Doctoral Thesis

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Understanding Positive Risk Management: A Qualitative Investigation

Doctorate in Clinical Psychology

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Section	Main Text	Appendices including References, Figures and Tables	Total
Thesis Abstract	297	-	297
Systematic Literature Review	6586	3691	10,227
Research Paper	7002	7217	14,219
Critical Appraisal	3843	520	4363
Ethics	4822	7805	12,627
Total	**22,550**	**19,233**	**41,783**

Thesis Abstract

This thesis focuses on exploring positive risk management (PRM) within mental healthcare. Section one is a realist review which aimed to understand the contexts and resulting mechanisms by which PRM may work, or not work, within mental healthcare settings. A systematic search of empirical literature across five databases, alongside a grey literature search, returned 20 eligible papers for inclusion. Analysis resulted in eight context, mechanism, outcome (CMO) configurations pertaining to two key theory areas: quality of life and risk. The review suggests there are several key contexts and resulting mechanisms acting as barriers of facilitators to the implementation of PRM within mental healthcare settings including access to relevant staff support and training, pressures and lack of resource in services, personal views on risk acuity and over reliance on structured risk tools. Findings highlight the need for increased staff support and clearer guidance for services to adopt a PRM approach. Future research should focus on testing and refinement of initial theories.

Section two outlines an empirical study which aimed to qualitatively explore how staff working in adult community mental health services experience, understand and utilise PRM. Twelve professionals from community services took part in semi structured interviews and data was analysed using reflexive thematic analysis. Three themes were identified: ‘The System: Working With us or Against us?’, ‘Internal States’ and ‘Staff and Service Users: Working Together to Drive Recovery’. Findings suggest the ability to safely and effectively use PRM was influenced by several factors including systemic level pressures impacting staff’s emotional well-being and confidence, with connection and togetherness acting as a key facilitator of a collaborative, PRM approach. Future research involving the service user voice is recommended.

Section three details the critical appraisal which discusses the process of completing this thesis, considering decisions, personal reflections and challenges encountered.

Declaration

This thesis contains research undertaken for the Doctorate in Clinical Psychology at the Division for Health Research, Lancaster University. The work presented here is the author's own, except where due reference is made. This work has not been submitted for any other academic award.

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Positive Risk Management in Mental Health Care: A Realist Review

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Abstract

National policy and guidelines promote the use of positive risk management within mental healthcare. Despite this, yet it's use remains limited, suggesting there are likely barriers to its implementation. The use of a collaborative, strengths-based approach to risk management promotes recovery and independence for service users, whilst restrictive practice limits opportunity for independence and the promotion of responsibility over one's own risk management. This realist review attempts to understand the contexts and resulting mechanisms by which PRM works within mental health care settings. The author completed a systematic search of empirical literature in CINAHL, PsychINFO, SOCindex, Medline and Embase, alongside a grey literature search. Context, Mechanism and Outcome (CMO) configurations were generated iteratively alongside an expert panel and the wider research team and grouped into relevant theory areas. 20 eligible manuscripts were identified, resulting in eight CMO configurations within two theory areas. The theory areas pertained to key outcomes relating to the use of PRM for staff and service users: risk and quality of life. The findings suggest the need for further support structures in place for staff working with risk in mental health services to promote the use of PRM. Considerations for future work are discussed.

Introduction

Risk assessment and management in clinical practice is vital as it provides opportunity for collaboration between service users, family and professionals with a joint aim of promoting recovery and safety (Worthington et al., 2013). For healthcare services to adopt a genuine person-centred approach, professionals need to exhibit a fundamentally proactive mindset and a willingness to take certain risks (Morgan & Andrews, 2016). Effectively assessing and managing risk is a key factor in the provision of mental health care and is therefore essential for staff working in these settings (Hawley et al., 2010). Risk of various forms is inevitable within mental health services, including risk of self-harm or suicidal behaviours. The National Confidential Inquiry into Suicide and Safety in Mental Health (Healthcare Quality Improvement Partnership, 2024) reports 18,339 suicide deaths by people in contact with mental health services from 2011-2021, 46% of which had contact with services in the week before their death. During this time, 4,767 service users died by suicide in acute mental health care settings, including inpatient, post discharge care, and crisis resolution or home treatment. Assessment of the behavioural characteristics of those who died by suicide during this period found 63% had a known history of self-harm. Importantly, this inquiry states clinicians judged the immediate risk of suicide to be ‘low’ or ‘not present’ for 82% of service user deaths at their final contact. This highlights that there are important opportunities for prevention, further learning, and reflection on risk management approaches within mental health services to ensure the safety and well-being of vulnerable populations.

National policy and guidance within the United Kingdom promote the use of positive risk management (PRM). In their policy on best practice in risk management, the Department of Health (2009) define PRM “…risk management, which improves the service user's quality of life and plans for recovery, while remaining aware of the safety needs of the service user, their carer, and the public”. The term positive risk taking (also known as therapeutic risk taking, collaborative risk taking and various related terms) was first recognised during the 1990’s, with the aim of clinicians taking a more collaborative, person centred response to supporting service users with more severe, long term mental health difficulties (Morgan & Andrews, 2016). Since then, research has indicated PRM can reduce overall risk of harm and improve quality of life for service users (Roberston & Collinson, 2011). For staff, PRM may incorporate actions such as open collaboration with service users and family/carer’s, understanding strengths and promoting independence through empowerment, trust, and choice. Policy and best practice guidance advocate for the adoption of PRM within mental health services. However, it is not consistently utilised by staff working in psychiatric settings. In one study, only 10% of service users within an inpatient setting were found to have been involved in their risk management plans and discussions (Coffey et al., 2019). In addition, Langan (2008) found most professionals were not involving service users in risk assessment and the majority of service users interviewed in this study were unaware that professionals were undertaking risk assessments on them.

Further work has highlighted the need for additional support, education and training for practitioners to apply shared decision making with family members and caregivers whose loved ones have a diagnosis of severe mental illness (Bradley & Green, 2017). Existing research in this area suggests there are further contextual factors affecting the use of PRM within practice.

A further barrier to the implementation of PRM is that its definition varies considerably across the literature and there is a distinct lack of clear guidance on how to use this this approach appropriately (Just et al., 2021a). In a recent systematic review of PRM policy and guidelines Just et al. (2021a) found discrepancies and tensions in the conceptualisation of PRM both within and between policies, as well as contradictory definitions across documents suggesting further barriers to its application.

Throughout the history of the NHS various methods have been used to assess current or future risk to self or others within mental health settings. Standardised clinical risk tools are still used within services despite the National Institute for Health and Care Excellence (NICE) guidance emphasising that such tools are not a suitable, reliable method for predicting future suicide or repetition of self-harming behaviours (NICE, 2022). The guidance goes on to state these actuarial risk tools should not be used to predict future behaviours or determine access to treatment or hospital admission. In recent years an emphasis has been placed on encouraging risk management to be personal and individualised, focussing on building strong therapeutic relationships and continually aiming to involve family or carer's in decision making (Healthcare Quality Improvement Partnership, 2024), in line with a PRM approach. The reliance upon standardised risk tools within services may minimise opportunity for such collaboration. The accuracy and practicality of these tools are reliant upon appropriate use, interpretation and dissemination by the person administering them and research has highlighted significant variation in the predictive ability of risk scales as well as their limited impact on the outcomes of risk events such as violence toward others and suicide (Callaghan & Grundy, 2018; Quinlivan et al., 2014; Steeg et al., 2018).

There is a distinct lack of literature exploring the use, experience and application of PRM within clinical practice and limited understanding barriers to its use. Little is known about the contextual factors that may play a role in determining the success of PRM and the mechanisms by which these might operate across different settings. Realist reviews aim to make sense of complex interventions which are offered across various contexts, such as PRM (Pawson & Tiley, 1997; Wong et al., 2017). Realist reviews seek to answer the question "what works for whom, in what circumstances, how and why?" (Wong et al., 2016) by attempting to understand different contexts which then trigger mechanisms underlying how the intervention works in practice and the various outcomes this may produce. Realist reviews are generally theory generating rather than theory testing and utilise a wide range of differing data sources to develop hypotheses and ideas which are then refined and lead to program theory development through context, mechanism, outcome (CMO) configurations. The aim

of this systematic realist review was to answer how, why, for who and in what context does PRM work in mental health care settings? The review sought to understand the key mechanisms of action and highlight contextual factors which influence how these mechanisms are activated in different environments within mental health settings.

Materials and Methods

The review draws on a realist approach (Pawson et al., 2004, 2005) and utilised RAMESES guidance for the reporting of realist reviews (Wong et al., 2016). The review protocol and search terms were published online prior to commencement (PROSPERO: CRD42023417299). This review employed an iterative, multi staged approach to develop and refine emerging findings.

Stage 1: Defining the scope of the review

During the initial stages the research team refined the scope and discussed the key aims of the review. The focus of the review was positive risk management (PRM), which can be conceptualised in multiple ways and has a varying definition across the literature. For the purpose of this review, the researchers adopted the Department of Health's (DoH) most recent definition of PRM (Department of Health, 2009). Core components of this definition of PRM include working collaboratively with service users, being attentive to views or carers and family, weighing up potential costs and benefit to different actions, a willingness to take a decision involving risk if positive benefits outweigh risk and ensuring service user and those around them are fully informed about the benefits and risks involved in such decisions.

2. Initial programme theory development

A preliminary scoping search of relevant literature was conducted as well as individual meetings with three expert panel members to produce broad initial theories and ideas around how positive risk management operates within different contexts. The expert panel consisted of two Clinical Psychologists specialising in higher risk forensic settings within the NHS and a mental health nurse with experience of both inpatient and community mental health settings. All panel members had expertise in, or enhanced knowledge of, positive risk management in mental healthcare. The first meeting involved discussing the panel members experience and knowledge of PRM, their perspectives on what makes PRM work, for whom and in which contexts. Detailed notes of each meeting were made and discussed within the research team to identify broader theory areas to scaffold the development of CMO configurations. Discussions with the expert panel members also supported the identification of two key outcomes: quality of life and risk related outcomes. A second meeting took place 6 months later with each panel member to discuss initial findings from the literature and further refine initial CMO configurations.

3. Identifying the literature

A systematic search of the literature was conducted in June 2023 using CINAHL, PsychINFO, SOCindex, Medline and Embase. Search terms were based on the key definitions and terminology within the literature, recognising the broad definitions and understanding of PRM that exist. Reference lists of eligible papers were also screened to identify further studies for potential inclusion. See Appendix 1-A for search terms used for each database.

The aim of the review process is to identify information that provides relevant insight and information toward the research question, independent of where the data are sourced (Rycroft-Malone et al., 2012). Selection is based on how the source contributes to the process of programme theory development, refinement and testing; therefore, the inclusion of grey literature is an important aspect of realist research. A further concurrent search of grey literature databases was conducted using Google, NHS England Publication website, NICE website, NHS England Publication website and GOV.UK. The terms ‘positive risk management’ and ‘positive risk taking’ were entered to identify documents containing information supporting the development of program theories. Additional terms relating to PRM, such as ‘therapeutic risk taking’ and collaborative risk taking’ were also explored within the grey literature search but led to the identification of a high number of irrelevant and spurious publications. Therefore, grey literature was limited to the above two key phrases. The reference list of other relevant literature, for example Just et al., (2021b) was screened to capture any further grey literature sources.

Identified papers were screened against an inclusion and exclusion criteria. Sources were included if they had a focus on positive risk management (or synonymous terms e.g. therapeutic risk taking) and provided insight into the mechanisms underlying positive risk management. Sources were excluded if they had a primary focus on social care or charity sector (e.g. a non mental healthcare setting), had a primary focus on physical health settings, were in non-English language or manuscripts which did not form whole policies (e.g. flyers/leaflets). All study designs were considered for inclusion in this review, in line with realist research guidance (Pawson et al., 2004; Booth et al., 2018). The sources needed to provide insight into the context and mechanisms in which PRM operates in mental health services. It is acknowledged that the fundamental aspects of PRM may be described and conceptualised differently across different sources of literature. This approach to risk management may be named variably depending on the environment and setting it is being used within, as well as the authors own understanding of its concept and utilisation. For example, terms such as ‘positive risk management’, ‘therapeutic risk taking’ and ‘proactive risk taking' are used synonymously across policy and literature, each conceptualising the core definition and aims of PRM, but are labelled in different ways.

Titles and abstracts of the identified empirical papers were screened by the lead author before full manuscripts were then reviewed against the inclusion/exclusion criteria. Reference lists of relevant

literature were screened to identify any further empirical papers for inclusion. For grey literature, full texts were read and searched for references relating to PRM. Included sources were required to provide relevant insight into the mechanisms and contexts in which PRM operates within mental health care settings.

This process included reviewing all literature and reports against the published standards of relevance, richness and rigour within realist research. These standards help to ensure the data are relevant to the topic area of PRM, rich both contextually and conceptually therefore adding depth and meaning to the program theory development and also rigorous in terms of the methodology and approach used (Booth et al., 2013; Dada et al., 2023; Pawson et al., 2004). Where there was no reported methodology, for example within some grey literature sources, rigor was assessed based on the credibility of any findings reported and the perceived trustworthiness of the source (Dad et al., 2023). Any reports deemed to be of low relevance, richness and/or rigor were excluded from the review given their lack of contribution toward identifying CMO's.

Data Extraction

Abductive and retroductive reasoning were used as a focus of the data extraction process to identify CMO configurations and develop program theories relevant to each broader theory area. Abductive reasoning seeks to identify the simplest and most likely conclusion from a set of observations amongst many alternatives, utilising a pragmatist perspective (Walton, 2005). Realist methodology commonly uses a retroduction as a form of reasoning, referring to the identification of hidden causal forces that sit behind identified patterns or changes in such patterns, with the assumption that societies have underlying causal properties which realist inquiry seeks to understand (Wong et al., 2017). All identified papers were read in depth and data relevant to understanding any aspect of elements of a CMO configuration were extracted and sorted into theory areas. Two of the authors contributed to this process, extracting relevant information and discussing findings to ensure reliability and consistency of findings.

Analysis and Synthesis Processes

As data were collected outcome patterns were observed and analysed iteratively, whilst working to identify CMO configurations. All authors contributed to the analysis. Authors met regularly throughout the analysis process to discuss findings and identify and refine CMO configurations. The authors reviewed the configurations ensuring adequate evidence for each, ensuring distinctness of each CMO and re grouping where necessary. CMO's were then sorted into relevant theory areas for reporting.

Results

Initial programme theory generation

Expert interviews and scoping searches identified preliminary theory areas which were then further developed and expanded upon through the empirical and grey literature review. Initial broad theory areas encapsulated ideas around emotions linked to risk management, the impact of PRM on the wellbeing of staff and service users and the impact of PRM on risk related outcomes.

Refinement and development of programme theory's

The systematic search and screening of empirical and grey literature sources resulted in 20 reports (see Figure 1-1 for flow diagram). 16 of the eligible reports were research articles and 4 were grey literature sources. Table 1-1 details included reports.

[Insert Figure 1-1 Here]

[Insert Table 1-1 Here]

During the realist synthesis process, the authors iteratively developed eight CMO's focused around two theory areas: 'Quality of Life' and 'Risk'. These two theory areas each relate to a key outcome of PRM, with each CMO configuration linking to at least one of these outcomes. The two theory areas represent a refinement of ideas from the initial expert panel interviews. Risk and quality of life were identified as key primary outcomes of PRM, encompassing bidirectional relationships within each outcome. For example, quality of life and level of risk may be either positively or negatively impacted by the context and mechanisms at play, each effecting various elements of the system including staff and service users. Table 1-2 illustrates the eight CMO's, grouped into their theory area alongside supporting quotes for each configuration. Importantly, the CMO's are not entirely independent of each other and instead are interlinked. The amalgamation of the theory areas and CMO's produce broader hypotheses around what makes PRM work within mental health care and crucially how this may lead to improved outcomes for both staff and service users operating within these systems.

[Insert Table 1-2 Here]

Theory Area 1: Quality of Life

Quality of life included numerous aspects of wellbeing and functioning, including independence, autonomy, choice and wellbeing. Factors affecting the application of PRM within mental health care settings, such as actuarial approaches to risk management, anxiety within healthcare professionals and staff's perceptions of risk-taking behaviours acted as major barriers to service users feeling supported and empowered, ultimately negatively impacting their recovery and quality of life. Staff's previous experiences of risk related incidents and access to relevant training and organisational support was felt to contribute to professional anxiety, defensiveness and a more restrictive approach to risk management being adopted. Conversely, providing staff with an environment whereby decisions can be shared, and people feel well connected influenced feelings of safety and confidence, resulting in positive risk taking which positively impacts service user quality of life through increased independence, ownership and trust. The five CMO's within this broader theory area are presented below.

CMO 1.1:

If risk management is used purely as a means to eliminate all risk, creating an impossible task, this increases professional anxiety and fear, resulting in more restrictive approaches which impacts quality of life for both service users and staff.

There was a tendency toward risk management being viewed as entirely preventative, with the aim of avoiding any and all harm which in turn reduced propensity to utilise PRM. Anxiety and fear acted mechanistically, driving aversion to positive risk taking through concerns around negative consequences resulting in more restrictive approaches. This was seen to not only impact service user quality of life through decreased opportunities for independence and recovery, but also may negatively impact staff. Working within a system where risk is viewed as something which can be entirely eliminated fuels feelings of anxiety and fear. Such risk averse environments result in staff practicing in a way which focusses on avoiding any type of risk occurring, therefore limiting collaboration, creativity and empowerment in allowing service users to learn to manage risks independently in line with a recovery model of care.

> *"The existing culture was perceived by participants, without question, as emphasizing that harmful consequences of taking risks are best avoided, limiting the possibilities of innovation and movement towards recovery-oriented approaches." Tickle et al, (2014) P104*

When risk management is viewed in such a way, it also led to feelings of disempowerment in staff. This acted as a further obstacle to the implementation of PRM as staff felt the need to conform to a risk-averse culture that they were employed within. This created difficulties in staff actively choosing to utilise a more collaborative, strengths-based approach to risk management and ultimately led to a less empowering experience for both service users and staff.

"Some mental health worker participants described how they experienced peer pressure to conform to their team's risk averse culture of practice and felt disempowered in encouraging service users to take positive risks toward recovery" – Holley et al, (2016) P 318

CMO 1.2:

If professionals are part of a well-connected team where responsibility it shared, this increases feelings of safety and confidence in decision making, increasing their ability to take positive risks with service users.

The reports in this review suggest the successful implementation of PRM within mental health services is reliant upon professionals feeling well supported through a connected team where responsibility surrounding risk can be readily shared and communicated. Connection with colleagues could come in various forms, for example through supervision and regular team meetings. Such connection was felt to support staff to feel safer in their own clinical judgement and increased confidence in making decisions to take a more proactive PRM focused approach to risk management.

"the participants described support from their colleagues was vital. This included letting off steam and seeking out emotional and practical support." Thompson et al, (2008) P158

Conversely, a lack of support and shared decision making within teams can lead to professionals feeling alone and overwhelmed, reducing their ability to take positive risks which promote aspects of quality of life such as independence and autonomy as well as the recovery of service users. It was felt that staff who are tasked with managing high levels of risk without the backing of colleagues to discuss and share decisions or concerns were less likely to feel confident in using PRM, and instead may take a more restrictive approach which feels 'safer' in terms of minimising the likelihood of a negative outcome.

"Lone based risk decisions felt too challenging and overwhelming, yet with the support of others, that uncertainty had become more manageable." Just et al, (2021b) P1905

CMO 1.3:

If staff members receive relevant training and exposure around recovery and risk management approaches, they feel clearer about its application and relevance for service users, allowing them to become more confident and skilled around using PRM which is key in the promotion of independence for service users to facilitate improved quality of life.

Some sources suggested that access to regular training around risk management and recovery was instrumental in supporting staff to feel skilled enough to use PRM when working with higher levels of risk. Staff who felt clear around the application and appropriateness of adopting a strengths-based, collaborative approach with service users may be more confident in taking positive risks compared to those who are less knowledgeable about PRM and how it relates to recovery. In the absence of adequate information, training and guidance, staff may defer to a more restrictive approach to ensure feelings of safety, despite the impact this may have on service user quality of life. This may be particularly important for more newly qualified staff, who have less exposure to PRM and its application within mental health services.

"the 2-day strengths model training program was associated with significant pre-post-increases in: knowledge and belief in recovery principles, therapeutic optimism, as well as significant decrease in providers aversion to supporting positive risk taking." Deane et al, 2019 P1427

CMO 1.4:

If staff have experienced previous risk related incidents with negative outcomes, this increases feelings of defensiveness and anxiety about future risk taking, resulting in more restrictive, less collaborative approaches to risk management which impacts service user independence and psychological wellbeing.

Several reports emphasised the link between previous experiences of serious incidents and future risk aversion. Staff's practice and decision making around risk assessment and management was influenced by their previous experiences of managing risk within services. It was suggested that prior difficulties or failures in reducing risk through positive risk-taking or less restrictive approaches may drive fear and defensiveness, resulting in avoidance in adopting such approaches with others. Previous negative experiences of risk taking with service users contribute to the development of risk averse attitudes which may be less favourable toward a collaborative, positive risk-taking approach, resulting in negative outcomes for service users. It is suggested such incidents may evoke feelings of defensiveness and anxiety within clinicians, linked to a sense of sole accountability for outcomes that practitioners may feel when working with service users and a lack of support from senior colleagues, linking to CMO 1.2.

"A clinician who holds fears regarding a consumers capability to achieve the goal of living alone in the community may be driven by prior failures to do so successfully" – Crowe and Deane, (2018) P29

CMO 1.5:

When professionals view an individual's risk as more acute or less predictable, this can lead to them feeling more anxious and less trusting of their own clinical judgment, resulting in the adoption of a more cautious approach. Such approach reduces their propensity to collaborate meaningfully and increases restrictive practice, negatively impact service user quality of life through reduced autonomy and empowerment over decision making.

Perceptions surrounding the acuity and predictability of a service users' current level of risk drove a lack of confidence and trust within staff, ultimately impacting the level of caution they took when considering risk management. Acuity and predictability were linked to mental health settings and even diagnoses. A bias toward certain diagnoses was noted in some reports, for example viewing individuals with certain diagnoses as being inherently riskier and using such judgements to inform decision making around managing risk.

"Beliefs about mental health dictated staff's use and practice of PRM. Practitioners used diagnoses to determine risk and suitability for PRM… Staff believed it was valid to use diagnoses to determine risk and that some diagnoses were riskier than others." Just et al, 2021B P1902

Views toward acuity and predictability were linked to the mental health setting staff were working within with those in inpatient or forensic settings appearing to have more barriers to PRM. There was a sense of normalisation of certain approaches to risk management within such settings, in comparison to community-based settings. Staff adopted a more cautious approach with those they viewed as higher acuteness to manage feelings of anxiety that a negative outcome may occur, linked to CMO 1.4. Some reports highlighted the impact such practice had on service users, including increased dependence and passiveness.

"A higher proportion of respondents working in acute inpatient services 'always' put the person on a level of observation, remove items of risk and identify de-escalation strategies compared to those working in the community". Higgins et al, (2016b), P164

Theory Area 2: Risk

The second theory area relates to increased or decreased risk as a key outcome of PRM within mental health care. Risk itself is defined variably across the literature. The DoH (2009) define risk as the "nature, severity, imminence, frequency/duration and likelihood of harm to self or others". This theory area emphasises the impact various factors may have on the exacerbation or reduction in risk for service users and staff, highlighting how PRM can support in reducing harm and support staff to navigate risk management meaningfully. There were three CMO's within this area.

CMO 2.1:

If services are over reliant on structured, actuarial risk assessment tools, this reduces staff's curiosity and meaningful connection with service users, meaning risk management plans are less individualised and reduces engagement.

Reports placed an emphasis on the need for clinical judgement and holistic formulation within risk management, rather than the use of actuarial, standardised risk assessment tools such as questionnaires. Where services and staff were over reliant upon utilising such tools to assess and manage risk, the ability to create meaningful connection with service users was reduced. This connection formed a strong basis for the implementation of a PRM approach, therefore when this was lacking PRM was less likely to be adopted. Risk management plans created without connection and a level of collaborative curiosity are less individualised and person centred. Some reports highlighted how such plans mean service users are less likely to engage with them and may become dismissive of taking ownership over their own risk management. This may ultimately increase levels of overall risk, as service users feel less inclined to engage with a plan that is not adapted to their specific needs.

"While reducing assessment to nominal categories might make for efficiency and provide a paper trail of evidence that a checking process has been carried out, the emphasis on tick boxes and lack of space to document ongoing evident, as evident in so many of the tools, has the potential to erode meaningful engagement with service users." Higgins et al, (2016a) P392

CMO 2.2:

If services and staff are operating within a highly pressured environment where there is a lack of time and resource, this reduces opportunity to develop strong relationships and rapport between service users and staff through a lack of actual time together, meaning both parties feel a lack of safety and connection with each other. This results in risk management plans that are not person centred, making them less effective in managing risk and reducing positive engagement.

Multiple reports highlighted the difficulties associated with time and resources for mental health clinicians and the knock-on effect this has on risk management and service user recovery. Pressures within the environment were broad and referred most commonly to actual time able to be spent with service users to develop a risk management plans as well as time to see service users regularly to build good relationships and connection. A lack of time due to competing demands and pressures elsewhere within the system act as a barrier to utilising PRM. Strong relationships and a good rapport between service users and staff form a fundamental aspect of PRM, allowing for the building of trust, openness and a sense of genuine connection. Reports suggest that where this is lacking, risk management becomes superficial in some ways, failing to produce a genuine person-centred plan where both parties feel safe to foster independence and take positive risk toward recovery.

"It is possible that initial enthusiasm for the new approach waned over time, something that has been found in other organizations particularly if there is a lack of stakeholder support, workforce issues, leadership issues and competing funding priorities" Deane et al, (2019) P1427

Furthermore, some literature emphasised how service users within inpatient services are likely to recognise the lack of time and resource staff are working under, which can create a deterrent in them requesting help and further increasing potential risk of harm.

"...she had noticed that individuals sometimes refrained from asking for help when they perceived the ward as being understaffed or the care providers as being too busy." Bjarehed et al, (2020) P1663

CMO 2.3:

If policy and guidance lack clarity and consistency in its definition and explanation of PRM within mental health care this causes confusion, uncertainty and stress for professionals, which leads to staff relying on more restrictive, familiar risk management interventions which are more reliant on risk aversion rather than positive risk taking.

Some literature highlighted the lack of clarity within policy and guidance surrounding PRM, it's application and purpose within mental health settings, as well as discrepancies between documents. Some of the literature emphasised how when staff feel unsure about PRM and its related concepts, this creates confusion and uncertainty around how, when and where to use PRM, ultimately leading to an overall level of avoidance of the approach as a whole to avoid the discomfort of uncertainty that this evokes.

"It is clear that there are discrepancies within documents with further agreement on a national level being required to ensure policies and guidelines provide a consistent and coherent message to frontline staff." Just et al, (2021a) P338

Such a lack of clear definition and coherence around PRM creates resistance within mental health staff, leading to a fallback to more restrictive, less collaborative approaches. This not only risks producing poorer outcomes for service users, but further fuels a risk averse culture within mental health services where risk averse practice becomes a default.

Discussion

This review was the first to explore the mechanisms by which PRM may work within mental healthcare settings, and the contextual factors which trigger such mechanisms to occur. Interviews with three expert panel members identified initial programme theories which were subsequently

refined and developed through the identification and analysis of 20 reports. The findings suggest the effective implementation of PRM is affected by how connected professionals are to each other, staff perceptions on risk and recovery, access to adequate training and previous experiences of risk related incidents affecting clinical practice. PRM's application is also negatively influenced by the over reliance on risk tools, pressures faced by staff impacting their time spent with service users and discrepancies within policy and guidance causing confusion and anxiety for professionals. These in turn can create feelings of anxiety, reduce curiosity and affect the development of trusting relationships between staff and service users, contributing to negative outcomes for both staff and service users.

Internal conflict and negative emotions acted mechanistically for staff within various contexts identified in this review. Anxiety and fear over the presence of higher risk behaviours and potential risk related incidents impacts decisions around risk management and can result in more restrictive approaches being adopted within services. Anxiety amongst mental health professionals is not uncommon and those in such professions are more likely to experience distress and negative emotion in the workplace (Volpe et al., 2013). The continual exposure to distress within the workplace heightens risk of burnout in the workforce, with existing research showing this creates less efficient teamwork and results in lower quality interventions being provided to service users (Fahrenkopf et al., 2008), further emphasising the impact of such feelings for both staff and service users. Additionally, research highlights risk of burnout is present early on in professional's careers, such as medical students (Dahlin et al., 2010; Fang et al., 2012), rather than this being a phenomenon that only occurs after many years of distress negative experience. This emphasises the need for early, consistent support for professionals to ensure they are well supported with risk management to minimise the impact of such emotions upon their own wellbeing and decisions around risk management.

The presence such emotions within staff, triggered by contextual factors highlighted in this review, were linked to detrimental outcomes for service user recovery. More restrictive approaches may be favoured as a way of managing such negative emotions, such as the fear and anxiety of a risk incident occurring. Restrictive practices should be employed as a last resort within psychiatric settings (Department of Health, 2014), though reports suggest such measures are still routinely employed, sometimes excessively (Department of Health, 2014). Some studies have explored the reasoning for such over reliance on restrictive measures and found it linked to staff shortages and a lack of adequately trained professionals (Marangos-Frost et al., 2000; Vedana et al., 2018), as well as a perception that no other effective alternatives exist (Sequeria & Halstead, 2004; Vedana et al., 2018), in parallel with findings from this review. Crucially, research highlights the damaging psychological impact of restrictive practice for both staff and service users (Chieze et al., 2019) including damaged relationships between both parties and feelings of re-traumatisation (Butterworth et al., 2022). The above findings resemble findings of the current study, highlighting the need for adequate training and

exposure to PRM alongside well-resourced services so professionals can feel safe and spend enough time with service users to apply PRM effectively. Such findings further highlight the link between the CMO's identified and the need for further exploration of not only staff and service user level difficulties, but importantly service level change.

There is an evident need for better support for mental health professionals who hold high levels of responsibility in managing varying levels of risk on a day-to-day basis in their roles. Findings suggest the presence of effective clinical supervision results in lower levels of reported burnout in mental health staff (Edwards et al., 2005), linking to findings in this study around feelings of connection and safety with other members of the team. Furthermore, research found staff wellbeing is associated with patient safety and quality of care, with levels of staff burnout found to be associated with increased reports of adverse events within services (Hall et al., 2016). Mental health settings can be unpredictable in nature and vary considerably depending upon various factors including location, population served and speciality. It is therefore difficult to entirely control for contextual factors influencing the use of PRM, with the very nature of the work within such settings meaning feelings of pressure and the presence of risk related incidents will always be somewhat inevitable. This highlights the need for clear, structured guidance for staff alongside a wider cultural shift within the NHS to promote a workplace culture that values staff wellbeing, encourages shared learning and fosters a sense of psychological safety for all. This is vital in ensuring staff and service users are supported in working together toward recovery in the least restrictive way possible, whilst maintaining feels of safety, autonomy and independence.

Realist reviews aim to make sense of complex interventions which are offered across various contexts, such as PRM, by attempting to understand different contexts which trigger mechanisms underlying how the intervention works in practice (Pawson & Tiley, 1997; Wong et al., 2017). The findings provide a wide overview of current issues surrounding PRM including barriers to its application and the outcomes of such processes within the wider system of mental healthcare. It is important that findings in this review are recognised as theories and initial hypotheses of the authors, further shaped by reflection and involvement of the expert panel. Theories identified require testing and refinement through extensive research into specific aspects of PRM for all involved within its use including staff, service users, family/carers and senior level leadership involved in policy development and implementation. Reports included within this review highlight the heterogeneity within the literature in this area. The variability of literature included in this review may reduce reliability of findings and further emphasise the need for increased interest in this area of research. Furthermore, only four studies in this review included the voice of service users. The remaining sources focussed on various professional groups meaning the contexts and mechanisms by which PRM works specifically for service users may be underrepresented in the current analysis and require further exploration. There is an evident need for increased awareness and understanding of PRM from

a service user perspective to ensure its use and implementation is appropriately understood and targeted effectively to ensure the best possible outcomes for recovery.

In conclusion, this review attempted to explore how, why, for whom and in what contexts does PRM work in mental healthcare settings. Findings highlighted multiple barriers and facilitators to the effective implementation of PRM including access to relevant training, feelings of support and a need for shared decision making amongst practitioners. Such factors affected both quality of life and levels of risk within services, highlighting the need for further recognition and insight in this area. Results emphasise the need for increased staff support and clear guidelines for services to be able to adopt a PRM approach to benefit the recovery of service users. Future work should focus on further testing and refinement of initial theories identified in this review and should aim to capture the voice of service users to ensure a holistic view of the impact of such factors upon all individuals involved.

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Declaration of Interest

The authors report there are no competing interests to declare.

References

Bjärehed, J., Ingelsson Lindell, E., & Westling, S. (2021). A thematic analysis of care provider experiences of using self-harm abstinence agreements in psychiatric inpatient care. *Nursing Open*. https://doi.org/10.1002/nop2.795

Booth, A., Harris, J., Croot, E., Springett, J., Campbell, F., & Wilkins, E. (2013). Towards a methodology for cluster searching to provide conceptual and contextual "richness" for systematic reviews of complex interventions: case study (CLUSTER). *BMC Medical Research Methodology*, *13*, 1-14.

Booth, A., Wright, J., & Briscoe ,S. (2018). *Scoping and Searching to Support Realist Approaches.* In Emmel N, Greenhalgh J, Manzano A, Monaghan M, Dalkin, S, editors. Doing Realist Research. SAGE Publications Ltd. 147-166.

Bradley, E., & Green, D. (2017). Involved, inputting or informing: "Shared" decision making in adult mental health care. *Health Expectations*, *21*(1), 192–200. https://doi.org/10.1111/hex.12601

Butterworth, H., Wood, L., & Rowe, S. (2022). Patients' and staff members' experiences of restrictive practices in acute mental health in-patient settings: systematic review and thematic synthesis. *BJPsych Open*, *8*(6). https://doi.org/10.1192/bjo.2022.574

Callaghan, P., & Grundy, A. (2018). Violence risk assessment and management in mental health: a conceptual, empirical and practice critique. *The Journal of Mental Health Training, Education and Practice*, *13*(1), 3-13. https://doi.org/10.1108/jmhtep-04-2017-0027

Chieze, M., Hurst, S., Kaiser, S., & Sentissi, O. (2019). Effects of Seclusion and Restraint in Adult Psychiatry: A Systematic Review. *Frontiers in Psychiatry*, *10*(491). https://doi.org/10.3389/fpsyt.2019.00491

Coffey, M., Hannigan, B., Barlow, S., Cartwright, M., Cohen, R., Faulkner, A., Jones, A., & Simpson, A. (2019). Recovery-focused mental health care planning and co-ordination in acute inpatient mental health settings: a cross national comparative mixed methods study. *BMC Psychiatry*, *19*(1). https://doi.org/10.1186/s12888-019-2094-7

Crowe, S., & Deane, F. (2018). Charecteristics of mental health recovery model implementation and managers and clinicians' risk aversion. *Journal of Mental Health Training, 13*(1), 00-00. DOI:10.1108/JMHTEP-05-2017-0039

Dada, S., Dalkin, S., Gilmore, B., Hunter, R., & Mukumbang, FC. (2023). Applying and reporting relevance, richness and rigour in realist evidence appraisals: Advancing key concepts in realist reviews. *Research Synthesis Methods, 14*(3), 504-514). doi:10.1002/jrsm.1630.

Dahlin, M., Fjell, J., & Runeson, B. (2010). Factors at medical school and work related to exhaustion among physicians in their first postgraduate year. *Nordic Journal of Psychiatry*, *64*(6), 402–408. https://doi.org/10.3109/08039481003759219

Deane, F. P., Goff, R. O., Pullman, J., Sommer, J., & Lim, P. (2018). Changes in Mental Health Providers' Recovery Attitudes and Strengths Model Implementation Following Training and Supervision. *International Journal of Mental Health and Addiction*, *17*(6), 1417–1431. https://doi.org/10.1007/s11469-018-9885-9

Department of Health. (2009). *Best Practice in Managing Risk. Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services.* . https://assets.publishing.service.gov.uk/media/5a8020a840f0b62302691adf/best-practice-managing-risk-cover-webtagged.pdf

Department of Health. (2014). *Positive and Proactive Care: reducing the need for restrictive interventions.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf

Downes, C., Gill, A., Doyle, L., Morrissey, J., & Higgins, A. (2016). Survey of mental health nurses' attitudes towards risk assessment, risk assessment tools and positive risk. *Journal of Psychiatric and Mental Health Nursing*, *23*(3-4), 188–197. https://doi.org/10.1111/jpm.12299

Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., Juggessur, T., Fothergil, A., & Coyle, D. (2006). Clinical supervision and burnout: the influence of clinical supervision for community mental health nurses. *Journal of Clinical Nursing*, *15*(8), 1007–1015. https://doi.org/10.1111/j.1365-2702.2006.01370.x

Fahrenkopf, A. M., Sectish, T. C., Barger, L. K., Sharek, P. J., Lewin, D., Chiang, V. W., Edwards, S., Wiedermann, B. L., & Landrigan, C. P. (2008). Rates of medication errors among depressed and burnt out residents: prospective cohort study. *BMJ*, *336*(7642), 488–491. https://doi.org/10.1136/bmj.39469.763218.be

Fang, D. Z., Young, C. B., Golshan, S., Moutier, C., & Zisook, S. (2012). Burnout in premedical undergraduate students. *Academic Psychiatry : The Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry*, *36*(1), 11–16. https://doi.org/10.1176/appi.ap.10080125

Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. (2016). Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review. *PloS one*, *11*(7), e0159015. https://doi.org/10.1371/journal.pone.0159015.

Hawley, C. J., Gale, T. M., Sivakumaran, T., & Littlechild, B. (2010). Risk assessment in mental health: Staff attitudes and an estimate of time cost. *Journal of Mental Health*, *19*(1), 88-98. https://doi.org/10.3109/09638230802523005

Healthcare Quality Improvement Partnership. (2024). *National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report 2024: England, Northern Ireland, Scotland and Wales.* https://documents.manchester.ac.uk/display.aspx?DocID=71818

Higgins, A., Doyle, L., Morrissey, J., Downes, C., Gill, A., & Bailey, S. (2016a). Documentary analysis of risk-assessment and safety-planning policies and tools in a mental health context. *International Journal of Mental Health Nursing*, *25*(4), 385–395. https://doi.org/10.1111/inm.12186

Higgins, A., Doyle, L., Downes, C., Morrissey, J., Costello, P., Brennan, M., & Nash, M. (2016b). There Is More to Risk and Safety Planning than Dramatic Risks: Mental Health Nurses' Risk Assessment and safety-management Practice. *International Journal of Mental Health Nursing*, *25*(2), 159–170. https://doi.org/10.1111/inm.12180

Holley, J., Chambers, M., & Gillard, S. (2015). The impact of risk management practice upon the implementation of recovery-oriented care in community mental health services: a qualitative investigation. *Journal of Mental Health*, *25*(4), 315–322. https://doi.org/10.3109/09638237.2015.1124402

Implementing Recovery through Organisational Change [imROC]. (2014). *Briefing: Risk, Safety and Recovery.* https://imroc.org/resource/9-risk-safety-and-recovery/

Just, D., Tai, S., & Palmier-Claus, J. (2021a). A systematic review of policy and clinical guidelines on positive risk management. *Journal of Mental Health*, *32*(1), 329–340. https://doi.org/10.1080/09638237.2021.1922643

Just, D., Palmier-Claus, J. E., & Tai, S. (2021b). Positive risk management: Staff perspectives in acute mental health inpatient settings. *Journal of Advanced Nursing*, *77*(4). https://doi.org/10.1111/jan.14752

Langan, J. (2008). Involving mental health service users considered to pose a risk to other people in risk assessment. *Journal of Mental Health*, *17*(5), 471–481. https://doi.org/10.1080/09638230701505848

Mental Welfare Commission for Scotland. (2016). *Good Practice Guide: Supported Decision Making.* https://naspc.scot/resources/good-practice-guide-supported-decision-making/

Marangos-Frost, S., & Wells, D. (2000). Psychiatric nurses' thoughts and feelings about restraint use: a decision dilemma. *Journal of Advanced Nursing*, *31*(2), 362–369. https://doi.org/10.1046/j.1365-2648.2000.01290.x

Morgan, S., & Andrews, N. (2016). Positive risk-taking: from rhetoric to reality. *The Journal of Mental Health Training, Education and Practice*, *11*(2), 122-132. https://doi.org/10.1108/jmhtep-09-2015-0045

Morrissey, J., & Higgins, A. (2018). “Attenuating Anxieties”: A grounded theory study of mental health nurses’ responses to clients with suicidal behaviour. *Journal of Clinical Nursing*, *28*(5-6), 947–958. https://doi.org/10.1111/jocn.14717

National Institute for Health and Care Excellence. (2022). *Self-harm: assessment, management and preventing recurrence (NG225).* . https://www.nice.org.uk/guidance/ng225/resources/selfharm-assessment-management-and-preventing-recurrence-pdf-66143837346757

Pawson, R., & Tiley, N. (1997). *An Introduction to Scientific Realist Evaluation. Evaluation for the 21st Century: A Handbook.* SAGE Publications Ltd. 405-418.

Pawson, R., Greenhalgh, T., Harvey, G., & Walshe, K. (2004). *Realist synthesis: an introduction. In: ESRC Research Methods Programme.* University of Manchester. https://www.betterevaluation.org/sites/default/files/RMPmethods2.pdf. Accessed 04 Apr 2023.

Quinlivan, L., Cooper, J., Steeg, S., Davies, L., Hawton, K., Gunnell, D., & Kapur, N. (2014). Scales for predicting risk following self-harm: an observational study in 32 hospitals in England. *BMJ Open*, *4*(5), e004732. https://doi.org/10.1136/bmjopen-2013-004732

Roberston, J. P., & Collinson, C. (2011). Positive risk taking: Whose risk is it? An exploration in community outreach teams in adult mental health and learning disability services. . *Health, Risk & Society 13*(2), 147-164.

Rycroft-Malone, J., McCormack, B., Hutchinson, A. M., DeCorby, K., Bucknall, T. K., Kent, B., Schultz, A., Snelgrove-Clarke, E., Stetler, C. B., Titler, M., Wallin, L., & Wilson, V. (2012). Realist synthesis: illustrating the method for implementation research. *Implementation science : IS*, *7*, 33. https://doi.org/10.1186/1748-5908-7-33

Simpson, A., Hannigan, B., Coffey, M., Barlow, S., Cohen, R., Jones, A., Všetečková, J., Faulkner, A., Thornton, A., & Cartwright, M. (2016). Recovery-focused care planning and coordination in England and Wales: a cross-national mixed methods comparative case study. *BMC Psychiatry*, *16*(1). https://doi.org/10.1186/s12888-016-0858-x

Sequeira, H., & Halstead, S. (2004). The psychological effects on nursing staff of administering physical restraint in a secure psychiatric hospital: “When I go home, it’s then that I think about it.” *The British Journal of Forensic Practice*, *6*(1), 3–15. https://doi.org/10.1108/14636646200400002

Steeg, S., Quinlivan, L., Nowland, R., Carroll, R., Casey, D., Clements, C., Cooper, J., Davies, L., Knipe, D., Ness, J., O’Connor, R. C., Hawton, K., Gunnell, D., & Kapur, N. (2018). Accuracy of risk scales for predicting repeat self-harm and suicide: a multicentre, population-level

cohort study using routine clinical data. *BMC Psychiatry*, *18*(1). https://doi.org/10.1186/s12888-018-1693-z

Sustere, E., & Tarpey, E. (2019). Least restrictive practice: its role in patient independence and recovery. *The Journal of Forensic Psychiatry & Psychology*, *30*(4), 614–629. https://doi.org/10.1080/14789949.2019.1566489

Thompson, A. R., Powis, J., & Carradice, A. (2008). Community psychiatric nurses' experience of working with people who engage in deliberate self-harm. *International Journal of Mental Health Nursing*, *17*(3), 153–161. https://doi.org/10.1111/j.1447-0349.2008.00533.x

Tickle, A., Brown, D., & Hayward, M. (2012). Can we risk recovery? A grounded theory of clinical psychologists' perceptions of risk and recovery-oriented mental health services. *Psychology and Psychotherapy: Theory, Research and Practice*, *87*(1), 96–110. https://doi.org/10.1111/j.2044-8341.2012.02079.x

Vedana, K. G. G., da Silva, D. M., Ventura, C. A. A., Giacon, B. C. C., Zanetti, A. C. G., Miasso, A. I., & Borges, T. L. (2018). Physical and mechanical restraint in psychiatric units: Perceptions and experiences of nursing staff. *Archives of Psychiatric Nursing*, *32*(3), 367–372. https://doi.org/10.1016/j.apnu.2017.11.027

Volpe, U., Luciano, M., Palumbo, C., Sampogna, G., Del Vecchio, V., & Fiorillo, A. (2014). Risk of burnout among early career mental health professionals. *Journal of Psychiatric and Mental Health Nursing*, *21*(9). https://doi.org/10.1111/jpm.12137

Walton, D. N. (2005). *Abductive reasoning*. The University Of Alabama Press.

Ware, A., Preston, A., & Draycott, S. (2022). "It Doesn't Get Taken Seriously until It Gets bad": Experiences of Risk Management from People Diagnosed with a Borderline Personality Disorder. *Mental Health Review Journal*, *27*(3). https://doi.org/10.1108/mhrj-02-2021-0016

Wong, G., Westhorp, G., Greenhalgh, J., Manzano, A., Jagosh, J., & Greenhalgh, T. (2017). *Quality and reporting standards, resources, training materials and information for realist evaluation: the RAMESES II project.* NIHR Journals Library.

Wong, G., Westhorp, G., Manzano, A., Greenhalgh, J., Joagosh, J., & Greenhalgh, T. (2016). RAMESES II reporting standards for realist evaluations. *BMC Medicine*, *14*(1), 96. doi:10.1186/s12916-016-0643-1.

Worthington, A., Rooney, P., & Hannah, R. (2013). *The Triangle of Care: A Guide to Best Practice in Mental Health Care in England. Second Edition.* . https://carers.org/downloads/resources-pdfs/triangle-of-care-england/the-triangle-of-care-carers-included-second-edition.pdf

Appendices

Appendix 1-A

Realist Review Search Terms

CINAHL (358 hits)
TI (((Positive OR therapeutic OR collaborative OR proactive) N3 (risk*))) OR AB (((Positive OR therapeutic OR collaborative OR proactive) N3 (risk*)))

((MH "Mental Health") OR (MH "Community Mental Health Services") OR (MH "Mental Health Services") OR (MH "Mental Health Organizations")) OR TI (((mental OR psych*) n3 (illness OR health OR condition OR disorder*))) OR AB (((mental OR psych*) n3 (illness OR health OR condition OR disorder*)))

Restricted to English language

PsycINFO (275 hits)
(DE "Mental Health" OR DE "Youth Mental Health" OR DE "Mental Health Inservice Training" OR DE "Community Mental Health Training" OR DE "Mental Health Programs" OR DE "Mental Health (Attitudes Toward)" OR DE "School Based Mental Health Services" OR DE "Public Mental Health" OR DE "Mental Health Services") OR TI (((mental OR psych*) n3 (illness OR health OR condition OR disorder*)))

TI (((Positive OR therapeutic OR collaborative OR proactive) N3 (risk*))) OR AB (((Positive OR therapeutic OR collaborative OR proactive) N3 (risk*)))

Restricted to English language

Medline (577 hits)
((MH "Mental Health") OR (MH "Mental Health Services") OR (MH "Mental Health Recovery") OR (MH "Community Mental Health Services")) OR TI (((mental OR psych*) n3 (illness OR health OR condition OR disorder*))) OR AB (((mental OR psych*) n3 (illness OR health OR condition OR disorder*)))

TI (((Positive OR therapeutic OR collaborative OR proactive) N3 (risk*))) OR AB (((Positive OR therapeutic OR collaborative OR proactive) N3 (risk*)))

Restricted to English language

SocINDEX (81 hits)
(DE "MENTAL health" OR DE "COMMUNITY mental health services" OR DE "MENTAL health services" OR DE "MENTAL health education") OR TI (((mental OR psych*) n3 (illness OR health OR condition OR disorder*))) OR AB (((mental OR psych*) n3 (illness OR health OR condition OR disorder*)))

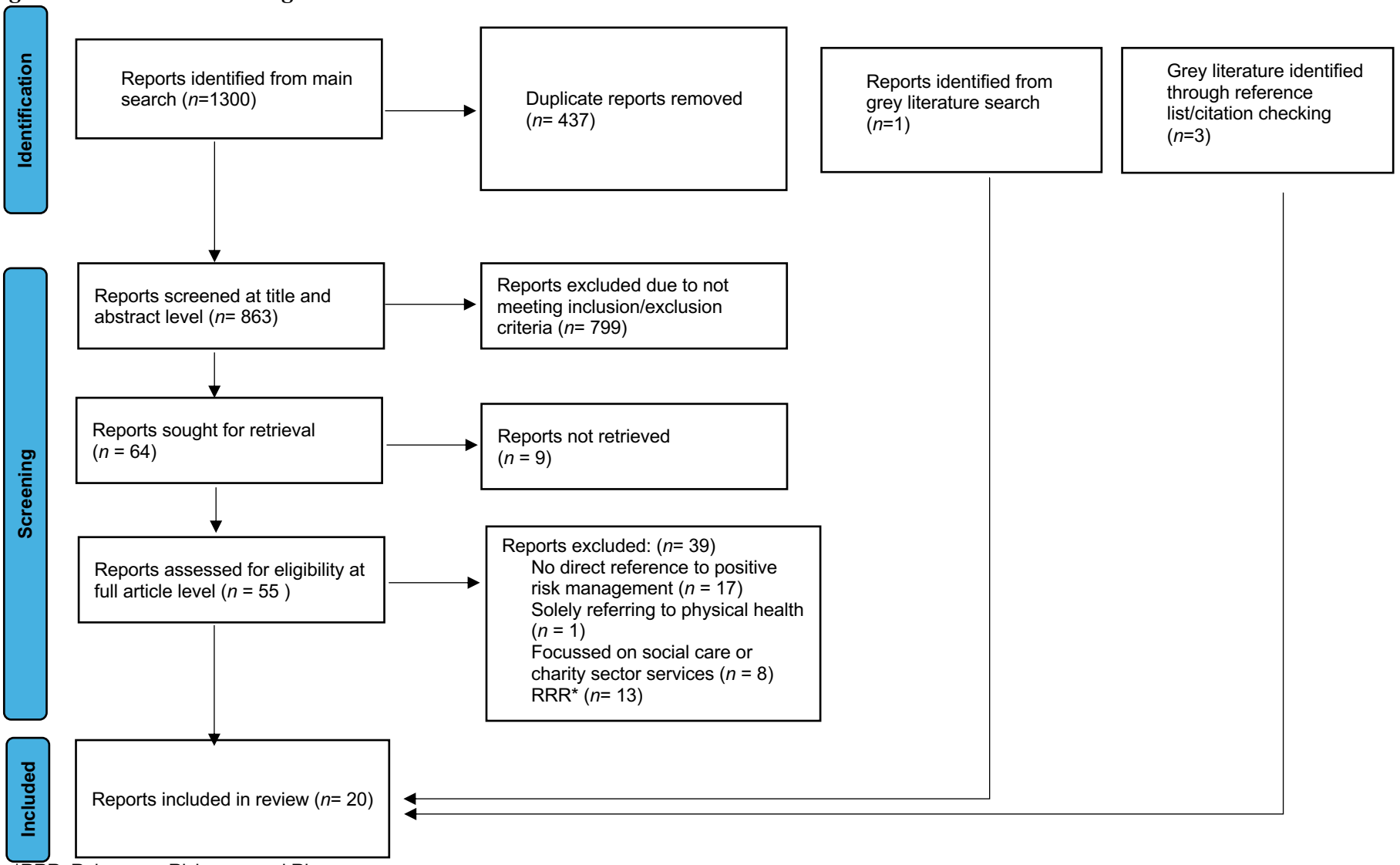
TI (((Positive OR therapeutic OR collaborative OR proactive) N3 (risk*))) OR AB (((Positive OR therapeutic OR collaborative OR proactive) N3 (risk*)))

Restricted to English language

Embase (Ovid) (9 hits)
(((Positive or therapeutic or collaborative or proactive) adj3 risk*) and ((mental or psych*) adj3 (illness or health or condition or disorder*))).ti. and ((mental or psych*) adj3 (illness or health or condition or disorder*)).ab.
Restricted to English language

Total: 1300 before duplicate removal.

Figure 1-1. Prisma Flow Diagram



*RRR: Relevance, Richness, and Rigour.

Table 1-1. Characteristics of Included Reports

First Author, Year	Document Type	Study Design	Sample/Population	Data Collection
Bjärehed, 2020	Academic Article	Qualitative Interviews	12 mental health professionals	Qualitative Interviews
Crowe, 2018	Academic Article	Quantitative Cross Sectional Survey	174 clinicians and 48 managers	54 item Quantitative Questionnaire
Deane, 2019	Academic Article	Pre Post Repeated Measures Design	76 mental health providers	6 Quantitative Questionnaires
Department of Health, 2009	Government Guideline (Grey Literature)	-	-	-
Department of Health, 2014	Government Policy (Grey Literature)	-	-	-
Downes, 2016	Academic Article	Quantitative	381 mental health nurses	Quantitative Survey (Likert Scale)
Higgins, 2016a	Academic Article	Documentary Analysis	123 documents from 22 directors of nursing	Documentary Analysis
Higgins, 2016b	Academic Article	Quantitative	381 mental health nurses	Self-Report Survey
Holley, 2016	Academic Article	Qualitative	8 mental health worker and service user dyads	Qualitative Interviews
ImROC, 2014	Briefing (Grey Literature)	-	-	-
Just, 2021a	Academic Article	Systematic Review	7 policies and 19 guidelines	Systematic Review
Just, 2021b	Academic Article	Qualitative	16 healthcare professionals	Qualitative interviews
Mental Welfare Commission for Scotland, 2016	Government Guideline (Grey Literature)	-	-	-
Morrissey, 2019	Academic Article	Qualitative	33 mental health nurses	Qualitative Interviews
Robertson, 2011	Academic Article	Qualitative	8 assertive outreach staff and 6 learning disability staff	Qualitative Interviews

Simpson, 2016	Academic Article	Mixed Methods	448 service users, 201 care coordinators, 117 case studies and 33 care plans.	Questionnaires and semi structured interviews
Sustere, 2019	Academic Article	Qualitative	12 male inpatients within a medium secure unit	Qualitative Interviews
Thompson, 2008	Academic Article	Qualitative	8 community psychiatric nurses	Qualitative Interviews
Tickle, 2014	Academic Article	Qualitative	11 Clinical Psychologists	Qualitative Interviews
Ware, 2022	Academic Article	Qualitative	9 adults with a diagnosis of BPD	Qualitative Interviews

Table 1-2. Supporting CMO's for Theory Areas with Supporting Quotes

Theory Areas/CMO's	Supporting Quotes
1. Quality of Life	
1.1 If risk management is used purely as a means to eliminate all risk, creating an impossible task, this increases professional anxiety and fear, resulting in more restrictive approaches which impacts quality of life for both service users and staff.	*"Discussion on suicide tended to be crafted with a preventative risk framework that emphasized professional responsibility or accountability…" Morrisey & Higgins, (2019) P951* *"…where more traditional risk averse practices were embedded within a team their ability to implement recovery oriented care was restricted." Holley et al., (2016) P 318*
1.2 If professionals are part of a well-connected team where responsibility it shared, this increases feelings of safety and confidence in decision making, increasing their ability to take positive risks with service users.	*"Sharing decision making and responsibility among team members, service users, and carers can reduce anxiety about risk and increased opportunities for taking positive risk, which can promote recovery." Tickle et al., (2014) P107* *"Decisions that involved risk were therefore the whole team's responsibility and not the individual mental health workers." Holley et al, (2016) P 318* *'Staff perceived successful PRM implementation as reliant on a sense of shared responsibility and being able to verify their decisions with senior colleagues." Just et al, (2021a) P1905* *"Risk management plans should be developed by multidisciplinary and multi-agency teams operating in an open, democratic and transparent culture that embraces reflective practice." DoH (2009), p7* *Clearly, many staff are concerned about adverse consequences and a lack of managerial and institutional support for changes in practice which are seen to increase risk. Inevitably, this leads to defensive practice. IMROC (2014), p5.*
1.3 If staff members receive relevant training and exposure around recovery and risk management approaches, they feel clearer about its application and relevance for service users, allowing them to become more confident and skilled around using PRM which is key in the promotion of independence for service users to facilitate improved quality of life.	*'The continued education and exposure to recovery concepts may reinforce use of recovery-oriented tools and the relationship with risk aversion" Crowe and Deane, (2018) P30* *"Those who had no risk assessment or safety planning training were more likely to be undecided on whether risk is capable of being predicted compared to those with prior training" Downes et al., (2016) P193* *"Practitioners access to recurrent training was a requirement for PRM across documents. The need for training to be updated regularly suggests recognition of the difficulties with one off training." Just et al, (2021a) P337* *"This linked to an expressed frustration that the organization had not underwritten any practical guidance on PRT leaving staff feeling insufficiently supported in some aspects of their work…in perceiving the organization as inconsistent participants felt left to create their own guidance". Roberston et al., (2011) P153* *"…amassing experience led to being feeling more confident about their clinical skills and also made the work seem more predictable and hence less anxiety provoking." Thompson et al., (2008) P156*

	"Those involved in giving or facilitating support for decision making should be adequately trained and informed about what supported decision making is, including where and in what context it's appropriate." Mental Welfare Commission for Scotland, (2016), p23
1.4 If staff have experienced previous risk related incidents with negative outcomes, this increases feelings of defensiveness and anxiety about future risk taking, resulting in more restrictive, less collaborative approaches to risk management which impacts service user independence and psychological well being.	*"…mental health workers aspirations to implement recovery oriented care could, in the real world, be contaminated by the responsibility they feel for managing and reducing service users exposure to risk." Holley et al, (2016) P 320* *"Participants fear of suicide risk was heightened for several months after the suicide. They reported that they frequently ruminated about the events leading up to the suicide, found it difficult to trust clients in similar situations and lacked confidence in their own clinical judgement." Morrisey & Higgins, (2019) P953* *"The overprovision of support, risk avoidance and taking control of other people's lives can lead to limitations of hope, autonomy and opportunity which, in turn, may be a barrier to recovery and increase the possibility of loss of confidence, institutionalisation and other harms." IMROC (2014), p8.*
1.5 When professionals view an individual's risk as more acute or less predictable, this can lead to them feeling more anxious and less trusting of their own clinical judgment, resulting in the adoption of a more cautious approach. Such approach reduces their propensity to collaborate meaningfully and increases restrictive practice, negatively impact service user quality of life through reduced autonomy and empowerment over decision making.	*"when care providers assumed too much responsibility for the safety and well being of individuals receiving inpatient care it was described to contribute to the individual becoming more passive and dependent." Bjarehed et al, (2020) P1663* *"PRM implementation is dependent on the practitioner's awareness of influences on their decision making process, as well as a service users level of risk and insight". Just et al, (2021a) P337* *"inpatient units were seen as requiring greater safety measures, and to that extent service ser behaviours were seen as more controlled in these units than they are in the community." Roberston et al, (2011) P152* *"it was sometimes assumed that patients who were labelled as having a 'personality disorder' could not engage or deliberately chose not to." Thompson et al, (2008) P157* *"Oppressive environments and the use of blanket restrictions such as locked doors, lack of access to outdoor space or refreshments can have a negative impact on how people behave, their care and recovery." DoH (2014), p20*
2. Risk	
2.1 If services are over reliant on structured, actuarial risk assessment tools, this reduces staffs curiosity and meaningful connection with service users, meaning risk management plans are less individualised and reduces engagement.	*"Clinicians who are more risk averse may be increasing their implementation of all recovery tools as a means of managing their anxiety about potential negative consequences" Crowe and Deane, (2018) P29* *"For service users and carers in particular, conversations and relationships were identified as being far more important than care plans in promoting recovery, along with family and friends." Simpson et al, (2016) P13* *"professionals were experienced as having to 'tick certain boxes', impacting negatively upon patient-professional relationships and*

	collaboration… this appeared to create a sense of hopelessness, rather than empowerment or personal responsibility." Ware et al, (2022), P339
2.2 If services and staff are operating within a highly pressured environment where there is a lack of time and resource, this reduces opportunity to develop strong relationships and rapport between service users and staff through a lack of actual time together, meaning both parties feel a lack of safety and connection with each other. This results in risk management plans that are not person centred, making them less effective in managing risk and reducing positive engagement.	*"There is a sizeable minority who reported a significant degree of uncertainty around the role of PRT… This uncertainty among respondents probably reflects the dilemma that practitioners encounter everyday in trying to balance competing demands to maintain the safety and autonomy of service users, whilst protecting themselves against allegations of negligence and protecting the organization against liability." Downes et al, (2016) P195* *"Staff regarded PRM as requiring sufficient time to implement and they were less likely to put it into practice when time was limited…PRM would be unsafe without giving it the necessary time and attention it required." Just et al, (2021b) P1906* *"The desire to be responsive and provide a more personalized approach to care coordination was often frustrated by the lack of capacity within a team's or individuals' caseload." Simpson et al, (2016) P11* *"non collaborative and poorly communicated risk management plans could seem meaningless." Ware et al, (2022), P341*
2.3 If policy and guidance lack clarity and consistency in its definition and explanation of PRM within mental health care this causes confusion, uncertainty and stress for professionals, which leads to staff relying on more restrictive, familiar risk management interventions which are more reliant on risk aversion rather than positive risk taking.	*"Apparent resistance to implementing ROC displayed by some mental health teams and individual workers may stem from this lack of explicit guidance at policy level where mental health workers are embedded in a risk averse organizational culture." Holley et al, (2016) P 321* *"Risk management requires an organisational strategy as well as efforts by the individual practitioner." DoH, (2009), p6*

Section Two: Research Paper

Exploring Community Mental Health Staff Perspectives on Risk Management: A Reflexive Thematic Analysis

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Abstract

The assessment and management of risk is a core component of the delivery of mental health care within community mental health services. National policy and guidelines promote the use of positive risk management (PRM); however, its use remains somewhat limited and studies have highlighted barriers to staff implementing this approach. It remains important to capture the views of community mental health staff in relation to PRM, to better understand it's utilisation. The current study aimed to qualitatively explore how staff working in adult community mental health services experience, understand and utilise PRM. The author analysed 12 semi structured interviews with community practitioners utilising reflective thematic analysis. Three themes were identified: 'The System: Working With us or Against us?', 'Internal States' and 'Staff and Service Users: Working Together to Drive Recovery'. The ability to safely and effectively use PRM was influenced by systemic level pressures impacting staff's emotional well-being and confidence, with connection and togetherness acting as a key facilitator of a collaborative, PRM approach. The adoption of PRM was affected by access to adequate support and the extent to which staff felt connected to their colleagues and the wider team. Staff valued PRM as an approach to working with risk and highlighted the benefits of providing empowerment, trust and positive relationships to service users and impacts of future risk decisions. The authors further discuss the clinical implications of the research.

Introduction

For health and social care services to adopt a genuine person-centred approach, it is necessary for professionals to exhibit a fundamentally positive mindset and a willingness to take certain risks (Morgan & Andrews, 2016). The ability to effectively assess and manage risk is a key component in the provision of mental health care and is essential for practitioners working in such settings (Hawley et al., 2010). The term risk itself may be defined in several ways, often dependent upon the nature of the setting it is being assessed within. The Department of Health (DoH) state that it is the "nature, severity, imminence, frequency/duration and likelihood of harm to self or others" (Department of Health, 2009).

Risk, in various forms, is inevitable within community and inpatient mental health settings. The National Confidential Inquiry into Suicide and Safety in Mental Health (Healthcare Quality Improvement Partnership, 2024) reported 18,339 suicide deaths by people in contact with mental health services from 2011-2021, of which 46% had been in contact with services in the week before their death. During this period 4,767 service users died by suicide in acute mental health care settings, including inpatient, post discharge care, and crisis resolution or home treatment. Assessment of the behavioural characteristics of service users who died by suicide during this period found 63% had a history of self-harm. Importantly, this inquiry states clinicians judged the immediate risk of suicide to be 'low' or 'not present' for 82% of service user deaths at their final contact. Findings such as these evidence that there are important opportunities for prevention and learning in future.

Various methods are used to assess current or future risk to self or others in mental health services. Whilst several standardised clinical risk tools are still used, the National Institute for Health and Care Excellence (NICE) guidelines make clear that risk assessment tools are not a suitable method for predicting future suicide or repetition of self-harming behaviours (National Institute for Health and Care Excellence, 2022). Therefore, guidance states such tools should not be used by practitioners to predict future behaviours or determine access to treatment or hospital admission. Risk assessment tools are not standardised and may be over relied upon in clinical practice. In addition, their accuracy and usefulness are somewhat reliant upon appropriate use, interpretation and dissemination by the individual administering the assessment. Research demonstrates substantial variation in the predictive ability of risk scales, as well as limited impact on risk events such as suicide or violence to others (Callaghan & Grundy, 2018; Quinlivan et al., 2014; Steeg et al., 2018). In more recent years, there has been an emphasis on ensuring risk management is personal and individualised, with a focus on building positive relationships and continually striving to involve family or carers in discussions and decisions (Healthcare Quality Improvement Partnership, 2024). The assessment and management of risk in clinical practice is immensely important as it provides opportunity for collaboration between

service users, family and staff with a joint aim of promoting recovery and safety (Worthington et al., 2013).

National policy and guidelines promote the use of positive risk management (PRM) in the United Kingdom (UK). The Department of Health (2009) policy on best practice in managing risk most recently defined PRM as "…risk management, which improves the service user's quality of life and plans for recovery, while remaining aware of the safety needs of the service user, their carer, and the public". The concept of positive risk taking (also referred to as therapeutic risk taking, collaborative risk taking and various related terms) was first recognised during the 1990's, with the aim of it being a more practical, person centred response to supporting individuals who had more severe, enduring mental health difficulties (Morgan & Andrews, 2016). PRM can reduce overall risk of harm and improve quality of life for service users (Roberston & Collinson, 2011). For staff, PRM may incorporate actions such as open collaboration with service users and family/carers, understanding strengths and promoting independence through empowerment, trust, and choice.

Despite advocation for the use of PRM, it is not consistently adopted within services. In one study, only 10% of service users within an inpatient setting were found to have been involved in their risk management plans and discussions (Coffey et al., 2019), suggesting there are marked barriers to its use in mental healthcare. Furthermore, it's definition varies considerably across the literature and there is a distinct lack of clear guidance on using this approach in practice (Just et al., 2021). In a recent systematic review of PRM policy and guidelines Just et al. (2021) found discrepancies and tensions in the conceptualisation of PRM both within and between policies, as well as contradictory definitions across documents.

There is limited research exploring how community mental health staff perceive, use and experience specifically PRM in their clinical practice. Just et al. (2021) explored inpatient staff's understanding and implementation of PRM through interviews with healthcare professionals within the NHS. Findings highlighted barriers to using PRM in this setting which included competing demands, difficulties with collaboration and a lack of support. Furthermore, participants who took part in this study were keen to utilise PRM but did not fully understand it or receive any formalised training around it which acted as a further barrier.

To date there have been no studies exploring NHS community staff perspectives on PRM. Community mental health services play a crucial role in delivering care for adults with severe, enduring mental health needs as close to home as possible (NHS, 2019). The NHS Long Term Plan (NHS, 2019) aims to significantly increase the provision of secondary care community based mental healthcare by 2023/2024, likely resulting in increasing levels of complexity and risk being managed in community settings. This study aimed to qualitatively explore how staff working within adult community mental health services understand, experience, and utilise PRM.

Materials and Methods

Design

A qualitative study used semi structured single interviews to explore community mental health staffs understanding, experience and utilisation of PRM. The study received ethical approval from Lancaster University Faculty of Health and Medicine Research Ethics Committee and the Health Research Authority (REC reference: 23/HRA/2156) (See section 4 Ethics Application).

Participants

Purposive sampling led to the recruitment of 12 participants between November 2023 and March 2024. Participants were all qualified staff from various professional backgrounds working within secondary care community mental health services at the time of the interview (see Table 1). Participants were recruited via poster advertisement (Appendix 4-C), word of mouth and online presentations at eligible community services within one NHS mental health trust in the Northwest of England. Eligible services were defined as secondary care community mental health teams (CMHT's) and early intervention teams (EIT's) as well as other associated services such as standalone psychological therapy or occupational therapy services. Participants were eligible to take part if they were over the age of 18, currently employed within an eligible service, had worked in mental health services as a qualified clinician for at least 12 months prior to the interview date and held a current position of registered mental health nurse, social worker, occupational therapist, psychiatrist, clinical psychologist, allied therapist or other qualified mental health professional. There was a specificity for staff within qualified positions given their roles and responsibility in managing varying levels of risk on a day-to-day basis, compared to non-qualified staff who may not always hold clinical responsibility for risk. Participants were also required to converse proficiently in English and self-report of having managed risk in their clinical practice within their current role.

Procedure

Individuals who expressed an interest in taking part were screened against the eligibility criteria and provided with a participant information sheet containing further details of the study (Appendix 4-D). Each participant was given time to ask questions and consider their participation. They provided informed audio consent (Appendix 4-E) and completed a short demographic questionnaire (Appendix 4-F) prior to starting the interview. Participants were offered the choice of either face to face, telephone or online interviews. The qualitative interviews were based upon a topic guide containing questions on the definition, understanding, barriers, facilitators, and knowledge of PRM (Appendix 4-G). The topic guide was created through consultation with two qualified staff members working within community mental health teams and discussion within the research team. Questions were

updated iteratively as the interviews progressed, considering emerging areas of interest coming from previous interviews. All interviews started with an open question asking participants what risk management meant to them as practitioners before questions focussed more specifically on PRM. Field notes were taken during the interviews to make note of key points as well as a reflective log used throughout the research process to support the analysis. Participants received a £10 Amazon shopping voucher for their time.

Analysis

The data were analysed using reflexive thematic analysis (Braun & Clarke, 2006; Braun et al., 2019; Braun & Clarke, 2020), consisting of six stages which were worked through iteratively. The data were familiarised through manual transcription of each interview (see Appendix 2-B for extract of transcribed interview) reading and re reading the entire dataset to facilitate immersion in the data. Next, NVivo14 software (Lumivero, 2023) was used to support the generation of initial codes, working systematically through the dataset. An inductive approach to coding was adopted, with the aim of best representing the meaning participants communicated in the interviews (Braun and Clarke, 2013). Following this, codes were assembled into initial theme ideas before these were then reviewed and further developed by the research team. Themes and sub themes were then defined and named, and a final report was produced. A reflective log and notes from the interviews aided the analysis. The wider research team were consulted throughout the analysis process, contributing to each phase by discussing codes, initial theme/subtheme ideas and the interpretation of the data. The study was underpinned by a critical realistic perspective, as it focused on the meaning and objectivity of participants experiences with PRM. Therefore, the research was guided by an understanding that multiple truths exist and are shaped by contextual factors alongside individual meaning of experiences and wider social contexts. An inductive, semantic approach to coding and theme development was adopted, capturing the breadth of the whole dataset.

Reflexivity Statement

The lead author is a trainee clinical psychologist whose clinical experience has been predominantly within community-based NHS mental health services, including time spent in secondary care CMHT's supporting adults with risk management. However, they have had no previous training in PRM and had a very limited understanding of its application prior to conducting this research. This allowed them to conduct the analysis from a somewhat non-expert perspective when considering PRM directly. Although, they had engaged in depth with the literature in this field prior to conducting the interviews whilst completing the systematic literature review element of this thesis. It is acknowledged that this may have created a potential for bias in relation to their approach to this research and the interpretation of the findings. Recognising this, the author reflected on the impact this might have early in the research process, regularly discussed ongoing thoughts around potential

bias or subjectivity during supervision and kept a reflective log to document ongoing thoughts and reflections. For example, the author had initially discussed with supervisors a prior expectation held that PRM may be less utilised because of a wider lack of understanding about what it actually is and how it can be used clinically, though results contradicted this. This is reflected on further within the critical appraisal element of this thesis.

The wider research team was made up of three clinical psychologists/academics with extensive experience working within NHS mental health services. All reflected on having used positive risk management within their clinical roles at some point and the impact this could have on the research, for example in terms of what may be viewed as best practice and prior assumptions related to working in CMHT and EIT's. To ensure rigour within the analysis, the research team conducted frequent discussions around the emerging codes and themes and potential assumptions.

Results

The lead author completed 12 interviews lasting between 35 and 56 minutes (mean: 46 minutes). Participants chose the time and location of the interview, with all participants opting to take part via Microsoft Teams. All interviews were audio recorded and transcribed by the author and any identifying information was removed. Participant names were replaced with pseudonyms. See Table 2-1 for participant demographics.

[Insert Table 2-1 Here]

Three key themes were generated in the analysis alongside seven sub themes linked to participants understanding, experience and utilisation of PRM (see Table 2-2). The lead author led the analysis with support from the wider research team. Initial relationships between codes and themes were discussed and refined in an iterative process. Table 3 provides additional extracts from interviews further supporting themes and sub themes.

[Insert Table 2-2 here]

Theme One: The System: Working With us or Against Us?

Theme one relates to the influence that the overall system has on practitioners' ability to implement PRM in their practice. The system included the wider team, linked services, the NHS trust, and external agencies such as local media. These external influences can negatively impact clinical practice and in turn impact attitudes toward risk management as a whole. Connection and a sense of togetherness with others operating within the same system is integral, and can facilitate a positive risk taking approach. This was particularly important within the context of community working, with participants reflecting on the nuances associated with this line of work. The three sub themes elaborate on key factors within the system that influenced PRM use.

Sub Theme 1.1: Blame Directed Care

This sub theme relates to how experiences of blame and accountability were integral to how staff used PRM. Negative experiences during investigations or serious incidents shaped future decision making around risk, sometimes resulting in staff being less likely to use PRM in future following such experiences as a form of defence. Staff felt targeted when incidents had occurred, with a sense that one individual would be held solely accountable and blamed for any harm that had occurred, as demonstrated in the quote below.

"There's still that sense of someone to pin, people want someone to pin it on, this is why this happened, it was this. Like if it was a fault that nobody could own up to like a gas main blew up that's why they died, that's literally like best case scenario as nobody could plan for that. But if you were there and you saw that person I think there's still this sense of sort of blame culture" – (Lisa)

Staff reflected on the impact these factors had on their future practice and risk-taking decisions with service users, for example Tracy spoke about practitioners avoiding PRM in future if a culture of blame and targeted accountability is predominant within a service.

"I can remember years ago that kind of language being used you know 'somebody's gonna take it for this' or whatever you know, and what does that create? It will create avoidance wont it, of being open and reflective and you know developing yourself, learning from it, being reflective enough to say I got it wrong" – (Tracy)

Furthermore, participants described how risk aversion may occur out of fear of the outcome of a process, such as coroners court, given the feeling of individual blame that can occur following incidents. Staff may opt for a 'safer', potentially more restrictive, approach to risk management to avoid these experiences.

"it's hard because it could be you, and that's why people maybe or colleagues may be risk averse because they're fearful of what the outcome may be. And I think that's hard to get your head round and I think that interferes a lot with positive risk taking." Jennifer

Sub Theme 1.2: The Impact of External Pressures

This sub theme relates to impact of external, systemic level pressures faced on a day-to-day basis which significantly impacts practical ability to use PRM. Overwhelmingly pressured systems placing large volumes of competing demands on practitioners resulted in individuals feeling it was not always feasible to implement a PRM approach with service users. This is despite recognising the importance and benefits of the approach. For example, increasing caseloads alongside higher levels of complexity seen in the community creates tension in the ability to safely and effectively operationalise PRM with each service user.

"I suppose it's about the intensity of your caseload at that time really as you sort of spin plates with other patients as well and there's always that thing in the back of your mind thinking well if the risk in increased with one patient you're kind of neglecting other patients and what happens with them? Or you're kind of distracted." – Simon

Access to basic resources such as adequate staffing levels and time with patients due to increasing demands acted as a barrier to staff feeling able to adopt a PRM approach in their practice, ultimately impacting patient care.

"when we're maybe more time pressured and lower on staffing maybe less time for those reflective like supervisions or conversations with colleagues I think that's when as a team it can maybe go into more firefighting mode which isn't helpful" – Rebecca

Sub Theme 1.3: Connection and Togetherness in the Community

This sub theme relates to felt connectedness laying an important foundation for PRM. The environment and wider team can act as a facilitator to adopting a PRM approach in the community. Feeling connected to colleagues, having access to support and a sense of shared responsibility was of key importance when determining the approach to risk management. For example, a well-connected multi-disciplinary team (MDT) increased confidence in working with PRM.

"now is the time I feel most comfortable with risk management because it is shared and there's very very clear structures both formally in terms of the specific meetings and supervision structures that we have but also at that kind of informal level of having a relatively cohesive team with support, relationships between staff members." – Sue

Conversely, isolation was seen as detrimental to risk management. Decision making around risk is negatively impacted when practitioners feel they are sitting alone with risk, rather than being able to

work together with others. Isolation contributes to feelings of loneliness and a sense of sole responsibility, exacerbated by the very nature of community working, compared to ward-based work.

"I say its basically like we run a giant acute ward with 500 patients, but it doesn't have any walls or roof and all the staff we go home. So we are perpetually spinning plates and managing a lot of risks with lots of different people in all sorts of environments" – Joe

Furthermore, spending considerable amounts of time lone working in the community impacted feelings of safety and shared decision making, resulting in staff feeling more pressure around their risk management approach and decisions. This increasing pressure acts as a barrier to PRM at times as it potentially decreased confidence in taking a more collaborative, positive risk taking approach when in the community.

"The hardest bit is like I say lone working, because even though you're taking positive risks you're the one whose out there facilitating the session and even if you've got a plan you're the one at the end of the day taking charge of that plan" – Vicky

Notably, there were a number of positive strategies implemented within teams which helped combat some of the difficulties associated with lone working in the community. For example, being office based increased access to peer support and staying well connected virtually when in the community meant, despite lone working, staff still felt togetherness and support which acted as a key facilitator to using PRM effectively.

"it doesn't matter that we're kind of on our own you can just drop a text into the WhatsApp group and be like is anybody free for a chat about something and people will be like yeah sure. There's no sort of, there's a very open door culture" - Lisa

Theme Two: Internal States

The second theme relates to staff's internal feelings, emotions and awareness day to day and how this impacted their approach to risk management, with feelings of anxiety and fear being a barrier to implementing PRM. Also, practitioners' own perception of their level of skill or proficiency was pivotal when deciding whether they felt safe enough to take positive risks with service users. Sub themes highlighted within Theme One likely contribute to the development of such internal states, with staff members recognizing fear of blame and a lack of connection to the wider team may lead to increased feelings of anxiety or internal conflict. This theme distinctly relates to the internal processes unique to each staff member, rather than overall external influences as a whole as noted in theme one.

Sub theme 2.1: Degrees of Anxiety

Anxiety of varying degrees was influential in shaping the approach practitioners took to working with high risk in the community. Feelings of anxiety were felt to be a key driver in deciding whether to adopt a PRM approach versus a more restrictive approach which may feel safer and contain professional anxiety more readily. Anxiety about a serious incident occurring, and the shame associated with this should a practitioner be targeted as 'responsible' drives risk aversion, with staff also emphasizing the knock-on effect this can have on service users.

"If we're really worried and we act in a way that maybe like disempowers them basically and we sort of firefight for them and do everything you know to try and make it better, without looking at the tools they can use" – Rebecca

Defensive practice was fueled by professional anxiety; veering staff away from PRM and toward a more restrictive approach as a way of managing difficult feelings around something going 'wrong.' Despite recognition of such patterns, the degree of anxiety experienced made it difficult for practitioners to practice PRM whilst sitting with such uncomfortable feelings.

"I'm thinking how am I managing my anxieties around making sure I've done enough to make my practice defensible, because I always remember them telling me it should be defensible practice not defensive practice which I think we still practice. And I do still practice very defensively and its hard to shake that…" – Lisa

Moreover, individual differences and overall personal attitudes toward individual risk-taking behaviours also influenced experiences of using PRM. Some individuals are just generally more risk averse in their everyday life, including outside of work, and this naturally impacts feelings of safety when adopting a positive risk-taking approach at work. Staff who identified as being more 'risk averse' outside of work spoke more cautiously about adopting a PRM approach.

"I'd be constantly questioning have I done it well enough? Have I covered everything? Is there something I'm forgetting? Have I seen it from all the perspectives? And again I'm the type of practitioner, and just person outside of work, that would struggle with that level of uncertainty and anxiety." – Sue

Sub Theme 2.2: Perceptions of Proficiency

The second sub theme relates to how participants' perceptions and feelings around their level of skill and clinical experience influences whether they may use PRM, as well as how this is then experienced if they do try this approach. A lack of experience or being more newly qualified is viewed as a barrier to working in this way with service users, which was linked to a perception that they would not be confident enough to manage various potential outcomes, for example increased risk taking

behaviours. For example, some participants reflected on when they were newly qualified and how they managed risk differently then, compared to present day.

"I did have some situations when I was newly qualified when I had someone who was quite risky and I wasn't very good at that sort of sharing responsibility with him with them" – Sarah

Having less experience working with risk reduced feelings of confidence and therefore safety, meaning staff acted more risk averse with service users. Having more experience working with risk helped staff tolerate the uncertainty that can come with adopting a more PRM aligned approach where the client maintains a level of responsibility within their risk management.

"I think people who are more mature and doing it a long time are better at that not jumping on board looking for a solution, we don't always need a solution." – Joe

Theme 3: Staff and Service Users: Working Together to Drive Recovery

This theme demonstrates that participants had a good understanding of PRM as a concept, it's effectiveness when used and how it can empower the service user to take back some control over their recovery resulting in more positive outcomes. Staff demonstrated a very good understanding of key elements of PRM such as collaboration, empowerment, working alongside family and building trust; recognising the positive impact this can have on service user well-being. Despite recognising the above, there was a level of hopelessness at times related to the sense that it was still not always possible to implement PRM with service users, due to factors discussed in previous themes.

Sub theme 3.1: The Protective Nature of Relationships

This subtheme relates to rapport and the maintenance of positive relationships between staff and service user acting as a key facilitator to PRM working effectively for both parties. If there was not ample opportunity to develop meaningful relationships with service users whilst supporting them with risk management, individuals felt more apprehensive to consider positive risk taking and may inadvertently adopt a more restrictive approach.

"before we start to do any meaningful intervention like that I'd make sure the service user feels comfortable and absolutely a rapport has been built, its very important to have a therapeutic relationship with a service user otherwise like I say them risks they're going to be probably feeling too much for them." – Vicky

Building relationships naturally led to a trusting, reciprocal relationship between staff and service users which then enabled effective collaboration and a more open, honest discussion when risk increased, laying an important foundation for PRM. When risk management failed or an incident of harm occurred, the relationship helped to ensure that this could be explored in a productive, safe way to then prevent future risk without resorting to a restrictive, less collaborative approach.

"We live with an agreed acceptance that this is who they are what they do and it would be unrealistic, unnatural, abnormal, probably impossible to remove that risk. So we live with it, and we hope that we develop a sufficiently strong therapeutic relationship that they trust us enough to come with us if they make a mistake or get it wrong or go to far or that they feel unsafe" – Joe

Sub Theme 3.2: The Power of Empowerment

Staff naturally leant toward a collaborative, empowering approach to risk management and there was a felt sense that this was a given, obvious approach to take due to the positive impact it had on service users. Staff reflected on experiences of using PRM and how this empowered people they worked with and led to positive change. This in turn made staff more likely to use the approach again, as they recognised it's benefit, emphasising the powerful change that can occur when PRM is utilised effectively.

"I think usually its quite collaborative which I think is for me that would kind of be the ideal that you're working together rather than the patient feeling like they're just answering questions. So I guess involving them as much as possible, trying to explore what's worked for them in the past and what's been helpful" – Rebecca

Finally, this sub theme also pertains to the negative impact that can occur when service users feel disempowered because of a more uncollaborative, restrictive approach to managing risk. For example, some staff reflected on noticing that when service users feel disempowered and 'done to' rather than 'done with' they are then less likely to adhere to risk management plans. This, in turn, increases levels of risk that staff then need to manage, further affecting relationships between both parties.

"Well how would you feel if you had a group of professionals sat around making decisions for you, it's not very empowering. People feel disempowered ok, they feel like their value is undermined. And if we don't give people opportunities to try strategies and to work with us, then if it doesn't work they'll say "well I wasn't involved I wasn't included I didn't know anything about it I don't really know what you mean"" – Jennifer

[Insert Table 2-3 here]

Discussion

The current study was the first to qualitatively explore how staff working within adult community mental health services understand, experience and utilise PRM. Effectively assessing and managing risk is a key component in the provision of mental health care and is essential for practitioners

(Hawley et al., 2010). PRM can reduce overall risk of further harm and improve quality of life for service users (Robertson & Collinson, 2011). However, despite policy and clinical guidance, it is not implemented consistently with service users (Bowers, 2011; Coffey et al., 2019).

Three themes relating to PRM were identified: the system: working with us or against us?, internal states and staff and service users: working together to drive recovery. Theme one illustrates how external factors relating to the overarching system that staff operate within can negatively, or positively, impact risk-based decisions. Theme two, 'internal states' pertained to the challenges associated with internal thoughts, feelings and emotions such as anxiety and perceived skilfulness and these factors acting as a barrier to actively adopting a PRM approach with service users, somewhat fuelled by factors highlighted within theme one. Lastly, theme three demonstrates the in depth, accurate understanding community staff had of PRM as a concept. Practitioners want to use a collaborative, empowering approach with service users, recognising the benefit this can hold for all parties. However, factors noted within previous themes meant they struggled to always put it into practice.

The current study found that working with higher levels of risk in the community had a significant impact on staff psychological well-being, associated with feelings of anxiety and shame resulting from feeling blamed for incidents rather than risk being shared across a wider team. Working with high levels of risk can have a significant impact on staff. There is a growing body of research indicating the long-standing, detrimental impact of service user suicide on mental health professionals. A mixed methods study exploring the personal and professional impact of service user suicide found that staff reported guilt, reduced self-confidence and a fear of negative publicity, with associated feelings of sadness, shock and surprise lasting a prolonged period of time (Murphy et al., 2022). In addition, Sandford et al. (2021) found the impact of such an event is comparable to other traumatic life events and, crucially, often results in staff becoming more cautious and defensive when working with future risk. Increasing levels of burnout and poor well-being are on the rise in NHS healthcare staff (Royal College of Physicians, 2015), with the current study suggesting the presence of negative emotions not only influences the implementation of PRM but may further increase risk aversion by way of staff avoiding having to experience such negative effects.

Furthermore, the findings of this study support existing hypotheses surrounding causes of burnout within mental health staff. The Conservation of Resources Theory (Hobfoll, 2002) proposes burnout may occur due to an over investment of resource from the individual alongside a lack of necessary tools meaning the task cannot be completed as intended and limited gain occurs. This fits with the current findings, demonstrating staff's solid knowledge of PRM but external systemic level factors mitigating their ability to implement it safely and confidently. The theory states such a lack of return

on investment may result in individuals becoming overly cautious with future investment in similar situations, fitting with barriers to adopting PRM highlighted in this study.

Findings of this study also align with similar work in this area. Recent research into barriers and facilitators of PRM within acute inpatient staff found practitioners expressed firm intention to provide person centred risk management but were often overwhelmed by fear of harm occurring and a lack of support from teams and more senior level staff (Just et al., 2021). Furthermore, a review of mental health professionals perceived barriers and enablers to shared decision making in risk management found beliefs about consequences provoked negative emotions and stopped professionals from utilising shared decision making with service users in risk management (Ahmed et al., 2021), echoing findings from the current study. Research highlights the continued existence of a blame led culture and risk aversion within mental health services (Manuel & Crowe, 2014; Morgan, 2007; Wand, 2017), demonstrated in the current study by staff's reflections on the importance of togetherness and connection rather than accountability and shame. Radhakrishna (2015) emphasises a need for a shift away from a medical paradigm requiring practitioners to practice to 'perfection', and toward an understanding that it is impossible to create an error free system given the fallibility of humans. Therefore, focus should be shifted toward failures within the system, rather than the individual.

Strengths and Limitations

The current study was the first to explore community staff's perspectives on PRM, addressing a gap in the literature. The sample was made up of staff from various professional backgrounds, capturing views from at least one of every qualified professional group employed within community secondary care services and therefore drawing upon a range of different experiences and training. Whilst distinct differences between occupations were not found during the analysis, it may be interesting for further research to explore whether occupation and job role has any impact on perceptions of risk-based decisions more generally, given notable differences in the role of, for example, a registered mental health nurse versus a clinical psychologist.

Furthermore, the sample had a mean average of 17.1 years of experience working within mental health services. In some ways, this was a strength of the research, as it enabled participants to draw on a broad range of clinical experience across multiple different settings, creating a richness and depth to the data collected. Nonetheless, whilst one participant had been qualified for only 3 years, most of the sample were made up of highly qualified practitioners. This is a potential limitation of the study as it fails to capture the experiences of more newly qualified, less experienced clinical staff. It is possible that understanding, experience and utilisation of PRM may be different in staff who have less experience working within NHS mental health services, given their reduced opportunity to work with higher risk and make risk-based decisions, possibly reducing confidence. Additionally, it is possible there is some sampling bias in relation to the types of practitioners who agreed to take part.

Individuals who had a preconceived awareness and potential bias toward PRM may have been more likely to respond to the study advert and discuss these views more openly. On the other hand, staff members who felt less confident around risk, were less favourable of PRM or may adopt a more risk averse approach in their practice may have been less likely to opt to take part in a interview about these concepts. Lastly, a further limitation of this study is that it fails to capture the voice of service users and their own experiences of PRM whilst receiving care from secondary care services, therefore conclusions around service user care are somewhat limited. Future research could explore service user perspectives on PRM within various settings across the NHS to capture a more in depth, first-hand account of the impact of such practice upon recovery and well-being and to support the co-development of guidelines for services to improve collaborative, person centred care.

Clinical Implications

The way in which services and staff manage risk has several crucial implications. First, emphasis should be placed on risk needing to be a shared responsibility where staff have access to support and adequate supervision, to protect the emotional well-being of practitioners. Supporting service users where there is higher risk can be challenging and provoke various emotions for staff. Findings of this study highlighted that staff well-being and functioning can also be positively or negatively impacted by the process and outcomes of risk management plans. Not only does this highlight the need for better staff support and supportive learning environments following incidents, but consideration should also be given to the potential impact staff well-being has on service user recovery.

Another key implication relates to the well-being of the service users accessing care whose autonomy, safety, recovery, and progress is dependent upon effective, meaningful collaboration with services and practitioners. Staff well-being and burnout is associated with both patient safety and care quality, highlighting further important implications. A review by Hall et al. (2016) found 25 of 30 studies found a significant link between increased burnout and higher levels of adverse events within services. Further studies demonstrate associations between poor staff well-being, negative patient safety indicators and poorer patient satisfaction of care (Welp & Manser, 2016; Salyers et al., 2017). Advocating and continuing to aim toward a workplace culture that values and prioritises staff well-being, fosters shared learning and ensures staff feel supported and confident should be considered vital to the adoption of PRM within mental health services.

The current study found feeling of skilfulness and proficiency were important in fostering a sense of safety to use PRM. Access to adequate supervision, shadowing opportunities to share learning and training on risk management more broadly may be beneficial for more newly qualified, less experienced mental health staff in particular. Experience and support in building up to managing high levels of complexity alongside lone working within a community context should be nurtured within

newer members of the workforce, potentially further impacting staff retention and well-being if staff feel safe and valued in their role.

Conclusion

This study explored how staff working in adult community mental health services experience, understand and utilise PRM. External pressures at a systemic level alongside internal feelings experienced by staff influenced staff's feelings of safety in utilising PRM with service users. The results demonstrated that despite staff having a good understanding of the fundamental aspects of PRM and its importance within mental health practice, they experience barriers to operationalising it successfully which were further exacerbated by features linked to community-based work, such as lone working and a lack of connection. Despite this, participants reported how PRM contributed to the protective nature of strong relationships, positively influencing future disclosure of risk behaviours and adherence to risk management plans. Results illustrate the need for further support for practitioners and systemic level change to shift away from a culture of blame still evident within healthcare settings more widely, as well as further training, support and guidance for less experienced practitioners working with risk. The findings correspond with wider literature surrounding PRM and risk management more generally.

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Declaration of Interest

The authors report there are no competing interests to declare.

References

Ahmed, N., Barlow, S., Reynolds, L., Drey, N., Begum, F., Tuudah, E., & Simpson, A. (2021). Mental health professionals' perceived barriers and enablers to shared decision-making in risk assessment and risk management: a qualitative systematic review. *BMC Psychiatry*, *21*(1). https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-021-03304-0

Bowers, A. (2011). Clinical risk assessment and management of service users. *Clinical Governance: An International Journal, 16*(3), 190-202, DOI: 10.1108/14777271111153822.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. *https://doi.org/10.1191/1478088706qp063oa*

Braun, V., & Clarke, V. (2013). *Successful Qualitative Research: A practical guide for beginners* (1st ed.). Sage Publications Ltd.

Braun, V., & Clarke, V. (2019). Reflecting on Reflexive Thematic Analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597.

Braun, V., & Clarke, V. (2020). One Size Fits all? What Counts as Quality Practice in (reflexive) Thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328–352. *https://doi.org/10.1080/14780887.2020.1769238*

Callaghan, P., & Grundy, A. (2018). Violence risk assessment and management in mental health: a conceptual, empirical and practice critique. The Journal of Mental Health Training, Education and Practice, 13(1), 3-13. https://doi.org/10.1108/jmhtep-04-2017-0027

Coffey, M., Hannigan, B., Barlow, S., Cartwright, M., Cohen, R., Faulkner, A., Jones, A., & Simpson, A. (2019). Recovery-focused mental health care planning and co-ordination in acute inpatient mental health settings: a cross national comparative mixed methods study. BMC Psychiatry, 19(1). https://doi.org/10.1186/s12888-019-2094-7

Department of Health. (2009). Best Practice in Managing Risk. Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services. . https://assets.publishing.service.gov.uk/media/5a8020a840f0b62302691adf/best-practice-managing-risk-cover-webtagged.pdf

Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. (2016). Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review. *PloS one*, *11*(7), e0159015. https://doi.org/10.1371/journal.pone.0159015.

Hawley, C. J., Gale, T. M., Sivakumaran, T., & Littlechild, B. (2010). Risk assessment in mental health: Staff attitudes and an estimate of time cost. Journal of Mental Health, 19(1), 88-98. https://doi.org/10.3109/09638230802523005

Healthcare Quality Improvement Partnership. (2024). National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report 2024: England, Northern Ireland, Scotland and Wales. https://documents.manchester.ac.uk/display.aspx?DocID=71818

Hobfoll, S. E. (2002). Social and psychological resources and adaptation. *Review of General Psychology*, *6*(4) , 307. https://doi.org/10.1037/1089-2680.6.4.307

Just, D., Palmier-Claus, J. E., & Tai, S. (2021). Positive risk management: Staff perspectives in acute mental health inpatient settings. Journal of Advanced Nursing, 77(4), 1899-1910. https://doi.org/10.1111/jan.14752

Just, D., Tai, S., & Palmier-Claus, J. (2021). A systematic review of policy and clinical guidelines on positive risk management. Journal of Mental Health, 32(1), 329-340. https://doi.org/10.1080/09638237.2021.1922643

Lumivero (2023) *NVivo* (Version 14) www.lumivero.com

Manuel, J., & Crowe, M. (2014). Clinical responsibility, accountability, and risk aversion in mental health nursing: a descriptive, qualitative study. *International journal of mental health nursing*, *23*(4), 336–343. https://doi.org/10.1111/inm.12063

Morgan, J. F. (2007). *Giving Up the Culture of Blame. Risk Assessment and Management in Psychiatric Practice*. London UK: Briefing document for the Royal College of Psychiatrists.

Morgan, S., & Andrews, N. (2016). Positive risk-taking: from rhetoric to reality. The Journal of Mental Health Training, Education and Practice, 11(2), 122-132. https://doi.org/10.1108/jmhtep-09-2015-0045

Murphy, P. T., Clogher, L., Van Laar, A., O'Regan, R., McManus, S., McIntyre, A., O'Connell, A., Geraghty, M., Henry, G., & Hallahan, B. (2022). The impact of service user's suicide on mental health professionals. Irish Journal of Psychological Medicine, 39(1), 74-84. https://doi.org/10.1017/ipm.2019.4

National Institute for Health and Care Excellence. (2022). Self-harm: assessment, management and preventing recurrence (NG225). https://www.nice.org.uk/guidance/ng225/resources/selfharm-assessment-management-and-preventing-recurrence-pdf-66143837346757

Quinlivan, L., Cooper, J., Steeg, S., Davies, L., Hawton, K., Gunnell, D., & Kapur, N. (2014). Scales for predicting risk following self-harm: an observational study in 32 hospitals in England. BMJ Open, 4(5), e004732. https://doi.org/10.1136/bmjopen-2013-004732

Radhakrishna S. (2015). Culture of blame in the National Health Service; consequences and solutions. *British journal of anaesthesia*, *115*(5), 653–655. https://doi.org/10.1093/bja/aev152

Roberston, J. P., & Collinson, C. (2011). Positive risk taking: Whose risk is it? An exploration in community outreach teams in adult mental health and learning disability services. . Health, Risk & Society 13(2), 147-164.

Royal College of Physicians. (2015). *Work and Wellbeing in the NHS: Why Staff Health Matters to Patient Care*. London: Royal College of Physicians.

Salyers, M. P., Bonfils, K. A., Luther, L., Firmin, R. L., White, D. A., Adams, E. L., & Rollins, A. L. (2017). The Relationship Between Professional Burnout and Quality and Safety in

Healthcare: A Meta-Analysis. *Journal of general internal medicine*, *32*(4), 475–482. https://doi.org/10.1007/s11606-016-3886-9

Sandford, D. M., Kirtley, O. J., Thwaites, R., & O'Connor, R. C. (2021). The impact on mental health practitioners of the death of a patient by suicide: A systematic review. Clinical Psychology & Psychotherapy, 28(2), 261-294. https://doi.org/10.1002/cpp.2515

Steeg, S., Quinlivan, L., Nowland, R., Carroll, R., Casey, D., Clements, C., Cooper, J., Davies, L., Knipe, D., Ness, J., O'Connor, R. C., Hawton, K., Gunnell, D., & Kapur, N. (2018). Accuracy of risk scales for predicting repeat self-harm and suicide: a multicentre, population-level cohort study using routine clinical data. BMC Psychiatry, 18(1). https://doi.org/10.1186/s12888-018-1693-z

Wand T. (2017). Considering the culture of blame in mental health care and service delivery. *International journal of mental health nursing*, *26*(1), 3–4. https://doi.org/10.1111/inm.12258

Welp, A., & Manser, T. (2016). Integrating teamwork, clinician occupational well-being and patient safety - development of a conceptual framework based on a systematic review. *BMC health* services research, 16, 281. https://doi.org/10.1186/s12913-016-1535-y

Worthington, A., Rooney, P., & Hannah, R. (2013). The Triangle of Care: A Guide to Best Practice in Mental Health Care in England. Second Edition. . https://carers.org/downloads/resources-pdfs/triangle-of-care-england/the-triangle-of-care-carers-included-second-edition.pdf

Appendices

Appendix 2-A

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Updated 28th February 2024

Appendix 2-B

Extract from Participant Transcript

R: Researcher

P: participant

R	What does risk management mean to you?
P	For me especially in my role it would be assessing risk to the patient themselves and to others whether that's family or friends or wider community and looking how to safeguard the patient and others as well so sometimes that involves safety planning, sometimes it involves referring to other services like adult social care if it's a safeguarding concern or you know if it's a risk to themselves or others through their mental health it might be looking at that additional mental health support and hospital if they're really unwell.
R	What do you think are the most important things to consider in risk management?
P	I think as I said its risk to the self or others I think that's a big thing because someone might not be a risk to others at all but might be a big risk to themselves, thinking about risk of their mental health declining potentially them neglecting their own needs neglecting to look after themselves. Sometimes were looking at risk of self harm or suicide as well managing those risks trying to support people ot not hurt themselves, looking at risks to others we work with people in relationships or family situation at home so we're looking at risk to children in the house even if its just through them witnessing the parents being unwell. Yeah and potentially carer's that are in the house as well and looking after the patient, there's quite a few patients that have had delusional beliefs about the carer that's looking after them so its trying to support them to still care for the patient but looking at that risk to them and not letting them get in harms way. Yeah id say the main thing that I do in risk management would probably be risk assessment in my role and then safety planning with patients
R	You mentioned there safety planning with patients, can you tell me your thoughts on involving the service user in the risk management process?
P	Yeah so a lot of my role up until recently has been in the assessment process so the very initial referral into the service within that process its usually an hour assessment that someone will have and we will then go through those questions with them and talk quite openly about the risks they might have toward themselves or others so we'll usually ask if they're having any thoughts to hurt themselves or any suicidal thoughts. We'll ask about the history of that as well and what that looked like in the past compared to now whether its worse or improved. So we'll ask about that, we always ask if there's children in the house that's something we're expected to ask at every initial contact and then review regularly and we also ask about domestic abuse so there's a new thing introduced called routine enquiry where basically we regularly ask about the relationship even if there's no reported domestic abuse just to make sure that they have the opportunity I guess to disclose anything. So that's asked about at the initial assessment then regularly reviewed. In terms of the safety planning, when someone's allocated that's usually one of the first pieces of work we'll focus on is getting that safety plan in place and that's kind of an agreement as well at the start of the piece of work I suppose that when they are struggling they can access support they need. I think in the most basic sense the safety plan always has a number they can contact out of hours and who in hours so contacting HTT, contacting our duty service but it also looks into coping strategies they find helpful and what works for them.

R	Thank you. What are your views on the concept of eliminating risk entirely, is that something that comes up in the CMHT?
P	I don't think I've heard many discussions about trying to eliminate risks entirely, I think that's often not possible. There is always going to be risk and part of our role is trying to work with that risk in a positive way that's not restrictive but also keeps everyone safe so it really depends what the risk is I suppose. I'm trying to think of an example maybe that would be more helpful, I suppose if someone's having suicidal thoughts its you know you cant stop someone from feeling that way you know and you've got to work through that with them so sometimes there will be times people do express suicidal thoughts then its going back to the safety plan and coping techniques and how they can work through that and keep themselves safe or sometimes its getting a carer involved who might live with them to get on board with that safety plan. Yeah I think the word eliminate is quite a strong word isn't it because yeah that's quite hard to do in the community especially because someone can maybe come into an appointment and tell you that they're completely fine and you don't always know I suppose whether they are when they leave that appointment. I would just say maybe minimising risk is a better term for what we try and do obviously we don't want people to have risks in life but yeah.
R	You said something there about working with risk in a positive way and the least restrictive way, can you tell me a bit more about that?
P	Yeah I think for me risk obviously comes with a lot of professional anxiety that you want people to be safe and you want them to feel ok so I guess taking those positive risks when its safe to do so and when you know someone's got the support in place to make sure they're ok then empowers them to make those decisions in the future. I think so I'm trying to think of an example, for instance if someone's having suicidal thoughts and is worried they cant keep themselves safe then we can put a safety plan in place with coping strategies they know work and maybe a carer whose able to check in and call for support if things aren't working, that then encourages the patient to do that in future when they're struggling rather than the first port of call being they need to come to mental health services or they need to be admitted to hospital because they're struggling to cope. I suppose it just encourages them to develop their confidence with managing their own risks and yeah instead of being restricted I guess.
R	What do you think for you as a practitioner, what makes you feel safe enough to use that type of approach to risk management and to be less restrictive?
P	I think one of the big things for me has been accessing group supervision and the MDT's that we have, we have quite a lot of MDT's we have a daily huddle where we can meet and talk about immediate risks or things that need to be addressed that day and then we have a weekly complex decisions meeting as well where we can talk through cases that are maybe more complex and do have a lot of risks involve and I find it really helpful to get the opinion of other people in the team who maybe come from a different background whether that's nursing or consultant or psychology just to I guess air that a little bit and talk through different ways we can manage the risk positively. So I think that is very helpful for me and that's something that the patients not often aware of or is aware of in a very basic sense of its going to be discussed at a meeting, but that does help with my confidence. I suppose I think what makes me feel safe is knowing whether there is enough support for it to be managed, so you know if there's a patient that comes in that maybe doesn't have any support, maybe there's risk factors there of you know they don't have any future focus, they've maybe harmed themselves in the past and all those risk factors are there that would then decrease my confidence in how it can be managed and we might have to offer even more support but yeah if there's I guess I don't know whether this is the right word but I'd maybe call them safety factors well protective factors I guess they are aren't they like

	having family support, being able to get through it and evidence they've been able to do that in the past and I guess that they've got some insight into what's going on for them so if they recognise what they're struggling with at that point and show some motivation to want to change that.
R	How do you think… say if we think about the positive risk taking approach you talked about, how does that affect the client what have you noticed in your work in using that or where it's not been used?
P	I think it helps to show the client that they can make changes themselves I think it gives them more sort of, I'm trying to think of the right word, but just a bit more power I guess that they can influence their own mental health journey and that they can rely on themselves as well as other people because I think in the past patients have had quite a lot of dependency maybe on services and maybe get into a pattern of attending services and seeking support which is great that they do attend and seek support that's what we want isn't it when people are struggling. But also that they have some of those tools themselves and I'm thinking of someone that I only met the first time recently she's been involved with services a very long time she's had over 100 admissions to hospital so been really really unwell and is now at the point where she hopes she can be discharged at some point and that's because she's got her own strategies in place however maybe individual they are to her so yeah I think just maybe encouraging that so people don't feel like the only option is they need to seek support from mental health services. I guess it builds their confidence as well in that I guess control over their own mental health condition as well.

Appendix 2-C

Codes Grouped into Initial Theme Ideas

Theme 1: togetherness, connection, psychological safety, relating to each other?

- MDT Approach
- Access to Support
- Supervision
- Learning from Each other
- Sharing Responsibility
- Multi Agency Working
- Service Relationships
- Managing Risk Alone
- Community vs inpatient
- Community working
- Hospital Admission

Theme 2: An obviousness to the approach? Staff enabling change? 'unless you give them an opportunity to manage something how would anybody know?' Focus on recovery? Driving change?

- Who PRM is for
- Defining PRM
- Taking risks to manage risk
- Positive impact of PRM
- Working with Family/Carers
- SU factors impacting PRM
- SU Engagement
- A Focus on Risk Factors
- Diagnoses Dilemma's
- SU's being let down
- Negative Impact on SU's
- Tools for risk assessment
- Formulating Risk
- Predicting Risk
- Strengths Based Approach
- Collaboration with SU's
- Lack of collaboration
- Effective SU Involvement
- Defining PRM
- Therapeutic Relationships
- SU vs Staff Priorities
- Trust
- Empowering the SU
- Openness and Honesty
- Individualised Approach
-

Theme 3: 'never good enough'? 'crossing the t's and dotting the I's'? "damned if you do and damned if you don't"? "the more you give the more you're blamed"?

- Anxiety
- Fear of Negative Outcome
- Difficult Feelings
- Staff's need for safety
- Barriers
- Blame, Shame, Fault
- Culture
- Finding Balance
- Levels of Control
- Staff Burnout
- Staff Rigidity

Theme (potentially sub theme to theme or 3 as its relating to anxiety?): practitioner growth? personal perceptions of risk?

- Level of Experience
- Personality
- Training on Risk
- Variations Between Practitioners
- Prior Risk Experiences
- Staff's Confidence
- Need for information
- Staff Knowledge

Theme 4: systemic, out of our hands? System overhaul? 'we're not mind readers'? A need for accountability?

- Inevitability of Risk
- Unable to eliminate risk
- Professional Responsibility
- 'Tick Box' Exercises
- Time on paperwork
- Doing our Best
- Value of Time
- Recording Decisions
- Pressured Systems
- Lack of Beds
- Ignoring the Good Stuff
- Management Disconnect
- Decision Making
- Acting with Caution
- Legal Implications
- Reacting to Incidents
- Workload and Capacity

Table 2-1

Summary Demographics of Participants (n=12)

Age, mean *(SD)*, min-max	44.6 *(11.3),* 27-59
Male, *n*	3
Female, *n*	9
Ethnicity, *n*	12
White British	8
Asian British	2
White Polish	1
White Irish	1
Number of years in current role, mean *(SD)*, min-max	4.03 *(2.93)*, 0.3-10
Number of years qualified, mean *(SD)*, min-max	17.1 (*10.9*), 3-38
Service, *n*	2
Community Mental Health Team (CMHT)	10
Early Intervention Team (EIT)	2
Occupation, *n*	6
Clinical Psychologist	2
Social Worker	3
Registered Mental Health Nurse	4
Occupational Therapist	1
Consultant Psychiatrist	1
Psychological Therapist	1

Table 2-2

Outline of Key Themes and Associated Sub Themes

Theme	Sub Theme
1. The System: Working With us or Against Us?	1.1 Blame Directed Care 1.2 The Impact of External Pressures 1.3 Connection and Togetherness in the Community
2. Internal States	2.1 Degrees of Anxiety 2.2 Perceptions of Proficiency
3. Staff and Service Users: Working Together to Drive Recovery	3.1 The Protective Nature of Relationships 3.2 The Power of Empowerment

Table 2-3

Additional Extracts from Data Illustrating Themes

Sub Theme	Extract	Source
1.1	*"But I think sometimes the more you give the more you're blamed, does that make sense?"*	Hayley
	"I don't think you're celebrated for doing things well, you're pulled up for you know you got 8/10 on a test that's not good enough."	Lisa
	"I thought oh is this my fault, are people going to think it's my fault, will people think I'm doing the wrong thing, am I a bad therapist?"	Sarah
	"I guess there is some, in addition to everything else, some fear of gosh what would happen if I say I end up coroners court as a practitioner, as a witness? And you know was there some aspect of my practice that wasn't good enough? That's a big fear as well."	Sue
	"I think I can speak for everybody in the sense of we don't as a workforce want to feel solely responsible for if something happens and that seems to be the culture of the passing. I do it myself, I go oh well I told that person so the buck lies with them now and I hear that thought in my head like well I've done this so this means its on them"	Lisa
1.2	*"If I had more time rather than doping paperwork I could spend a lot more time with him, go out and kind of look at what we could do better really but you know he knows I'm going to come for that hour and that's it."*	Simon
	"It takes a lot of personal organization to be top of all the continual re assessment, risk assessment, outpatient appointments, medication reviews and depot medication, dealing with families, carers sometimes they need hospital they have to attend tribunals or ward rounds things like that and a perpetual cycle of new referrals coming in every week"	Joe
	"You know we are predominantly attempting to prevent repeated hospital admission, sometimes historically the view would have been to manage risk is put them in hospital but we want to keep people out of hospital. So, we managed a lot of risk that we would have never pre EIS would have never managed in the community"	Tracy
	"There is something about the general demands of work, the job, you know I don't think there's ever been a time that I've worked in the NHS and the actual expectations around this is the work you need to complete that matching the hours that are available"	Sue

1.3	*"It works very well because we work closely in the MDT and our service is very involved in terms of working with risk very closely and monitoring it. I think we do it as a team when we manage risk."*	Tom
	"I liaise like I say with as many other professionals as I can and get advice from as many people as I can in my so that's where I really do liaise with others if there's any risk that's when I'm probably doing that the most.. it also feels like it's not just you alone worrying about that it feels like others are involve it makes the worry less as well"	Helen
	"I think if you have professional meetings and everybody's aware of the difficulties then you would feel better about your risk taking because you've got people backing you, everybody's signed up to it."	Jennifer
	"Its about the learning from it isn't it? I think with the right people around teams that mentality allows risk management to become everyday language not reactive language and not avoidant language like 'you just have to do this' and everybody looks away. You know it's 'let's do this as a team'"	Tracy
	"Speaking for myself I know sometimes if I've got someone else involved it feels a little bit easier to manage really, you're not doing it all on your own."	Simon
	"Lone workings hard and in a CMHT you do a lot of lone working I think a lot of people talk about that lone working because that in itself can be difficulty because you feel like sometimes you're carrying a risk on your own."	Vicky
	"it was very strange for me to go from having such a team sort of sense on the ward because you're in a team that was very cliquey, to being in a team that didn't feel like a team because everybody was in and out left right and centre because of this new home working situation"	Lisa
	"with the CMHT you manage your own caseload it can feel very sort of isolated sometimes you're managing that risk behaviour on your own."	Simon
	"MDT discussions are massive so that you're not feeling you're taking that risk alone, with positive risk taking its good to have a team approach."	Vicky
	"I am much more likely as a practitioner to go and talk to about this risk issue. If I wasn't able to do that the flippant part of me wants to say id just leave my job, I couldn't I just couldn't work in that kind of environment. I think I would definitely be more anxious, I would second guess myself a lot more, I would spent more time kind of dotting I's and crossing T's"	Sue
	"I think definitely being in an office like office based all the time we don't work from home and that can be really helpful just to have that peer support there."	Rebecca

2.1	*"it's [PRM] something that sits very uncomfortably with some health professionals they would just never do that, potentially to the detriment of the recovery or the service user learning new strategies…."*	Tracy
	"You know I'd wake up in the night thinking oh my god I didn't write that in the notes, what if it's important? Or what if something happens?"	Lisa
	"I think it's always been anxiety provoking as a clinician when you look at somebodies risks and you think oh they've done this, this and this, why would I then put them in a situation?"	Vicky
	"Managing risk is very stressful for staff because of that, because of them reasons. Because they're uncertain they don't know if they're doing the right thing, they're taking a chance. It doesn't mean that when you leave the office at 5 o clock you forget about it you know"	Jennifer
	"sometimes you do have to maybe.. I have to check myself and think am I contacting this patient for their benefit or is it to sort of make me feel less anxious about the situation and weigh that up and decide what's actually best for the patient at the time?"	Rebecca
	"if I felt that there was any risk at all {pause} sometimes I felt quite anxious about it"	Sarah
	"the team didn't do anything else about it as the risk had passed whereas I were you know really anxious over it"	Helen
	"I think I sit more on the side of I over function I think because I'm anxious so I will over do to make sure I can be as defensibly defensive as possible. Some people are not as maybe as anxious"	Lisa
2.2	*"I suppose there you know if you'd asked me 8 years ago if somebody comes into a room and verbalizes suicidal ideation you know the thought of 'letting them go' id find very difficult whereas now I've worked with lots of people whereby those patterns are very evident and where again we've got that shared risk assessment and management approach"*	Sue
	"I think in more experienced staff they will take that approach, less experienced staff will generally in my experience be very avoidant of that"	Tracy
	"I think managing risk comes with experience of trying to deal with risk and looking at ways forward, so somebody whose newly qualified might struggle with that"	Jennifer
	"that's a really big thing in managing risk as well is having trust and confidence"	Simon

	"yeah I was a bit like out of my comfort zone and also I was worried about how to handle the response I'd get. So if there was someone that said yeah I'm going to harm myself, it's how do I respond to that, do I respond in the correct way or incorrect way?"	Hayley
	"because I've only been in the team a year and this is my first mental health team I think maybe if I feel less informed about a amental health condition so for me psychosis is something that I still struggle with a little bit and I've had less experience of those kind of mental health conditions, I think that then makes me take more of a risk averse stance because I guess I don't want to miss anything"	Rebecca
3.1	*"So a good relationship is quite important because people will be more open, more willing to tell you what's going on, more willing to talk about things where risk might occur"*	Sarah
	"I'm still maybe not 100% confident around psychosis and schizophrenia and stuff like that as a whole but I've got a few patients on my caseload who do have those diagnoses because I've worked with them now for a quite a long period of time I maybe feel more confident doing that PRT as I've got that relationship with them."	Rebecca
	"I guess it's about how well you know the service user as well….you need to spend time with people to do the preventative work to reduce the risk and the likelihood of risk in the long term."	Jennifer
	"if the rapport is there and usually it's that working relationship isn't it, if its not there then it can sometimes push the patient away which makes it really hard to manage that risk really and assess it properly"	Simon
3.2	*"before people have said 'you can't' a lot, you can't do this you can't do that because of the way the historical risks are but actually by saying you can and I'm not going to stop you sometimes it gives them that empowerment and I think a level of that you put trust in them that yeah its quite powerful."*	Vicky
	"I think part as well is having that conversation with the SU and people around them about why we're taking the risk, what the aim of it is really. Part of it is having them on board with it as well"	Simon
	"We're actually asking the patient to tell us what's important to them, rather than what WE think is most important to them, it's very tempting in mental health to make assumptions about what people need"	Joe
	"to do it collaboratively you need to ask questions and come up with a plan together, its all well and good me saying I think you should go to IRS or into	Lisa

hospital but a patient is not going to do that they have to come to their own plan alongside that"	
"I guess taking those positive risks when its safe to do so and when you know someone's got the support in place to make sure they're ok then empowers them to make those decisions in the future."	Rebecca
"PRM I think is the term that we use and have used historically and I think with some people it is it can bring about a big catalyst for change for them because you allow the person to take responsibility."	Tracy
"at the end of the day when you're treating patients or managing patients its about their care isn't it so you cant exclude them from every plan you know. So they should be part of the risk and unless of course including them in something would be detrimental to their mental health."	Tom

Section Three: Critical Appraisal

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Critical Appraisal

The third section of this thesis will begin by summarising both papers. Individual reflections on each paper are then discussed, highlighting specific challenges experienced throughout the research process. Strengths and limitations of both papers are discussed, before future directions and conclusions are considered.

Summary of the Systematic Literature Review

The systematic literature review utilised realist methodology to examine how, why, for whom and in what contexts does positive risk management (PRM) work in mental health care settings. The realist review sought to understand the key mechanisms of action and highlight specific contextual factors which influence how these mechanisms are activated in varying environments within mental health settings. The search process identified twenty documents for inclusion from a range of sources and of varying methodology, in line with a realist approach. The findings from this review suggested there are multiple contextual factors influencing internal mechanistic processes for those utilising PRM including over reliance on structured risk assessment leading to reduced curiosity and meaningful connection and access to relevant training increasing confidence of working with risk. These factors influenced two key outcomes relating to PRM: quality of life for both staff and service users and influencing levels of risk for service users. This was the first realist review on PRM and the first to explore why PRM does or does not work as an intervention within a range of settings. The review highlighted the need for further qualitative research into PRM, particularly capturing staff and service user voices to explore the issues raised within the findings further and better understand how to support the facilitation of PRM in clinical practice.

Summary of Empirical Paper

The empirical paper used qualitative methodology to explore community mental health staff perspectives on positive risk management by using thematic analysis. The aim of this study was to explore how staff working within community mental health services understand, experience and utilize PRM. 12 participants completed semi structured interviews. Three key themes were identified from the analysis: 1) The System: Working With us or Against Us?, 2) Internal States and 3) Staff and Service Users: Working Together to Drive Recovery. Associated sub themes highlighted that blame directed care, external pressures, connection and togetherness, anxiety, proficiency, relationships and empowerment were central to participants experiences, understanding and utilization of PRM in their clinical practice. Participants highlighted the personal impact of working with high levels of risk in the community and the importance of a shared sense of responsibility around risk management.

Findings highlighted barriers to implementing PRM in practice, notably systemic level factors such as a culture of blame and a lack of resource, despite practitioners' desire to work collaboratively with service users. This study is the first to explore first hand community staff perspectives on positive risk management, offering a valuable contribution to the literature. The findings highlighted the need for improved, longer-term support for staff working with risk to not only support staff well-being but also to ensure patient safety and high quality care for service users and their families. Future research should aim to explore service user perspectives on PRM, including their experiences and understanding of the key elements of PRM and how these impact various aspects of well-being. Future studies may also explore perspectives of less experienced, newly qualified staff members across both community and non-community settings.

Reflections on the Systematic Literature Review

Selecting a Topic and Method

The process of selecting a topic for the review element of the thesis took place after the empirical topic had been agreed and became one of the more challenging aspects of the thesis. My initial scoping searches highlighted that there is a distinct lack of literature looking at PRM within mental health in general. There is also a large degree of heterogeneity within the literature that does exist, complicated further by the varying terms used to define PRM across documents. I was keen to explore PRM as a concept more broadly within the review, as I had focused in on one particular setting and population for the empirical paper.

Realist reviews have grown in popularity in recent years (Wong, 2019). They are particularly suitable for unpicking the impact of complex interventions as they aim to understand how the intervention is working within a range of different contexts and why (Rycroft-Malone et al., 2012). Given the lack of clarity around PRM across policy and guidelines (Just et al., 2021), as well as the scope of which PRM is used across a range of differing services within mental health care, I felt a realist approach would be most appropriate for exploring PRM more widely with the hope of shedding light on how PRM functionally works, or does not work, within clinical practice. The aim of realist evaluation is to support decision makers to elicit a deeper understanding of the intervention and consider how it can be made to work most effectively (Pawson et al., 2005). More traditional methods of review often focus on measuring or reporting the effectiveness of an intervention but provide less insight into specifically *why* the intervention did or did not work when applied in varying circumstances or contexts. Whilst this review does not aim to answer whether PRM simply does or does not work; it was hoped instead it would provide a rich, detailed, practical understanding of PRM which may lay a foundation for further exploration and more effective implementation.

Whilst realist reviews follow similar stages to a more traditional systematic review, there are some key differences which make this approach more unique. Multiple sources of information can be

included within the review, making them larger in scope and incorporating a broad range of evidence to support theory development. The inclusion of grey literature was felt to be a vital aspect of exploring PRM in this way given national policy and guidance promoting its use within practice. Furthermore, the involvement of stakeholders within the theory generation and refinement is a core aspect of realist reviews (Saul et al., 2013). The contributions from the expert panel in this review supported greatly with expanding understanding of PRM across different settings for different staff groups and allowed for further refinement of the literature from a 'real world' perspective.

Search Strategy

One of the challenges of the review process was defining the search terms. As previously noted, one of the key issues with PRM is the discrepancies within its definition in the wider literature (Just et al., 2021). The core concepts of PRM such as collaboration, promoting autonomy and the involvement of wider family or carers may be conceptualised under different terms other than 'PRM'. Initial scoping searches of the literature alongside reviewing current policy and guidance supported in identifying key related terms used across settings, such as therapeutic risk taking, positive risk taking and collaborative risk taking. It was important to ensure relevant literature was captured within the search, whilst also remaining aware of the feasibility and scope of the project as a whole. Whilst there is limited literature specifically exploring PRM, there is a much larger body of research looking into risk management more broadly within services. Whilst a search in this area would have yielded a very high number of studies, it would have neglected a core focus on PRM. Frequent discussion with the wider research team supported in narrowing down the search terms to a number of key terms which encapsulated the key elements of PRM and ensured the literature search yielded the most relevant data.

Challenges

Despite realist reviews becoming increasingly more popular in recent years (Wong, 2019), they remain a fairly novel approach. I was not familiar with realist methodology prior to starting clinical training and had not received any core teaching on realist synthesis throughout my studies. Realist reviews require flexible thinking and require the author to deal with a large degree of complexity by working iteratively with high volumes of information (Rycroft-Malone et al., 2012). At times the review felt overwhelming, and it was challenging to find balance between being specific enough to ensure the review question was answered whilst also stepping back and reviewing the evidence from an objective perspective. However, the iterative nature of the review made this easier in some respects, allowing for frequent back and forth discussions between myself and the wider research team to discuss potential biases, review evidence together and consider emerging context, mechanism, outcome (CMO) configurations as a team. Following publication standards for realist methodology (Wong et al., 2013) provided me with a sense of structure despite this being a less familiar, intricate

approach. I also sought advice early on from wider researchers within the University who were more familiar with realist methodology, to ensure accuracy and to consider any nuances within the approach.

Reflections on the Empirical Paper

Selecting a Topic

Choosing a topic and method for the empirical study was done in partnership with my supervisors to ensure the scope of the project was in line with the training program timeline. I felt drawn toward a broader topic that could be applied across multiple settings, rather than focusing on an area of psychology that was possibly more niche toward one specific area or population. My own experiences working with varying levels of risk within mental health services as well as a personal interest within staff well-being sparked an interest in this area more generally, and I was keen to learn more about the perspectives of other practitioners working within NHS mental health services. Given the aim of the research was to capture a broad range of staff perspectives on PRM, it was important that the method of qualitative analysis was consistent with this epistemological position. Reflexive thematic analysis (TA) was chosen over other qualitative approaches, for example interpretive phenomological analysis (IPA), as the flexibility of TA allowed for the identification of wider themes across the whole data set rather than focusing on features of individual cases (Braun & Clarke, 2020).

Positioning Myself within the Research

The study was underpinned by a critical realistic ontological framework sitting broadly within contextualism, as it focused on the meaning and objectivity of participants experiences with PRM. The research was guided by an understanding that multiple truths exist and are shaped by contextual factors alongside individual meaning of experiences and wider social contexts. Such positions emphasise the importance of research subjectivity and interpretation to elicit meaning from the data. Supervision helped me to maintain and continually reflect upon this epistemological stance throughout the research process.

A key component of the research process involved reflexivity. Understanding my own values, attitudes, prior experiences and lived reality was crucial in considering how these factors may impact the research process. PRM was a term I had heard of but knew fairly little about in practice and I had not received any training specifically on this approach to risk management. This allowed me to conduct the research from a fairly non-expert perspective, which supported me in maintaining a balanced, impartial view during the interview process. Despite this, through the keeping of a reflective log and regular supervision, I recognised certain biases and preconceptions of potential outcomes creeping in early on. For example, given my own initial lack of understanding of PRM despite six years working within mental health settings in the NHS, I had assumed that the lack of

implementation of PRM was likely linked to an overall lack of understanding of what it is and how it is used. Noticing this bias was helpful in ensuring I monitored myself during the interviews and remained impartial, to ensure I wasn't guiding the interviews in any certain direction. My supervisors also reviewed interviews and transcripts to ensure consistency and rigor. Utilising stakeholder involvement during the development of the topic guide further supported in ensuring personal bias and assumptions had little impact on the nature of the interviews. Interestingly, the findings of the study disproved my initial thoughts, instead finding most participants had a very good understanding of PRM and how to use it, but just did not have the support and structures in place to be able to use it effectively.

Data Collection

Participants taking part in this study had the choice to be interviewed face to face, by video call or by telephone. Interestingly, every participant opted to take part via video call. Some participants reflected on their level of home working, meaning video calling presented a more accessible option allowing them to take part flexibly at a time which suited them rather than relying on private office space. I had wondered whether the lack of in person interviewing may reduce opportunity to build rapport, potentially reducing feelings of safety and trust needed for participants to be honest during their interview. However, I was surprised during the interview process that participants appeared fairly comfortable, and I felt able to establish a sense of rapport with them despite the physical barrier. Research has highlighted video interviews can be an effective method of qualitative interviewing and serve as a viable alternative to in person interviews (Deakin & Wakefield, 2013; Irani, 2019). During the interviews, participants naturally reflected on personal experiences of risk management which at times evoked emotional responses within them. A detailed risk protocol was in place (see Appendix 4-H) to support in managing such responses or potential disclosures of malpractice. Upon reflection, it is possible the use of video call to facilitate the interviews may have supported participants in feeling more relaxed within a familiar home environment which supported them in feeling able to share their experiences transparently. This experience has supported me in considering future research I may be involved with and ensuring multiple options and strategies are in place to support involvement of a wide range of participants through various means.

Sample Size

There are no specific requirements for sample size within thematic analysis, although the concept of data saturation is widely discussed within qualitative research in general (Braun & Clarke, 2021). Data saturation refers to the point in data collection and analysis when new information contributes little change to existing codes and no new themes are thought to be emerging from the data (Guest et al., 2006; Morse, 2015). Some studies report a sample size of as low as seven was enough to achieve saturation (Constantinou et al., 2017), with others reporting data saturation

occurred after 12 or 16 interviews (Guest et al., 2006; Hagaman & Wutich, 2017). A maximum sample size of 20 was set prior to the study start date, in line with the scope of the project and recruitment timeframe. As interviews progressed, I noted and discussed data quality and consistent emerging ideas. My supervisors and I discussed and agreed when it appeared as though little new information was emerging from more recent interviews. The researchers also aimed to ensure the sample was not biased toward one professional group, ensuring a range of professional experiences were captured and representative of a typical CMHT staff group. Importantly, Braun & Clarke (2021) highlight that coding and analysis do not necessarily reach a fixed end point, instead the researcher will inevitably need to make an interpretative judgement about when to stop each stage of collection and analysis. Therefore, given the somewhat subjective nature of the concept of data saturation, Braun & Clarke (2021) argue 'full' saturation may never truly occur within a reflexive approach and authors may never truly know whether such saturation has occurred. Given the depth of the data collected and experiences captured in this study, a final sample size of 12 was achieved.

Data Analysis

Throughout the analysis I closely followed Braun & Clarke's (2006) six stage process for reflexive TA. As I approached this research fairly novice toward TA as a whole, working within the recommended steps supported in developing confidence with the methodology. Aspects of the analysis were sometimes challenging as I felt a pull toward 'doing it right' rather than curiously leaning into the analysis. Through supervision and continual familiarisation with the data I felt myself moving toward a more interpretive stance and identifying themes within the dataset came more intuitively. The iterative nature of reflexive TA was helpful in this respect, as it allowed me to work with the data over a longer time period throughout the back and forth of data collection, transcription and coding. Furthermore, using NVivo software (Lumivero, 2013) proved to be hugely beneficial in keeping the analysis organised and allowed me to flexibly and visually work through the data set and share this with supervisors for second opinion. An initial challenge of the analysis was the time taken to transcribe a very large data set, which I had initially underestimated. It was crucial the interviews were accurately transcribed with an appropriate level of detail to capture the individual experiences of each participant. The process of transcription, though lengthy, proved to be a key component of the analysis as it allowed me to immerse myself fully within the data. Evidence suggests through this familiarisation (Braun & Clarke, 2006), the researcher gains a sense of the entirety of the dataset which enables a better understanding of the phrasing and meaning when viewed within a wider context (Castleberry & Nolen, 2018).

Strengths, Limitations and Future Directions

Both papers in this thesis offer a novel contribution to the literature. This thesis explored PRM, which remains poorly represented within the literature despite its application across a wide variety of mental

health settings. The review component of this thesis is the first to explore PRM from a realist perspective and captured a wide body of literature and publications, allowing connections to be drawn across various contexts. This review supported in understanding how PRM works and why it might not, providing a practical, applied view of PRM which combined published data with real-world experiences. Whilst realist reviews incorporate a broad range of literature and publications, allowing for an in-depth overview of the subject area, this also acts as a potential limitation to this research. The variability of literature included in this review may reduce the reliability of findings. Furthermore, the iterative nature of realist reviews makes them less linear or rigid than more traditional systematic reviews (Dada et al, 2023). Whilst this may be perceived as both a strength and limitation of the paper, it is important future research further explores individual theories highlighted in the review to improve reliability and validity of findings in this area.

A limitation highlighted in both papers relates to the lack of service user voice captured within the findings. Risk management affects both staff and service users, and there is a distinct lack of representation of service user views and experiences in this area within the existing literature. Whilst the voice of professionals working in mental health settings is crucial in understanding barriers and facilitators to effective, collaborative risk management, it is also vital that service users contribute to the development of any training, policy development or implementation of strategies to improve risk management processes in mental healthcare. Future research should aim to qualitatively explore service user experiences of PRM across varying services and settings including both community and inpatient to support with the development of recommendations and guidance for practitioners and services.

The empirical paper was the first to qualitatively explore community staff perspectives of PRM. The inclusion of a range of qualified professions within the sample allowed for representation of various staff groups within CMHT's meaning findings are not biased toward one particular staff group. One of the limitations of the empirical paper related to the level of experience of participants who took part. It is possible the study appeared more appealing to more experienced staff and may have presented as more anxiety provoking for clinicians with less experience who may feel less confident discussing risk management freely. In some respects, this was felt to be a strength of the paper as it allowed for a depth and richness to the data which captured a wide variety of perspectives from very experienced practitioners who could reflect on a longer career in mental health. However, it also meant the study failed to capture the views of more recently qualified, less experienced mental health staff. The data collected within the study highlighted that participants were very pro PRM, despite systemic factors acting as a barrier to its use. It remains unclear whether staff with less experience of managing varying levels of risk, as well as staff from other NHS settings, would have similar views on PRM therefore this should remain a future direction for further research. It is recognised that within nursing the transition from student to newly qualified can be stressful and create feelings of overwhelm and

vulnerability in this population (Collard et al., 2020). Furthermore, a recent review of newly qualified clinicians in the UK found workplace culture can have a significant impact on the transition experience highlighting the need for on-going support for all aspects of practice, including risk management, post qualification (Smythe & Carter, 2022). Despite the level of experience of the sample in this study, perceptions of proficiency to be a key factor in whether staff may choose to adopt a PRM approach with service users, with feelings of inadequacy or lack of confidence acting as a barrier to them taking positive risks with clients. This further emphasises the need for future research to explore less experienced members of staffs understanding, experience and utilisation of PRM, to determine whether further barriers may exist which policy and guidance will need to address. This will prove crucial as the NHS workforce progresses and more newly qualified staff members join services where risk management forms a key aspect of their role.

Conclusion

In conclusion, this thesis is made up of two distinct papers each exploring PRM within mental health care. Each papers offers novel findings relevant to the field of clinical psychology and lays a foundation for future research to further build upon. The literature review highlighted overall contextual and mechanistic factors affecting outcomes related to effective PRM implementation. The empirical paper demonstrated community staff perspectives on PRM, highlighting key barriers and facilitators to the adoption of PRM within community-based settings. The findings in these papers are relevant to all staff working within mental health services, but also to service users, families and carers who may wish to better understand options for risk management within their care. Crucially, the findings are of particular pertinence to senior management and leadership figures within the NHS, including policy writers and training providers who play a key role in shifting the deep-rooted systemic issues facing the workforce as a whole. Future research examining wider settings and other populations is recommended.

Whilst the process of completing this thesis felt challenging at times, through supervision, the use of guidance and wider consultation with stakeholders I was supported in making decisions which led to the production of two meaningful papers which hopefully capture staff and service user well-being at the heart of them. This process has supported me to develop my skills as a clinical psychologist and researcher and I feel privileged to have had the opportunity to capture the voice of those involved in the research.

References

Wong, G., Greenhalgh, T., Westhorp, G., Buckingham, J., & Pawson, R. (2013). RAMESES publication standards: realist syntheses. *BMC Medicine*, *11*(1). https://doi.org/10.1186/1741-7015-11-21

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. *https://doi.org/10.1191/1478088706qp063oa*

Braun, V., & Clarke, V. (2021). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, *21*(1), 37–47. https://doi.org/10.1002/capr.12360

Braun, V., & Clarke, V. (2021). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health*, *13*(2), 201–216. https://doi.org/10.1080/2159676X.2019.1704846

Castleberry, A., & Nolen, A. (2018). Thematic analysis of qualitative research data: Is it as easy as it sounds?. *Currents in pharmacy teaching & learning*, *10*(6), 807–815. https://doi.org/10.1016/j.cptl.2018.03.019

Collard, S. S., Scammell, J., & Tee, S. (2020). Closing the gap on nurse retention: A scoping review of implications for undergraduate education. *Nurse Education Today*, *84*(84), 104253. https://doi.org/10.1016/j.nedt.2019.104253

Constantinou, C. S., M. Georgiou, and M. Perdikogianni. (2017). "A Comparative Method for Themes Saturation (Comets) in Qualitative Research." *Qualitative Research* ,*17*(5): 571–588. doi:10.1177/1468794116686650.

Dada, S., Dalkin, S., Gilmore, B., Hunter, R., & Mukumbang, FC. (2023). Applying and reporting relevance, richness and rigour in realist evidence appraisals: Advancing key concepts in realist reviews. *Research Synthesis Methods, 14*(3), 504-514). doi:10.1002/jrsm.1630.

Deakin, H., & Wakefield, K. (2014). Skype interviewing: reflections of two PhD researchers. *Qualitative Research*, *14*(5), 603–616. https://doi.org/10.1177/1468794113488126

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough? An Experiment with Data Saturation and Variability. *Field Methods*, *18*(1), 59–82. https://doi.org/10.1177/1525822X05279903

Hagaman, A. K., and A. Wutich. (2017). "How Many Interviews are Enough to Identify Metathemes in Multisited and Cross-cultural Research? Another Perspective on Guest, Bunce, and Johnson's (2006) Landmark Study." *Field Methods, 29*(1): 23–41. doi:10.1177/1525822X16640447.

Irani, E. (2018). The Use of Videoconferencing for Qualitative Interviewing: Opportunities, Challenges, and Considerations. *Clinical Nursing Research*, *28*(1), 3–8. Sagepub. https://doi.org/10.1177/1054773818803170

Just, D., Tai, S., & Palmier-Claus, J. (2021a). A systematic review of policy and clinical guidelines on positive risk management. *Journal of Mental Health*, *32*(1), 329–340. https://doi.org/10.1080/09638237.2021.1922643

Morse, J. M. (2015). "Data Were Saturated … ." *Qualitative Health Research, 25*(5): 587–588. doi:10.1177/1049732315576699.

Pawson, R., Greenhalgh, T., Harvey, G., & Walshe, K. (2005). Realist review--a new method of systematic review designed for complex policy interventions. *Journal of Health Services Research & Policy*, *10 Suppl 1*(1), 21–34. https://doi.org/10.1258/1355819054308530

Rycroft-Malone, J., McCormack, B., Hutchinson, A. M., DeCorby, K., Bucknall, T. K., Kent, B., Schultz, A., Snelgrove-Clarke, E., Stetler, C. B., Titler, M., Wallin, L., & Wilson, V. (2012). Realist synthesis: illustrating the method for implementation research. *Implementation Science*, *7*(1). https://doi.org/10.1186/1748-5908-7-33

Saul, J. E., Willis, C. D., Bitz, J., & Best, A. (2013). A time-responsive tool for informing policy making: rapid realist review. *Implementation Science*, *8*(1). https://doi.org/10.1186/1748-5908-8-103

Smythe, A., & Carter, V. (2022). The Experiences and Perceptions of Newly Qualified Nurses in the UK: An Integrative Literature Review. *Nurse Education in Practice*, *62*(62), 103338. https://doi.org/10.1016/j.nepr.2022.103338

Wong, G. (2019). *The rise and rise of realist reviews? — Centre for Evidence-Based Medicine (CEBM), University of Oxford*. Www.cebm.ox.ac.uk. https://www.cebm.ox.ac.uk/news/views/the-rise-and-rise-of-realist-reviews

Section Four: Ethics Section

Word count (excluding references, tables and appendices): 4822

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1. Approved Ethics Application

☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

◉ England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which applications do you require?

☑ IRAS Form
☐ Confidentiality Advisory Group (CAG)
☐ HM Prison and Probation Service (HMPPS)

Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?

◉ Yes ○ No

4b. Please confirm the reason(s) why the project does not require review by a REC within the UK Health Departments Research Ethics Service:

☐ Projects limited to the use of samples/data samples provided by a Research Tissue Bank (RTB) with generic ethical approval from a REC, in accordance with the conditions of approval.
☐ Projects limited to the use of data provided by a Research Database with generic ethical approval from a REC, in accordance with the conditions of approval.
☐ Research limited to use of previously collected, non-identifiable information
☐ Research limited to use of previously collected, non-identifiable tissue samples within terms of donor consent
☐ Research limited to use of acellular material
☐ Research limited to use of the premises or facilities of care organisations (no involvement of patients/service users as participants)
☑ Research limited to involvement of staff as participants (no involvement of patients/service users as participants)

5. Will any research sites in this study be NHS organisations?

◉ Yes ○ No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out the research e.g. NHS support costs) for this study provided by a NIHR Biomedical Research Centre (BRC), NIHR Applied Research Collaboration (ARC), NIHR Patient Safety Translational Research Centre (PSTRC), or an NIHR Medtech and In Vitro Diagnostic Co-operative (MIC) in all study sites?

Please see information button for further details.

○ Yes ◉ No

Please see information button for further details.

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

○ Yes ◉ No

The NIHR Clinical Research Network (CRN) provides researchers with the practical support they need to make clinical studies happen in the NHS in England e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, information from your IRAS submission will automatically be shared with the NIHR CRN. ***Submission of a Portfolio Application Form (PAF) is no longer required.***

6. Do you plan to include any participants who are children?

○ Yes ◉ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ◉ No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ◉ No

9. Is the study or any part of it being undertaken as an educational project?

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
This project forms part of a doctoral thesis for the qualification of Doctorate in Clinical Psychology. The trainee (student) is supervised by a member of staff of the DClinPsy team at Lancaster University, who will act as principal investigator for the study.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

◉ Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ◉ No

Integrated Research Application System
Application Form for Research involving qualitative methods only

IRAS Form (project information)

Please refer to the E-Submission and Checklist tabs for instructions on submitting this application.

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Community staff perspectives on risk management.

Please complete these details after you have booked the REC application for review.

REC Name:
HRA

REC Reference Number:
n/a

Submission date:
30/05/2023

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Exploring community mental health staff perspectives on risk management, a reflexive thematic analysis.

A2-1. Educational projects

Name and contact details of student(s):

Student 1

Title	Forename/Initials	Surname
Miss	Mollie Ellen Rose	Skinner

Address	Lancaster University
	Health Innovation Campus
	Lancaster
Post Code	LA14YW
E-mail	m.skinner2@lancaster.ac.uk
Telephone	07710267081
Fax	

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
Doctorate in Clinical Psychology (DClinPsy)

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title	Forename/Initials	Surname
	Professor	William	Sellwood
Address	Lancaster University		
	Health Innovation Campus		
	Lancaster		
Post Code	LA14YW		
E-mail	b.selwood@lancaster.ac.uk		
Telephone	01524663086		
Fax			

Academic supervisor 2

	Title	Forename/Initials	Surname
	Dr	Jasper	Palmier-Claus
Address	Lancaster University		
	Health Innovation Campus		
	Lancaster University, Lancaster		
Post Code	LA14YW		
E-mail	j.palmier-claus@lancaster.ac.uk		
Telephone	01524663086		
Fax			

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Miss Mollie Ellen Rose Skinner	☑ Dr Jasper Palmier-Claus ☑ Professor William Sellwood

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

- ○ Student
- ◉ Academic supervisor
- ○ Other

A3-1. Chief Investigator:

	Title	Forename/Initials	Surname
	Professor	William	Sellwood
Post	Senior Lecturer & Principal Clinical Psychologist		
Qualifications	BSc, MSc, PhD		
ORCID ID	0000 0001 8260 9503		
Employer	Lancaster University		
Work Address	Health Innovation Campus		
	Lancaster University		
	Lancaster		
Post Code	LA14YW		
Work E-mail	b.sellwood@lancaster.ac.uk		
* Personal E-mail	b.sellwood@lancaster.ac.uk		
Work Telephone	01524663086		
* Personal Telephone/Mobile	01524663086		
Fax			

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.

	Title	Forename/Initials	Surname
	Ms	Becky	Gordon
Address	Lancaster University		
	Research and Enterprise Service		
	B062, Bowland Main		
Post Code	LA1 4YT		
E-mail	sponsorship@lancaster.ac.uk		
Telephone	+44 1524 510188		
Fax			

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	n/a
Sponsor's/protocol number:	n/a
Protocol Version:	1
Protocol Date:	28/04/2023
Funder's reference number (enter the reference number or state not applicable):	N/a
Project website:	N/A

Additional reference number(s):

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)"

section.

A5-2. Is this application linked to a previous study or another current application?

○ Yes ◉ No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

People who use mental health services are sometimes at risk of harming themselves or others. Mental health staff assess and manage risk in different ways. But these are not always good at preventing harmful behaviours. Effective risk management in mental health services is important to ensure the safety and recovery of people using the service. Also, service user suicide has extremely negative effects on staff members well-being and future practice.

Positive risk management (PRM) is an approach which promotes quality of life and recovery whilst remaining aware of safety needs. PRM has been shown to be effective in reducing risk, but mental health professionals do not always use it. We want to gain the perspective of staff working in community secondary care mental health services to understand what PRM means to them and how they use it. We will interview 10-20 staff members working in these services to explore their experiences of PRM. This study will help us to understand when PRM may work well and what are some of the barriers to using it. The results of this study could promote good care which is focussed on recovery, autonomy and quality of life.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, HRA, or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

Recruitment

Recruitment of NHS clinical staff working in community secondary care mental health teams will be conducted within Lancashire Care NHS Foundation Trust, where the academic supervisor of the project holds a clinical role. Staff who wish to take part will be made aware that their participation is voluntary. There will be no pressure for individuals to take part in the study. Prior to the interview, we will provide participants with a copy of the participant information sheet and give them a minimum of 24 hours to decide if they would like to take part. Participants will be given the opportunity to ask questions about the research and receive answers to any queries they might have before agreeing to participate. Participants will be informed that this study forms a thesis for doctoral qualification in Clinical Psychology. Before completing the interview, participants will sign a written consent form. The participant information sheet will highlight that participation is completely voluntary, participants are able to withdraw from the study at any time and have any data collected destroyed.

Distress/Discomfort from interviews

The interviews are likely to contain questions addressing risk, previous experiences of working in mental health services and restrictive practice. Some participants may experience emotional discomfort whilst recalling this information. The participants will be informed of the nature of questions included in the interview prior to them taking part. They will be informed that they can stop the interview at any time, decline to answer certain questions, or take a comfort break when needed. The interviewer will be observant for signs of potential distress during the interviews. If

distress occurs, the researcher will provide empathy, signposting to local support helplines and support. The researcher may offer to call participants 24 hours after the interview to follow-up on any distress and check in. Contact numbers for local support helplines will be included on the participant information sheet. Participants who become distressed will also be encouraged to access support from their GP. The researcher will adhere to a detailed distress and risk protocol which will outline how to manage distress, any disclosures of risk and safeguarding concerns.

Data protection and confidentiality

Issues surrounding confidentiality are highlighted in the participant information sheet. Confidentiality will be discussed with each participant at the time of consent and before beginning the interview.

•Audio recordings of the interview will be destroyed once the project has finished.
•Hard copies of questionnaires will be kept in a locked cabinet on University premises.
•Files stored electronically will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected.
•Interview recordings will be stored securely on University Secure Cloud Storage, only accessible by the researchers.
•All reasonable steps will be taken to protect the anonymity of the participants involved in this project.
•Any personal data will be confidential and will be kept separately from interview responses.

Remote interviews will take place via Microsoft Teams and be recorded using LSCFT encrypted laptops. Data will immediately be transferred to University secure cloud storage once the interview is complete. The identity of participants will remain confidential and will not be shared outside of the research team. Confidentiality would only be broken where entirely necessary if there is adequate concern that a participant or other individual may be at risk of harm. Informed consent to the study will be obtained.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply*:

- ☐ Case series/ case note review
- ☐ Case control
- ☐ Cohort observation
- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☑ Qualitative research
- ☑ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

The aim of this study is to explore community secondary care mental health staffs understanding, experiences and perspectives of risk management. We are particularly interested in understanding what PRM means to staff, how they use it and if there are any barriers to them using this type of risk management in their role. The research question for this study is: How do staff working in adult community secondary care mental health services understand, experience and utilise positive risk management?

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

Not applicable.

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

The Problem:
For health and social care services to adopt a genuine person-centred approach, professionals must exhibit a fundamentally positive mindset and a willingness to take certain risks (Morgan & Andrews, 2016a). Risk may be defined in several ways, often dependent upon the setting it is assessed within. The Department of Health (DoH) most recently defined risk as the 'nature, severity, imminence, frequency/duration, and likelihood of harm to self or others' (Department of Health, 2009, p63). The ability to effectively assess and manage risk is a vital component in the delivery of mental health care and is essential for all staff working in these settings (Hawley et al., 2010).

Risk continues to be common within both community and inpatient mental health services. Between 2008-2018 there were 13,984 suicides by individuals who had been in contact with mental health services in the 12 months prior to their death in England. This figure represents 27% of the general population's suicides. Assessment of the behavioural characteristics of service users who died by suicide during this time also revealed 65% had a history of self-harm and 21% had a history of violence. Furthermore, clinicians judged the short-term risk of suicide at the time of final contact to be 'low or none' for 83% of service user suicides (University of Manchester, 2021). This highlights there are important opportunities for prevention in the future.

Mental health services use a variety of risk assessment tools to determine the likelihood of harm an individual may pose to themselves or others. These risk assessments typically consider psychological, environmental, and social factors in order to capture a broad view of a person's individual needs and level of risk. The assessment of risk in clinical practice is deemed of immense importance as it provides opportunity for collaboration between a service user, their family, and services with the joint aim of promoting recovery and safety (Worthington et al., 2013).

However, the National Institute for Health and Care Excellence (NICE) guidelines make clear risk assessment tools are not a suitable method of predicting potential future suicide or repetition of self-harming behaviours (NICE, 2011). Risk assessment tools are not standardised, and clinicians may over rely on their use in practice. Moreover, their effectiveness is somewhat reliant upon adequate training and appropriate use from the practitioner undertaking the assessment. Research has shown huge variation in the predictive ability of risk scales as well as minor impact on the reduction of events such as suicide or violence (Callaghan & Grundy, 2018; Quinlivan et al., 2014; Steeg et al., 2018). A recent report into the assessment of clinical risk in mental health services highlighted that the management of risk should be personal and individualised with an emphasis on building good relationships and involving family/carers (The University of Manchester, 2018).

In the United Kingdom, national policy and guidelines promote the use of positive risk management (PRM). Definitions of PRM vary considerably across the literature (Just, Tai, et al., 2021) and despite evidence advocating its implementation with service users, staff do not always utilise it in practice. The Department of Health most recently defined PRM as '…risk management, which improves the service user's quality of life and plans for recovery, while remaining aware of the safety needs of the service user, their carer, and the public' (DoH, 2009, p9). For staff this includes actions such as collaborating openly with the service user and their family, understanding their strengths, and promoting independence through empowerment, trust, and choice.

The concept of positive risk taking (also known as therapeutic risk taking) became more recognised in the 1990's. At this time, it was established with an aim of being a more practical, person-centred response to managing individuals who had, what were then viewed as, more severe, enduring mental health difficulties (Morgan & Andrews, 2016a). Since then, evidence has indicated PRM can reduce risk and improve quality of life (Robertson & Collinson, 2011), yet it's use is still limited. A recent study found only just over 10% of service users within inpatient settings were involved in their risk management plans and discussions (Coffey et al., 2019). A recent systematic review found discrepancies in how PRM is defined within policy and guidelines, when it should be used and who should be utilising it (Just et al., 2021).

Why is this research important?
The way in which risk is managed within services has several important implications. Firstly, and most importantly, the well-being of the service users whose autonomy, safety, recovery, and well-being depends upon effective collaboration with staff. The well-being of staff members may also be either positively or negatively impacted by the outcomes of risk management protocols they implement with service users. There is a growing body of research highlighting the long-standing detrimental impacts of service user suicide on mental health professionals. Sandford et al., (2020) found the impact of such an event is comparable to other traumatic life events and results in staff becoming more defensive and cautious in managing future risk.

We intend to interview 10-20 community mental health staff to ask them about their understanding and experiences of

risk management within community services. The aim of the interviews will be to better understand how community staff manage risk, whether there are certain factors that make it easier or more challenging to utilise a person centred, collaborative approach to risk, their experiences of risk management and to identify needs and recommendations for services moving forward. By obtaining this information, we hope to identify a clearer, more in depth understanding of what is needed for services to effectively implement PRM. This study hopes to give staff members opportunity to directly voice their own personal experiences of managing risk in community services.

By highlighting the potential barriers, strengths and resistances of PRM, we hope to advocate for further guidance, training and information for staff and service users who may be exposed to risk management within their practice/care. The outcome of the study may also support the further development of policy and guidelines around risk in mental health services to promote clarity and accessibility.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

Overview:
We will conduct 10-20 qualitative interviews with community secondary care mental health staff to gain information related to their experiences and perspectives of PRM. The researchers will conduct a reflexive thematic analysis to identify key themes and findings from the data.

Recruitment:
We will recruit 10-20 mental heath staff from community secondary care mental health teams and early intervention services within Lancashire and South Cumbria NHS Foundation Trust (LSCFT). We will utilise purposive sampling by placing poster advertisements across eligible services. Staff members who are eligible to take part may also be approached by the researcher to discuss participation and be provided an information sheet. We have pre existing links with community services within LSCFT.

Participants who are approached or express an interest in the study will be provided with a participant information sheet (PIS). The researcher will make it clear that they do not have to take part and can change their mind at any time. Participants will be given at least 24 hours to read the PIS and will be given time to ask any questions or request further information before deciding whether to take part.

If they decide to take part, informed consent will be obtained. Participants will be asked to consent to their interview being audio recorded. They will be informed of the process of anonymising data and bounds of confidentiality, as described in the PIS. Participants will be made aware that they are free to withdraw at any time, however once the interview has been anonymised their data will be unable to be redacted from the study (as detailed in the PIS). Participants will be asked to complete a brief demographic questionnaire before conducting the interview.

The inclusion criteria are:
Aged 18+
Currently employed within a Community Mental Health Team (CMHT), Early Intervention Team (EIT) service or associated service (e.g standalone psychological therapy services or occupational therapy services) within LSCFT.
Have worked in mental health services as a qualified clinician for at least 12 months prior to the interview date.
Current position of registered mental health nurse, social worker, occupational therapist, psychiatrist, clinical psychologist, allied therapist or other qualified mental health professional (specificity for qualified staff given their role in managing risk on a regular basis)
Able to converse proficiently in English.
Self report of having managed risk in their clinical practice within their current role.

The sample size of 10-20 is an estimate. Sample size will be determined by data sufficiency so adequate data can be collected. Braun and Clarke (2016) highlight that sample size should be revisited during data collection in a 'live, critically-reflexive, evaluative way', therefore sample sizes may vary from the proposed figure depending on earlier interviews.

Qualitative Interviews:
Interviews will occur at either an LSCFT site, Lancaster University premises, the participants home or virtually via Microsoft Teams or telephone call. All interviews will follow a topic guide developed to address the research questions and based on pre existing literature. The topic guide will be developed and revised based on earlier interviews, to continue to assess emerging themes and narratives which may occur. Interviews will be audio recorded and transcribed verbatim by the researcher. Interviews are anticipated to take no longer than one hour.

Data Analysis:
Reflexive thematic analysis (RTA) (Braun & Clarke, 2006; Braun, Clarke, Hayfield & Terry, 2019) will be used to analyse

the data. RTA allows for the identification and analysis of patterns and themes within the data set collected. The reflexive approach to thematic analysis emphasises the researchers' own role in the production of knowledge, making it a flexible method in which themes are produced by organising codes around a core commonality that is interpreted from the data (Braun & Clarke, 2019). Braun and Clarkes' six step process will be utilised, beginning with intensive reading of each transcript (data familiarisation). Subsequent steps include generating initial codes, initial themes, reviewing themes, defining and naming themes and producing the final report. The student researcher will lead the analysis and supervisors will review and contribute to each stage of the analysis by discussing codes, reviewing potential assumptions and the quality of interpretations. This will allow for multiple perspectives on the data. Coding will be conducted using appropriate coding software (NVivo). All quotes will be anonymised and/or paraphrased to avoid any identifiable information.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

- [x] Design of the research
- [ ] Management of the research
- [x] Undertaking the research
- [ ] Analysis of results
- [x] Dissemination of findings
- [ ] None of the above

Give details of involvement, or if none please justify the absence of involvement.
Staff from relevant services have been consulted to support development of the topic guide. The aim of this was be to gain their perspective on the wording used and content of the interviews. They will not be participants in the study. We will interview 10-20 staff members for this study. Results will be disseminated to services and participants involved.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

- [ ] Blood
- [ ] Cancer
- [ ] Cardiovascular
- [ ] Congenital Disorders
- [ ] Dementias and Neurodegenerative Diseases
- [ ] Diabetes
- [ ] Ear
- [ ] Eye
- [ ] Generic Health Relevance
- [ ] Infection
- [ ] Inflammatory and Immune System
- [ ] Injuries and Accidents
- [x] Mental Health
- [ ] Metabolic and Endocrine
- [ ] Musculoskeletal

- ☐ Neurological
- ☐ Oral and Gastrointestinal
- ☐ Paediatrics
- ☐ Renal and Urogenital
- ☐ Reproductive Health and Childbirth
- ☐ Respiratory
- ☐ Skin
- ☐ Stroke

Gender:	Male and female participants
Lower age limit: 18	Years
Upper age limit:	Years

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

Aged 18+
Currently employed within a Community Mental Health Team (CMHT), Early Intervention Team (EIT) service or associated service (e.g standalone psychological therapy services or occupational therapy services) within LSCFT.
Have worked in mental health services as a qualified clinician for at least 12 months prior to the interview date.
Current position of registered mental health nurse, social worker, occupational therapist, psychiatrist, clinical psychologist, allied therapist or other qualified mental health professional (specificity for qualified staff given their role in managing risk on a regular basis)
Able to converse proficiently in English.
Self report of having managed risk in their clinical practice within their current role.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Unable to converse proficiently in English or give informed written consent.
Less than 12 months experience (at date of interview) as a qualified clinician in mental health services.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Consent taking	1	0	5	Research team member; face to face at place of mutual convenience or remote (telephone/webcam)
Demographic Questionnaire	1	0	5	Participant; face to face at place of mutual convenience or remote
Semi Structured interview	1	0	50	Research team member; face to face at place of mutual convenience or remote

A21. How long do you expect each participant to be in the study in total?

1 hour.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

1. Distress during interview:
Some might find discussing experiences such as suicide, risk and harm to self/others distressing. We have developed a risk management protocol and detailed participant information sheet to address this. We will minimise the potential impact using the following strategies:
- Interviewers will create a warm, non judgemental and receptive interview environment.
- Participants will be informed they can withdraw from the study at any time. They can also continue the interview but decline to answer certain questions if they do not want to discuss certain themes.
- The researcher will be provided with regular supervision to ensure they are sensitively and appropriately dealing with any distress arising during sessions. The student researcher is a band 6 clinician with considerable experience of managing distress and risk situations.
- The participant information sheet contains details of where participants can seek further support outside of the interview if required.
- The interviewer will offer a follow up call 24 hours following the interview if participants would like a debrief and time to reflect.

2. Confidentiality
There could be potential safeguarding difficulties in interviewing individuals about risk and risk management experiences. A participant may say something which results in the researcher needing to break confidentiality to share concerns with external individuals. This could result in distress for participants. We will minimise the potential impact of this by using the following strategies:
- All participants will be provided with detailed information relating to confidentiality prior to them taking part in the study.
- Participants will be reminded of the bounds of confidentiality at the beginning of the interview.
- Participants will be informed the researcher will inform them if they need to break confidentiality (where appropriate and safe to do so).
- If participants become distressed, the steps above relating to participant distress will be followed.
- The researcher will refer to the risk management protocol if risk is elevated following a need to breach confidentiality.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

◉ Yes ○ No

If Yes, please give details of procedures in place to deal with these issues:

During interviews there is potential that someone may share an experience which falls outside of the bounds of confidentiality (e.g., risk incident, malpractice). I will outline confidentiality with all participants involved in the study before conducting interviews and follow usual safeguarding procedures if this occurs. Details of confidentiality bounds are made clear on the PIS and consent form. If a breach of confidentiality is required, I will discuss this with the participant where appropriate. I will inform my research supervisors immediately of any potential safeguarding concerns and follow LSCFT guidance on reporting any safeguarding concerns.

The student researcher is a band 6 practitioner with clinical experience of risk management, community mental health services and distress protocols. Student researcher has access to regular supervision for reflection and feedback.

A24. What is the potential for benefit to research participants?

Whilst there is no immediate benefit in taking part in this study, we hope the interviews will provide participants with a safe space to share their personal experiences and contribute to a better understanding of patient centred care and risk management in services.

A26. What are the potential risks for the researchers themselves? *(if any)*

If conducting interviews face to face or visiting LSCFT services during recruitment, usual trust policy will be adhered to. If conducting interviews in the participants home the researcher will also adhere to the Lancaster University and LSCFT lone working policy. The researcher will make their whereabouts known to the wider research team when conducting interviews or visiting LSCFT sites. Researchers will not use personal mobile numbers to conduct telephone interviews. It is possible participants may disclose upsetting information. If the researcher experiences any distress from the information disclosed, this would be discussed in supervision with a senior clinically trained psychologist.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?*For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

The researcher will visit relevant services to present the study, answer any questions and discuss potential participation with relevant staff members. Poster advertisements will also be displayed in these services and circulated via email with the Team Leaders consent. Participants can self refer into the study after seeing poster adverts in their workplace through the contact details listed. Word of mouth may also generate self referral to the study . We will utilise relevant social media outlets for people working in LSCFT (Twitter account) to advertise the study also.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

○ Yes ◉ No

Please give details below:
No identifiable personal information of any individuals will be reviewed or screened.

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

◉ Yes ○ No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).
Posters will be distributed across relevant services in LSCFT.

A29. How and by whom will potential participants first be approached?

Staff who wish to take part can respond to poster adverts or self identify to take part following presentation of the study within their service. Staff can request further information via the researcher email address listed on the advert. They will then be sent a PIS by the student researcher. Staff members in these services may also be approached by the researchers to discuss the study or provide information sheets.

A30-1. Will you obtain informed consent from or on behalf of research participants?

◉ Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

All participants will have received their own copy of the PIS either in person, via email or through the post. All participants will have multiple opportunities to ask questions, request further information and have any concerns addressed (by phone, email or in person). All participants will be given at least 24 hours to consider taking part in the study. The student researcher will ensure the participant is fully aware of what participating involves before collecting informed consent via a consent form.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

◉ Yes ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

Participants will be given at least 24 hours to decide if they would like to take part, but can take as long as they need to read the PIS, ask questions and have any concerns addressed.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? *(e.g. translation, use of interpreters)*

Unfortunately, the interviews require proficiency in English in order to converse with the researcher and provide written informed consent. For this reason, this is part of our exclusion criteria.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

○ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

○ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

○ The participant would continue to be included in the study.

○ Not applicable – informed consent will not be sought from any participants in this research.

◉ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

Capacity will be monitored throughout the interview. However once the interview is complete it is not practical to continue to monitor capacity as involvement will cease at this point.

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?*(Tick as appropriate)*

- ☐ Access to medical records by those outside the direct healthcare team
- ☐ Access to social care records by those outside the direct social care team
- ☑ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☑ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☑ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☑ Use of audio/visual recording devices
- ☑ Storage of personal data on any of the following:
  - ☑ Manual files (includes paper or film)
  - ☑ NHS computers
  - ☐ Social Care Service computers
  - ☐ Home or other personal computers
  - ☐ University computers
  - ☐ Private company computers
  - ☐ Laptop computers

Further details:
Participants may be contacted via email, telephone or post. Participants expressing an interest or wishing to take part may be emailed a copy of the participant information sheet. A test email will be sent before sending any information via email. All correspondence will be marked private and confidential. We will endeavour to limit what information is sent via email and post by providing hard copies in person where possible.

A37. Please describe the physical security arrangements for storage of personal data during the study?

Interviews will be recorded using an LSCFT encrypted laptop belonging to the student researcher. As soon as the interview has ended, the data will be transferred from the laptop to University approved secure cloud storage. Only the researchers will have access to this data. Any electronic documents relating to the study (for example consent forms completed electronically and transcriptions of the interviews) will be stored in the same way. Any documents containing identifiable information (such as consent forms) will be stored in a separate area from interview data. Physical copies of any data from the study will be stored in a locked filing cabinet within the the DClinPsy department at Lancaster University, only accessible by the researchers. Audio recordings will be destroyed once the project has finished. Hard copies of data will be kept for 10 years then destroyed (in line with Lancaster University guidelines).

A38. How will you ensure the confidentiality of personal data?*Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

All reasonable steps will be taken to protect the anonymity of participants involved in this project. The questionnaire and transcribed interview will not have any personal identifiable information on them. Any names mentioned during the interview will be changed when transcribed to ensure anonymity. The results of this project may be written in a research report, which may be published in a scientific journal. We may use quotes from interviews in this report, but all details will be anonymised, so the participants identity remains protected. Consent forms containing identifiable information will be stored securely (as stated above).

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

Only the researchers will have access to the participants personal data during the study. This will be securely stored as detailed in the participant information sheet. Individuals from Lancaster University, Lancashire and South Cumbria NHS Foundation Trust or regulatory authorities may need to look at the data collected for this study to make sure that we are carrying out the project as planned or check for any problems. This may involve looking at identifiable data, but all individuals involved in auditing and monitoring the study will have a strict duty of confidentiality to the research participant. This information is also contained in the information sheet.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

Data will be analysed by the student researcher using an LSCFT encrypted laptop, Microsoft Excel and NVivo Software. Transcripts will be anonymised. Any identifiable information regarding the participant or anybody they may discuss within their interview will remain confidential throughout the process of analysis. The audio recording of the interview will be transcribed by the student researcher and stored securely on university secure cloud storage. Recordings of the interview will be destroyed once the study is complete.

A42. Who will have control of and act as the custodian for the data generated by the study?

	Title	Forename/Initials	Surname
	Professor	William	Sellwood
Post	Programme Director		
Qualifications	BSc, MSc, PhD		
Work Address	Health Innovation Campus		
	Lancaster University		
	Lancaster		
Post Code	LA1 4YW		
Work Email	b.sellwood@lancaster.ac.uk		
Work Telephone	01524663086		
Fax			

A43. How long will personal data be stored or accessed after the study has ended?

- ○ Less than 3 months
- ○ 3 – 6 months
- ○ 6 – 12 months
- ○ 12 months – 3 years
- ◉ Over 3 years

If longer than 12 months, please justify:
All personal data and audio recordings will be destroyed when no longer required once the study is complete (other than consent forms for audit and governance by regulatory authorities).

A44. For how long will you store research data generated by the study?

Years: 10
Months: 0

A45. Please give details of the long term arrangements for storage of research data after the study has ended.*Say where data will be stored, who will have access and the arrangements to ensure security.*

The storage of research data will comply with the NHS and University's policy of storing data so it will be retained for 10 years after study completion and publication in an external archiving facility. At the end of the retention period, paper will be destroyed using paper shredders. Electronic data will be deleted.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

◉ Yes ○ No

If Yes, please give details. For monetary payments, indicate how much and on what basis this has been determined.
Participants will be compensated for their time in the form of a £10 voucher. Vouchers are preferred to cash reimbursement as they can be provided online in the case of online interviews.

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

○ Yes ◉ No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ◉ No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ◉ No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

○ Yes ◉ No

Please give details, or justify if not registering the research.
This research will not be registered as it is a small qualitative study being conducted as part of doctoral training.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

- [x] Peer reviewed scientific journals
- [x] Internal report
- [ ] Conference presentation
- [x] Publication on website
- [ ] Other publication
- [ ] Submission to regulatory authorities
- [ ] Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- [ ] No plans to report or disseminate the results
- [ ] Other (please specify)

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

Any direct quotes will be anonymised. Transcripts of interviews will not include any identifiable information. Participants will be assigned a pseudonym for the inclusion of published quotes.

A53. How and when will you inform participants of the study results?

If there will be no arrangements in place to inform participants please justify this.
Participants will be asked on entry to the study if they would like to be informed of the results. All participants wishing to be informed of the results will receive an end of study newsletter, written in a format understandable to a lay person.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

- [ ] Independent external review
- [ ] Review within a company
- [ ] Review within a multi−centre research group
- [x] Review within the Chief Investigator's institution or host organisation
- [x] Review within the research team
- [x] Review by educational supervisor
- [ ] Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
The study has been reviewed and approved internally by the University DClinPsy research team. It has also been reviewed by both supervisors.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size:	20
Total international sample size (including UK):	20

Total in European Economic Area: 0

Further details:
A sample size of approximately 10-20 is proposed.

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

Sample size will be revisited in a live, critically reflective, evaluative way, in line with Braun and Clark's (2016) guidance on thematic analysis. Therefore, sample size may vary from the proposed figure. However, we aim to achieve a minimal sample size of 10 to allow for a breadth of experiences and perspectives to be attained.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

Qualitative interviews and field notes will be analysed using thematic analysis to identify patterns of themes across the data. Thematic analysis will utilise Braun and Clark's six-step process starting with intensive reading of transcripts. Qualitative analysis will proceed simultaneously with data collection to allow emerging information to be incorporated and explored in subsequent interviews.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co−applicants, protocol co−authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title	Forename/Initials	Surname
	Professor	William	Sellwood
Post	Clinical Psychologist, Programme Director		
Qualifications	BSc, MSc, PhD		
Employer	Lancaster University		
Work Address	Health Innovation Campus Lancaster University Sir John Fisher Drive		
Post Code	LA1 4YW		
Telephone	01524663086		
Fax			
Mobile			
Work Email	b.sellwood@lancaster.ac.uk		

	Title	Forename/Initials	Surname
	Dr	Jasper	Palmier-Claus
Post	Clinical Psychologist and Senior Lecturer		
Qualifications	BSc, MSc, PhD, DClinPsy		
Employer	LSCFT, Lancaster University		
Work Address	Health Innovation Campus, Lancaster University Sir John Fisher Drive,		
Post Code	LA1 4YW		
Telephone	01524663086		
Fax			
Mobile			

Work Email	j.palmier-claus@lancaster.ac.uk

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status:
- ○ NHS or HSC care organisation
- ◉ Academic
- ○ Pharmaceutical industry
- ○ Medical device industry
- ○ Local Authority
- ○ Other social care provider (including voluntary sector or private organisation)
- ○ Other

Commercial status: Non-Commercial

If Other, please specify:

Contact person

Name of organisation	Lancaster University
Given name	Becky
Family name	Gordon
Address	Lancaster University
Town/city	Lancaster
Post code	LA1 4YT
Country	United Kingdom
Telephone	+44 1524 510188
Fax	
E-mail	sponsorship@lancaster.ac.uk

Legal representative for clinical investigation of medical device (studies involving Northern Ireland only)
Clinical Investigations of Medical Devices that take place in Northern Ireland must have a legal representative of the sponsor that is based in Northern Ireland or the EU

Contact person

Name of organisation	
Given name	
Family name	
Address	
Town/city	
Post code	
Country	
Telephone	

Fax
E-mail

A65. Has external funding for the research been secured?

Please tick at least one check box.

- [ ] Funding secured from one or more funders
- [ ] External funding application to one or more funders in progress
- [x] No application for external funding will be made

What type of research project is this?

- ○ Standalone project
- ○ Project that is part of a programme grant
- ○ Project that is part of a Centre grant
- ◉ Project that is part of a fellowship/ personal award/ research training award
- ○ Other

Other – please state:

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? *Please give details of subcontractors if applicable.*

○ Yes ◉ No

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes ◉ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

	Title	Forename/Initials	Surname
		Beverley	Lowe
Organisation	Research and Development, LSCFT		
Address	The Lantern Centre		
	Vicarage Lane		
	Fulwood, Preston		
Post Code	PR2 8DW		
Work Email	beverley.lowe@lscft.nhs.uk		
Telephone	01772773498		
Fax			
Mobile	07971337261		

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 01/06/2023
Planned end date: 30/08/2024
Total duration:
Years: 1 Months: 2 Days: 30

A71-1. Is this study?

- (•) Single centre
- ( ) Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

- [x] England
- [ ] Scotland
- [ ] Wales
- [ ] Northern Ireland
- [ ] Other countries in European Economic Area

Total UK sites in study

Does this trial involve countries outside the EU?

( ) Yes (•) No

A72. Which organisations in the UK will host the research?*Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

[x] NHS organisations in England	1
[ ] NHS organisations in Wales	
[ ] NHS organisations in Scotland	
[ ] HSC organisations in Northern Ireland	
[ ] GP practices in England	
[ ] GP practices in Wales	
[ ] GP practices in Scotland	
[ ] GP practices in Northern Ireland	
[ ] Joint health and social care agencies (eg community mental health teams)	
[ ] Local authorities	
[ ] Phase 1 trial units	
[ ] Prison establishments	
[ ] Probation areas	
[ ] Independent (private or voluntary sector) organisations	
[x] Educational establishments	1

☐ Independent research units

☐ Other (give details)

Total UK sites in study: 2

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

○ Yes ◉ No

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

There are no planned audits from external organisations. However, data from the project may be audited at any point by relevant agencies from LSCFT or Lancaster University. We will make this clear to all participants before they agree to take part in the study.

A76. Insurance/ indemnity to meet potential legal liabilities

***Note:** in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland*

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster university legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster university legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at

these sites and provide evidence.

☑ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☑ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Lancaster university legal liability cover will apply.

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

○ Yes ◉ No ○ Not sure

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For further information please refer to guidance.*

Investigator identifier	Research site	Investigator Name
IN1	○ NHS/HSC Site ◉ Non-NHS/HSC Site Institution name: Lancaster University Department name: Health Innovation Street address: Sir John Fisher Drive Town/city: Lancaster Post Code: LA1 4YW Country: United Kingdom	Forename: William Middle name: Family name: Sellwood Email: b.sellwood@lancaster.ac.uk Qualification (MD...): BSc, MSc, PhD Country: United Kingdom
IN2	◉ NHS/HSC Site ○ Non-NHS/HSC Site Organisation name: NHS LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE BOARD Address: 2ND FLOOR PRESTON BUSINESS CENTRE WATLING STREET ROAD FULWOOD PRESTON Post Code: PR2 8DY Country: ENGLAND	Forename: William Middle name: Family name: Sellwood Email: b.sellwood@lancaster.ac.uk Qualification (MD...): BSc, MSc, PhD Country: United Kingdom

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to fulfil the responsibilities of the chief investigator for this study as set out in the UK Policy Framework for Health and Social Care Research.
3. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
4. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
5. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
6. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
7. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
8. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
9. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 2018.
10. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
    - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
    - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
    - May be sent by email to REC members.
11. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 2018.
12. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the Health Research Authority (HRA) together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after the issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication*(Not applicable for R&D Forms)*

HRA would like to include a contact point with the published summary of the study for those wishing to seek further

information. We would be grateful if you would indicate one of the contact points below.

- ◯ Chief Investigator
- ◯ Sponsor
- ◯ Study co-ordinator
- ◯ Student
- ◯ Other – please give details
- ◯ None

Access to application for training purposes *(Not applicable for R&D Forms)*

Optional – please tick as appropriate:

☐ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

This section was signed electronically by Prof William Sellwood on 26/05/2023 13:06.

Job Title/Post:	Professor of Clinical Psychology
Organisation:	Lancaster University
Email:	b.sellwood@lancaster.ac.uk

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co−sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The responsibilities of sponsors set out in the UK Policy Framework for Health and Social Care Research will be fulfilled in relation to this research.

   Please note: *The declarations below do not form part of the application for approval above. They will not be considered by the Research Ethics Committee.*
7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.
8. Specifically, for submissions to the Research Ethics Committees (RECs) I declare that any and all clinical trials approved by the HRA since 30th September 2013 (as defined on IRAS categories as clinical trials of medicines, devices, combination of medicines and devices or other clinical trials) have been registered on a publically accessible register in compliance with the HRA registration requirements for the UK, or that any deferral granted by the HRA still applies.

This section was signed electronically by An authorised approver at sponsorship@lancaster.ac.uk on 15/05/2023 10:08.

Job Title/Post:	Associate Director of Research Services
Organisation:	Lancaster University
Email:	y.fox@lancaster.ac.uk

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the UK Policy Framework for Health and Social Care Research.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

This section was signed electronically by Dr Jasper Palmier-Claus on 30/05/2023 10:37.

Job Title/Post:	Senior Lecturer/Principal Clinical Psychologist
Organisation:	Lancaster University
Email:	J.Palmier-Claus@lancaster.ac.uk

Academic supervisor 2

This section was signed electronically by Prof William Sellwood on 26/05/2023 13:07.

Job Title/Post:	Professor of Clinical Psychology
Organisation:	Lancaster University
Email:	b.sellwood@lancaster.ac.uk

Appendices

Appendix 4-A

Health Research Authority (HRA) Approval Confirmation Email (22nd June 2023)

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Professor William Sellwood
Lancaster University
Health Innovation Campus
Lancaster
LA14YWN

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

22 June 2023

Dear Professor Sellwood

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Exploring community mental health staff perspectives on risk management, a reflexive thematic analysis.**
IRAS project ID:	**316698**
Protocol number:	**n/a**
REC reference:	**23/HRA/2156**
Sponsor	**Lancaster University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

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

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **316698**. Please quote this on all correspondence.

Yours sincerely,
Penny Beresford

Approvals Specialist

Email: HCRW.approvals@wales.nhs.uk

Copy to: *Ms Becky Gordon*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Poster Advert]	V1	28 April 2023
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance Certificate]		01 August 2022
Interview schedules or topic guides for participants [Topic Guide]	V1	20 January 2023
IRAS Application Form [IRAS_Form_30052023]		30 May 2023
Letter from sponsor [Sponsorship Letter]		31 May 2023
Non-validated questionnaire [Demographic Questionnaire]	V1	20 January 2023
Other [Risk Protocol]	V1	20 January 2023
Participant consent form [Consent Form]	v2	16 June 2023
Participant information sheet (PIS) [Participant Information Sheet]	V1	28 April 2023
Participant information sheet (PIS) [Participant Information Sheet]	V2	16 June 2023
Research protocol or project proposal [Research Protocol]	v2	16 June 2023
Summary CV for Chief Investigator (CI) [Chief Investigator CV]		25 November 2022
Summary CV for student [Student CV]		09 May 2023
Summary CV for supervisor (student research) [Supervisor CV]		25 November 2022

IRAS project ID	316698

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
This is a single site study sponsored by the participating NHS organisation therefore there is only one site type.	The single participating NHS organisation of this type is also sponsoring the research. You should work with your sponsor R&D office to make arrangements to set up the study. The sponsor R&D office will confirm to you when the study can start following issue of HRA and HCRW Approval.	This is a single site study sponsored by the participating NHS organisation therefore no agreements are expected.	No external study funding has been sought.	Principal Investigators are expected to be in place at participating NHS / HSC organisations where locally employed staff take responsibility for research procedures.	Where an external individual is conducting only research activities that are limited to access to staff, or staff data (in either identifiable or anonymised form), or anonymised patient data then a Letter of Access is required only if these activities will take place in NHS facilities. This should be issued be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed). Where these activities will not take place in NHS facilities then no arrangements under the HR Good Practice Pack are required.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix 4-B

HRA Non-Substantial Amendment Approval Email (17th October 2023)

IRAS Project ID 316698. HRA and HCRW Approval for the Amendment

A

Approvals <approvals@hra.nhs.uk>

Tuesday 17 October 2023 at 11:26

To: b.selwood@lancaster.ac.uk; sponsorship@lancaster.ac.uk

Dear Professor Sellwood,

IRAS Project ID:	316698
Short Study Title:	Community staff perspectives on risk management.
Amendment No./Sponsor Ref:	NSA02
Amendment Date:	22 September 2023
Amendment Type:	Non Substantial Non-CTIMP

I am pleased to confirm **HRA and HCRW Approval** for the above referenced amendment.

You should implement this amendment at NHS organisations in England and Wales, in line with the guidance in the amendment tool.

User Feedback

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

Please contact amendments@hra.nhs.uk for any queries relating to the assessment of this amendment.

Kind regards

Mrs Helen Williams - Wales
Approvals Officer
Health Research Authority

E.amendments@hra.nhs.uk
W. www.hra.nhs.uk

Sign up to receive our newsletter HRA Latest.

Appendix 4-C

Research Poster used in Recruitment Process

Lancaster University

Exploring Community Staff Perspectives on Risk Management

Does your clinical work involve managing risk in the community?

Are you a qualified member of staff?

Have you worked in a mental health service for at least 12 months?

We would like to hear about your perspective of risk management, to help promote good care for people who access community mental health services.

Would you like to take part in a one hour interview to share your experiences?

Please email Mollie (Trainee Clinical Psychologist) for further information:
m.skinner2@lancaster.ac.uk

This research has been approved by the Health Research Authority and Lancaster University Research Ethics Committee (REC ref: 23/HRA/2156)

Poster Advert, V1 28/04/2023; IRAS ID: 316698

Appendix 4-D

Participant Information Sheet

Doctorate in Clinical Psychology | Lancaster University

Participant Information Sheet

Community Staff Perspectives on Risk Management

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

You are being invited to take part in a research study being carried out by a Trainee Clinical Psychologist as part of their doctorate training programme. Before you decide if you would like to take part, it is important you understand why we are conducting this research and what it involves. Please read the following information carefully and discuss with others if you would like to. Please ask any questions if something is not clear or you would like further information. Thank you for taking the time to read this.

Who will conduct the research?
This research is being conducted by Mollie Skinner, a Trainee Clinical Psychologist at Lancaster University. Dr Jasper Palmier-Claus and Prof. Bill Sellwood are supervising the project. They are both qualified Clinical Psychologists. Lancaster University is the sponsor for this research.

What is the study about?
This purpose of this study is to explore mental health staff perspectives, understanding and experiences of risk management within community mental health services. The study involves interviewing mental health professionals about their experiences of risk management. This research aims to help us to better understand how staff navigate this complex area. It is hoped this may identify recommendations for services to develop better policies and practices for managing risk in the community.

Why have I been approached?
You may have responded to an advert for the study within your trust and expressed an interest. You might have been approached to see if you would like to take part if you work in a community mental health team and your role involves managing risk.

What will I be asked to do if I take part?
The study involves talking to a researcher for up to one hour about your experiences of risk management. You might be asked questions about things such as what risk management means to you and how you manage risk in your work. We would like to hear about what helps you manage risk effectively and what might make this more difficult. This information will help us to understand how best to support staff and services in working with service users.

What happens to my personal information?
For you to take part, we will need to collect some personal information about you such as:

- Information about your role and the service you work in (this will not include your name).
- An audio recording of the interview
- The interview will be transcribed and anonymised. Anonymised quotes may appear in the published research.

- If you would like to hear about the findings of the research, we will ask for your contact details so we can send you these once the study is complete.

The data collected for this study will be stored securely using University approved secure cloud storage and only the researchers conducting this study will have access to this data. The questionnaire and transcribed interview will not have any personal identifiable information on. Any names you mention during the interview will be changed. The results of this project may be written in a research report, which may be published in a scientific journal. We may use quotes from your interview in this report, but all details will be anonymised, so your identity remains protected.

- Audio recordings of the interview will be destroyed once the project has finished.
- Hard copies of questionnaires will be kept in a locked cabinet on University premises.
- Files stored electronically will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected.
- Interview recordings will be stored securely on University Secure Cloud Storage, only accessible by the researchers.
- All reasonable steps will be taken to protect the anonymity of the participants involved in this project.
- Any personal data will be confidential and will be kept separately from your interview responses.
- Anonymised interview transcripts will be securely stored and destroyed after 10 years.

Please also note that individuals from Lancaster University, Lancashire and South Cumbria NHS Foundation Trust or regulatory authorities may need to look at the data collected for this study to make sure that we are carrying out the project as planned or check for any problems. This may involve looking at identifiable data, but all individuals involved in auditing and monitoring the study will have a strict duty of confidentiality to you as a research participant.

We will not share anything that you talk about to your colleagues or anybody else. The only exception to this is if you told us something which made us think you or someone else could be at risk of any harm. In this case, we would need to share that information with relevant professionals to keep you and others safe. We would talk to you about this first so you know who we would be sharing the information with and why.

Lancaster University will be the data controller for any personal information collected as part of this study. Under the GDPR you have certain rights when personal data is collected about you. You have the right to access any personal data held about you, to object to the processing of your personal information, to rectify personal data if it is inaccurate, the right to have data about you erased and, depending on the circumstances, the right to data portability. Please be aware that many of these rights are not absolute and only apply in certain circumstances. If you would like to know more about your rights in relation to your personal data, please speak to the researcher on your particular study.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection.

Doctorate in Clinical Psychology | Lancaster University

What happens if I do not want to take part or change my mind?
It is your choice whether you decide to take part in this study. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part, you are free to withdraw at any time without giving any reason and with no detriment to yourself. Once your data have been anonymised and forms part of the dataset, we will be unable to remove your data from the project as we will be unable to identify your specific data. During the interview it is important you always feel comfortable. You can ask to stop recording at any time or take a break if needed.

Who has reviewed the project?
The study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University. This study has also received Health Research Authority (HRA) approval (REC reference: 23/HRA/2156).

Will I be paid for participating in the research?
You will be given a £10 voucher at the end of the interview as compensation for your time.

How long will the interview take?
The interview will take around 1 hour. We will also ask you to complete a short demographic questionnaire which will take a couple of minutes.

Where will the research be conducted?
We will arrange a convenient time and place with you to do the interview. Interviews can be face to face, via Microsoft Teams or via telephone. Face to face interviews will be conducted at a location convenient to you (e.g your home, an NHS site or University premises).

Are there any risks to taking part?
There are no specific risks anticipated with participating in this study. However, sometimes people find talking about risk related experiences difficult and recalling certain experiences may bring up certain emotions. If you experience any distress before, during or following participation you are encouraged to inform the researcher and utilise the resources provided at the end of this sheet.

What will happen to the results of the study?
Results will be summarised and reported and may be submitted for publication in an academic or professional journal. You can also request to receive a summary of any findings once the research is complete. If you would like to receive this please provide contact details to the researcher.

Where can I obtain further information about the study?
If you have any questions about the study, please contact the main researcher or supervisors:

Mollie Skinner (Trainee Clinical Psychologist)
m.skinner2@lancaster.ac.uk

Dr Jasper Palmier Claus
j.palmier-claus@lancaster.ac.uk 01524 663086
Professor William Sellwood
b.sellwood@lancaster.ac.uk

Doctorate in Clinical Psychology | Lancaster University

What if I wish to make a complaint?
If you wish to make a complaint about any aspect of this study you can contact the researchers above.

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Dr Ian Smith Tel: (01524) 592282
Research Director; Email: i.smith@lancaster.ac.uk
Health Innovation One
Sir John Fisher Drive,
Lancaster University,
LA1 4YW

If you wish to speak to someone outside of the Doctorate in Clinical Psychology programme, you may also contact:

Dr Laura Machin Tel: +44 (0)1524 594973
Chair of FHM REC Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

Resources you may find helpful in the event of distress:
Should you feel distressed as a result of taking part, these resources may be helpful.

- Employee Assist is available to employees of LSCFT: the trust's Employee Assistance Programme, Health Assured. They can be contacted by a free 24 hour phone line on 0800 030 5182. Employee Assist can offer a range of help, support and advice. Visit their website at: http://www.healthassuredeap.co.uk
- LSCFT Resilience Hub supports the health and well being of people employed by LSCFT. You can self refer via their website: https://lscresiliencehub.nhs.uk/
- Mind are a charity who offer a range of support via their website: https://www.mind.org.uk/information-support/guides-to-support-and-services/

Appendix 4-E

Audio Consent Form

Audio Consent Form

Lancaster University

Project Title: Community Staff Perspectives on Risk Management

Name of Researchers: Mollie Skinner, Dr Jasper Palmier-Claus, Professor William Sellwood
Email: m.skinner2@lancaster.ac.uk, j.palmier-claus@lancaster.ac.uk, b.sellwood@lancaster.ac.uk

Note: This form is only to be used where consent is being taken remotely (e.g. during a video call) and hence a paper consent form is not possible.

*"Before we start the interview, I need to confirm with you that you understand what is involved and whether or not you agree to take part. I will be recording this process. Is that all right with you?" (If **yes,** start recording and proceed as follows)*

"I am going to read some statements to you. After each one, please answer 'yes' if you agree with the statement; or, 'no' if you do not agree with the statement".

	ENTER RESPONSE
1. I confirm that I have read and understand the information sheet (version: V2, date: 16.06.2023) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I will be asked to complete a short demographic questionnaire which will help the researchers understand the type of staff who have taken part in the study. I understand that this questionnaire will not contain my name and will be stored securely either electronically on university secure cloud storage or in a locked filing cabinet at Lancaster University.	
3. I understand that my participation is voluntary and that I am free to withdraw at any time during my participation in this study, without giving any reason. If I withdraw after my interview has been transcribed my data will remain in the study. I understand that as my data will be anonymised at this point, it will not be possible to identify, and therefore remove, my data from the data set.	
4. I understand that any information disclosed within the interview remains confidential and any identifiable information will be anonymised following the interview in the transcription. I understand that if the researcher is concerned about potential risk to myself or other people, they may need to share this information with relevant professionals, therefore breaking confidentiality. I am aware the researcher will always discuss this with me first where possible.	

5. I understand that any information given by me may be used in future reports, academic articles, publications or presentations by the researchers, but my personal information will not be included, and all reasonable steps will be taken to protect the anonymity of the participants involved in this project.	
6. I understand that direct quotes from my interview may be used in future reports, publications and academic articles but that these will remain anonymous and all reasonable steps will be taken to protect my anonymity.	
7. I understand that my name/my workplace name will not appear in any reports, articles, or presentation without my consent.	
8. I consent to my interview being audio recorded and transcribed. I understand that this data will be protected on university secure cloud storage and encrypted devices and that the audio recording will be destroyed once the study is complete.	
9. I understand that anonymised data, such as interview transcripts, will be kept according to university guidelines for a minimum of 10 years after the end of the study.	
10. I agree to take part in this study.	

*(If all mandatory responses are '**yes**' proceed as follows)*

"Thank you. Now I need you to state your name for me so that it is recorded with this consent information" *(wait for response and print name)*

"Please can you confirm that this is the date on which you have given your permission" *(wait for response and complete the section below)*.

Person taking consent also states name and date for audio recording.

_____ _____

Name of participant Date

_____ _____ _____

Name of the person taking consent Signature Date

One copy of this form will be given to the participant and the original kept in the files of the researcher at Lancaster University

Appendix 4-F

Demographic Questionnaire

Title of Project: Exploring community staff perspectives of risk management.

This questionnaire is designed to gather some more information about you. Please ask the researcher if you would like anything explained further.

Age	
Gender	
Ethnicity	
Service (i.e CMHT, EIT)	
Professional registration (e.g NMC, RCoOT)	
Years qualified	
Length of time in current role (years and months)	
Length of work experience within community mental health settings (years and months)	

Thank you for taking the time to fill this in.

Appendix 4-G

Topic Guide

Interview Topic guide

This document is a guide to the topics which are likely to be covered in the interviews with staff to explore their understanding of positive risk management (PRM) within the community, what risk management means to them in their practice and what some of the potential barriers or facilitators to using PRM may be. It is likely topics will also emerge spontaneously, so the order of questioning and specific content will vary as the interview proceeds. The following topics and prompts are to be used as a guide.

General Topic	Aim	Key Questions	Prompts
1. Understanding of PRM	To recognise how clinicians understand PRM.	Risk management is a term you've likely heard of in your work in mental health. What does 'risk management' mean to you?	*Could you tell me a bit about your thoughts on involving service users in risk management?*
		What do you perceive as the most important factors/things to consider in risk management?	*What are your thoughts on how risk management can affect the individual's life?*
			What are your views on the concept of eliminating risk entirely?
			What are your thoughts on the idea of taking risks in order to manage risk?
			Could you tell me about your views on the relationship you have with service users whilst managing their risk?
2. Defining PRM	To understand the type of language staff use to define PRM.	Have you heard of the term 'positive risk management' before?	*How does PRM differ to risk management in general?*
		What does PRM mean to you?	*What do you think are the key parts of PRM?*
			How would you explain PRM to someone who hadn't heard of it before?
3. Using PRM	To identify how clinicians use PRM and its components	How might PRM be relevant to your work in the community?	*Could you talk about a time when you used PRM?*
		Could you tell me how you use PRM, or any aspects of PRM?	*How do you find using this approach?*
			How do you engage/involve service users in their risk management plans?
			Could you tell me about how your relationship with the client is affected throughout the process?
			How does PRM affect your client?
			If a risk could not be eliminated entirely, how would you manage it?
			What might it be like for you and/or the client if you had to take a risk in order to manage a risk?
4. Barriers and Facilitators to PRM	To highlight barriers and facilitators to using PRM	What helps you to use PRM?	*What makes you use or not use PRM?*
		Are there any parts of PRM you find easier or harder?	*What works well/not so well for you when you use PRM?*
			How does your environment (team, trust, colleagues, service etc) help/not help the process?
			What other things help/hinder you to manage risk in this way?

				How does your environment influence your approach to risk management?
				What might stop you from using or encourage you to use PRM?
5.	**Assessing the Evidence**	To identify what informs staff use/understanding of PRM	Why do you use the type of risk management approach that you use?	*Why do you use PRM?*
			How do you choose the most appropriate risk management approach when you are working with clients?	*Could you tell me about any risk management policies, guidelines, training or research you are aware of or have experienced in your work.*
				Do any of these (above) inform your practice in any way? If so could you tell me how?
				How might you justify your approach to risk management?
				What other evidence is your approach to risk informed by or influenced by?
6.	**Summary**		Is there anything else it would be helpful for me to know to better understand your views?	
			Do you have any questions for me?	

General Prompts:

- *"Could you give me an example of…"*
- *"Tell me more about…"*
- *If PRM has not been used ask: "how might it be relevant to you in the future? How might it be relevant to colleagues you work with?"*

Appendix 4-H

Risk Protocol

Doctorate in Clinical Psychology | Lancaster University

Project Title: Community Staff Perspectives of Risk Management
Risk Protocol

Overview
This protocol provides guidance to researchers in responding to the presence of distress and risk during the study 'Community staff perspectives on risk management'. Whilst it is not anticipated that significant risk and distress will arise during the study, there is a possibility some participants may discuss topic which they find distressing. There is a possibility participants may disclose incidents relating to risk which may fall outside of the bounds of confidentiality, resulting in safeguarding procedures to be adhered to. The interviews are being conducted by a trainee clinical psychologist at Lancaster University and Lancashire Care NHS Foundation Trust (LSCFT). Response and management of risk occurring through the interview will be managed primarily with reference to LSCFT policy and requirements which take precedence over this document. For situations where risk or instances of participant distress occur within the interview component of this study, this guidance will be followed.

General Principles
A realistic discussion should be had with all participants prior to consent being taken about the potential for distress during the interview, and what might be a helpful response if this were to happen.

This discussion will include informing participants about the type of topics that could come up in the interview (as detailed in the participant information sheet (PIS)). It will also cover any strategies they find helpful in times of distress and other suggestions for helpful resources if needed.

This discussion will also include the limits of confidentiality and discuss how to manage this should any issues arise. During this discussion, it should be agreed what actions will be taken by the participant and researcher if any distress/risk becomes apparent.

The researcher should explain to the participant that the contact email address and telephone numbers will not be monitored consistently throughout each day or overnight. The researcher may not be available outside of the agreed interview slot. It will be sensitively explained that the researcher cannot act as a crisis or clinical service.

This study will involve interviews with participants, which may take place face to face, video call (MS Teams) or telephone. The type of contact will affect how the researcher responds, therefore steps for when contact is in person or remote (video call or telephone) are outlined below.

Procedures to be followed throughout the study:

To be enacted if the researcher is concerned about the participants current and subsequent welfare, for example if a participant:

- Reports or displays notable distress
- Reports thoughts or feelings related to suicide
- Reports any urge to harm themselves or others

If participant reports or shows signs of low or moderate distress:

- Pause the interview (with participants agreement) and allow time to discuss current feelings, take a comfort break and to observe levels of distress.
- If distress seems to have reduced, discuss with participant if they wish to continue with the interview.
- If distress remains present, or worsens, follow steps below.

If participant reports more severe distress:

- Pause interview.
- Assess what the participant needs now. Use active listening, validation, acknowledgement, and normalisation.
- Allow participant an appropriate amount of time to speak about how they are feeling and allow time to listen, be non-judgemental and empathetic to experiences.
- Assess risk. Ask specifically about any thoughts of suicide/harm, if not already mentioned.
- If these are present, assess levels of any immediate risk (as part of a calm, collaborative conversation). The researcher will ask about intent to harm, planning, access to means and how hard it feels to resist this for both suicide/other forms of harm.
- Participant to be asked: "Do you feel taking part in this interview is affecting how you feel? If so, in what way?"
- If so, explain that researcher has a duty of care and refer to previously agreed plan of action.
- This should be a collaborative process, considering the wishes of the participant, however limits of confidentiality should be reiterated.

Where taking part in the study is having an adverse effect on the participant, the study should be halted immediately.

If the researcher considers the distress level to have returned to low/moderate, and the participants distress has reduced, they will be asked if they would like to continue with the interview. The participant will be reminded of their right to withdraw at any time without any consequence. They may also be asked if they wish to reschedule the interview for another day/time if felt necessary. Participant can be offered a follow up phone call 24 hours after the interview as a debrief, if felt to be appropriate.

In judging level of risk there is likely to be uncertainty. Researchers should adopt a cautious position where in doubt, assuming the higher level of risk.

Procedure for concern over risk to others, for example if a participant:

- Discloses clinical practice from themselves or others that could put a service user, colleague or any other member of the public at risk of harm.
- Discloses an incident of clinical malpractice.
- Discloses any historical incidents where an individual may have been subjected to unnecessary harm or abuse (of any kind).

If participant reports something which raises concern over potential risk of harm (past, current or future) to others, including service users in their care:

- Researcher will listen, making note of factual details where appropriate, without asking leading questions.
- Researcher will gather necessary information to establish whether confidentiality may need to be broken.
- If researcher feels risk to others is present, confidentiality will be broken. They will share reasoning of this to participant in a sensitive manner.

- Researcher will highlight they have a duty of care, and this action is about keeping the participant and others safe.
- It can be discussed who this information will be shared with, if appropriate.
- Researcher will follow Lancashire and South Cumbria NHS Foundation Trust (LSCFT) safeguarding protocols following the disclosure.
- This involves informing the LSCFT safeguarding team of such disclosures and following any agreed action.
- The student researcher will immediately contact project supervisors to discuss any safeguarding related concerns.
- If risk of imminent harm is suggested, researcher will contact emergency services to inform them of the level of risk and enlist their assistance.
- Call participant 1-2 days following the above to follow up, if appropriate.

Additional considerations with remote contact
Where the session is remote, the researcher should always start the session by checking:

- The participant has a confidential space to be in for the meeting where they won't be interrupted.
- Agreeing a plan if the call ends or cuts out (e.g due to connection issues). This will likely include trying to re-establish the video call/telephone call, contacting them through other means (e.g by phone if meeting was via video call), and if that fails sending an email to rearrange the interview.

Where a participant is experiencing distress or there is possible risk and the call ends/cuts out, the following steps should be taken:

- Attempt to re-establish contact with the participant, following the plan agreed at the start of the session.
- If contact cannot be re-established after several attempts, send the participant a message/email with attached signposting information and outlining a plan to call them the next working day.
- If it is felt the level of risk is potentially high, confidentiality should be broken and the participants team manager/clinical lead of the service should be informed, as appropriate.
- In cases where imminent high risk was indicated prior to the end of the contact, emergency services should be contacted as appropriate and informed of the situation.
- Project supervisors should be informed of any adverse events.

Personal safety and boundaries:
In responding to above situations, it is important the researcher balances these actions against their own personal safety and should avoid situations where their personal safety feels compromised. Lone working policies from Lancaster University and LSCFT will be adhered to if interviews take place face to face.

Where any of the above events take place, the researcher should inform their supervisors and arrange a time to debrief with regards to the situation, including a focus on how/if they have personally been affected.

All participants will be provided with the following sources of support prior to the interview, via the participant information sheet:

- Employee Assist is available to employees of LSCFT: the trust's Employee Assistance Programme, Health Assured. They can be contacted by a free 24 hour phone line on 0800 030 5182. Employee Assist can offer a range of help, support and advice. Visit their website at: http://www.healthassuredeap.co.uk

- LSCFT Resilience Hub supports the health and well being of people employed by LSCFT. You can self refer via their website: https://lscresiliencehub.nhs.uk/
- Mind are a charity who offer a range of support via their website: https://www.mind.org.uk/information-support/guides-to-support-and-services/

Appendix 4-I

Research Protocol

Title: Exploring community mental health staff perspectives on risk management, a reflexive thematic analysis.

Trainee: Mollie Skinner

Research Supervisors: Prof. Bill Sellwood and Dr Jasper Palmier-Claus

Field Supervisor: Dr Daniela Just

Introduction

The ability to effectively assess and manage risk is a vital component in the delivery of mental health care and is essential for all staff working in these settings (Hawley et al., 2010). Risk may be defined in several ways, often dependent upon the setting it is assessed within. The Department of Health (DoH) most recently defined risk as the 'nature, severity, imminence, frequency/duration, and likelihood of harm to self or others' (Department of Health, 2009, p63).

Risk continues to be common within both community and inpatient mental health services. Between 2008-2018 there were 13,984 suicides by individuals who had been in contact with mental health services in the 12 months prior to their death in England (University of Manchester, 2021). Assessment of the behavioural characteristics of service users who died by suicide during this time also revealed 65% had a history of self-harm and 21% had a history of violence. Furthermore, clinicians judged the short-term risk of suicide at the time of final contact to be 'low or none' for 83% of service user suicides (University of Manchester, 2021). This highlights there are important opportunities for prevention in the future.

Mental health services use a variety of risk assessment tools to determine the likelihood of harm an individual may pose to themselves or others. These risk assessments typically consider psychological, environmental, and social factors in order to capture a broad view of a person's individual needs and level of risk. However, the National Institute for Health and Care Excellence (NICE) guidelines make clear risk assessment tools are not a suitable method of predicting potential future suicide or repetition of self-harming behaviours (NICE, 2011).

In the United Kingdom, national policy and guidelines promote the use of positive risk management (PRM) (DoH, 2009). Definitions of PRM vary considerably across the literature (Just, Tai, et al., 2021) and despite evidence advocating its implementation with service users, staff do not always utilise it in practice (Coffey et al., 2019). The Department of Health most recently defined PRM as '…risk management, which improves the service user's quality of life and plans for recovery, while

remaining aware of the safety needs of the service user, their carer, and the public' (DoH, 2009, p9).

PRM can reduce risk and improve quality of life (Robertson & Collinson, 2011), yet its use is still limited. A recent study found only just over 10% of service users within inpatient settings were involved in their risk management plans and discussions (Coffey et al., 2019). A recent systematic review found discrepancies in how PRM is defined within policy and guidelines, when it should be used and who should be utilising it (Just et al., 2021).

The way in which risk is managed within services has several important implications. First, and most important, is the well-being of the service users whose autonomy, safety, recovery, and well-being depends upon effective collaboration with staff. The well-being of staff members may also be either positively or negatively impacted by the outcomes of risk management protocols they implement with service users. There is a growing body of research highlighting the long-standing detrimental impacts of service user suicide on mental health professionals. Sandford et al., (2020) found the impact of such an event is comparable to other traumatic life events and results in staff becoming more defensive and cautious in managing future risk.

To date, there has been just one study exploring how mental health clinicians perceived, understood and operationalised PRM (Just et al., 2021). This study explored the perspective of staff within acute inpatient settings. There have been no studies exploring the experiences of PRM for staff working in community mental health services. Community mental health services play a crucial role in delivering care for adults with severe mental health needs as close to home as possible (National Health Service (NHS), 2019). The NHS Long Term Plan aims to significantly increase the provision of secondary community based mental health care by 2023/2024 (NHS, 2019). Therefore, the current study will aim to develop an understanding of staff's perspective of using PRM clinically, including what it means to them and how they use it. Given the lack of clarity within policy and guidelines and the continual limited use of PRM within clinical practice, this study will also aim to produce recommendations for staff and services to promote care centred around autonomy, quality of life and recovery for service users.

Research Question: How do staff working in adult community mental health services understand, experience and utilise positive risk management?

Method

Participants and Design

I will recruit a purposive sample of 10-20 participants via poster advertisements, word of mouth and approaching eligible services across Lancashire & South Cumbria NHS Foundation Trust.

Eligible Services:

Secondary care Community Mental Health Teams (CMHT's)

Secondary care Community Early Intervention Teams (EIT)

Other associated Services (e.g standalone psychological therapy services or occupational therapy services).

Inclusion Criteria:

- Aged 18+
- Currently employed within a Community Mental Health Team (CMHT), Early Intervention Team (EIT) service or associated service (e.g standalone psychological therapy services or occupational therapy services) within LSCFT.
- Have worked in mental health services as a qualified clinician for at least 12 months prior to the interview date.
- Current position of registered mental health nurse, social worker, occupational therapist, psychiatrist, clinical psychologist, allied therapist or other qualified mental health professional (specificity for qualified staff given their role in managing risk on a regular basis)
- Able to converse proficiently in English.
- Self-report of having managed risk in their clinical practice within their current role.

Materials

Participants will be asked to complete a demographic questionnaire (see appendix A). A topic guide will be developed and used to inform the content of the semi structured interviews (see Appendix B).

Procedure

I will screen staff members who express an interest in taking part in the study against the eligibility criteria. Eligible participants will be provided with participant information sheets, consent forms (see appendix C and D) and a demographic questionnaire to complete prior to the interview. Participants will be given opportunity to read the information sheet and ask

any questions prior to providing informed consent. Participants will be aware that they are free to withdraw at any time. An interview will be scheduled at a convenient time for the participant via Microsoft Teams or face to face (where most convenient for the participant) and will last approximately 50 minutes. The semi structured interview will be made up of questions about the individual's experiences, barriers, knowledge of and facilitators of PRM. Participants will receive a £10 reimbursement in the form of a voucher for their time.

Interviews will be recorded using an encrypted laptop provided by Lancashire & South Cumbria NHS Foundation Trust. Data collected will be transferred to University secure cloud storage at the earliest opportunity. I will make initial notes during and following the interview. Recordings will be transcribed manually as soon as possible after the interview. Transcriptions will be anonymised and stored securely on University secure cloud storage drive, shared electronically with supervisors using a secure One Drive shared folder. Any paper documents such as questionnaires and consent forms will be securely stored in a locked cabinet on University premises.

Proposed Analysis

Reflexive thematic analysis (RTA) will be used to analyse the data. I will use the Braun & Clarke (2006) six stage process. This consists of data familiarisation, initial code generation, identifying initial themes, reviewing themes, defining and naming themes and producing the report. I will lead the analysis and my supervisors will review and contribute to each stage of the analysis by discussing codes, reviewing potential assumptions and the quality of the interpretations. RTA allows for the identification and analysis of patterns and themes within the data set collected. The reflexive approach to thematic analysis emphasises the researchers' own role in the production of knowledge, making it a flexible method in which themes are produced by organising codes around a core commonality that is interpreted from the data (Braun & Clarke, 2019).

Data familiarisation involves reading and re reading the data, allowing the researcher to become immersed and highly familiar with any content. Initial notes and observations will be made. NVivo software will be used to support coding. Codes will be generated to capture essential features of the data relevant to the research question being asked. Codes will be collated, and initial themes will be generated over time. Potential themes will be generated, and the viability of such themes will be discussed. Themes will be reviewed and developed before being defined and named. There will be a detailed analysis of each theme. Once themes are named and confirmed, the write up will aim to contextualise the analysis for the

reader. Movement back and forth between the six stage process is likely, to ensure a rigorous analysis of the data.

Practical Issues

I will offer interviews virtually to overcome potential barriers in accessing room space on site. This study will require HRA approval, which may take longer than internal university approvals. I will need to hold this in mind whilst considering the timescale of the study and submitting for ethical approval.

Ethical Concerns

There could be potential safeguarding difficulties in interviewing individuals about risk and risk management experiences. Some might find discussing experiences such as suicide, risk and harm to self/others distressing. I will address this by having a clear distress and risk protocol (see appendix E) in place prior to conducting interviews. The participant information sheet will also contain details of where participants can seek further support outside of the interview if required. I will offer a follow up call 24 hours following the interview if participants would like a debrief and time to reflect.

During interviews there is potential that someone may share an experience which falls outside of the bounds of confidentiality (e.g., risk incident, malpractice). I will outline confidentiality with all participants involved in the study before conducting interviews and follow usual safeguarding procedures if this occurs. This is also stated on the participant information sheet. If a breach of confidentiality is required, I will discuss this with the participant where appropriate. I will inform my research supervisors immediately of any potential safeguarding concerns and follow LSCFT guidance on reporting any safeguarding concerns.

End of Study:

This study will be completed by August 30th 2024.

Timescale

October 2022: Thesis Proposal Granted. Ethics application process begins.
May 2023: Submit NHS ethical approval. Begin searches for review paper whilst awaiting ethical approval.
June-August 2023: Ethical approval received.
September 2023: Begin data collection.
January 2024 – Analysis

September 2023 – March 2024: Write up.

March 2024: Submit Thesis.

References

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101, DOI: 10.1191/1478088706qp063oa.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health,* 11(4), 589-597, DOI: 10.1080/2159676X.2019.1628806.

Coffey, M., Hannigan, B., Barlow, S., Cartwright, M., Cohen, R., Faulkner, A., Jones, A., & Simpson, A. (2019). Recovery-focused mental health care planning and co-ordination in acute inpatient mental health settings: A cross national comparative mixed methods study. *BMC Psychiatry*, *19*(1), 1–18. https://doi.org/10.1186/S12888-019-2094-7/TABLES/5

Department of Health. (2009). *Best Practice in Managing Risk Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services*. www.nimhe.csip.org.uk/risktools

Hawley, C. J., Gale, T. M., Sivakumaran, T., & Littlechild, B. (2010). Risk assessment in mental health: staff attitudes and an estimate of time cost. *Journal of Mental Health (Abingdon, England)*, *19*(1), 88–98. https://doi.org/10.3109/09638230802523005 *International Journal of Social Research Methodology,* 9, 127-142.

Just, D., Palmier-Claus, J. E., & Tai, S. (2021). Positive risk management: Staff perspectives in acute mental health inpatient settings. *Journal of Advanced Nursing*, *77*(4), 1899–1910. https://doi.org/10.1111/jan.14752

Just, D., Tai, S., & Palmier-Claus, J. (2021). A systematic review of policy and clinical guidelines on positive risk management. *Journal of Mental Health,* 1–12. https://doi.org/10.1080/09638237.2021.1922643

NHS (2019). *The NHS Long Term Plan. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf*

NICE. (2011). *Self-harm in over 8s: long-term management.* www.nice.org.uk/guidance/cg133

Pawson, R. 2006. Digging for nuggets: How 'bad' research can yield 'good' evidence.

Robertson, J. P., & Collinson, C. (2011). Positive risk taking: Whose risk is it? An exploration in community outreach teams in adult mental health and learning disability services. *Health, Risk & Society*, *13*(2), 147–164. https://doi.org/10.1080/13698575.2011.556185

Sandford, D. M., Kirtley, O. J., Thwaites, | Richard, & O'connor, R. C. (2020). *The impact on mental health practitioners of the death of a patient by suicide: A systematic review*. https://doi.org/10.1002/cpp.2515

University of Manchester. (2021). *National Confidential Inquiry into Suicide and Safety in Mental Health*. www.hqip.org.uk/national-programmes