trends across the first response field. This flexibility also played an important role in the advocacy for women first responders where few women continue to occupy professional roles.

**Abstracts**

**QUALITATIVE METHODS AT THE INTERSECTION OF PSYCHODYNAMIC THERAPY AND FUNCTIONAL NEUROLOGICAL DISORDER: A CRISIS OF INTERPRETATION**

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**Background** Psychodynamic therapy (PDT), has an empirical evidence base, and a rich literature of therapist perspectives, but a dearth of patient perspectives. People with functional neurological disorder (FND), are often or poorly treated by psychiatry and neurology, because they have physical problems, without the usual neurological causes, and treatment is often prolonged and complicated. The intersection of PDT and FND introduces a dilemma about interpreting unconscious processes, and centres the importance of researcher reflexivity.

**Aims** This paper will explore the intersection of FND and PDT, which represents a crisis of interpretation in qualitative research.

**Methods** This exploration uses the wider literature on FND and PDT, and the analysis of 22 exit interviews from adults with FND after completing a four-session pilot study including PDT. Reflexive thematic analysis was used with critical a realist epistemology.

**Results** Some participants rejected the suggestion by the therapist that their problems were connected to emotions or past experiences, while others found the experience helpful. Psychodynamic theory argues that we may be unconscious of, or actively avoid important aspects of our lives, yet participants should have more privileged access to their own inner world than a therapist. These disagreements may arise from avoidance of unconscious and disturbing material, inaccurate interpretations by the therapist, or shortcomings of the psychodynamic model. Interpreting this data, requires acknowledging the theory-ladenness of PDT, and its limitations, yet we should not dismiss PDT because of this. Above all, it is not acceptable to dismiss participants’ consciously reported experience and assume that distress caused by eliciting painful emotions is evidence for the psychodynamic interpretation, as this would be a circular argument and an act of violence.

**Conclusion** Researchers (and therapists) must not assume superior knowledge about their clients’ internal world and should instead maintain theory reflexively, as a tentative hypothesis.

**AN ETHNOGRAPHIC APPROACH FOR STUDYING NON-INTERVENTION AND DYING IN CARE HOMES**

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**Background** Older people who live in care homes have complex health and care needs. As a result, a careful consideration of the potential benefits and burdens of proposed interventions are required at times of deterioration. Despite growing acceptance that non-intervention can be clinically appropriate, studying non-intervention is challenging for researchers, who are tasked with ‘seeing’ things that are not immediately visible.

**Aim** To explore non-intervention in the context of deteriorating and dying in care homes.

**Methods** We combine data from two ethnographic studies conducted in care homes in England between 2018 and 2021.

**Results** Through the presentation of two cases, of Alice and of Arthur, we identify two forms of non-intervention that occurred in care homes. These are not transferring deteriorating residents to hospital, and not pushing foods and fluids to deteriorating residents with swallowing difficulties. We draw on these cases to describe three ways in which ethnography enabled us to study non-intervention. An ethnographic approach enabled us to: (1) identify the negatively defined content of non-intervention (the events and actions staff avoided or sought to prevent from occurring and avoided engaging in); (2) identify the positively defined content of non-intervention (the alternative events and actions staff engaged in instead); and (3) explore in what contexts staff practiced non-intervention as a chosen form of care.

**Conclusions** An ethnographic approach enabled us to examine the ways staff understood different forms of non-intervention, to identify the work involved in ‘doing’ non-intervention and to examine the practices staff used to distinguish non-intervention from neglect. We consider directions for future research, and methods to study non-intervention which do not require the researcher’s physical presence within the researched context. As the recent COVID-19 pandemic highlighted, being present within the care home is not always a viable option and alternatives should be explored.

**CARE-EXPERIENCED YOUNG PEOPLE’S EXPERIENCES OF GOING TO THE DOCTORS: USING PODCASTING TO GIVE A PLATFORM TO SELDOM HEARD VOICES**

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**Background** Podcasting is a form of arts-based research. It uses sound to create a space of emotional engagement with research participants, allowing listeners to hear and respond to research findings and discussion differently than with text. We used this approach in a study about young people (YP) in care’s experiences of accessing primary care. YP in care have a high prevalence of acute and chronic health conditions and much greater mental health needs than other non-care experienced YP. The limited existing evidence suggests YP enter the care system with a poor understanding of normative healthcare, and YP in care are more likely to experience difficulties accessing health services.

**Aim** To understand care-experienced YP’s views and experiences of the barriers to accessing primary care services.

**Methods** Working with two local authorities’ care-experienced YP’s participation groups, we carried out four creative focus groups with 14 YP (aged 13 to 22 years) who were in care or were care leavers.

**Results** Young people spoke about their annual health reviews, whether they trusted doctors, opening up about their mental health and care, and YP in care are more likely to experience difficulties accessing primary care services.
health, being affected by trauma, and being judged by healthcare professionals. Aspects of the podcast process that we considered: scaffolding conversations and use of commentary; level of editing and sound design; consent and involvement of participants in editing.

Conclusion Podcasting is a powerful way to hear the voices of YP who are rarely heard. Transparency in decision-making, reflective practice, and collaboration are central to both the research and podcasting process.

23 RACIALISED EXCLUSIONS IN DIGITAL HEALTHCARE: COMBINING INSIGHTS FROM NARRATIVE INTERVIEWS AND HUMAN COMPUTER INTERACTION
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Racialised exclusions pertaining to accessing and using healthcare services are systemic, consistent and prevalent within the contemporary landscape of health inequalities in UK cities (Wadhawan et al., 2023). Further, there is a concern that the rapid digital transformation of health services may exacerbate racialised exclusions for minoritised ethnic (ME) communities as a result of the digital divide, language barriers and digital literacy-related difficulties embedded in ethno-cultural differences (Topol, 2019). At present, there is limited understanding of the extent to which ME communities encounter systemic exclusions from digital healthcare services that require English language skills, literacy skills, accessibility to a device (e.g. a computer or smartphone) and mobile data and the skills and confidence to navigate digital platforms. Driven by a critical realist intersectional approach, our multidisciplinary research investigates the socio-technical challenges in accessing digitalised healthcare by exploring ME communities’ lived experiences. By deploying a two-tier qualitative methodology combining 100 in-depth narrative interviews with follow-up audio-visual interviews which draw on human computer interaction (HCI) methodologies, we explore how digitalised health services intersect with ethnicity and other ethnocultural dimensions to contribute to digital exclusion from healthcare services. The in-depth narrative interviews indicated how participants’ ethnicity interacted with multiple dimensions of identity as well as language, (digital) literacy, levels of informal support and income to influence access and use of digitalised primary care services. The follow-up HCI-influenced audio-visual interviews, meanwhile, enabled us to produce a more nuanced understanding of the barriers ME communities face in accessing digital healthcare, in particular, by enabling us to better explore the intersection of language barriers, digital literacy barriers and interface design. We also reflect on the challenges associated with conducting interdisciplinary research to explore the socio-technical barriers faced by different intersections of ME communities, which are often under-researched due to the linguistic or cultural diversity of ME communities.

24 NO DECISION ABOUT ME WITHOUT ME: AN EXPLORATION OF SHARED DECISION MAKING PRINCIPLES IN RELATION TO MEDICATION MANAGEMENT IN EARLY INTERVENTION FOR PSYCHOSIS SERVICES
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Medication (primarily antipsychotics) is a mainstay of treatment for psychotic disorders such as schizophrenia. Recent NICE guidelines explicitly recommend that Shared Decision Making (when a health care provider and a user work together to make a treatment decision that is best for the service user) in everyday practice across all healthcare contexts. However, mental health, especially psychiatric medication, has lagged behind other areas of medicine. Much of the literature on SDM and medication management in psychiatric care has revealed a paradox in which service users and clinicians alike advocate for it, but service users widely report they are not involved in decisions about their care. Early Intervention in Psychosis (EIP) services provide specialist community-based care for people experiencing a first episode of psychosis (usually in early adulthood). They often have a therapeutic culture oriented towards recovery and optimizing service engagement, and therefore provide fertile ground for SDM relating to medication in first service contacts and early medication use. This study aimed to evaluate how psychiatric medication is managed in relation to SDM using ethnographic techniques in EIP services within a London based service. I observed multidisciplinary staff meetings, clinical consultations and other interactions in which medication was discussed. Observations were recorded as handwritten notes, which were then typed up and analysed using thematic analysis. Findings will focus on strategies used by staff and service users to facilitate SDM, as well as organizational barriers and facilitators to SDM in psychiatric medication management, with an emphasis on risk and power dynamics. Findings will also map the medication journey for service users in EIP services, noting key decision points, types of decision making, and different actors and their roles in the process. This work can inform healthcare improvement and create organisational change models that will be fed back to service providers.

25 COMMUNITY RESEARCH THROUGH CREATIVE METHODOLOGIES AS A TOOL TO EXPLORE HEALTH INEQUALITIES WITHIN THE URBAN LOCAL PE
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Background Research over the last few years conducted by Centric in South London, supported by Impact on Urban Health, has revealed that there is limited trust in healthcare institutions. For some communities, resentment and cynicism