above ethics committee reference number in all correspondence.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

We wish you well with your study.

Yours sincerely

Claire Lindsay
Administrator
Multi-region

Email: claire_lindsay@moh.govt.nz

Appendix 2 – Letter to the Multi-region Ethics Committee

Rebecca Stewart
Administrator
Multi-region Ethics Committee
Ministry of Health
133 Molesworth Street
PO Box 5013
Wellington
6145

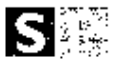
27 May 2011

Dear Rebecca

Ethics Reference: **MEC\10\01\003**
Study Title: **Influences of the virtual social environment on suicidal behaviours: a qualitative investigation of the perspectives of young male adult website users**

Further to my recent correspondence on 18th and 25th February 2011, I am writing to inform the committee of a proposed modification to the above study. The primary data collection phase of the study has identified critical issues relating to sampling procedures and institutional barriers which have restricted access to the field of study and resulted in failure to recruit the intended number of participants.

It is proposed to revise the study aim to include a further objective which aims to provide a detailed examination of the issues that occurred as a product of undertaking practice-based mental health service research in the context of this study. The additional objective is stated as follows:-



Social Psychiatry & Population Mental Health Research Unit
Te Repu Rangahau Hauora Hinengaro

University of Otago, Wellington

Te Whare Wānanga o Otāgo, Te Whanga nui-a-Tara
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To investigate the perceived barriers among clinicians and mental health service managers towards introducing participation in online research to clients presenting with self-harm and suicidal behaviours.

This objective will be achieved through conducting an analysis of the literature focusing on the processes involved in collaborating with mental health services and performing online research on sensitive subject matter with difficult-to-reach populations. It is expected that the outcomes of this phase of data collection will hold significance for (1) enhancing understanding of factors that impede mental health research (2) increasing knowledge of the complex social processes of gaining access to vulnerable populations and, (3) establishing new insights from related public health disciplines which may inform strategies to increase research participation.

Indepth face-to-face interviewing using a semi-structured interview plan will provide the data collection tool and a purposive sample of clinicians and mental health service managers will be the participants for the study. The sample will be identified from field discussions held during the primary data collection phase.

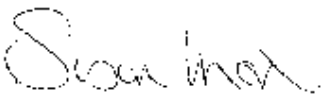
Please find attached copies of supporting documentation including:-

- Information sheet
- Consent form
- Letter of Invitation
- Questionnaire/interview guidelines.

Please do not hesitate to contact me if you require further information.

Best wishes.

Yours sincerely



Susan Knox

Appendix 3 – Multi-region Ethics Committee Approval (modification to the original study)

Health and Disability Ethics Committees

Multi-region Ethics Committee
Ministry of Health
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15 June 2011

Ms Susan Knox
University of Otago - Wellington School of Medicine
Social Psychiatry and Population Mental Health Research Unit
University of Otago, Wellington
PO Box 7343 - Wellington 6242

Dear Ms Knox -

Ethics ref: **MEC/10/01/003** (please quote in all correspondence)
Study title: Influences of the virtual social environment on suicidal behaviours: a qualitative investigation of the perspectives of young male adult website users

Thank you for your letter dated the 27th of May 2011 enclosing documentation relating to the above named study. This documentation has been reviewed and approved by the Chairperson of the Multi-region Ethics Committee under delegated authority.

Approved Documents

- Letter dated 27 May 2011 advising the Ethics Committee of a modification to the above named study
- Information Sheet – April 2011
- Consent Form Version 1 – 19 April 2011
- Letter of invitation – April 2011
- Questionnaire – April 2011

Please do not hesitate to contact me should you have any queries.

Yours sincerely

Elise Agostino
Administrator
Multi-Region Ethics Committee
Email: Multiregion_ethicscommittee@MOH.govt.nz

Appendix 4 – Questionnaire Topic Guide

Wellington School of Medicine and Health Sciences

Media Influences on Suicidal Behaviours: Key Informant Interviews

QUESTIONNAIRE TOPIC GUIDE

This topic guide has been developed using issues of interest emerging from field discussions with practice-based mental health service managers and clinicians.

Aim

To investigate the perceived barriers among clinicians and mental health service managers towards introducing participation in online research to service consumers presenting with self-harm and suicidal behaviours

Objectives of Questionnaire

- Understand the level of relevance/priority given to clinical and administrative issues over research participation
- Explore clinician/managers' concerns about protecting vulnerable populations and the impact on the clinician-consumer therapeutic relationship
- Assess clinician/manager perspectives of acceptability of online methods for undertaking research with vulnerable populations
- Assess the perceptions of the level of skills/knowledge and confidence needed to introduce a request for research participation within a potentially sensitive consultation

1. General views about mental health research

Prompts:

- Views about collaborating with population mental health research institutions
- Perceptions of challenges in undertaking research with vulnerable populations
- Ethical issues arising from mental health research

2. Views about clinical relevance of public health research which explores determinants of health (socio-cultural influences on mental health)

Prompts:

- Specific relevance of data collection for the Media Influences study in relation to clinical/service priorities
- Priority to clinical/administration matters over research participation
- Media Influences study relationship to clinical goals
- Practical and organisational constraints to increasing levels of participation in this study

3. Views about aspects related to research approach and online methods for undertaking research with young mental health service consumers in the context of the Media Influences study

Prompt:

- Individual service requirements to amend/recommend changes to the research protocol
- Ethical implications for research with vulnerable populations (added scrutiny to the study - parental consent for 16-18 age group)
- Equity factors for including the study population (economic factors present for minority ethnic groups and internet access for Maori\Pacific)
- Perceptions of acceptability of online research method
- Confidence with online method

4. Experience of introducing the Media Influences study during a consultation

Prompts:

- Views and experience of recruiting to research studies which focus on sensitive subject matter
- Experience of most recent consultation and factors influencing clinician's decision to invite participation in the study
- Factors present at the consultation which impeded participation in the study – complexity of client's immediate situation
- Perceived ease or difficulty in introducing the study
- Knowledge of reasons for non-consent
- Perceived risks and benefits to participating in the study

5. Perceived effect of the Media Influences study on clinician-consumer relationship

Prompts:

- Effect of involving an outsider and increasing multiple contacts
- Effect of researcher involvement on clinician establishing rapport and trust
- Issue of recruitment coercion

6. Interpersonal issues for clinicians/service managers

Prompts:

- Issues with researcher's outsider position (non-clinician status and professional background of researcher)
- Concerns about the role/status of the researcher
- Establishing boundaries for clients (possible emergence of a therapeutic relationship)

7. Perceptions of factors which impeded collaboration and/or recruitment to the Media Influences study

Prompts:

- Ethical concerns
- Research design
- Allocation of time within the consultation
- Perceived skills/confidence and experience of introducing research and encouraging up-take
- Knowledge deficits and resource needs
- Practical and logistical issues
- Recruitment criteria (difficulties due to recruiting specialist population groups)
- Unintentional or intentional recruitment failure
- Research incentives

8. Mental Health Service Characteristics

- Clinician/Service
- Clinician gender
- Clinician research interests/experience

- Number of studies involved in during the previous 12 months
- Evidence of active research culture within the service
- Level of service collaboration (agreement in principal Y/N, if not why?)
- Level of commitment to recruitment (Y/N, if yes what were the recruitment outcomes?)

Appendix 5 – Letter of Invitation

Wellington School of Medicine and Health Sciences

Media Influences on Suicidal Behaviours: Key Informant Interviews

LETTER OF INVITATION

Background

The Social Psychiatry and Population Mental Health Research Unit at the University of Otago is exploring the influences of social media on self-harm and suicidal behaviours.

Phase 1 of the study invited mental health service consumers to participate in email interviews. The aim of this phase was to investigate young men's reports of how the virtual social environment influences suicidal behaviours in young men. This phase is now complete.

Phase 2 of the study will aim to investigate factors which impede and facilitate research participation with practice-based mental health services. Clinicians and Mental Health Service Mangers will be invited to participate in key informant interviews.

Ethics Reference: MEC/10/01/003

Why we need you

Locality approvals have been received from Hutt Valley DHB and Capital and Coast DHB. Mental health services have had the opportunity to participate in Phase 1 of the study. Key informant interviews in Phase 2 will involve a single face-to-face interview with interested clinicians/managers to gain a deeper understanding of what it is like for clinicians working in the area of mental health and participating in research studies. The interview will be around 30 minutes' duration.

We do not need to talk to any clients in the service.

Susan Knox is the principal investigator. For further information you can contact her at: susan.knox@huttvalleydhb.org.nz

Professor Sunny Collings, Dean of the University of Otago is the primary research supervisor and co-investigator. For further information you can contact her at: sunny.collings@otago.ac.nz

Appendix 6 – Information Sheet

Wellington School of Medicine and Health Sciences

Media Influences on Suicidal Behaviours: Key Informant Interviews

INFORMATION SHEET

Introduction

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you of any kind and we thank you for considering our request.

What is the aim of the project?

This phase of the research study aims to investigate factors which impeded and facilitate research participation with practice-based mental health services. The initial phase of the study involved data collection from consumers of mental health services and identified critical issues relating to sampling procedures and clinician concerns about recruiting vulnerable populations groups. Phase 2 of the study aims to provide a detailed examination of the issues that occurred as a result of undertaking mental health research with young mental health service consumers.

What types of participants are being sought?

We are seeking the participation of clinical professionals involved in providing secondary mental health care. This may include, but is not limited to: contracted therapists, psychiatrists, clinical psychologists and service mangers.

What will participants be asked to do?

Should you agree to take part in this project, you will be asked to share your views during a face-to-face semi structured interview. This will be a single interview lasting no more than 30 minutes

The interview questions should not cause you any discomfort and you can end your participation at any time. You will never be asked to break patient confidentiality.

Can participants change their mind and withdraw from the project?

You can withdraw from participation in the project at any time and without any disadvantage to yourself of any kind.

What data or information will be collected and what use will be made of it?

The interview asks for participants to share their responses to a number of questions. Survey material will be available to the project investigators only.

The results of the project may be published in peer-reviewed scientific journals at the end of the project. Data will be aggregated and every attempt will be made to preserve your anonymity. You are most welcome to request a copy of the results of the project should you wish.

The data collected will be securely stored in such a way that only those mentioned below will be able to gain access to it. At the end of the project any personal information will be destroyed immediately except that, as required by the University's research policy, any raw data on which the results of the project depend will be retained in secure storage for five years, after which it will be destroyed.

Reasonable precautions will be taken to protect and destroy data gathered by email. However, the security of electronically transmitted information cannot be guaranteed. Caution is advised in the electronic transmission of sensitive material.

Statement of Approval

This project has received ethical approval from the Multi-region Ethics Committee (reference MEC/10/01/003).

Information and Support

If you have any questions or concerns about your rights as a participant in this research project, you can contact an independent health and disability advocate. This is a free serviced provided under the Health and Disability Commissioner Act.

Telephone, NZ wide: 0800 555 050, Free Fax, NZ wide: 0800 2787 7678 (0800 2 SUPPORT)

Email: advocacy@hdc.org.nz

Please feel free to contact Susan Knox, the Principal Investigator or the Co-investigators if you have any questions about this project.

Susan Knox
Email: susan.knox@huttvalleydhb.org.nz
Phone: 04 479 8694
Professor Sunny Collings (Co-investigator and Research Supervisor)
Email: sunny.collings@otago.ac.nz
Phone: 04 385 5541
Dr Sarah Fortune (Co-Investigator and Research Supervisor)
Email: sarahfortune@xtra.co.nz
Phone: 09 265 4000

Appendix 7 – Consent Form

Wellington School of Medicine and Health Sciences

Media Influences on Suicidal Behaviours: Key Informant Interviews

CONSENT FORM

I have read and understood the information sheet dated 18th April 2011 for volunteers taking part in this project.

I have had the opportunity to discuss the project and I am satisfied with the answers I have given.

I understand that taking part in this project is my choice and that I may withdraw at any time with no disadvantage to myself.

I understand that my participation in the project will be confidential and that no material which could identify me will be used in any reports on the project.

I understand that the survey documents will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for five years, after which it will be destroyed.

I, _____, hereby consent to take part in this project.

Signature: Date:

Please feel free to contact the undernoted investigators if you have any questions about this project.

Susan Knox (Principal Investigator)

Email: susan.knox@huttvalleydhb.org.nz

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Professor Sunny Collings (Co-investigator and Research Supervisor)

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